The State of Population Health: Eighth Annual Numerof Survey Report

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

March 2024

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Preface

Our eighth State of Population Health Survey was launched May 2023 – roughly three years after the Covid-19 pandemic swept into the United States, and at about the same time as the associated medical emergency in the U.S. was declared over. The population was cautiously coming out of isolation; the healthcare system, thoroughly exhausted, was trying to get back to normal despite ongoing shortages of staff and materiel. Federal support programs ended with the emergency, and most hospitals looked at their balance sheets with a new level of concern.

Given the chaos of the pandemic, we considered it entirely possible that little had changed with regard to population health since the last survey. After all, for much of the preceding three years it was all most clinicians and administrators could do to keep the doors open. On the other hand, not everything had come to a halt. New payer contracts were signed, even during the pandemic. The latent financial risk in a fee-for-service model had been made abundantly clear: when patients stay home, cash flow stops. So there was the possibility, even during the chaos of the pandemic, that healthcare executives might have shifted in their views of a population health approach. We were intrigued by the possibility.

We wondered too about the durability of the large and small changes that we had seen in previous surveys. For example, would the spike in utilization of virtual health be sustained, or as patients ventured out again, would we see it fade and if so, how much? Would the growth we had seen in offerings across the care continuum and in services designed to address social determinants of health (SDOH) continue or not? Would attitudes about population health – the reasons to do it, and to not do it, shift? And finally, would we see any change in the percentage of revenue that hospitals in our sample were willing to link to their management of cost and/or quality?

Our interest in the evolution of practice across healthcare executives regarding the way they deliver care is more than academic. At the macro level we see an industry struggling to maintain even its mediocre performance ranking relative to healthcare systems of comparable developed economies. U.S. healthcare has burdened itself with a business model that grows less profitable every year, and which leaves more and more patients frustrated and alienated in the process. Despite this state of affairs, industry executives for the most part seem unwilling to seriously contemplate an alternative. With consumer dissatisfaction growing louder daily, and a horde of retail challengers aggressively moving to take advantage of every misstep, it's an industry that seems headed for some sort of breaking point. We believe it is important to

report and discuss our analysis of what is happening in the industry in the hope that it might facilitate the constructive resolution of a situation that has already taken too large a toll on the nation.

Executive Summary

For the eighth year, Numerof & Associates, in collaboration with Dr. David Nash, Founding Dean Emeritus of the Jefferson College of Population Health, conducted a study of the evolution of population health management across U.S. healthcare delivery. As margins based on fee-for-service grow ever thinner and retail challengers intensify their penetration in the primary care space, we have focused on the adoption of population health management by traditional healthcare providers as part of our broader interest in the realignment the healthcare industry to deliver better care at lower costs.

This report is based on an online survey of nearly 100 C-suite healthcare executives who graciously shared their perspective with us. Key study findings include:

Despite general agreement that the importance of population health is growing, risk-based models remain a small component of health systems' business.

Consistent with years past, a majority of respondents (64%) said that population health would be "critically" or "very" important for future success, but they also made it clear that their organizations are still early in their journey toward a new model. While 99% of respondents said their organizations have some revenue at risk, the median amount of revenue at risk – as measured by the percentage of revenues in risk-based agreements – was just 25% – an increase from prior administrations of this survey but still small, nonetheless. Given the very modest level of first-hand experience, it comes as no surprise that only about 1 in 3 respondents believe they are "very" or "completely" prepared for risk-based agreements.

For the first time since this survey was initiated, progress toward population health matched predictions made 2 years prior.

In the 2021 survey, participants predicted that a median of 25% of total revenue would be at risk in 2023 – correctly anticipating the actual amount of revenue at risk. In all previous administrations of the survey, respondents' organizations did not live up to their own expectations. This could be an indicator that not only are delivery organizations adopting public health principles more broadly, but respondents are also getting more realistic about the gradual pace of progress.

There continue to be three primary motives for organizations to pursue population health: 1) performance-based financial incentives; 2) to control clinical costs, quality, and outcomes; and 3) alignment with company mission/culture. However, the threat of financial loss looms large for delivery organizations and is often cited as the primary barrier to population health.

The promise of performance-based financial incentives was the most commonly cited driver for pursuing population health (28% of respondents). *Controlling clinical cost and quality* (26%) and alignment with o*rganization mission/ culture* (22%) were the second and third most commonly cited. In light of the pandemic's disruption of fee-for-service revenue streams, we explored the extent to which increased revenue predictability was a driver. It appears at this point that enhancing revenue predictability is not a significant factor in adopting population health.

Consistent with prior years, the *threat of financial loss* was the most often cited barrier to population health (23% of respondents). *Issues with internal systems and difficulty modeling the cost of care across the continuum* were also commonly acknowledged key challenges.

For many organizations the fear of financial loss is well founded because they lack the capabilities needed to manage variation in costs at the physician level.

