The State of Population Health: Sixth 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

The environment in which our sixth annual State of Population Health Survey was administered was undoubtedly different from the previous five. At the time of launch, our nation was fully immersed in the Covid-19 pandemic and managing the crisis demanded the full attention of our nation's healthcare leaders. Thanks to their efforts and with great costs, we appear to be emerging from the pandemic and able to return to some sense of normalcy.

However, simply returning to the way things were done before the pandemic would be a grave mistake. Rather, we must consider the profound lessons Covid-19 taught our society, many of which carry enormous relevance to population health as an approach to care delivery and the way we pay for it.

One 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.

Another 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 on those grounds, the industry has historically and stubbornly clung 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 many hospitals across the country in financial freefall and forced them to realize that there is risk in fee-for-service. Those few provider organizations with a substantial number of patients covered by capitated contracts continued to collect their per-member-per-month payments, but these providers were few and far between – and the greater healthcare delivery community has been significantly damaged as a result.

This is the context in which we report the most recent findings from our State of Population Health Survey. The data was collected while the country was still

very much combatting the pandemic, from September 2020–February 2021, and the results we report here reflect incremental change in the face of an entrenched status quo.

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 future assessments, when the pandemic is fully behind us and its implications are more clearly defined.

Executive Summary

For the sixth 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 300 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 increased incrementally in 2020. Similar to 2019, 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*. 72% said their organizations were "moderately" to "completely" prepared, a slight but significant improvement over the corresponding metric of 66% in 2019.

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, 70% said their organization was better than average, a significant improvement since 2016. When it came to managing *cost* at the individual physician level, only 38% 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 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 their management of cost and quality. This year's survey showed little change on these key processes relative to 2019, and, indeed, there has been virtually no movement on these processes since our initial survey in 2015. Only half (50%) of respondents reported that their organizations routinely used a process to identify physicians who were outliers in cost or quality, and even fewer (40%) 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. While the percentage of respondents who do not have any annual revenue at risk has remained static over the past couple of years, those who do have risk-based contracts have increased the percentage of revenue they have at risk. Notably, those who had at least a fifth of their annual revenue at risk increased from 34% to 42% from 2019 to 2020. Still,

over forty percent (44%) of respondents reported that 10% or less of their revenue came through risk-based contracts. While this measure appears improved compared to prior surveys, it fell significantly short of the projections respondents previously made regarding how much revenue *would* be at risk in 2020.

Nevertheless, executives agree that population health is the future. Consistent with past surveys, 80% 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 31%-35% (up from 26%-30% in 2019).

In accordance with this, organizations are interested in expanding their population health service offerings. Approximately 70% of respondents reported that it was at least somewhat probable that their organization would implement more joint efforts with payers to apply population health practices. A similar percentage of respondents thought that it was at least somewhat probable that their organization would engage in more direct-to-employer contracts that include population health components.

Service offerings increasingly acknowledge the importance of social determinants of health. One of the most significant continuing trends over the past six 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 30% provide housing or community development support, most often in partnership with other community organizations.

The pandemic dramatically increased organizations' use of telehealth and sensitivity to access issues. One of the most significant changes driven by the pandemic was increased ownership of telehealth programs, from 42% in 2019 to 77% in 2020. Additionally, 94% of respondents plan to use telehealth delivery more frequently than they did pre-pandemic, and post-pandemic, 63% of respondents plan to make home health services a larger component of the care that they provide.

However, it has not accelerated the desire to increase revenue at risk. Only about 1 of 3 respondents said they think that they will significantly increase their revenue in at-risk contracts, including capitated contracts, post-Covid.

Risk-based initiatives remain marginal for most organizations. As in our last survey, more than 4 out of 5 respondents (86%) reported some experience with an alternative payment contract, but for most (64%), less than 20% of revenue was involved. Among those who claimed experience with an alternative payment contract, a substantial portion didn't risk actual loss. Their risk was upside only – that is, not receiving a "bonus" if targets are not achieved.

The threat of financial loss and difficulty in changing organizational culture were the most commonly cited barriers. Consistent with prior years, fear of financial loss and navigating cultural change remain the most commonly cited barriers (30% and 24%, respectively) to moving to a risk-based model. Responses suggest that progress has been made to address other commonly cited concerns, which include uncertainty about when to make the transition from the current model (17%, down from 27% in 2016), difficulty in modeling the cost of care across the continuum (24%, down from 38% in 2016), and issues with systems like IT, tracking, and management (20%, down from 32% in 2016).

In summary, respondents' confidence in their organization's readiness to take on risk related to cost and quality has improved significantly over the past six survey administrations, but that confidence is not proportionally 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. David Nash, Founding Dean Emeritus of the Jefferson College of Population Health, on an annual study to define and track the evolution of population health management in the U.S.

In this sixth 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 10,806 individuals were invited to participate in the online survey, which was fielded from September 2020 to February 2021. 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 279 surveys,[1] corresponding to a response rate of 2.6% of individuals and 12.1% 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 (83%) were overrepresented compared to recently published numbers (20%).[2]

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

[1] 269 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, provider- rather than patient-centric, and has 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 by providing the right intervention for each patient at the least costly point in the care continuum. 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, Patient Protection and Affordable Care Act (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 continued to advance towards a market-based healthcare system that prioritizes value over volume. Through the *Pathways to Success* redesign of the MSSP program and the introduction of Direct Contracting, the Trump administration sought to expedite delivery organizations' adoption of two-sided risk. These programs coincided with a 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.

Despite significant resistance from the American Hospital Association (AHA) and other hospital groups, the Trump administration achieved a significant step towards instituting a market-based model when the pricing transparency rule went into effect January 1, 2021 after being upheld in federal court a month prior. The rule requires hospitals to publish consumer-friendly pricing information regarding the items and services they provide, otherwise face a $300 daily fine. While this rule offers the promise of making competition based on cost and outcomes easier, non-compliance with the rule remains widespread, and numerous administrative, legal, and economic barriers must be addressed before it will make a significant impact on the industry.

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 the Medicare Access and CHIP Reauthorization Act (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-2021 for example, Walmart has opened thirteen 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.

From a financial perspective, the pandemic redefined risk for healthcare providers; or at least, it should have. What is apparent is that those few providers with capitated contracts continued to receive their PMPM payments through the pandemic. The 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.

More importantly, the pandemic proved that the health of one population cannot be viewed independently of its most at-risk segment. In light of this

realization, it is incumbent on provider organizations to consider population health management a fundamental component of their mission to improve the health and well-being of those they serve.

The data summarized in this report was gathered during the pandemic. 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. As we continue to emerge from the pandemic, 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 cost, 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. David Nash, Founding Dean Emeritus of the Jefferson College of Population Health, on a multi-year assessment of healthcare delivery organizations across the U.S. This report highlights key findings from the first six years of our study.

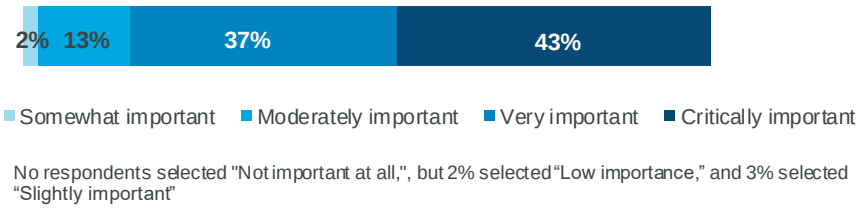
Key Research Findings

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 (93%) rated it between "moderately" and "critically" important, with 43% rating it as "critically important" (see Figure 1). Numerous comments were consistent with this data; for example, the CFO of a regional hospital system said, "the current health care system is not sustainable" and population health "defines future success for our organization based on our mission."

