The State of Population Health: Fifth Annual Numerof Survey Report

Conducted by Numerof & Associates in collaboration with David Nash, Founding Dean Emeritus of the Jefferson College of Population Health

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Preface

As March 2020 approached, the Numerof team prepared to release the results of its State of Population Health Survey, as it has done annually over the past five years. Just at that point in time, however, what had started out as a minor medical curiosity on a far shore took center stage across the world: Covid-19.

Since then, the Covid-19 pandemic has dominated nearly all conversations related to healthcare, business, and much more. It has taught our society a few profound lessons – with enormous relevance to population health as an approach to care delivery and the way we pay for it.

The first lesson is about the folly of believing that the health of any population can be independent of its most at-risk segment. In its relentless focus on disadvantaged subpopulations and others burdened with chronic disease, Covid-19 has highlighted the inadequacy of a transaction-based approach to care. Fee-for-service reimbursement reinforces an approach that is fragmented, provider- rather than patient-centric, that has ignored social determinants of health, and that overutilizes and under-delivers as a result. This has created reservoirs of vulnerable subpopulations among the larger society, and we are all paying a price for that.

The second major lesson that Covid-19 has taught us is that there is more than one kind of "financial risk." For decades now, the traditional healthcare establishment has largely resisted efforts by payers, particularly CMS, to link reimbursement to the efficiency and quality of care delivered. Payment schemes that made providers' payment contingent on their management of cost and quality have been regarded as too "risky," and the industry has clung stubbornly to fee-for-service.

Covid-19 has totally changed this picture. The cancellation of elective procedures to cope with the influx of Covid patients has left hospitals across the country in financial freefall. Those few provider organizations with a substantial number of patients covered by capitated contracts have continued to collect their per-member-per-month payments, but these providers are few and far between and the greater healthcare delivery community has been significantly damaged as a result. The question is whether this experience will change any minds about what "financial risk" really means.

This is the context in which we report the most recent findings from our State of Population Health Survey. The data was collected prior to onset of the pandemic, and the results we report here reflect incremental change in the face of an entrenched status quo, but we believe it is important to report and discuss

this data as it will prove particularly insightful in contrast to the picture that emerges from our sixth annual assessment in 2020. We are looking forward to that.

Executive Summary

For the fifth consecutive year, Numerof & Associates has partnered with Dr. David Nash, Founding Dean Emeritus of the Jefferson College of Population Health, to study the evolution of population health management in the United States. As U.S. government policy grows more focused on moving to a value-based model, population health management will be increasingly seen as a key part of the solution for realigning the healthcare industry to deliver better care at lower costs.

This report is based on an online survey of approximately 500 C-suite healthcare executives, combined with open-ended interviews with selected executives that provide additional color around the numbers. Key study findings include:

Based on the percentage of revenues from contracts involving bonuses or penalties linked to cost and quality, progress toward meaningful implementation of population health remained static in 2019. However, the data does reveal limited improvement in processes that support the management of quality, and in perceived organizational readiness for managing risk-based contracts. What has *not* changed however, is perceived organizational capability to manage *cost*, and institutional engagement with physicians to drive improvement in quality and cost effectiveness.

This is based on three subsets of survey data: 1) Global perspectives of respondents; 2) Reported progress on implementing supporting management processes; and 3) Reported assumption of risk-based contracts.

At a global level, respondents were more confident about their organization's *readiness to take on financial risk for cost and quality*. Two-thirds (66%) said their organizations were "moderately" to "completely" prepared, a slight but significant improvement over the corresponding metric of 62% in 2018.

Drilling down, the data suggest that respondents' assessment of their organization's readiness to be accountable for cost and quality is more wish than fact. When respondents rated their organization's ability to manage *quality* at the individual physician level, 65% said their organization was better than average, a significant improvement since 2016. When it came to

managing *cost* at the individual physician level, only 35% said their organization was better than average, a result that has not significantly improved since our initial survey in 2015.

Increased confidence in organizational capability to manage quality may reflect broader implementation of supportive management processes involving patients that have potential to impact cost and outcomes. Examples include the use of inpatient care navigators, referrals of patients to community organizations (like food pantries, prescription assistance programs and other safety net programs), and patient follow-ups to discuss discharge recommendations. Current data show significant increases in the number of respondents who say that their organizations routinely implement these processes. But there is still much room for improvement, as none of these very basic processes are routinely used by even 75% of respondents.

Respondents' lack of confidence in the ability of their organizations to manage cost at the individual physician level likely reflects a continuing lack of institutional engagement with physicians to drive improvement in quality and cost effectiveness. That engagement was assessed in a series of questions about the use of processes that focus on physicians' role in managing cost and quality. Examples include establishing care paths, using order entry systems to flag variation from care paths, providing physicians with comparative cost and quality data, and linking physician compensation to management of cost and quality. This year's survey showed no change on these key processes relative to 2018, and indeed, there has been virtually no movement on these processes since our initial survey in 2015. Less than half (47%) of respondents reported that their organizations routinely used a process to identify physicians who were outliers in cost or quality, and even fewer (37%) had a process to address such variation when it came to light. Just 35% linked compensation to cost and quality performance for any clinicians.

Our principal measure of population health operationalized "on the ground" is the percentage of revenues received from contracts with up and/or downside risk associated with them. There was no reported change in the percentage of revenue at risk in the 2019 data. Nearly half of respondents reported that 10% or less of their revenue came through risk-based contracts. This measure not only remained flat relative to prior surveys, but also fell significantly short of the projections respondents previously made regarding how much revenue *would* be at risk in 2019.

Nevertheless, executives agree that population health is the future. Consistent with past surveys, 83% of respondents said that population health would be "very" or "critically" important going forward. Nearly all respondents

(99%) project their organization will have some revenue in models with upside gain and/or downside risk in two years. The median estimate of the percentage of annual revenues that would be at risk in two years was 26%-30%.

Service offerings increasingly acknowledge the importance of social determinants of health. One of the most significant continuing trends over the past five years is growth in the percentage of organizations that are responding to community health needs in the areas of housing, transportation, and food insecurity. Approximately half of respondents said that their organizations offer assistance with transportation, food, and nutrition, and nearly 30% provide housing or community development support, most often in partnership with other community organizations.

Smaller healthcare delivery institutions lag. In our sample, 96% of large hospitals and/or health systems said they had at least one at-risk contract compared to 83% of mid-sized institutions and 69% of smaller institutions. Smaller organizations may have a limited ability to absorb the impact of outliers, but they can make up for it with nimble program design and implementation. For those organizations that have undertaken risk-based agreements, smaller hospitals tend to have a lesser percentage of revenue at risk than medium and large hospitals.

Most organizations are still just experimenting with risk-based contracts. As in our last survey, over three-quarters of respondents reported some experience with an alternative payment contract, but for most (66%), less than 20% of revenue was involved. Among those who claimed experience with an alternative payment contract, a substantial portion (24%) didn't risk actual loss. Their risk was upside only – not receiving a "bonus" if targets were not achieved.

The potential for financial loss remains the single greatest barrier to the implementation of population health. Approximately 1 in 5 respondents cited the threat of financial loss as the primary barrier to moving to a risk-based model, followed by other concerns that include issues with systems like IT, tracking, and management (15%), uncertainty about when to make the transition from the current model (13%), difficulty in modeling the cost of care across the continuum (10%), and difficulty changing the organization's culture (9%).