Concerns about the *threat of financial loss* have reliably been the leading obstacle to implementation of population health. That is consistent with the fact that more than half of respondents rated their organizations' ability to manage variability in cost of care as "average" or "below average." Our data suggests that relatively few organizations have engaged physicians – who are the leading driver of utilization costs – in efforts to establish reasonable standardization in clinical practice patterns. Effectively managing variability in cost of care requires deliberate infrastructure improvements such as evidence-based care paths or order entry systems that flag variations. Routine use of any one of several key infrastructure processes was found to be positively correlated with organizations' preparedness for risk and reported ability to manage cost at the physician level. But they remain absent or underdeveloped in most organizations with little progress made over the past six surveys.

Progress toward offering more services to address social determinants of health (SDOH) has stalled.

One of the most significant trends over the previous six survey administrations was increased institutional involvement providing services in response to underlying social determinants of community health. Services including telehealth, preventative care and wellness programs, home health services, and retail clinics have become more prominent in recent years. In the current survey, however, growth in the percentage of institutions providing these services seems to have stalled.

In summary, respondents indicate that population health will be important to their organizations' future, but risk-based agreements remain a marginal part of the industry's collective revenue model. While there has been some small growth in the adoption of at-risk contracting, fee-for-service remains the overwhelming model in use. Most organizations have not meaningfully engaged physicians in efforts to manage cost and quality and remain reluctant to contract at-risk for fear of financial loss. We offer our observations on what it will take to accelerate this process.

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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 eighth 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 14,231 individuals were invited to participate in the online survey, which was fielded from May 2023 to November 2023. 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 98 surveys, corresponding to a response rate of 0.69% of individuals and 3.7% 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 (35%) were overrepresented compared to recently published numbers (20%).[1]

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] 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 cost 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 compensation of provider organizations has not been linked to quality or cost 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.

Despite falling short of their value-based payment goals for 2018, CMS continued to pursue a market-based healthcare system that prioritizes value over volume. The Trump administration introduced the Pathways to Success redesign of the MSSP program and Direct Contracting to expedite delivery organizations’ adoption of two-sided risk. These programs coincided with an initiative to expand patient choice and improve site-of-care flexibility for Medicare beneficiaries. Price transparency rules followed shortly thereafter, requiring hospitals to post their prices for 300 common services by the start of 2021. However, despite a Supreme Court decision affirming the new rules, non-compliance with the rule remains widespread. Numerous administrative, legal, and economic barriers must be addressed before it will make a significant impact on the industry.

Meanwhile, the Medicare Access and CHIP Reauthorization Act (MACRA) remains in effect with broad political support. 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. Stakeholders across the industry see the program as an improvement to the preceding legislation intended to control federal healthcare spending, but MACRA is by no means a holistic solution to reshaping physician practice patterns.

Outside of the policy realm, 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. Walmart continues to open standalone clinics offering primary care, dentistry, eyecare, lab tests, even behavioral health services, at costs significantly less than most conventional providers. The company had 32 health centers in early 2023, is planning on 75 locations by the end of 2024, and is reportedly exploring majority ownership in ChenMed, a primary care company with more than 100 health centers in 15 states.

CVS Health bought Oak Street Health in 2023, adding 169 urgent care centers in 21 states to a health-care empire that already includes a major insurer and drugstore chain. CVS maintains over 1100 Minute Clinics across the country offering basic ambulatory treatments for emergent illnesses and injuries; and over 900 HealthHUBs (i.e., “Minute Clinics on steroids”) specializing in chronic disease and offering expanded medical and wellness services.

A long list of other challengers – Amazon, Apple, Walgreens, and even Dollar Stores – are also building and testing unconventional solutions with the potential to cause major disruption for traditional providers.

If these organizations’ internal investments weren’t enough to concern traditional healthcare organizations, their M&A activity should be. Walmart acquired MeMD, providing it with virtual care capabilities to go alongside its growing brick-and-mortar presence. As part of its goal to “reinvent healthcare”, Amazon bought One Medical along with its disruptive patient-centric primary care technology platform. **Taken together, the strategic moves by not-in-kind competitors and others sends a clear message: Barriers to entry in healthcare are eroding and if traditional health systems won’t satisfy consumers’ unmet needs, somebody else will.** While some delivery organizations have taken steps to compete with these new players on the basis of cost and quality, most have not. They’ve instead turned to familiar protective strategies, such as reducing direct competition through M&A or lobbying aggressively to create regulatory barriers through trade groups such as the American Hospital Association (AHA).

And of course, there’s the recent pandemic. 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 latent 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 3 years after the onset of 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 the memory of the pandemic fades, 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 slowly 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 eighth year of our study.

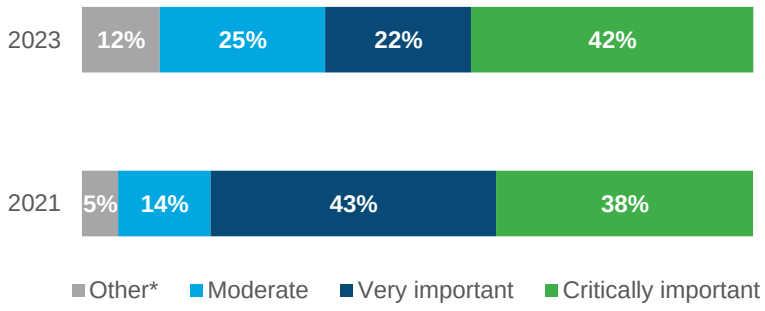
Key Research Findings

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

1. Population health is expected to be an important driver of future success; however, participation in risk-based initiatives continues to be marginal

Consistent with past surveys, a majority of respondents considered population health very or critically important for their organizations' future success. However, in 2023, only 64% of respondents said that population health would be "critically" or "very" important for future success, a marked decrease from 81% in 2021, and a departure from six prior years in which responses were reliably in the 80-85% range.