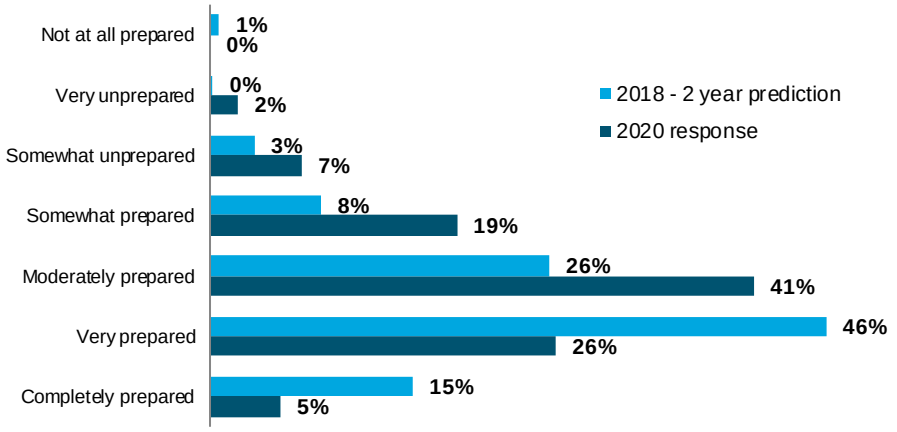
Figure 1: How important is population health for future success?



No respondents selected "Not important at all,", but 2% selected "Low importance," and 3% selected "Slightly important"

The overwhelming agreement by executives that population health will be important to future success represents a clear contrast with their organizations' progress in operationalizing it. In the 2018 survey, over half of respondents (62%) predicted they would be at least "very prepared" to take on risk in 2020. In the current survey, however, only 31% felt they had achieved that mark (see Figure 2).

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



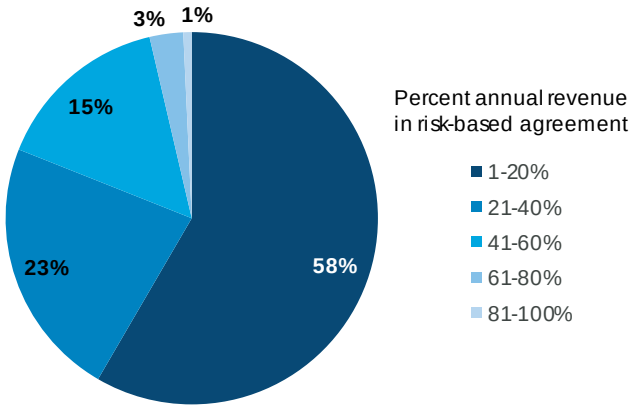
Similar to the last several years, the importance of a positive strategic vision was echoed by many executives. The Chief Population Health Officer of a large healthcare system stated that their organization sees population health as "a core strategy but [they are] running from behind the market."

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 CMO at an academic medical center explained "the transition from an acute care focus has been slower than many would like, but our entire infrastructure was built around this model. It will take some time to unwind."

2. Risk-based initiatives continue to be marginal for most organizations

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 2019, more than four in five (86%) respondents reported their organization was in at least one agreement with a payer that includes upside gain and/or downside risk. That one figure alone makes it sound like most organizations have tried risk-based contracts, and they have – but only in a very limited fashion. When asked about the *amount of revenue at risk*, a minority of these respondents (42%) said 20% or more of their organization's revenue is at risk (see Figure 3). Although not quite statistically significant (p=0.07), this is up from last year (34%). In addition, a substantial portion of respondents 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

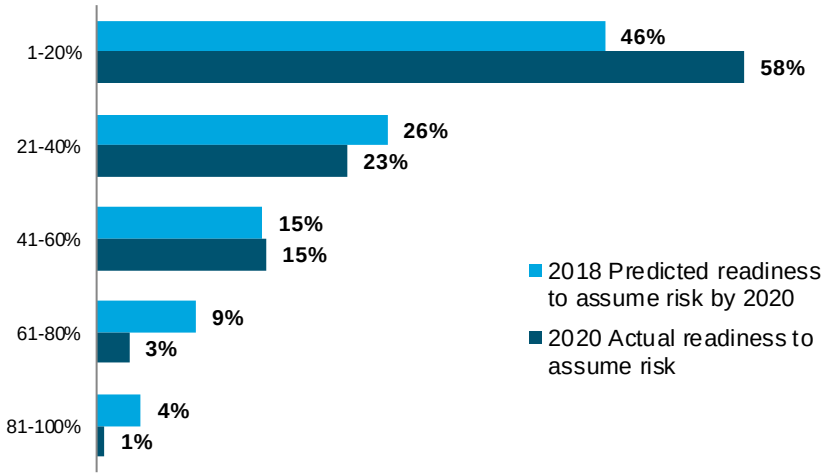


In each of the survey's prior administrations, respondents predicted a dramatic increase in the percentage of annual revenue that would be at risk in the next two years; however, actual progress has failed to keep pace with expectations. As shown in Figure 4, respondents consistently overestimated what their 2020 involvement in risk-based agreements would be when asked in 2018. In our 2018 survey, nearly 1 in 3 respondents projected that by 2020 their organizations would have at least 40% of their revenue in risk-based

agreements, but only 19% of respondents to the most recent survey met that threshold. In short, respondents two years ago expected more rapid progress than has materialized.

Slower progress towards population health than expected was a common theme among respondents. This was the case for one mid-size system whose VP of population health shared "population health isn't embedded within the organization; it's still seen as another program tacked on to the core business." Due to unfamiliarity with the concept, many systems continue to only explore population health models, as shared by one executive at a regional hospital system, "we will continue to explore how to fit the needs of the community with a model that is fiscally responsible." Until organizations are willing to fully commit themselves to a new model, success – in terms of both clinical impact and improved margins – will remain elusive. One Chief Population Health officer emphasized this key point, commenting, "we believe population health is THE way to serve our community, and we can't have our feet in two canoes!"

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



In some cases, respondents were hesitant to engage in at-risk contracting because physician compensation was not aligned with the model. The CMO of an integrated regional health system reported that a challenge to implementing population health was that with regard to physician compensation, "incentives to do more outweigh other financial rewards for quality, utilization, etc."

In other cases, defining arrangements to appropriately share risks/rewards with payers proved to be a barrier. As one vice president of a major health system noted, "we must work with employers and payers to build models that incentivize the move to value." This person positioned Medicare Advantage

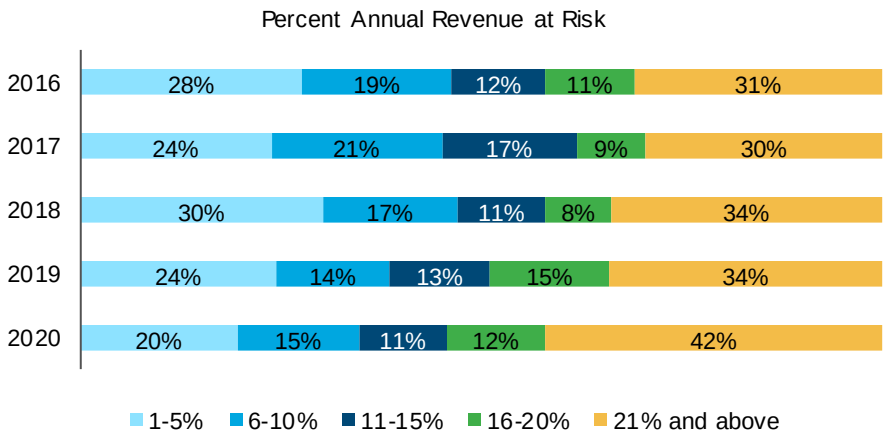
and Managed Medicaid as potential catalysts for this move, along with the Medicare Shared Savings Program (MSSP).