In summary, respondents' confidence in their organization's readiness to take on risk related to cost and quality has improved significantly over the past five survey administrations, but that confidence is not reflected in organizations actually taking on more value-based contracts.

In addition, there has been progress implementing some supportive processes that can improve quality for patients. However, hospitals have yet been reluctant to accept accountability for cost and quality, the principal reason being fear of financial loss. As long as administrators are reluctant to engage with physicians to address the impact of clinical choices on cost and quality, the principal driver of these outcomes will remain outside their control.

Methodology

Although population health management has garnered significant attention, there has been little effort given to tracking the actual progress made toward value-based models of care. Recognizing the critical need for this research, Numerof & Associates partnered with Dr. Nash on an annual study to define and track the evolution of population health management in the U.S.

In this fifth year of our study, we utilized the same approach as in prior years; an online survey which was designed to assess progress, challenges, and success factors in healthcare delivery organizations' transition to population health management, with particular interest in year-over-year trends. Approximately 9,800 individuals were invited to participate in the online survey, which was fielded from June 2019 to September 2019. The target audience was defined as physician group executives or vice presidents, as well as individuals working in U.S. provider organizations including healthcare systems, hospital and academic medical centers.

We received 485 surveys,[1] corresponding to a response rate of 4.9% of individuals and 16.5% of institutions. Respondents included C-suite executives across the entire U.S. in urban, suburban, and rural areas. They represented stand-alone facilities, small systems, and IDNs; for-profit, not-for-profit, and government institutions; and academic and community facilities. Similar to previous years, survey respondents participating in accountable care organizations (77%) were overrepresented compared to recently published numbers (20%).[2]

In addition to aggregated data from the full set of survey participants, this white paper includes illustrations from open-ended responses and interviews with selected executives.

[1] 480 responses passed the inclusion criteria, which required that respondents work for a healthcare delivery organization or physician practice as well as have at least partial knowledge of their organization's current population health management efforts (i.e., a score of 3 or greater on a 7-point knowledgeability scale).

[2] Colla et al. Health Affairs, March 2016. Vol 35, no. 3, pgs 431-439.

Introduction and Context

It is increasingly recognized that the current model of healthcare is broken. It is unaffordable, fragmented, and provider-centric rather than patient-centric, with little accountability for outcomes. Moving forward, the model must focus on transparency and accountability for outcomes across the continuum. It must take into account both quality and cost to define relative value through the eyes of consumers, payers, and other stakeholders.

Population health has gained traction as an important solution in addressing the issues inherent in the current system. Although there are multiple definitions of population health, all articulate the general goal of achieving better health outcomes at lower costs. Regardless of the definition, new efforts toward effective implementation of population health management represent a paradigm shift.

The Evolution of Population Health

To understand this shift, it's helpful to take a historical perspective. Since the 1970s, Congress and successive administrations have tried to slow the growth of healthcare costs. Attempts have included the introduction of Medicare hospital payment formulas based on fixed payments for hospital services (payments for diagnostic related group services or DRGs), health maintenance organizations (HMOs), and preferred provider organizations (PPOs).

Costs have continued to rise despite these efforts. At the same time, concerns about fragmentation of care and diminished quality have increased significantly. **What has been missing from the discussion, and what lies at the heart of why healthcare hasn't changed, is the fact that costs have not been linked to outcomes.**

At the same time, employers have challenged increasing costs, seeking new ways to control them, and shifting some of the burden to employees through higher deductibles, copays, and responsibility for premiums. Payers have also been challenged by plan sponsors to reduce costs, and both payers (commercial and government) and consumers are trying to get more value for the checks they write. Their mantra has become "moving from volume to value," with many adding in, "How do I achieve better outcomes for less?"

With the advent of "never events" in 2008, the Centers for Medicare and Medicaid Services (CMS) took a stand. For the first time, it attempted to connect payment to outcomes. No longer would CMS pay for mistakes that

should have been prevented (e.g., hospital-acquired infections, medication errors, wrong site surgery, etc.). In 2010, PPACA legislation picked up on this theme with a range of pilot programs designed to help delivery organizations get used to the idea that going forward, quality and outcomes would affect reimbursement. This has been reflected in approaches like bundled pricing and accountable care organizations, among others.

CMS continued on the path toward value-based care by announcing in 2015 that 50% of Medicare payments would be structured according to value-based models by 2018. To meet this goal, CMS introduced various programs, including bundled payment models. Commercial payers followed suit, publicly stating their own value-based payment goals and programs for achieving them.

While Medicare failed to meet their value-based payment goals for 2018, CMS has not wavered in its commitment to moving to a market-based healthcare system that prioritizes value over volume. The announcement of its *Pathways to Success* redesign of the MSSP program illustrates the administration's focus on expediting ACOs' transition to risk-based agreements and standardizing quality measures in the process. This movement toward two-sided risk within shorter time horizons coincided with the CMS initiative to expand patient choice and improve site-of-care flexibility for Medicare beneficiaries. The move to site-neutral payment practices emphasizes the overall trend in lower reimbursement experienced throughout the market.

While the administration has used administrative rule changes to push the market toward price transparency and improved quality, its real impact is yet to be felt. If the administration's hotly contested rule requiring disclosure of negotiated rates by providers continues to hold up in court, competitive costs and outcomes will suddenly become much more relevant. In the meantime, healthcare systems and providers continue to take on financial risk only reluctantly. Despite CMS measures to revamp MSSP, ACO enrollment shrank by 10 percent from 2018. However, those enrolled are showing increased commitment to value-based care as the number of MSSP enrollees accepting downside risk increased by 30%.

Though not all efforts have had the desired impact, more focus on connecting payment to outcomes is certainly warranted. This explains the broad political support for MACRA. Signed into law in 2015 with data collection starting in 2017, MACRA is designed to encourage physicians to shift from fee-for-service to alternative payment models linked to cost and quality. As the replacement for less popular legislation intended to control federal healthcare

spending, MACRA still enjoys bipartisan support. But MACRA's focus is on reshaping physician practice patterns – it is by no means a holistic solution.

In the meantime, non-traditional players continue to methodically build out their presence in the delivery space and chip away at the market that has belonged to conventional providers. As of mid-2020 for example, Walmart has opened five standalone clinics offering primary care, dentistry, eyecare, lab tests, even behavioral health services, at up to 40% less than most conventional providers. Another example, CVS, already has 1100 Minute Clinics across the country offering basic ambulatory treatments for emergent illnesses and injuries. The company is now building out HealthHUBs – "Minute Clinics on steroids," specializing in chronic disease and offering expanded medical and wellness services. The company plans to have 1,500 HealthHUBs operating by the end of 2021.

A long list of other challengers – like Amazon, Apple, and other less recognizable names – are building and testing unconventional solutions with the potential to cause major disruption for traditional providers. When such events started to make headlines in 2018, many healthcare providers registered shock and concern that the private sector might actually represent a threat. More recently though, complacency has reasserted itself, with most providers content to fortify their market position through acquisition of adjacent providers and physician practices. The idea of taking accountability for cost and quality has been given token attention by the majority because of the potential for "financial loss." Until Covid-19.

The pandemic that has been front and center for most of 2020 has redefined risk for healthcare providers; or at least, it should. What is apparent is that those few providers with capitated contracts continued to receive their PMPM payments monthly through the pandemic. The balance of providers who relied on expensive, FFS elective procedures to sustain their balance sheets found themselves in financial freefall. After years of calling capitation "taking on risk," the pandemic showed the unlimited risk that lies in fee for service.