Figure 1: How important do you think population health will be for the future success of your organization?

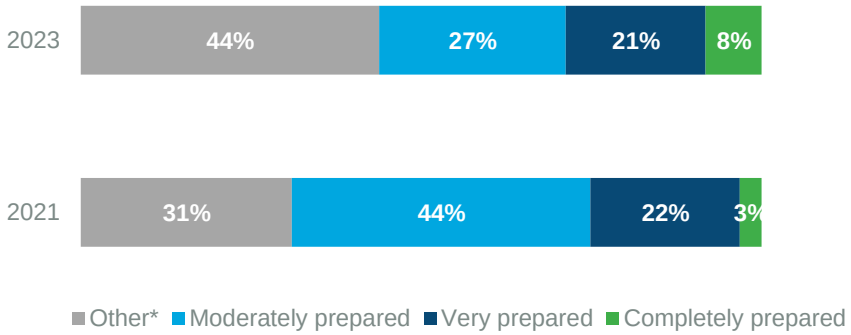


*Represents responses of "Slightly" or "Somewhat important"

Does the drop in perceived future importance of population health suggest that survey respondents are becoming more skeptical about its adoption? We analyzed the current response pattern against the prior six years and did not find the departure statistically significant. So, we can't conclusively say that the data signals a change in sentiment, but for now it's just an unexpected change which bears watching.

When we asked respondents how ready they felt their organization is to manage against cost and quality outcomes, we were surprised to find the suggestion that confidence had retreated. In the last survey, 69% of respondents had felt their organizations were at least moderately prepared for at-risk management; but in this administration only 56% felt that way.

Figure 2: How prepared do you think your organization is now for payment models involving financial risk related to cost and quality outcomes?



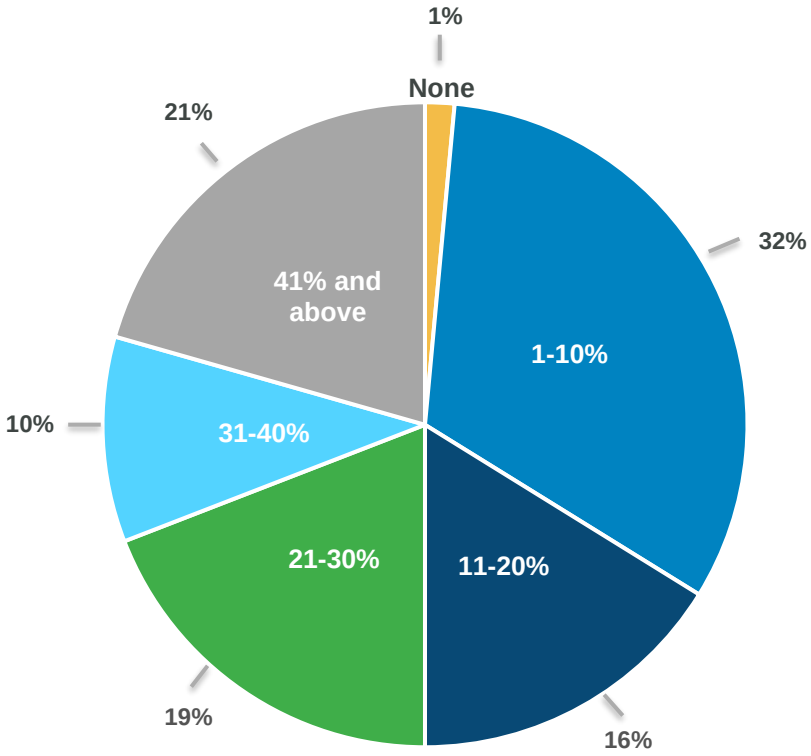
*Represents responses of "Somewhat prepared", "Somewhat unprepared" or "Very unprepared"

Based on our analysis of this administration results against the prior six administration, the size of the sample and of the change does not reach statistical significance, but the data does suggest a downturn in confidence that, if continued, would be cause for concern

Participation in Risk-Based Initiatives

When we asked participants how much of their revenue is subject to performance-related gain or loss, results were generally a step toward population health adoption. Almost all respondents – 99% – reported some participation in alternative payment models, up substantially from 80% in 2021 ($p<0.01$).

Figure 3: How much of your revenue is subject to performance-related gain or loss



The biggest surprise was that **the median amount of reported revenue that flows through risk-based contracts was 25%.** While this is still a very limited share, it does represent a meaningful increase over 2021, and compares well to median revenue reported over the past six administrations, as shown in Figure 4, below.