Even those systems that are leaders in risk-based contracts experience challenges in changing the mindset and culture of their organization. The Chief Population Health Officer of a large hospital network stated that their organization is, "making steady progress despite an internal 'heads in beds' culture and payor resistance to population-based payment (capitation) and delegation." Many organizations like this one struggle to develop integrated population health solutions and to communicate their overall value proposition to appropriate stakeholders.

3. Organizations that have adopted risk continue to (slowly) adopt more

The percentage of respondents who do not have any annual revenue at risk has remained static over the past couple of years (15% in 2018 and 2019, and 14% in 2020). But of those who do have revenue at risk, the percent at risk has been slowly increasing (see Figure 5). Notably, the percentage of respondents who had over 20% of their annual revenue at risk increased from 34% to 42% from 2019 to 2020.

Figure 5: Respondents who are taking on risk are increasing their annual revenue at risk

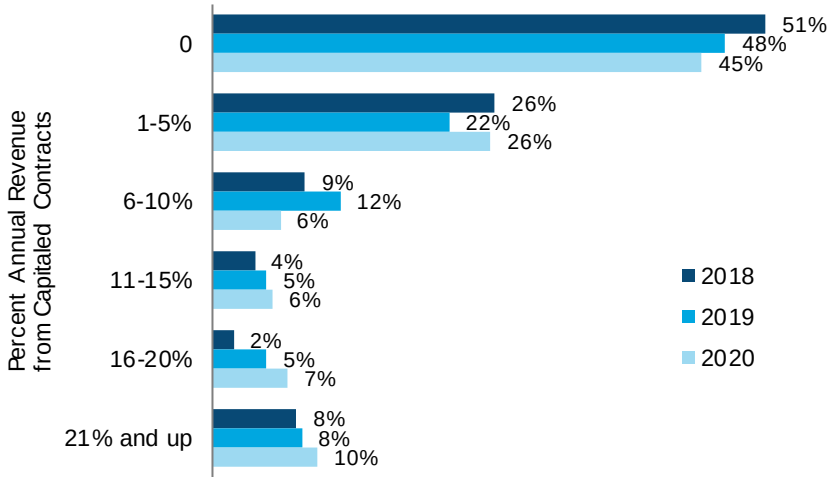


Consistent with past surveys, organizations' comfort with fee-for-service limits their appetite for risk-based models. Population health represents uncharted

territory for delivery organizations and until external events require it, comparatively few organizations will be willing to make the journey.

Over the past three administrations, the percentage of respondents who indicated that their organizations receive some percentage of revenues from capitated contracts has also demonstrated nominal incremental growth (see Figure 6).

Figure 6: Growth in capitated contracts has lagged the modest increase in revenue at risk seen at some organizations



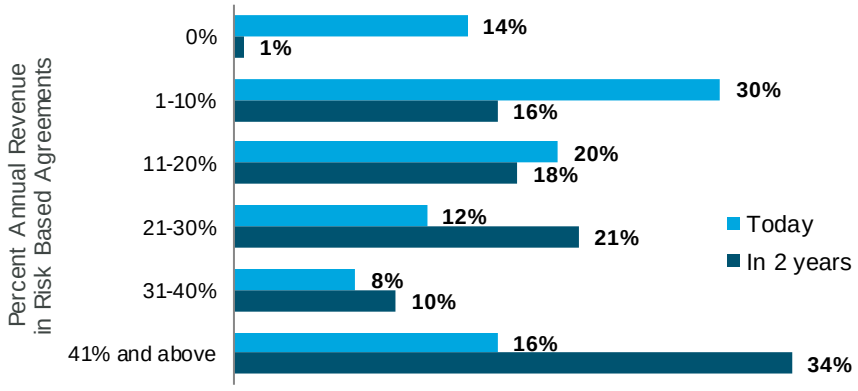
In 2018, a little over half (51%) of respondents did not have any revenue in capitated contracts. Although not a significant change, this percentage was down to 45% in 2020.

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

Respondents see the market continuing to move towards 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), meaning the small segment of organizations without risk-based contracts (14%) is expected nearly disappear.

In every administration of the survey for the past six years, respondents projected that risk-based contracting would increase in the future. And in each administration, the reality fell short of expectations. This was the case again in 2020. The majority of respondents failed to meet the 2018 forecast of having one-quarter of revenues in risk-based contracts by 2020. In fact, respondents' 2020 median percentage of revenue from alternative payment models was only 15% – two-thirds of what was projected for 2020 in 2018. Two-year future expectations remained static in 2020 at 25% for the third year running (see Figure 8). If organizations are going to meet even this modest goal, they have a significant amount of work ahead of them.

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



Respondents' 2-year projections remained the same in 2020 as they have been in the past two administrations, at 25%.

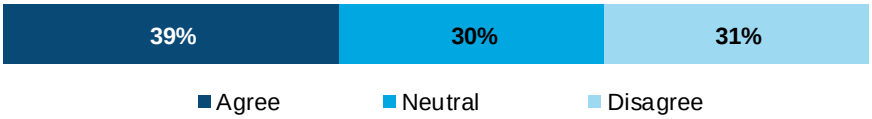
Figure 8: Respondents continue to moderate their expectations for future revenues in risk-based contracts

	2016	2017	2018	2019	2020
Median % of revenue at risk today	10%	10%	10%	10%	15%
Median % of revenue at risk expected in 2 years	30%	30%	25%	25%	25%

This data suggests healthcare executives' expectations around value-based care have plateaued for now at a very modest point. This may be due to growing uncertainty regarding the future of value-based care.

Given the financial damage done to provider organizations by the suspension of elective procedures during the pandemic, the extent that the pandemic has accelerated the transition towards population health remains unclear. When asked whether they think that the pandemic will accelerate at-risk contracting, organizations gave mixed responses (see Figure 9).

Figure 9: Mixed responses to the suggestion that at-risk contracting will increase post-covid



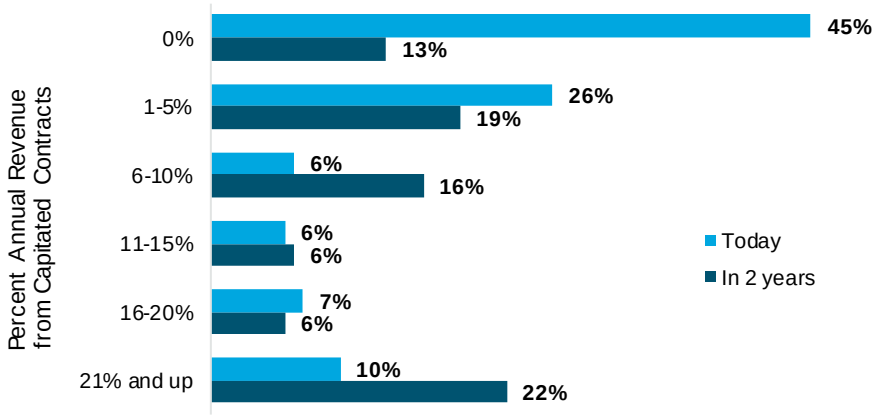
The risks inherent in fee-for-service were clear to many healthcare executives, including one from an academic medical center, who said, "we need to balance our portfolio and not have all our eggs in the FFS basket. We'll need to partner with payors, employers and other disruptors to respond proactively to the changes we see."