The data summarized in this report was gathered pre-Covid-19. It reflects the thinking of those closest to population health efforts across the conventional healthcare delivery community, and the implementation status of their institutions. It illustrates the slow progress of a new idea in the face of established interests developed over decades. Once this pandemic is brought under control, the same tensions – over the cost and quality of care, the proper role of the consumer/patient, and the accountability of providers – will reassert themselves with greater urgency than ever. Where the industry goes from here will be a function of what we see in this data, the experience

that executives take away from the pandemic, and the growing pressure for change.

The principal driver of healthcare cost growth is a payment model that rewards the provision of service, and not the clinical or financial outcomes achieved. Until that issue is addressed, we will not succeed in bending the cost curve. Providers still have the opportunity to rethink their business models and demonstrate the critical role they can and should play in keeping our population healthy and healthcare costs low. We strongly believe the push toward value will continue, but exactly how that will translate into future policy remains to be seen. Forward-thinking providers will continue to move in this direction – as long as they can maintain control over their trajectory.

Charting Progress Toward Population Health

If we are serious about better health and better health outcomes at lower costs, then we need to think about using nontraditional delivery options and consider how these tie into current efforts. Population health is not a new concept, but it has attracted renewed interest across the healthcare industry as a way to move toward a value-based model. Whether it's thought of in terms of the health of individuals in a given geographic area, or as a financial risk model relying on capitated funding for delivering health services, population health is likely coming into its own.

Despite a variety of definitions, at its core, population health is about managing the health of a defined population by providing the right intervention for a specific patient at the least costly point in the care continuum. Its goals include improving care coordination, enhancing health and wellness, eliminating disparities, and increasing transparency and accountability. When population health management works well, acute care utilization is reduced, total healthcare costs are lower, and "healthcare" finally becomes more than just "sick care."

Inherent in making the transition to population health management is the ability to assume financial risk. **This is newly charted territory for most healthcare providers. Many have questions about how to initiate the journey, and most importantly, how to ensure a successful transition.**

In the midst of this dramatic change, it is critical to define where organizations are in the transformation process, and to track those changes year by year. In response to this need, Numerof & Associates partnered with Dr. Nash on a multi-year assessment of healthcare delivery organizations across the U.S. This white paper highlights key findings from the first five years of our study.

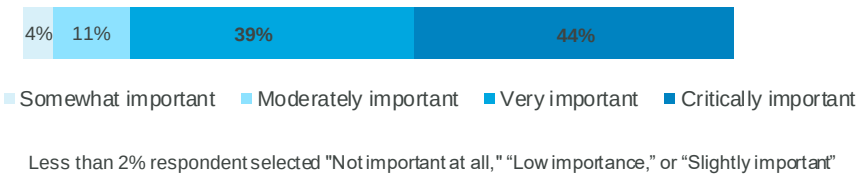
Key Research Findings

Building upon the firm's deep expertise in the realm of value-based care, Numerof's national surveys of healthcare executives across five successive years indicate that population health remains a dynamic area, as seen in the following key themes.

1. Executives agree population health is the future, but organizations have failed to keep pace with anticipated progress

In the survey, an overwhelming majority of respondents considered population health important for their future success. Almost all respondents (94%) rated it between "moderately" and "critically" important, with 44% rating it as "critically important" – a 4% increase from previous years (see Figure 1).

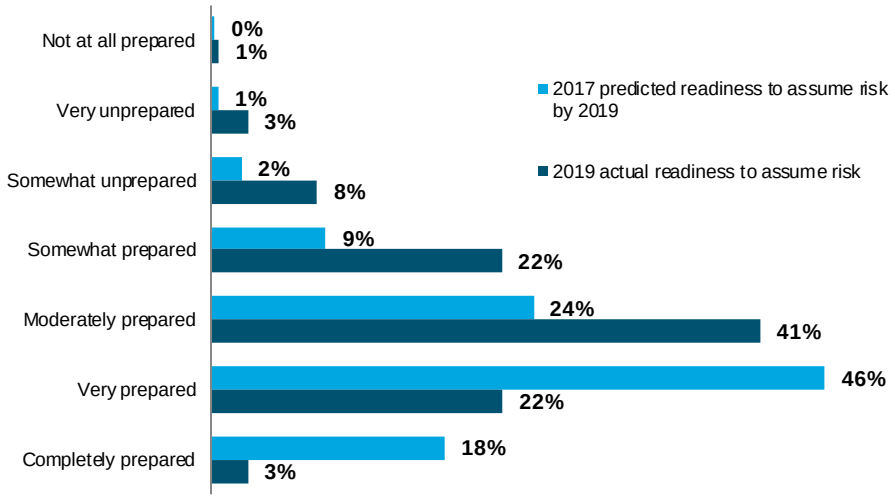
Figure 1: How important is population health for future success?



Less than 2% respondent selected "Not important at all," "Low importance," or "Slightly important"

The overwhelming agreement by executives that population health will be important to future success represents a clear contrast with their organization's progress in operationalizing it. In the 2017 survey, over half of respondents (64%) predicted they would be at least "very prepared" to take on risk in 2019. In the current survey, however, barely 25% felt they had achieved that mark (see Figure 2).

Figure 2: Respondents' readiness to assume risk falls extremely short of their prediction 2 years ago



Similar to the last several years, the importance of a positive strategic vision was echoed by many executives. One C-suite executive of a major medical center shared they had moved ahead with population health investments as a way to " … free up bed capacity for higher margin services. This required aligning on a key message that captured the head and heart of the organization."

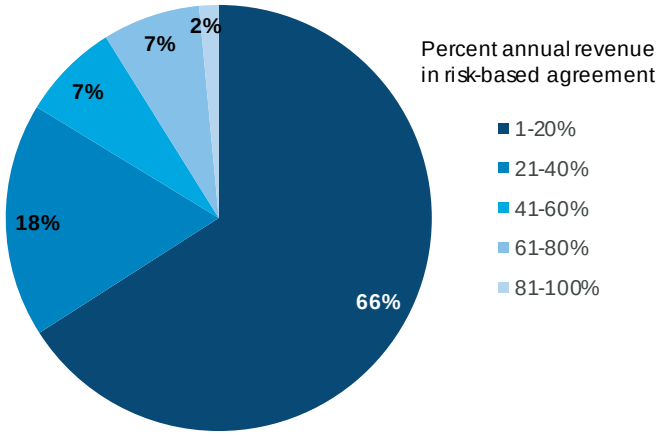
Because of the inherent conflicts between a population health approach and existing, fee-for-service oriented processes and systems, implementation can be a wrenching experience. One CEO at a regional hospital system pointed out that they had " …underestimated how much change stresses an organization despite high levels of nurse and physician engagement."

The challenge of building a central organizational strategy while addressing local market needs is a common theme for executives. The SVP of strategy and marketing at a mid-sized hospital system shared that, "Despite participation in some value-based payment models, our organization as a whole doesn't have a good understanding of changes it needs to make to our delivery model."