Figure 4: Median revenue subject to risk

	2016	2017	2018	2019	2020	2021	2023
Median % of revenue at risk	10%	10%	10%	10%	15%	10%	25%

We also surveyed participants on capitated contracts, and more than half of respondents reported 0-5% of revenue through capitation. This figure is remarkably consistent with previous survey administrations dating back to 2016, as illustrated in Figure 5 below.

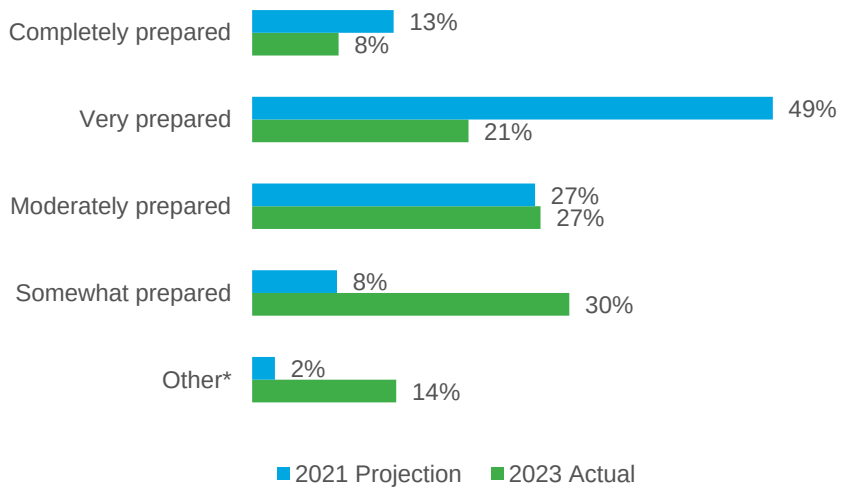
Figure 5: Median revenue through capitation

	2016	2017	2018	2019	2020	2021	2023
Median % of capitated revenue	5%	0%	5%	5%	5%	0%	5%

2. Organizations are failing to meet their own expectations around risk

In every survey we ask respondents how ready they believe their organizations will be to take on at-risk contracts in 2 years. So far, the reality has disappointed in each survey. In 2021 the survey asked, "how ready will your organization be to assume risk for cost and quality in 2 years?" As shown in Figure 6, estimates of progress that would be made far exceeded reported performance in the 2023 survey.

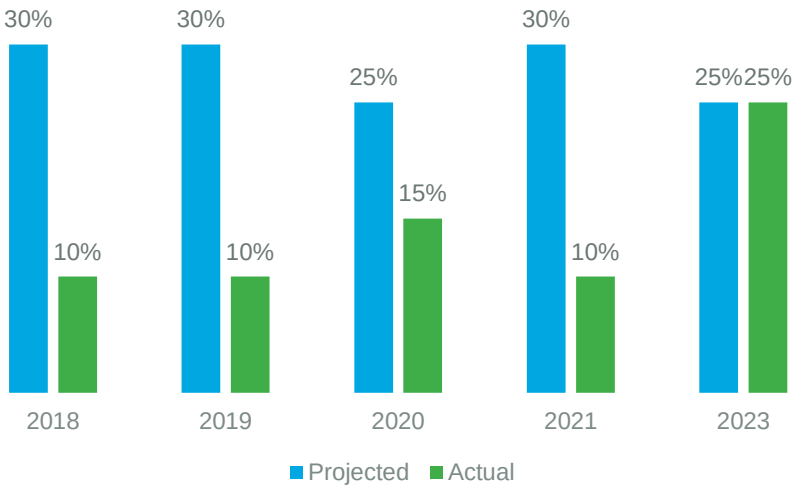
Figure 6: Respondents' readiness to assume risk in 2023 falls far short of their predictions two years prior



*Represents responses "Completely", "Very", or "Somewhat unprepared"

Similarly, respondents in the 2021 survey also predicted an increase in the percentage of annual revenue that would be at risk by 2023. As shown in Figure 7, according to respondents in our 2021 survey, a median of 25% of their organization's revenue was predicted to flow through risk-based contracts in 2023. This is the first time in the past five survey administrations that the actual median amount of revenue at risk matched what had been projected. This marked increase in the percentage of revenue at risk could be an indicator of broader adoption by the delivery sector of population health principles.

Figure 7: Median revenue at risk as a percentage of total revenue: Actual vs. projections made 2 years prior



Organizations have grown comfortable with fee-for-service. After decades of operating under the model, they know how to maximize their margins within it. In contrast, population health represents uncharted territory that, absent external events, many organizations are unwilling to enter.