While some respondents were less sensitive to the financial implications of the pandemic, the clinical implications were widely apparent. One VP of a standalone community hospital commented that, "comorbidities finally presented themselves as being vitally important with COVID."

5. Executives expect revenue in capitated contracts to grow – modestly

To better understand the full-risk side of the spectrum, we surveyed participants on capitated contracts. Executives do anticipate the use of capitated contracts to grow. Many respondents (87%) expect to have some revenue in them in two years (see Figure 10). However, capitated contracts accounted for fairly small amounts of revenue in 2020; only 23% of respondents reported more than 10% of their organization's revenue to be from capitated agreements.

Figure 10: 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 10% in 2 years (see Figure 11).

Figure 11: Respondents expect revenues from capitation to increase modestly in future

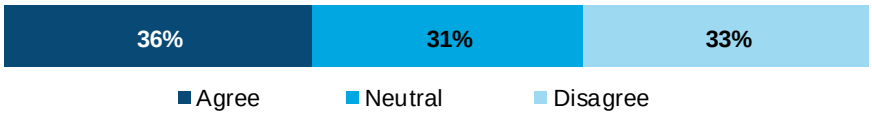
	2016	2017	2018	2019	2020
Median % of capitated revenue	5%	0%	5%	5%	5%
Median % of capitated revenue expected in 2 years	15%	10%	10%	15%	10%

When the pandemic forced the suspension of elective procedures, organizations with significant revenue coming from capitated models could still count on their PMPM payments for cash flow. We hypothesized this experience might encourage other delivery organizations to reconsider such models more favorably as a means of mitigating financial risk. We inserted a question in the survey asking if respondents thought the pandemic would accelerate the acceptance of capitated models. The results were not what we expected.

Some respondents did indicate that the pandemic had encouraged a re-thinking of capitation. For example, the VP of Population Health at a regional health system explained that a population health model, "would have helped us take better care of our patients and mitigate the negative effects of decreasing volumes." This was echoed by a national system's C-suite executive, who aptly pointed out the weaknesses of Alternative Payment Models (APMs), "we had built the population health muscle needed to care for all patients at risk of COVID and yet FFS-based Alternative Payment Models failed us. We need to move to pre-paid, population-based payments faster."

That said, responses to the question were far from unanimous. Despite some comments recognizing the point, the idea that capitated models would be more attractive as a result of the pandemic did not find strong agreement. Responses were nearly evenly divided across a three-point scale, as shown in Figure 12.

Figure 12: Mixed responses regarding the extent to which the pandemic will accelerate acceptance of capitated models

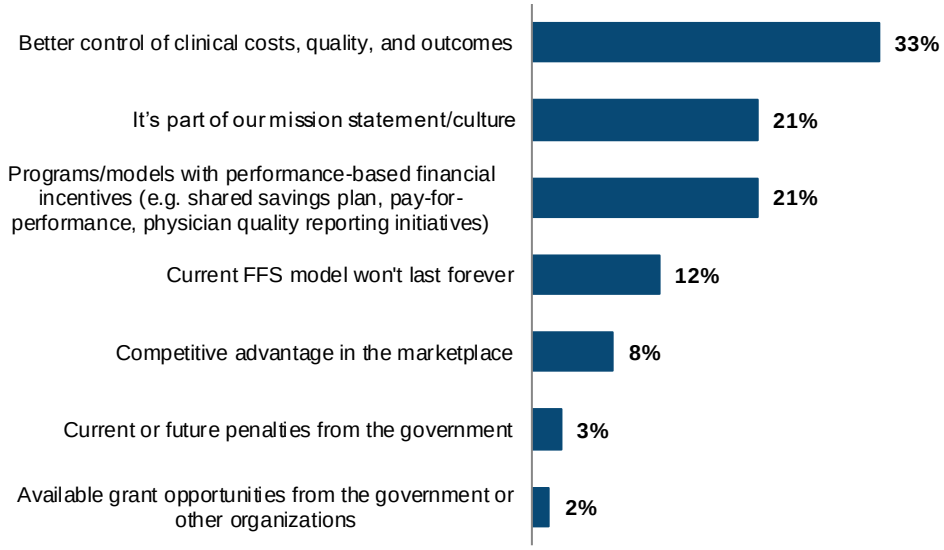


This was similar to the earlier question about the pandemic encouraging more at-risk contracting (see Figure 9). Apparently these sentiments don't appear to be widely shared.

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

Figure 13 below reflects what respondents said was the *primary* driver for pursuing population health in their organization. Consistent with prior surveys, controlling clinical cost and quality has been the leading driver each year since 2016. Organization mission/culture has consistently trailed as the second most cited driver. Interestingly, performance-based financial incentives were reported at parity with mission/culture in 2020, with 21% of respondents seeing potential profits as the primary driver for their organization's efforts around population health.

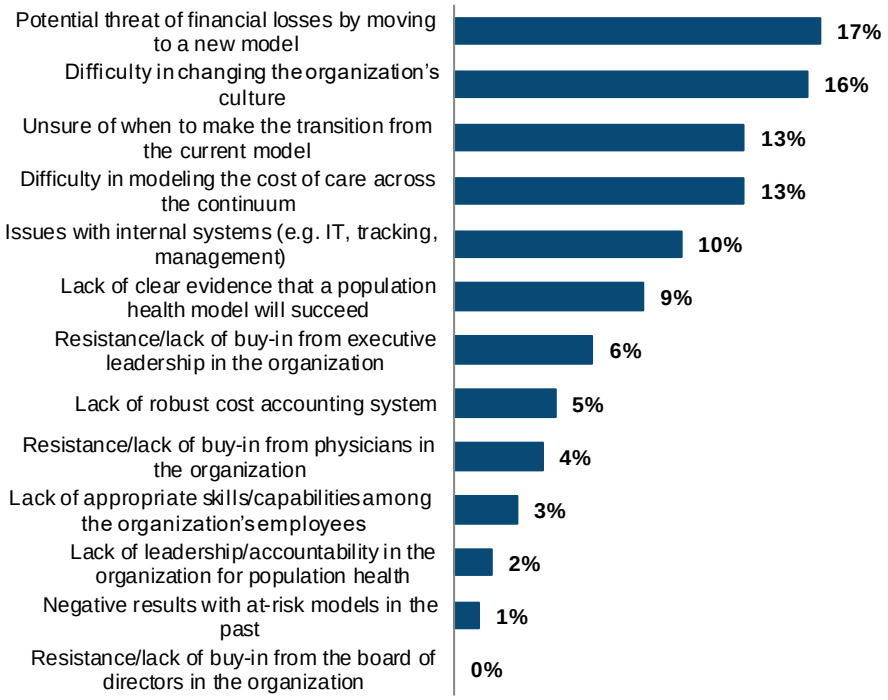
Figure 13: Primary reason for pursuing population health



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. Figure 14 below reflects the *primary* barrier to pursuing population health, where respondents select the single most challenging obstacle. The leading concern is the threat of financial losses by moving to a new model (17%), followed by difficulties changing the organization's culture (16%), uncertainty about when to make the transition from the current model (13%), and difficulty modeling the cost of care across the continuum (13%).

Figure 14: Primary barriers to pursuing population health



The leading barrier to moving toward population health has been and continues to be the *threat of financial loss*. This is consistent with respondents' self-assessment of their organizations' capability to manage the cost of care (see Figure 15 below). Very simply, most provider organizations have not engaged with clinicians to influence clinical decision-making in ways that would make it more efficient and that would minimize variability in cost and quality. Recognition that physicians – the leading driver of cost in the

hospital – are operating independently and without common processes and metrics make the organization subject to surprises in the cost of care. Concerns about financial loss have a solid basis in reality.