2. Most organizations are still just experimenting with risk-based agreements

Although most respondents reported some participation in alternative payment models, the extent of their progress – as measured by the percentage of revenues in risk-based agreements – still appears limited. Similar to 2018, more than three in four respondents reported their organization was in at least one agreement with a payer that includes upside gain and/or downside risk. However, organizations that are engaged in these agreements have limited exposure (see Figure 3). Two-thirds of the respondents in risk-based agreements said that less than 20% of their organization's revenue is at risk. In addition, nearly one quarter of respondents (24%) in risk-based contracts in fact had no downside risk, only the possibility of a "bonus" if targets were exceeded.

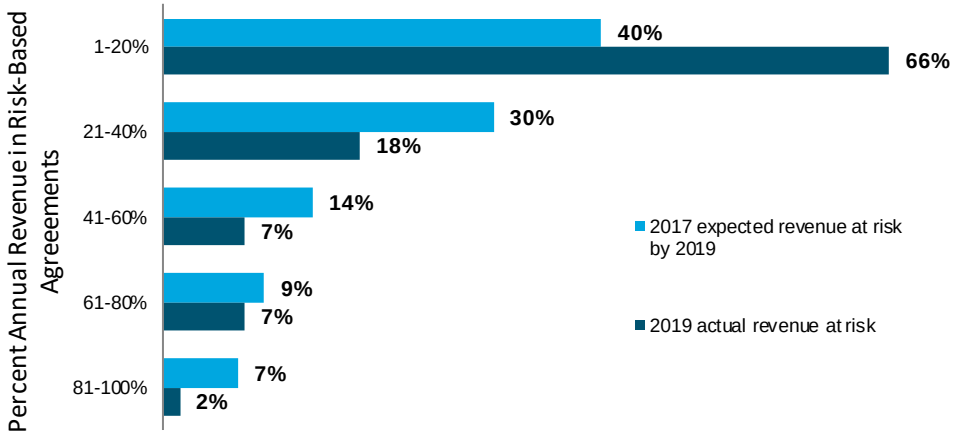
Figure 3: Respondents engaged in risk-based agreements have limited annual revenue at risk



In each of the survey's prior administrations, respondents predicted a dramatic increase in the percentage of annual revenue that would be at risk in the next two years; however, actual progress has failed to keep pace with expectations. As shown in Figure 4, respondents consistently overestimated what their 2019 involvement in risk-based agreements would be when asked in 2017. In our 2017 survey, nearly 1 in 3 respondents projected that by 2019 their organizations would have at least 40% of their revenue in risk-based agreements, but only 16% of respondents to the most recent survey met that

threshold. In short, respondents two years ago expected more rapid progress than has materialized.

Figure 4: Respondents failed to meet predicted percentage of annual revenue in risk-based agreements



In some cases, respondents' initial experiences with at-risk contracting went awry because physicians were not adequately engaged as stakeholders. In one such anecdote from last year, a Senior Medical Director recounted how his regional system had entered into a risk-based commercial contract without "selling" clinicians on accepting some portion of the risk themselves. Unable to get physicians to change their practice behavior, the contract was unsuccessful, and it colored future consideration of population health initiatives.

In other cases, organizations were eager to move toward population health but, as shared last year by a senior executive at a specialty hospital, their expectations did not align with their progress in part because "getting continued buy-in from executives and implementing processes to manage variation in a way that enables scaling up risk takes time."

Even those systems that are leaders in risk-based contracts experience challenges in changing the mindset and culture of their organization. One executive of a healthcare system with value-based contracts said that "CEOs still have a 'heads in beds' mentality." Many organizations like this one struggle to develop integrated population health solutions and to communicate their overall value proposition to appropriate stakeholders.

Though many healthcare organizations have not met their projected targets for risk-based contracts, there are those who continue to focus their efforts on making progress in the future. As part of this process, providers are reevaluating how risk is shared with payers. A senior executive responsible

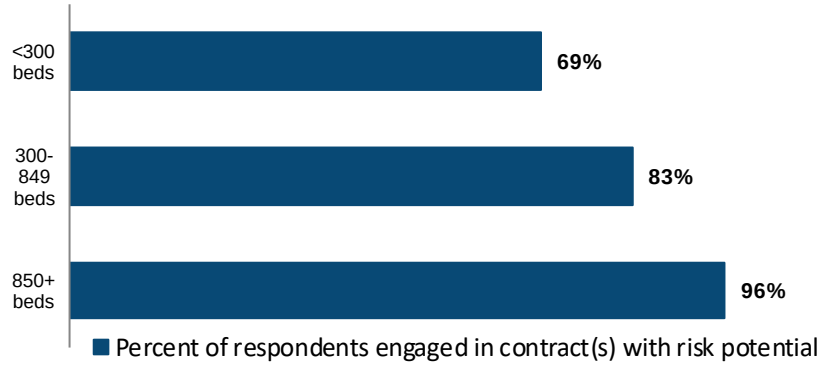
for accountable care strategy at a healthcare organization realizing significant savings from their risk-based model shared that, “As payers continue to opt for narrow networks to address coverage gaps while pushing for lower reimbursement, we’re improving our care management capabilities. We still need alignment with the payers though. We are optimizing our payer relationships based on where the world is going.” Another executive echoed this sentiment in saying, “Payer support is needed to ensure success.”

As was true in the last survey, there are some organizations that are comfortable with fee-for-service models and will not move until external events require them to do so. A senior executive of an urban system shared that, “Despite making money in some bundled payment programs, we will ride the fee-for-service horse as long as possible and will only shift to more value-based programs once the market requires it.”

3. Smaller healthcare delivery institutions lag behind on engaging in risk-based agreements

Looking at participation in risk-sharing agreements by hospital size, we found that larger hospitals were more likely to take on such arrangements than smaller institutions. In our sample, 96% of large hospitals and health systems said they had at least one at-risk contract, versus 83% of mid-sized institutions and 69% of smaller institutions (see Figure 5).

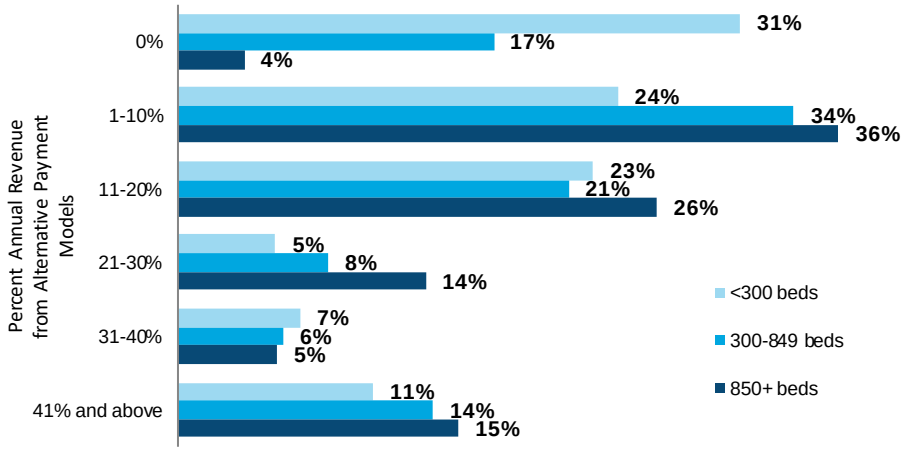
Figure 5: Larger hospitals and systems are more likely to be engaged in risk-based agreements



Risk is often more acutely felt at smaller institutions, which have more limited capital reserves and feel disadvantaged by the "tyranny of small numbers." That is, with a smaller population at risk, an outlier has a proportionally larger impact on overall results.