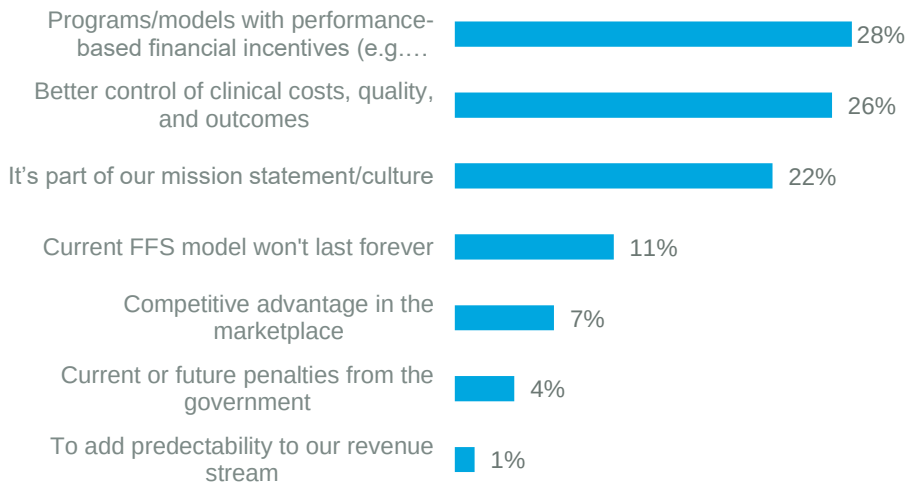
Despite the modest progress, expectations around alternative payment models remain high relative to what's in place today. Respondents predicted that a median of 35% of revenue will flow through risk-based contracts in 2025 – 40% more than the 2023 amount. A general observation we've made throughout the eight administrations of this survey is that until organizations adopt a sizable amount of risk and move up the experience curve, there's a degree of naivete regarding the challenges associated with transitioning to population health and a tendency to overestimate the pace at which risk will be adopted.

3. Organizations are finding the opportunity for financial incentives in population-based models increasingly appealing

Figure 8 below reflects what respondents said was the *primary* driver for pursuing population health in their organization. Responses to this question have been relatively consistent over past administrations. *Controlling clinical cost and quality* has been the leading driver each year since 2016. *Organization mission/culture* and *Performance-based financial incentives* have been the second and third most frequently cited driver in each of the last 4 administrations.

In the current administration, *Performance-based financial incentives* took the top spot as the leading driver, pushing the longstanding first and second choices to second and third place.

Figure 8: Primary reason for pursuing population health



In 2021 we added a choice labeled "To add predictability to our revenue stream" as an option. We had thought this might be a reason for pursuing population health, given the financial disruption that was common during the pandemic when FFS revenue streams dried up. Results, however, were very similar to those in 2021; only 1% of respondents reported "To add predictability to our revenue stream" as their primary reason for pursuing population health. In fact, this was deemed a "significant driver" only 35% of

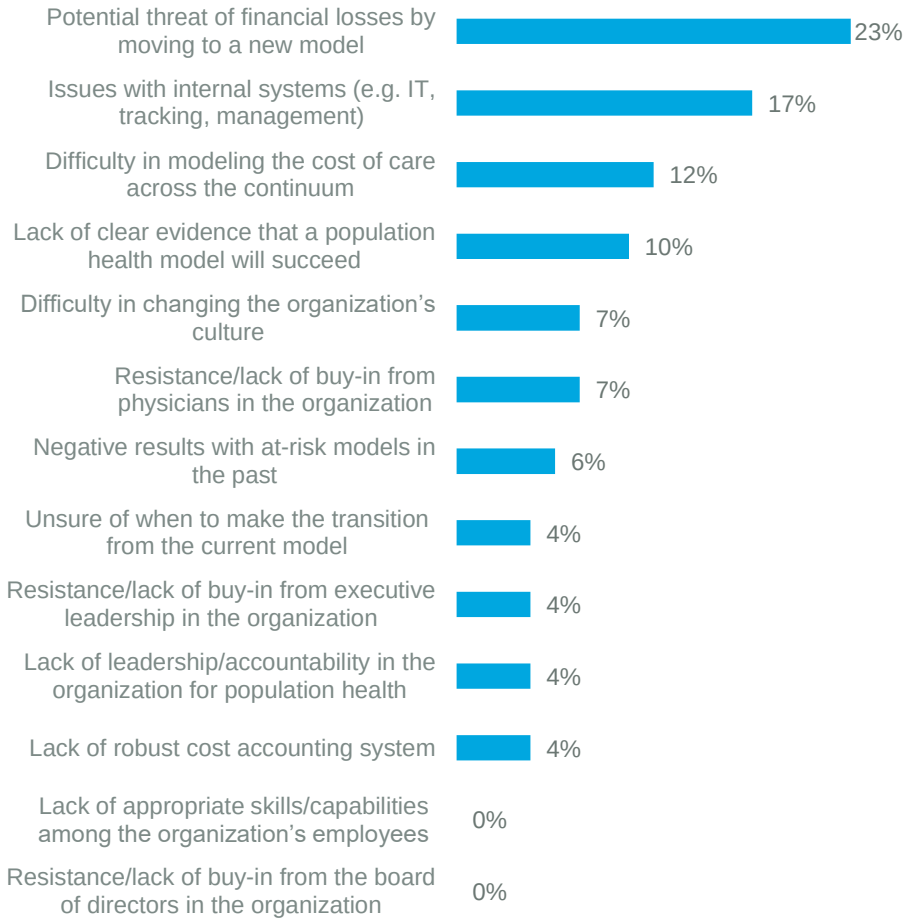
the time – the lowest frequency of all responses listed in Figure 8. This suggests that most health system leaders do not yet see a population health approach as offering superior financial stability over FFS.