The threat of financial loss is also related to issue number three, *difficulty in modeling the cost of care across the continuum*. Given this hasn't been a requirement in fee-for-service models, many organizations struggle with this assessment. The Chief Population Health Officer of an AMC reinforced this idea, commenting, "our move towards population health has been slow and tentative, largely because of the lack of a clear ROI."

In order to gain some measure of predictability and control over key cost drivers, significant effort is required of most organizations to design and implement care paths, model costs, and track performance and variability in real time. Resistance to undertaking this work from clinicians and administrators alike is likely what respondents had in mind when they identified difficulty in changing the organizations' culture as the second most significant obstacle in moving toward population health. Without these capabilities in place to manage risk, systems will remain reluctant to expand their population health footprint. As a VP at a pediatric ACO shared, "our growth (in population health) is restricted by measurement challenges."

Uncertainty about when to make the transition to population health (tied for third place) remains an obstacle for many providers. This issue has consistently ranked among the top three across multiple years. Part of the issue is that providers know that they've generally seen operating revenue from fee-for-service – even if it has been shrinking over time – but they don't have the tools and data to credibly model what their return would be under various at-risk scenarios. Consequently, many feel that exiting fee-for-service too early will leave money on the table. One CMO highlighted this challenge by explaining how his regional health system is ahead of their competitors in terms of operationalizing population health, but how their early transition, "has hurt our bottom line as we moved from volume to value ahead of the payers."

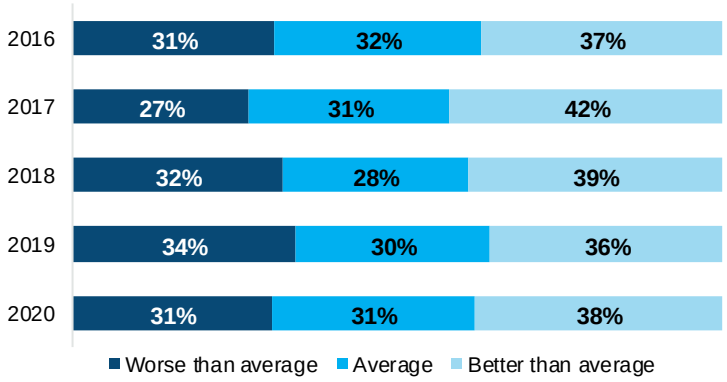
Success in population health requires *internal systems* (e.g., IT systems, organizational processes, and competencies/capabilities) that are far different from what most provider organizations have in place to support fee-for-service models. Recognition of that gap helps explain the fourth primary barrier. As one COO shared, "we've learned that typical hospital IT systems aren't designed for population health".

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.

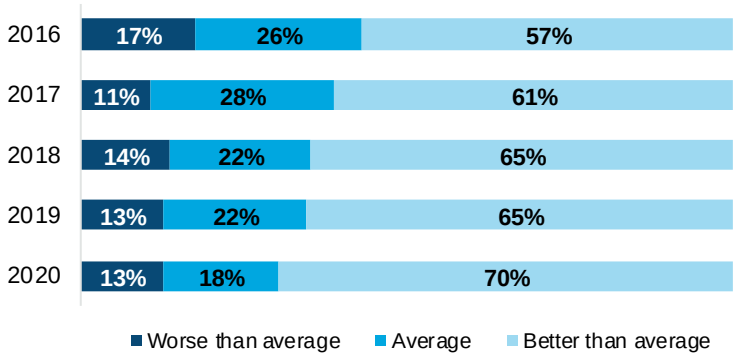
Respondents still see a need for better management of cost variation. A clear majority of respondents (62%) rated their organization's ability to manage variation in cost at the physician level as "average" or "worse than average." In the context of the past five survey administrations, no progress has been made in this area over time (see Figure 15).

Figure 15: Respondents believe their organizations' ability to manage variation in clinical cost at the physician level is not on pace with the demands of population health



In this sixth year of our survey, there was continued modest but significant progress in the management of variation in clinical quality. A little less than one-third of respondents (31%) view their organizations' ability to manage variation in quality at the physician level as "average" or "worse than average" (see Figure 16). The improvements made in this area since 2016 are significant when looking at increases in the percentage of respondents who rank their ability to measure variation in quality as better than average.

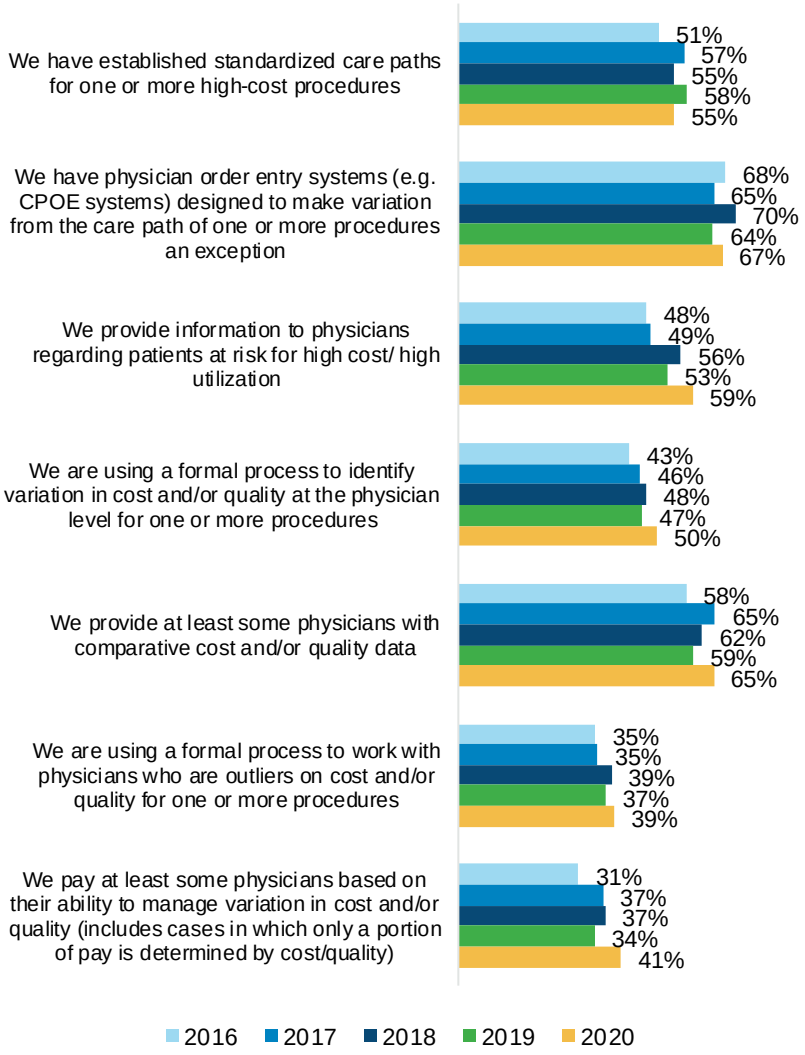
Figure 16: Respondents believe their organizations are slowly improving in their ability to manage variation in clinical quality at the physician level



Given that physician decision-making is the most significant driver of healthcare spending, organizations serious about managing cost and quality variability must develop mechanisms for administrative leaders to engage with physicians to influence clinical practice patterns. Mechanisms to this effect include developing evidence-based 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.

However, these mechanisms to hold physicians accountable for performance are not being used routinely at most organizations (see Figure 17), despite health systems now employing over half of the nation's physicians. This suggests that the investment needed to remove the wall between the administrative and clinical sides of health care delivery has yet to be made by many organizations. Until this is done, management will continue to struggle to manage the cost and quality of care, and the fear of financial loss referenced by many executives as the primary barrier to risk-based models will continue to be well justified.