This point is illustrated by the percentage of revenue at risk for hospitals participating in risk-based contracts. Only 15% of large hospitals and 14% of medium-sized hospitals had 40% or more of their revenue at risk, compared to 11% of smaller hospitals (see Figure 6).

Figure 6: Of those engaged in risk-based agreements, larger hospitals and systems are putting more revenue at risk



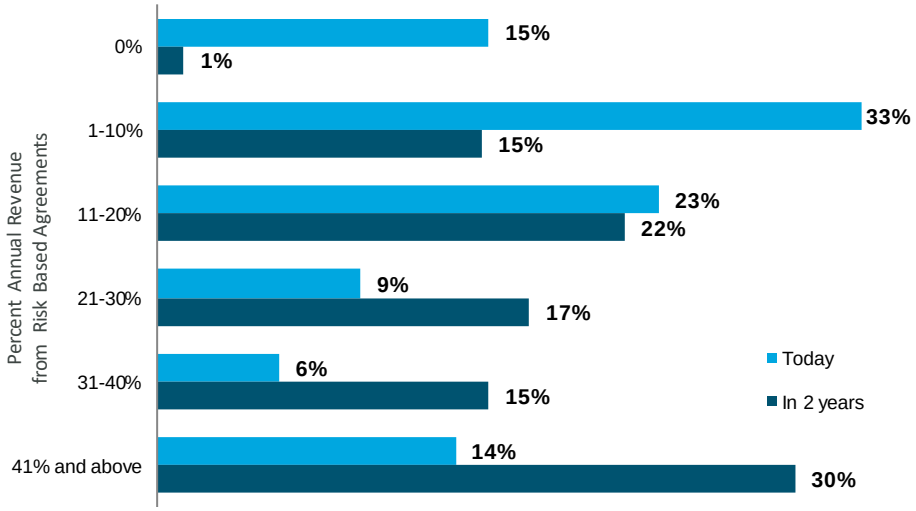
Looking at hospital size as a factor, we find smaller hospitals less likely to enter into at-risk contracts, but for those that do, the decision is potentially more consequential when the at-risk revenue is seen as a percentage of total revenue. The latter point may simply reflect the reality of a smaller revenue base and reinforces the caution taken by smaller institutions regarding risk-based contracting.

The corresponding advantage of smaller provider organizations is that their size can make timely monitoring and management of at-risk operations more efficient than these processes are for larger organizations. Through Numerof's work, we've seen smaller organizations make up for their limited ability to absorb the impact of outliers with nimble program design and implementation, along with early warning systems that enable more timely course corrections than larger organizations can typically execute.

4. Organizations continue to moderate their expectations about the pace of the market's transition to population health

Despite the limited amount of revenue currently at risk and the lack of progress over the last few years, respondents see the market moving to alternative payment models. Nearly all respondents (99%) project their organization will have some revenue in models with upside gain and/or downside risk in two years (see Figure 7).

Figure 7: Respondents expect to increase percent of annual revenue in risk-based agreements



Though their prediction to move toward risk-based contracts remains, the majority of respondents have failed to meet their 2017 forecast of having nearly one-third of revenues in risk-based contracts by 2019. In fact, respondents' median percentage of revenue in models with either upside gain or downside risk was 10%, which is only a third of what they projected 2 years ago. Furthermore, expectations for the future have seen little change as respondents' median projection for the percent of revenue in risk-based models has remained between 25% and 30% over the last several years (see Figure 8). If organizations are going to meet this goal, they have a significant amount of work ahead of them.

Figure 8: Respondents continue to moderate their expectations for future revenues in risk-based contracts

	2016	2017	2018	2019
Median % of revenue at risk today	10%	10%	10%	10%
Median % of revenue at risk expected in 2 years	30%	30%	25%	25%

Executives continue to highlight challenges that need to be addressed in order to meet this goal. One such challenging dynamic expressed last year by a senior executive is that "We know we need to do more with less and have hired a Chief Innovation Officer to drive that conversation internally to bring resistant stakeholders along in the journey."

Many organizations face the challenge of scaling the payment models they have piloted across the organization. As one population health executive shared last year, "We've outlined short, medium, and long-term steps we need to realize our vision for population health, but we have limited bandwidth to scale our efforts throughout the organization." This process requires translating experience into guidance that can be fully operationalized.

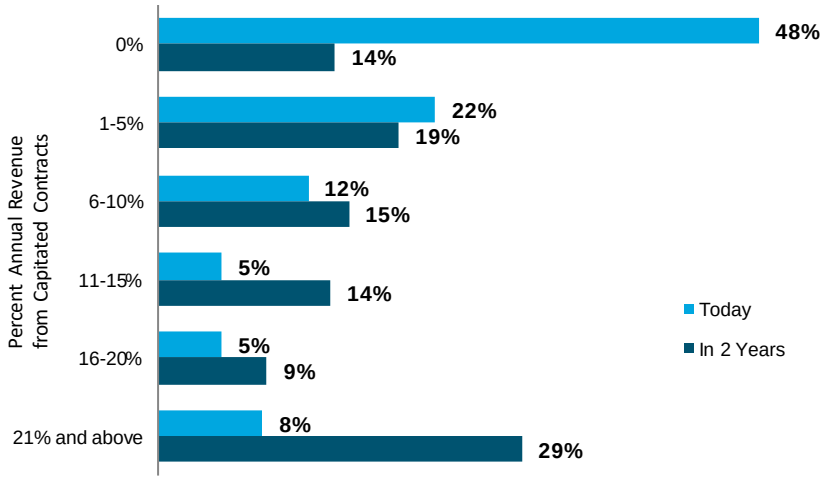
While executives of healthcare delivery organizations largely agree that population health is crucial to future success, many find it difficult to change to a new business model given their continued success in the old one. One executive at a healthcare system "facing financial challenges" that has "made investments in population health" noted their organization is, " … well aware hospitals were never meant to be destinations of choice as evidenced by new market models." Despite this recognition, this same executive shared that they are experiencing obstacles in moving to a population health model as " … getting acute care colleagues to understand the need to prepare now for a new vision of care is a challenge." In this case, a healthcare system's clear need to change given negative financial performance has still not motivated executives to fully embrace population health.

5. Executives expect revenue in capitated contracts to grow

To better understand the full-risk side of the spectrum, we surveyed participants on capitated contracts. While half of respondents (52%) are engaged in some capitated contracts today, we found them limited in their use and scope.

Executives do anticipate the use of capitated contracts to grow. Many respondents (86%) expect to have some revenue in them in two years (see Figure 9). However, organizations have fairly small amounts of revenue in capitated contracts. Only 18% of respondents have more than 10% of revenue in them currently (see Figure 9).

Figure 9: Respondents expect an increasing percentage of annual revenue in capitated contracts



As in 2018, respondents expect the proportion of their organization's revenue in capitated contracts to increase to 15% in 2 years (see Figure 10).