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

As discussed above, health systems see population health as important to their future success, but until 2023 have consistently fallen short of their own expectations regarding their transition to risk. This raises a simple but important question: Why?

Our survey explored the barriers impeding health systems' progress toward population health. Figure 9 below reflects what respondents most frequently reported to be the primary barrier – the single most challenging obstacle. As has been the case each year since 2016, the *threat of financial loss* was the most often reported primary barrier (23% of respondents). *Issues with internal systems,* and *difficulty modeling the cost of care across the continuum* have been and remained the second and third most frequently cited challenges.

Figure 9: Primary barriers to pursuing population health



The fact that respondents cite *threat of financial loss* as their primary barrier is consistent with respondents' self-assessment of their organizations' capability to manage the cost of care (see Figure 9). 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. The fact that physicians – the leading driver of cost in the hospital – are operating independently and without common processes and metrics makes the organization subject to surprises in the cost of care. Concerns about financial loss have a solid basis in reality.

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. At-risk initiatives launched by CMS (like Medicare Shared Savings) have provided organizations with some incentive to stand up these

mechanisms, but their development is often met with pushback from clinicians and administrators alike.

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. Respondents recognize this gap as indicated by it being identified as the 2nd most significant barrier.

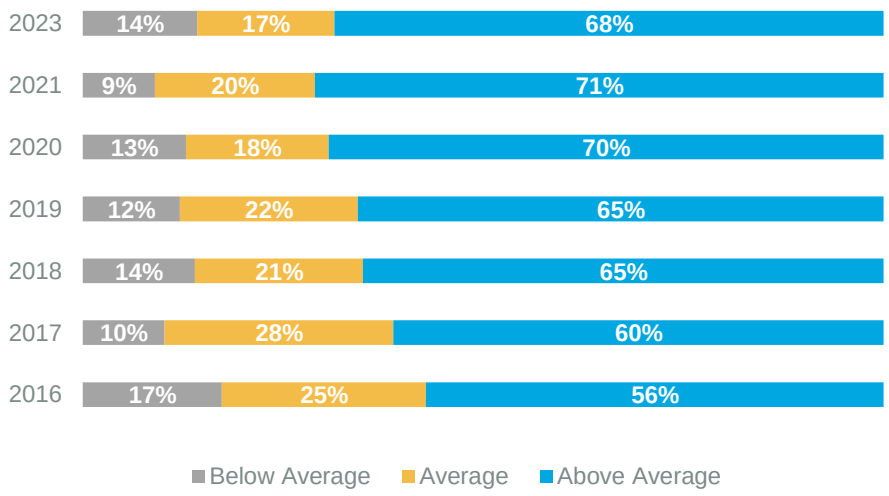
Modeling of the total cost of care across the continuum is an important exercise to mitigate the threat of financial loss and determine the appropriate pace at which organizations should transition to population health. However, many organizations struggle with this assessment as it hasn't been a requirement in fee-for-service models. Most organizations lack the tools and data to credibly forecast what their return would be under various at-risk scenarios and as a result, many respondents (12%) identified *difficulty in modeling the cost of care across the continuum* as their organizations' primary barrier.

5. Organizations' ability to manage variation in quality has grown while management of cost lags behind

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

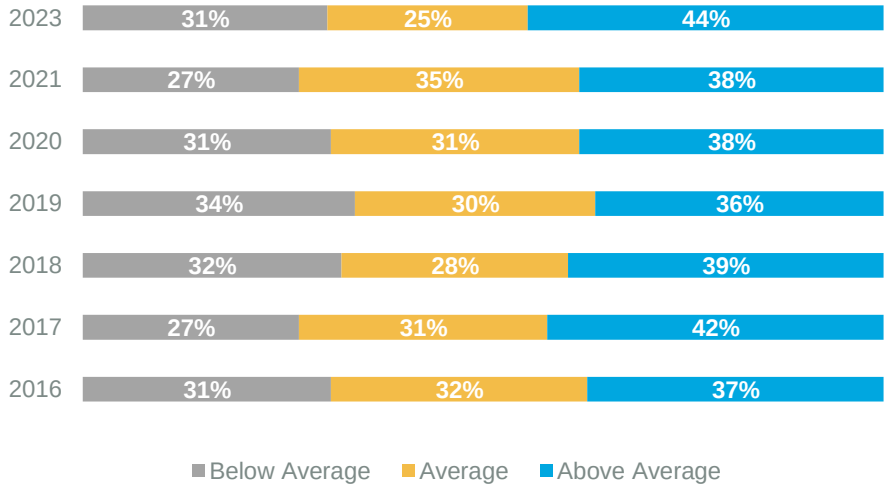
In this eighth year of our survey, progress in the management of variation in clinical quality has remained stagnant. The proportion of respondents who view their organizations' ability to manage variation in quality at the physician level as "above average" (which had grown by 15% between 2016 and 2021) appears in 2023 to have plateaued (see Figure 10).