Figure 17: Organizations are slow to adopt mechanisms to support physician accountability for cost and quality. Data indicates percentage of respondents reporting these mechanisms being used routinely at their organization

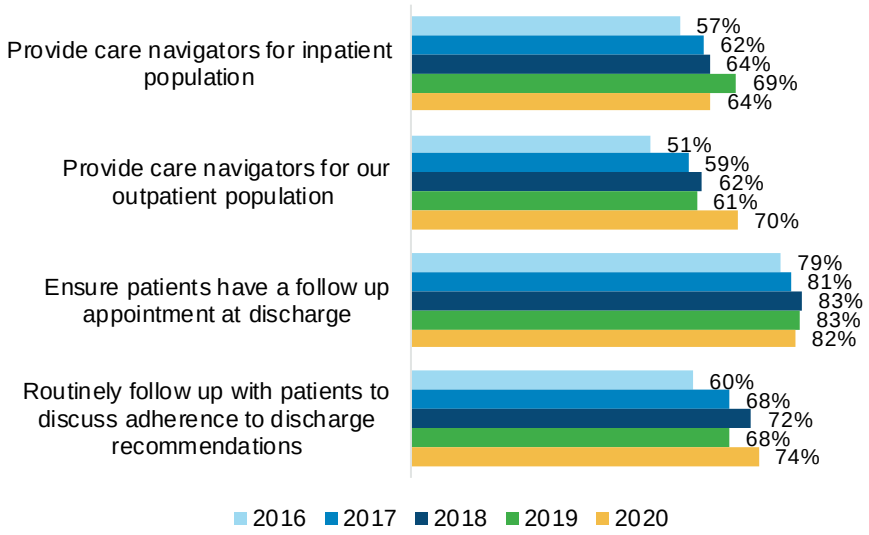


Data analytics were consistently recognized as important mechanisms for managing variation in cost and quality. One respondent, the president of an east coast medical group, emphasized the need to expand these capabilities, commenting that, "development of tools to generate actionable population health data analytics and APM modeling needs to be accelerated." He went on to explain that, "provider compensation models that align with population health goals also need to be implemented."

This latter point was frequently noted by respondents, including one who aptly attributed this barrier to the entrenched FFS culture, "physician compensation is a huge challenge. Incentives to do more still outweigh other value-based financial rewards for quality, utilization, etc." Challenges around cost management will continue to be difficult to overcome as long as leaders focus

on volume over value. This sentiment was echoed by multiple respondents, including the Director of Population Health of a regional system who shared, "we not only have to provide high-quality care using evidence-based, standardized practice and the best outcomes, we have to do it while controlling costs."

Figure 18: The reach of care navigators is moving beyond the walls of the hospital



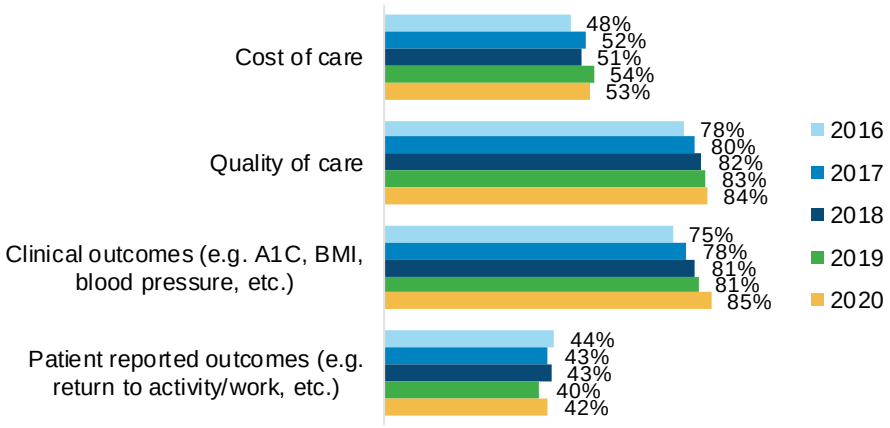
Responses of routinely doing these things are depicted above

One change possibly contributing to the perceived improvement in the ability to manage quality outcomes is the increasing use of care navigators. While the percentage of respondents who provide care navigators for their inpatient population has remained fairly static over the last couple of years (64% in 2018 and in 2020), there has been a significant increase in those who do this for their outpatient population (51% in 2016 and 70% in 2020). There has also been significantly increased routine follow-up with patients to discuss adherence to discharge recommendations (60% in 2016 and 74% in 2020).

9. Organizations are slowly improving their processes for tracking quality, while processes for tracking cost lag behind

Respondents reported a sixth year of improvement in their ability to track quality metrics (see Figure 19). In 2020, more than 4 out of 5 respondents viewed their benchmarks and metrics for tracking quality of care delivered (84%), and viewed clinical outcomes like A1C, BMI, and blood pressure (85%) as better than average. While improvements in these areas over the last four years is sustained and meaningful, only 53% reported the same for metrics around the cost of care delivered.

Figure 19: Organizations are slowly improving in their ability to track metrics related to quality, but lag on tracking costs



Responses of better than average are depicted above

While organizations are improving in the metrics used to track quality and clinical outcomes, improvement is needed in the processes used to track patient-reported outcomes like return to activity/work. Less than half of respondents (42%) 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. 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.

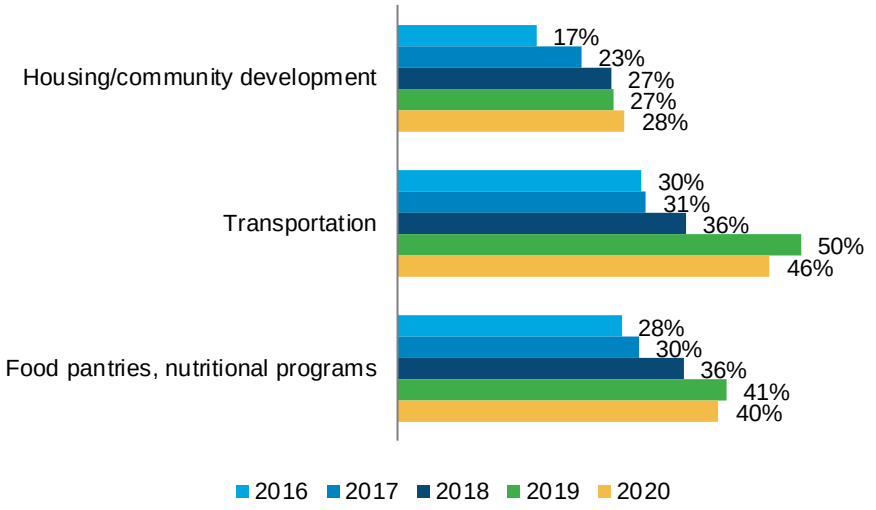
Success in this area requires leveraging data to enable change. One ACO director shared how critical data was in establishing a consistent approach across the organization, explaining, "we need stronger advocacy around having one approach to population health that is coordinated both internally and with our key external partners. Data analytics that are consistent, sustainable, and reliable need to be present to hold leaders accountable."

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

Social determinants like 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. As demonstrated in Figure 20, significant progress has been made to form partnerships to address challenges such as food insecurity, housing, and transportation needs since 2016. However, this year's survey suggests that progress stalled across each of these three areas in 2020.