Figure 10: Respondents have increased expectations for future revenues in capitated contracts from last year

	2016	2017	2018	2019
Median % of capitated revenue	5%	0%	5%	5%
Median % of capitated revenue expected in 2 years	15%	10%	10%	15%

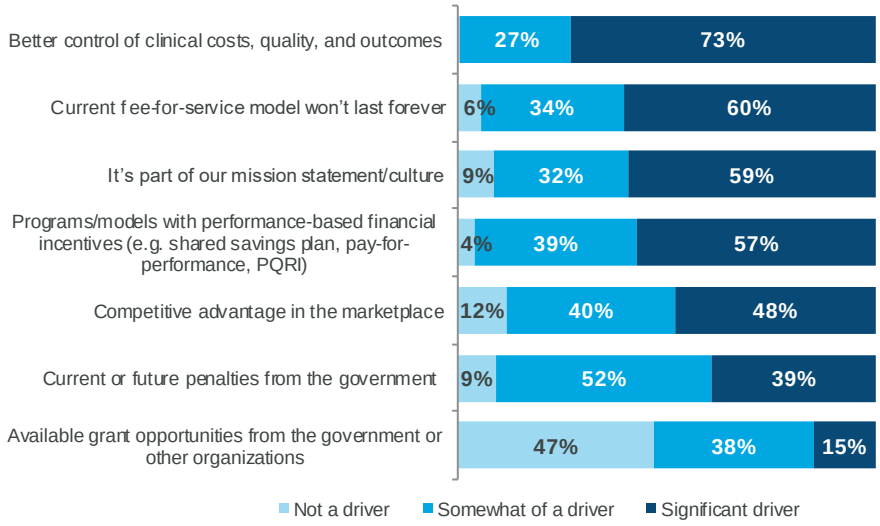
As was true in the 2018 survey, executives recognize that moving to capitation will be critical to maintain payers' perspective that their organizations are market leaders. Some organizations are actively "converting MDs to capitation by standardizing reimbursement." The director of health for one multi-regional health system shared that " … while some MDs may receive lower rates in moving to a capitated model, there is opportunity for them to make up for it through quality incentives."

Organizations that have been able to take on a substantial amount of capitated contracts attribute success to their decades long experience changing their business model. These organizations have "worked to identify high performing physicians committed to upping their game." They've developed new capabilities and infrastructure to support this work. As one senior executive shared, "Ultimately, we've created a system that supports the mission of population health by tightly linking reimbursement to value."

6. Organizations see population health as an opportunity to improve control of clinical costs, quality, and outcomes

In the survey, respondents indicated their organizations were pursuing population health for multiple reasons. There was clear consensus on two drivers of population health efforts: 1) to better control clinical costs, quality, and outcomes; and 2) an understanding that the current fee-for-service model won't last forever. Nearly all respondents (100% and 94%, respectively) rated each as a driver behind their move to population health (see Figure 11). This was closely followed by the recognition that population health is part the organization's mission/culture (91%).

Figure 11: Multiple drivers recognized for pursuing population health



Population health programs "encourage" organizations to redesign their care models, creating a self-perpetuating skill mix with the right competencies. Those that do it well succeed in both shared-savings MSSP[3] as well as employee healthcare spending.

[3] Medicare Shared Savings Program

7. The threat of financial loss remains the leading barrier to embracing population health

Respondents indicated numerous challenges in moving their organizations to population health. The leading concern is the threat of financial losses by moving to a new model (21%), followed by issues with internal systems (15%), and uncertainty about when to make the transition from the current model (13%) (see Figure 12).

Figure 12: Primary barriers to pursuing population health

Concern around the threat of financial loss may be due in part to uncertainty around how population health models will impact margins. It seems that many are unable to meaningfully assess the implications of payment models that incorporate financial risk related to cost and quality and their bottom line.

This was echoed last year by a senior medical director of a health system in the south who shared " … leaders are concentrating their efforts on increasing market share through mergers and acquisitions. We have a plan for taking on more risk-based contracts, but most hospital CEOs remain focused on

volume." This hesitancy to embrace change suggests leaders of healthcare organizations see value-based payment solely as a financial liability rather than a sustainable new business model.

Uncertainty about when to make the transition to population health remains an obstacle for many providers. An executive at a large regional healthcare network expressed the hesitancy within their organization concerning value-based contracts and knowing "when to move in that direction, because margin seems more certain under fee-for-service."

All of 2019's top five concerns remained the same as in 2018. Clearly, the risk of financial losses during the transition to alternative payment models remained at the top of the list. As an executive of one academic medical center noted, "It's still too early to tell if there's been any ROI on our investments in population health; so many of our leaders are focused on volume. This, paired with little appetite to change among some payers, makes it difficult to sustain a new model financially."

Technology continues to be a major hurdle for organizations in their move toward population health. As the current landscape evolves, one population health executive shared they are struggling with " … how to best marry our current IT infrastructure and mission with the new technologies that are constantly emerging." Her comment illustrates the challenge of technology platform interoperability that health systems face.

While there is widespread agreement that organizations need to move to population health, implementation often conflicts with established processes and systems built around fee-for-service. One of our interviewees, the head of population health at an academic system, pointed out that "our organizational structure and budgets aren't set up to support population health objectives. As a result, we've focused on small, proof-of-concept projects. The results are encouraging, but it limits their scalability."

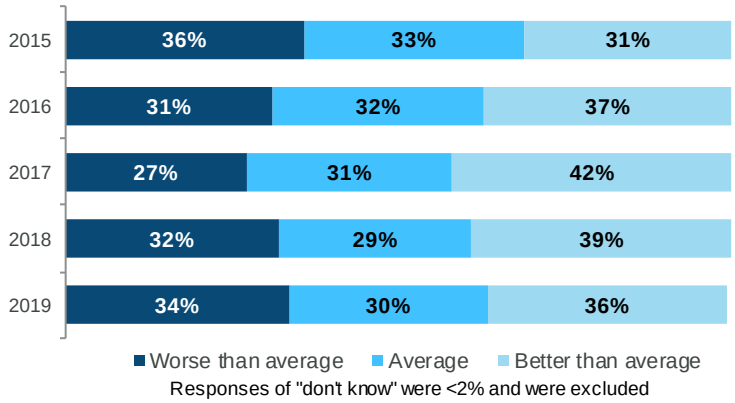
As has been true in prior-year comments, many view technology and other internal systems as a key hurdle in understanding costs. There are situations where a lack of timely data and a lack of IT system interoperability create additional challenges. Payers also experience this challenge noting the " … difficulty of implementing technology systems necessary to support risk. Systems need to be more user friendly and allow for interoperability."

8. Organizations' ability to manage variation in clinical cost and quality, and meet the growing demands of population health, is mixed

Making population health work requires a dual focus on improving clinical costs *and* patient outcomes. Many organizations have a high degree of variability in both areas.

Respondents still see a need for better management of cost variation. A clear majority of respondents (64%) rated their organization's ability to manage variation in cost at the physician level as "average" or "worse than average." In the context of the past five survey administrations, little progress has been made in this area over time (see Figure 13).

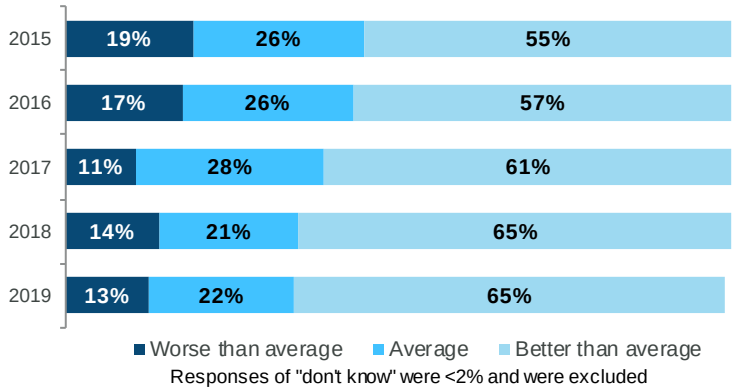
Figure 13: Organizations' ability to manage variation in clinical cost at the physician level is not on pace with the demands of population health



Responses of "don't know" were <2% and were excluded

In this fifth year of our survey, there was continued if modest progress in the management of variation in clinical quality. More than 1 in 3 respondents (35%) view their organizations' ability to manage variation in quality at the physician level as "average" or "worse than average" (see Figure 14). This number remains unchanged from last year, but the improvements made in this area since 2015 are still significant when looking at increases in the percentage of respondents who rank their ability to measure variation in quality as better than average.