Figure 10: The ability to manage variation in clinical quality at the physician level appears to have plateaued in 2023



The ability to manage variation in clinical cost at the physician level is a different story. A majority of respondents (56%) rated their organization's ability to manage variation in cost at the physician level as "average" or "below average" (see Figure 11). In the context of the past six survey administrations, little progress has been made in this area over time.

Figure 11: 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

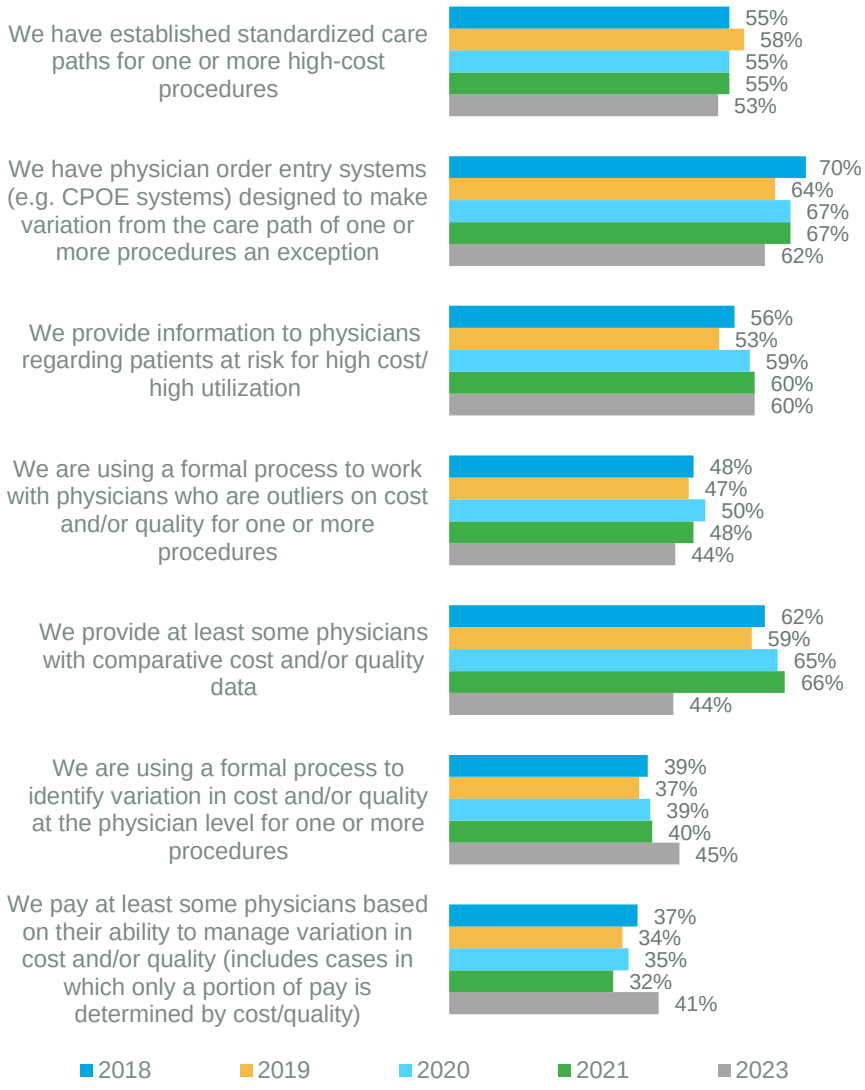


Given that physician decision-making is the most significant driver of healthcare spending, organizations serious about managing cost and quality variability must develop mechanisms for administrative leaders to engage with physicians to influence clinical practice patterns. Mechanisms to this effect 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 cost and quality performance are not being used routinely at most organizations (see Figure 12), despite health systems now employing over half of the nation's physicians. As one exception, in this administration of the survey, more respondents (60%) than in previous iterations reported that their organization routinely provides information to physicians regarding patients at risk for high cost/utilization. Identifying high-risk patients early allows healthcare organizations to implement preventive measures or interventions that can help avoid more expensive treatments or hospitalizations later on.

Our perspective has long been that until mechanisms like those cited here are used on a routine basis, management will continue to struggle to control clinical cost, the fear of financial loss will remain well founded, and revenue at risk will remain the exception rather than the norm.

Figure 12: 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



This year, we tested this hypothesis by exploring the relationship between the mechanisms listed in Figure 12 and other survey responses that indicate organizations' preparedness for population health. Most interestingly, regression analysis indicated that the routine use of any one of the mechanisms listed in Figure 12 was positively correlated with organizations' reported preparedness for risk and confidence in their ability to manage cost at the physician level.