Figure 20: Healthcare organizations are increasingly partnering with outside organizations to provide services to patients in an effort to improve community health



Addressing SDOH requires identifying barriers to healthy behaviors and providing preventative interventions to modify behaviors and social circumstances before individuals' health deteriorates. As one executive described, this requires a new way of thinking for most delivery organizations, "we think first about patients, not people. We need to understand how they live, why they get sick and how we can go 'upstream' in novel ways to manage their health or empower them to manage their own health with us as a trusted partner."

The pandemic cast a spotlight on SDOH by further exposing disparities in American healthcare. An executive of a regional system aptly explained this dynamic, "populations that have historically had poor access will suffer at higher rates in pandemic situations. They tend to consist of essential workers without the option of sheltering in place, maintain dense living situations, lack dedicated caregivers, and have no or limited data plans for telehealth. Given these barriers, bringing these segments into sustainable population health models presents a sizable challenge."

This reality has not gone unnoticed by other organizations. The Chief Population Health Officer of an academic medical center noted the pandemic raised his organization's level of awareness of SDOH and sparked new approaches to addressing them, saying, "we are doing more to segment populations based on social factors and have enhanced our outreach to these vulnerable populations to address outcome variations caused by SDOH."

Making progress in this regard requires partnership with community organizations that are equipped to address SDOH needs. These

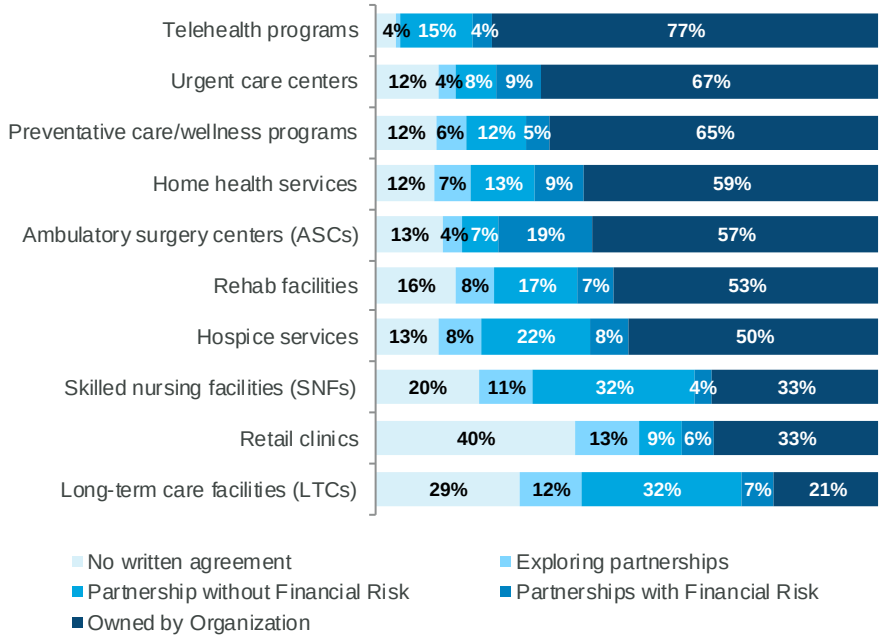
organizations must be engaged in a systematic way to ensure their interventions are delivered to the right people, at the right time, and in the right setting with success metrics in place to measure and optimize impact.

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 21).

While these partnerships had remained relatively static over the life of the survey, massive changes occurred in 2020. Due in no small part to the Covid-19 shutdowns, respondents reporting that their organizations' own telehealth programs jumped from 42% in 2019 to 77% in 2020 (see Figure 22). Among other components of the care continuum, ownership was also up of retail clinics (24% in 2019 to 33% in 2020), preventative care/wellness programs (58% in 2019 to 66% in 2020), and home health services (54% in 2019 to 59% in 2020) (see Figure 22).

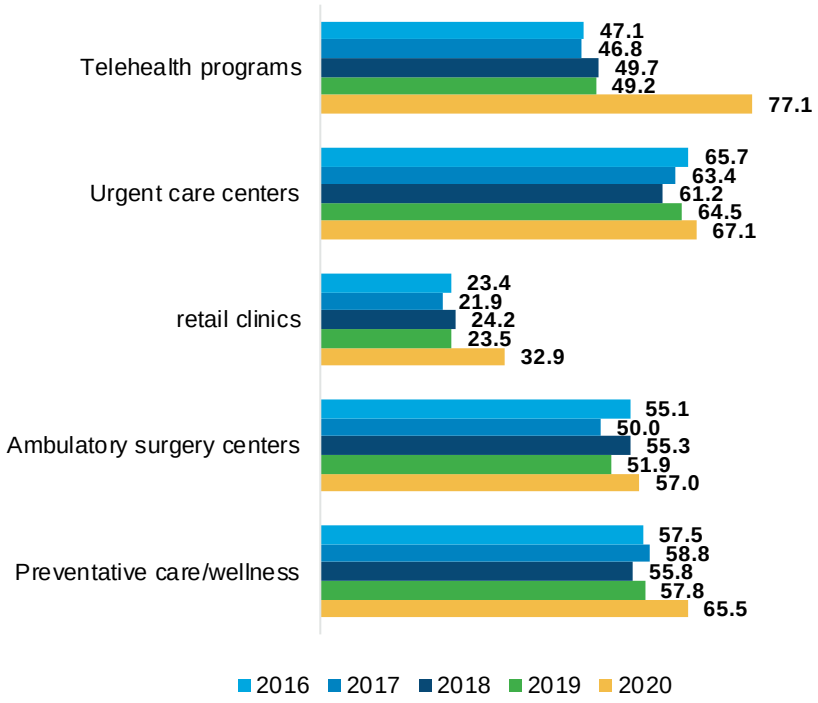
Figure 21: Coverage across the continuum through partnerships and acquisitions



Delivery organizations have traditionally had little incentive to provide care across the continuum and as a result, assets tended to be acute care oriented. Given this, significant capital investments are required to develop or acquire assets supportive of value-based models. Determining when and how to make these investments presents a challenge to decision makers. As one Chief Population Health Officer shared, "the optimal size and timing of investments depends on when the marketplace will change. Our initial investments yielded mixed success, so ongoing investment challenges remain."

Care coordination is central to providers' success in population health and will become increasingly challenging as coverage extends across the continuum. To address this need, many organizations are re-deploying licensed providers, as noted by the director of population health at a southeastern system saying that, "integrating population health teams into frontline care teams has been an effective model for us."

Figure 22: Coverage across the continuum through partnerships and acquisitions



12. The pandemic dramatically increased organizations' use of telehealth and sensitivity to access issues

The pandemic has made an indelible mark on nearly all industries, but perhaps none more so than healthcare. This notion is widely recognized, but the implications of it are less clear. When respondents were asked whether or not organizations would increase revenue at risk or the use of capitated models post-Covid, reactions were mixed (see Figures 9 and 11). On the other hand, organizations do appear to be more willing to adopt elements of population health as a result of the pandemic. Approximately 70% of respondents said implementing more joint efforts with payers to apply population health practices was at least somewhat probable for their organizations post-Covid (see Figure 23). Findings were similar regarding direct-to-employer contracts inclusive of population health components (see Figure 24).