Figure 14: Organizations are slowly improving in their ability to manage variation in clinical quality at the physician level



Improvements in managing variation in *cost* have flattened since 2018. While healthcare organizations have experienced incremental improvements in managing variation in clinical *quality* over the past five years, their ability to make meaningful progress in managing variation in *cost* remains largely unchanged since 2015. This may be due in part to organizations' ability to develop more meaningful metrics for tracking *quality* rather than for *costs.* Leaders' focus on volume over value only makes challenges around cost management more difficult to overcome. As one population health executive of a regional system shared, "We know we have to move toward value-based care, but the orientation of our leadership is still very much toward FFS. CEOs are reluctant to address negative outliers who are big volume generators."

The senior vice president of one clinically integrated network shared that, "Investing in care management reporting that focuses on population health is a required element for building a care model for the future. While this care model is taking shape in meaningful ways, we still haven't fully realized our strategic vision."

The executive vice president of a health system in the Northeast echoed the challenges around building a program that addresses outliers saying, "Taking a more systematic and standardized approach to managing cost and quality variances is one thing. Holding individuals accountable for outcomes, however, requires a discipline our organization doesn't have in place."

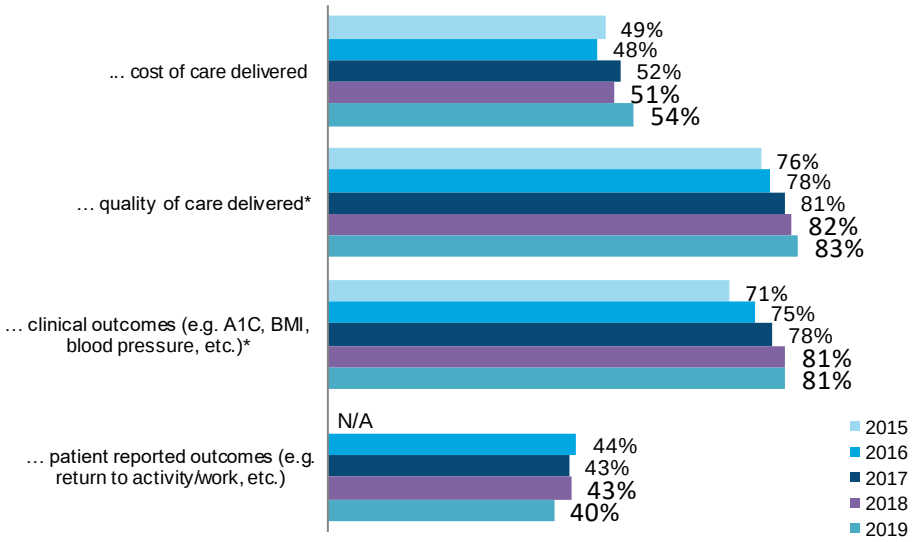
The executive of a large academic medical center described the power of data-informed quality metrics, sharing that, " … we introduced a compensation system that includes quality metrics. It wasn't long after we rolled out the compensation model that we began seeing improvements."

This demonstrates that pairing data informed solutions with the right incentive mechanisms can not only lower costs but improve quality as well.

9. Organizations are slowly improving their benchmarks for measuring quality and outcome metrics while defining cost measures lag behind

Respondents reported a fifth year of improvement in their ability to track quality metrics (see Figure 15). In 2019, 4 out of 5 respondents viewed their benchmarks and metrics for tracking quality of care delivered (83%) and clinical outcomes, like A1C, BMI, and blood pressure (81%), as better than average. While improvements in these areas over the last four years is sustained and meaningful, only 54% reported the same for metrics around the cost of care delivered.

Figure 15: Organizations are slowly improving in their ability to track benchmarks/metrics related to quality, but lag on tracking costs



Responses of better than average are depicted

While organizations are improving in the metrics used to track quality and clinical outcomes, improvement is needed on the benchmarks and metrics used to track patient-reported outcomes like return to activity/work. Less than half of respondents (40%) rated their organizations "average" or above when it comes to tracking patient-reported outcomes. In fact, healthcare organizations have made no improvement in this area since 2016.

As most alternative payment models do not require tracking of patient-reported outcomes, we are not surprised to see use of this type of metric lagging other quality metrics. However, organizations that have embraced population health initiatives for improving the overall health of their patient population recognize the value of capturing, tracking, and benchmarking metrics that patients care about.

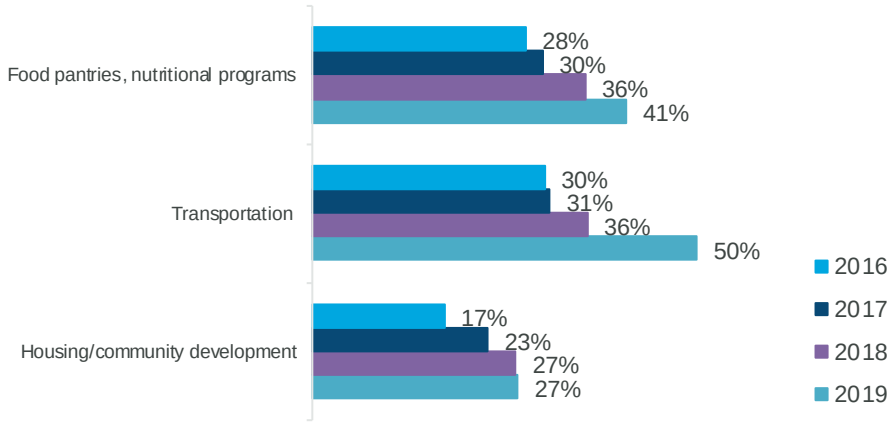
Success in this area requires leveraging data to enable change. One C-suite executive of a large IDN shared how critical data was in getting buy-in from medical staff, explaining, "Doctors responded to the reporting we developed once they trusted the data. Having the right data was essential for identifying opportunities and improving results."

10. Many organizations are working to address social determinants of health

Behavioral choices and social determinants – poverty, homelessness, behavioral illness, substance abuse, food insecurity, low education, lack of access to transportation, etc. – are important drivers of health outcomes. While hospitals and systems can't be solely responsible for addressing these factors, they can play an important role as a convener of services and a leader of community engagement efforts.

Healthcare systems have increased their commitment to addressing social determinants of health (SDOH) over the last several years by addressing challenges such as food insecurity, housing, and transportation needs. The number of respondents engaged in partnerships to address nutrition increased by 13% since 2016. Half of respondents report addressing transportation challenges for their patients. Though housing and community development partnership increased by 10% since 2016, there has been no year-over year change since 2018 (see Figure 16).