Figure 23: Post-Covid, organizations hope to implement more joint efforts with payers to apply population health practices

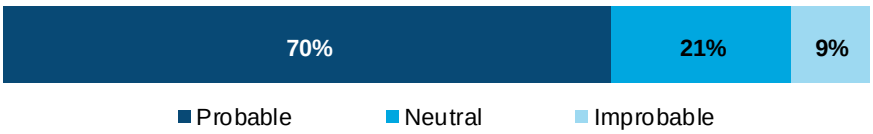
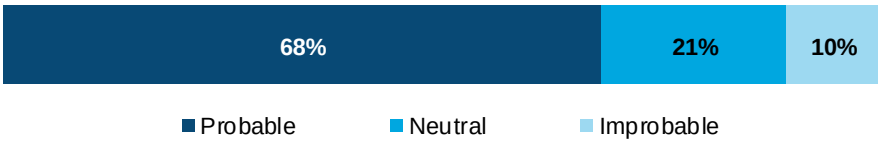


Figure 24: Post-Covid, organizations hope to engage in more direct-to-employer contracts that include population health components



Well before Covid-19 came on the scene, telehealth providers had positioned the technology as a cost-effective care delivery and population health platform. Despite those claims, adoption among healthcare providers prior to the pandemic had been relatively low. Constrained by complex regulation and reimbursed at far less than in-office visits, the technology generated limited provider interest. Outside of a small segment of early adopters and

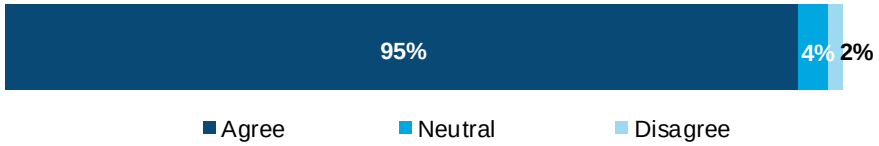
organizations with a meaningful financial commitment to value-based delivery models, utilization was marginal.

This all changed when in-person visits were shut down at the onset of the pandemic. As a means to maintain access to care, many telehealth regulatory restrictions were waived and reimbursement for virtual services was increased to parity with in-office visits. These changes, in combination with a newfound receptivity by providers, paved the way for an unprecedented spike in utilization. Across the country, virtual visits took the place of office visits and as a result, healthcare leaders and patients alike couldn't help but notice the value it unlocked. One VP of Population Health from a midwestern system shared, "we have learned the immense value of telehealth in providing access to certain types of care." This sentiment was shared by the COO of a peer organization on the east coast, who noted the economic advantages inherent to virtual care by commenting, "we have expanded our virtual offerings exponentially and were able to do so smoothly at a much lower cost (than in-person visits)."

Delivery organizations' rapid implementation of virtual care capabilities was both impressive and an encouraging step towards population health management. However, the extent that these capabilities will contribute to long-term impact on the cost and quality of care remains an open question, especially in light of our Telehealth Report finding that telehealth utilization dropped to less than 25% of visits after reopening, compared to nearly 80% during the shutdown.

When asked their agreement with the statement, "Post-Covid, we will use telehealth delivery more frequently than we did pre-Covid," 94% of respondents at least "somewhat agreed" (see Figure 25). The fact that 77% of respondents are part of an organization that owned a telehealth program in 2020 (see Figure 22) bodes well for organizations living up to this prediction.

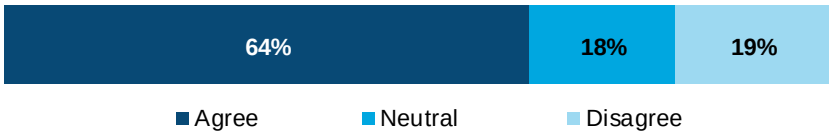
Figure 25: Organizations plan to use telehealth delivery more frequently than they did pre-pandemic



Home health is another service that demonstrated tremendous value as providers were forced to stand up new models of care. Many respondants (64%) believe their organizations are likely to make home health services a

larger component of the care that they provide post-Covid (see Figure 26). Furthermore, virtual capabilties are widely recognized as a vehicle to operationalizing integrated home health services. One VP from a regional system shared, “we were able to stand up a ‘hospital at home’ program, the development of which was significantly accelerated by the pandemic. We’ve learned we can do more in regard to care in the home via remote patient monitoring and telehealth, and this can improve outcomes and patient satisfaction while lowering costs and exposure risk.”

Figure 26: Organizations plan to make home health services a larger component of the care that they provide post-pandemic



The fate of services like telehealth or home health that rose to prominence during the pandemic likely depends on two factors: 1) the extent that they will be reimbursed at parity with traditional forms of care (e.g., in-person visits, acute care stays); and 2) the willingness of healthcare leaders to extricate themselves from transactional reimbursement by adopting risk-based models. This economic reality was widely recognized by respondents, including the CEO of a nationally recognized specialty hospital who shared, “telemedicine (as practiced today) can work from a care delivery perspective, but it does not work from a revenue perspective.”

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. From our perspective, population health represents a real opportunity for providers to improve not only the health and well-being of those they serve, but also their own financial health.

However, and despite general agreement with our outlook among survey respondents, our findings suggest most providers have yet to commit themselves to a new 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 have evolved their management and operational infrastructure to optimize margins within it.

Institutionally, most don't understand what it takes to be transparent, truly patient-centric, and financially accountable for cost and quality because these ideas don't easily fit into a fee-for-service framework. As a result, most organizations have done little more than experiment with population health.

At the same time, industry stakeholders continue to grow more concerned about healthcare spending. Payers, under fire from consumers and employers frustrated with the intractable rise of premiums and deductibles, would prefer to see healthcare costs moderate. However, consolidation of provider organizations across the country has enhanced the bargaining position of survivors, making it much more difficult for payers to push provider organizations to do that which they don't want to do. With no clear solutions coming from the market, politicians are becoming more involved by proposing new legislation, adding new layers of complexity to an already over-regulated industry.

With this context, the critical question is, 'How can this gridlock be fixed?' From our perspective, the greatest burden falls on CMS, given its immense market and regulatory power.

As the largest payer in the country and the responsible authority for about half of the insured lives in the country, CMS has the biggest stake in improving quality and lowering the cost of care. This unique positioning allows CMS to push the industry for concessions without fear of competitive backlash, something commercial payers rarely can do.

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 use the courts and whatever other means necessary to block efforts to change the rules of the game, just as they've done with price transparency.

Therefore, CMS has shied away from actively driving the industry towards value and have instead taken a passive approach. CMS has allowed healthcare inflation to outpace reimbursement increases for costly inpatient services, and has introduced specific policies such as site-neutral payment practices to motivate providers to evolve. While this strategy has resulted in cost and/or quality improvements in select areas, there has yet to be any clear indication of a fundamental change in the way healthcare is delivered in this country. Rather, CMS's approach has resulted in mere cost shifting, where delivery organizations, leaning on their enhanced bargaining power, force higher prices upon commercial payers. And in turn, payers pass these costs on to consumers and employers in the form of higher premiums, deductibles, and cost sharing, resulting in even louder calls for change from consumers.

As demonstrated by the rise of new entrants to the industry both large and small, these calls are being heard by leaders outside of traditional healthcare delivery. However, the entrenched fee-for-service model has proven too much of a barrier for any of these innovative companies to convince incumbents to give up the status quo. And until CMS is willing to demonstrate decisive leadership and disrupt this status quo, little is likely to change and the ultimate losers will continue to be consumers.

In the wake of the pandemic, there's never been a better time for CMS to step up to the plate. Indeed, 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.

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 have been better prepared to weather this onslaught.

With the suspension of elective procedures, hospitals across the country suffered a grievous blow to their balance sheets. Without government bailouts, many organizations would have been forced to shut their doors at a time when their services were most needed. On the other hand, those few institutions with significant capitated contracts were able to rely on predictable revenue independent of demand to remain solvent, but these organizations were few and far between.

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. This neglect has been enabled by a lack of leadership from CMS, which has chosen political expediency over the well-being of the population in its approach to regulating the industry.

Covid-19 is not the first pandemic to strike our society, nor will it be the last. Will this experience be enough to convince leaders to embrace a population health approach?

Time will tell …