Figure 16: Healthcare organizations are increasingly partnering with outside organizations to provide services to patients in effort to improve community health



Making progress in these areas requires partnership with several community organizations. The leader of one hospital association shared, "Homelessness is a huge challenge for our region. Our community requires screening programs to assess the size, scope, and nature of local health needs. This process leads to creative partnerships between providers and community leaders."

In at least two instances, senior executives at healthcare systems shared that nearly half of the individuals they screened for SDOH in initial efforts had at least one unmet need. These needs include personal safety issues, food insecurity, and the challenges of being a non-native English speaker. One senior vice president of multi-regional system highlighted the criticality of community health partnerships stating, "I cannot write a prescription for a meal if a stomachache is due to hunger, and no payer will reimburse for it either. This makes building a bridge to community resources and doing the necessary follow up essential for delivering 'people-centered care' and for improving the health and wellbeing of the community we serve."

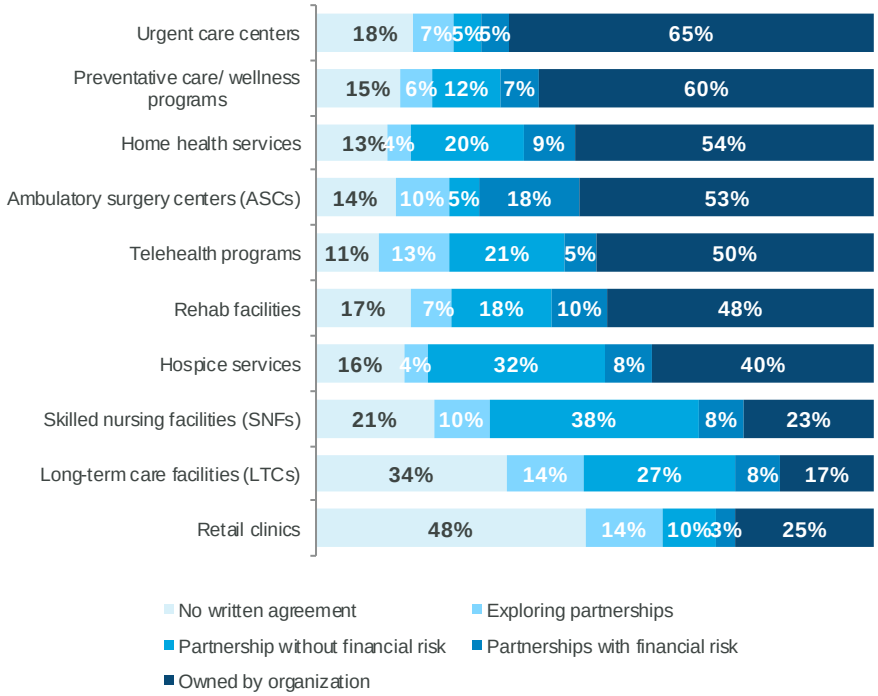
These sustained efforts are reflected in a comment from a senior health executive who said, "Our vision is to shift from a hospital-based organization to one focused on population and community health improvement." Part of the strategy for improving access includes " … developing scalable pilot programs for SDOH screenings that identify those at risk and in need of additional support." As was true before, nurse navigators, hospital case managers, social workers, and community health workers need to become familiar with each other as well as the resources available to make the right referrals. Here, scarce resources and inadequate data connectivity create obstacles.

A senior executive for a large multi-regional IDN highlighted the importance of integrated technology and shared, "Launching an EHR system that provides a directory of community resources they can refer patients to is core to making improvements. Community health workers can then log completion of these services which is essential for patient follow up."

11. Organizations are engaged in partnerships across the care continuum

Achieving lower costs and better health outcomes requires ensuring that patients get the right care, at the right time, and at the right place in the care continuum. Recognizing this, many hospitals and health systems have acquired or partnered with organizations that provide these services (see Figure 17). These partnerships have remained stable over the past year, and indeed, have remained static over the life of the survey.

Figure 17: Coverage across the continuum through partnerships and acquisitions



Care coordination across the continuum remains central to providers' success in their population health efforts. One senior executive responsible for post-acute care noted the importance of SNFs in lowering costs, raising the question, "Why have a patient in an inpatient bed that costs almost twice as much as a bed in a SNF? There is huge potential for creating value here." The vice president of another regional system shared, "We're developing care coordination teams that include RNs, pharmacists, and social workers. We're also working more actively with payers as we take on greater risk across the continuum including post-acute care." Bringing the right stakeholders together across the care continuum is essential to improving outcomes in a meaningful way.

Accelerating the Journey

The purpose of this research is to formally explore the progress that's been made by provider organizations toward population health management. Our findings suggest that although there has been some progress over the last five years, most providers have yet to make a substantial commitment to the population health model.

At a macro level, the persistence of the status quo is not that hard to explain. Healthcare organizations, in general, like fee-for-service. They understand it, and they have evolved their management and operational infrastructure to optimize margins within it. Generally, they don't understand what it would be like to be transparent, truly patient centric, and financially accountable for managing against cost and quality targets. The idea of choosing medical interventions to minimize cost while maximizing quality just doesn't easily fit into a fee-for-service framework. And as long as their experience with such programs is limited to discrete pilot efforts at the margins, their discomfort with this new way of thinking is unlikely to change.

Payers, in general, would prefer to see the total cost of healthcare moderate. They are under fire from employers and consumers who are straining to afford the premiums that result from substantially unconstrained provider pricing. The consolidation of provider organizations across the country has enhanced the bargaining position of the survivors, making it that much more difficult for payers to push provider organizations to do things they don't want to do.

As the largest payer in the country and the responsible authority for about half the insured lives in the country, CMS has the biggest stake in improving the quality and lowering the cost of care. With its market power, CMS can push the industry for concessions without fear of competitive backlash, unlike commercial payers.

But, CMS is constrained by politics. Healthcare organizations across the country are often among the largest employers in their state, with a substantial voice in state and national policy. Further, the AMA, AHA, and other representatives of the healthcare industry have made it clear that if political pressure isn't enough, they will counter every effort to change the rules of the game in the courts.

And so CMS has settled for a siege punctuated by smaller skirmishes – mandating the elimination of site-specific reimbursement being the latest (but not the last), combined with more requirements (like publicly disclosed

pricing) intended to push the industry in a market-based direction. Until 2020, the stage was set for a war of attrition in which the only real loser would be the consumer/citizen.

And then came the pandemic.

Covid-19 has taught many lessons, but the two most relevant to population health are: 1) The society at large is as vulnerable as the most vulnerable subgroup within it; and 2) When you sell what you make on a per-unit basis, if customers can't or won't buy, your revenue is zero.

So far through the pandemic, those with chronic disease and multiple co-morbidities have borne the brunt of the infection. Disadvantaged populations and many "essential workers" have had a disproportionate share of infections and deaths. And these subpopulations make it that much harder to bring Covid-19 under control. Had a population health approach been the organizing principle across the industry, we would all be better prepared to weather this onslaught.

With the suspension of all elective procedures, hospitals across the country suffered a grievous blow to their balance sheets – one that may take years to recover from. Only those institutions with significant capitated contracts could count on predictable revenue independent of demand – and these were few.

For years, healthcare organizations have given a cold shoulder to the wisdom that every other business understands – that predictable recurring revenues are superior to transactional revenues. Covid-19 is not the first pandemic to strike our society, nor will it be the last. Will this experience provide an incentive to embrace a population health approach?

Time will tell …