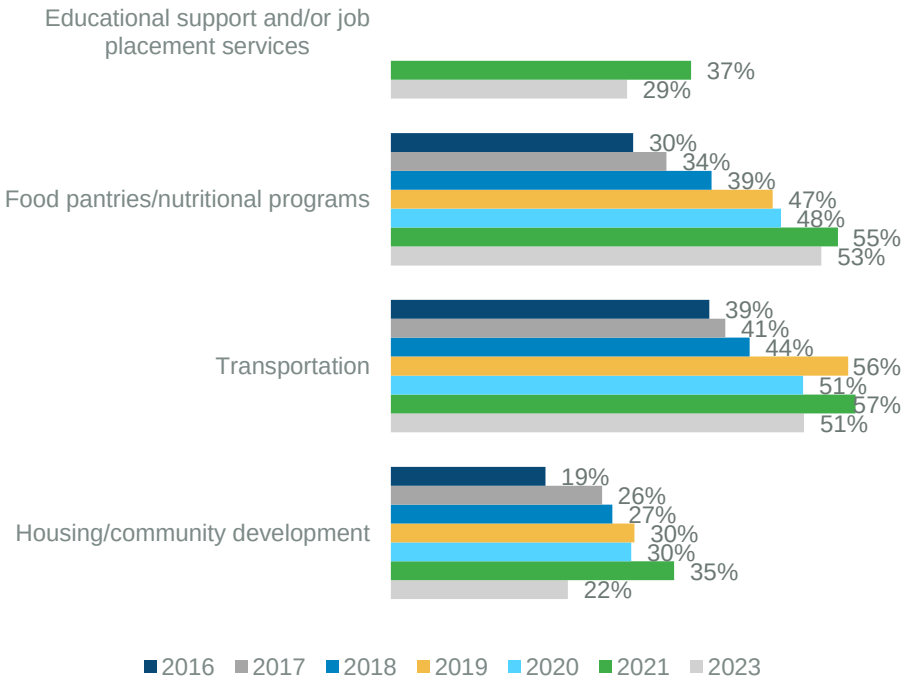
Certainly, strong support from the highest ranks of leadership is critical to operationalizing any one of these mechanisms. Leadership must define the organization's vision for population health and ensure staff understand why these capabilities are critical to achieving it.

6. 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 13, significant progress has been made by respondents' organizations to address challenges such as food insecurity, housing, and transportation needs since 2016, but progress in these areas appears to have peaked across the board in 2021, and declined in 2023. In fact, service offerings to address housing and community development needs have actually decreased from 35% in 2021 to 22% 2023. Educational support and/or job placement services were also explored for the second time, with only 29% of respondents (compared to 37% in 2021) reporting that their organizations have such programs in place.

Figure 13: Progress toward offering more services to address social determinants of health has stalled. Chart indicates organizations offering services via partnership or through direct ownership of programs

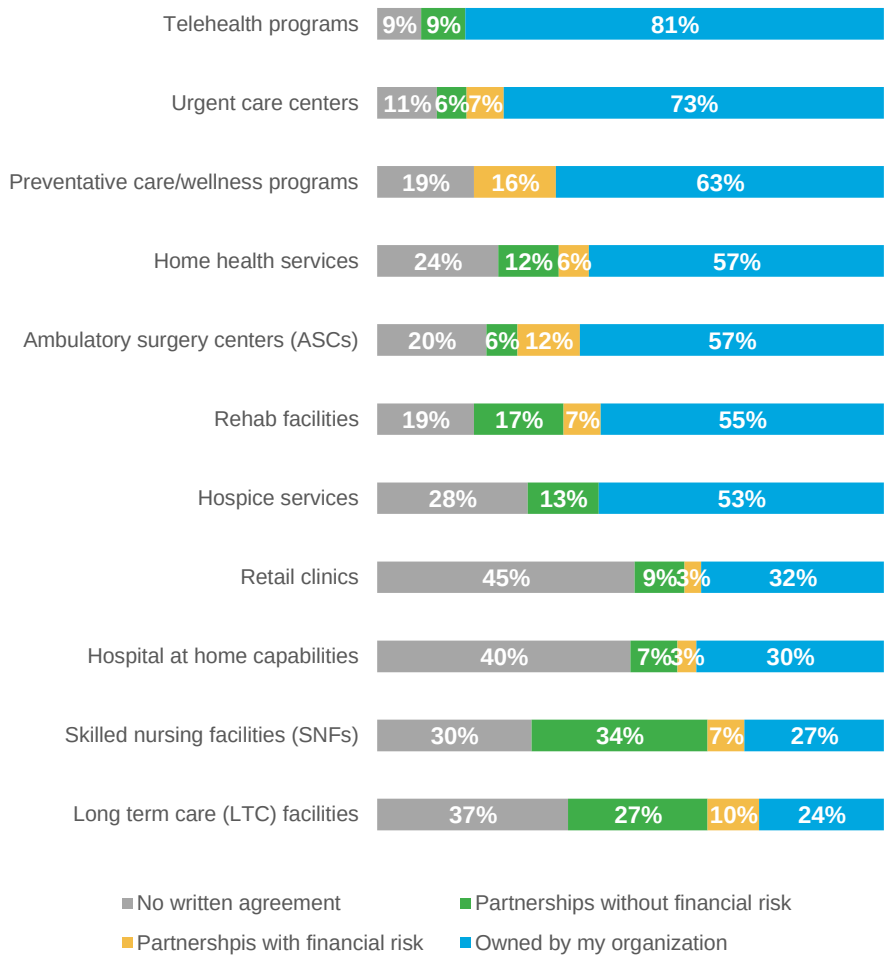


The pandemic's disproportionate impact on less affluent populations underscored the health disparities that exist across our society. Likewise, the pandemic made it impossible to get serious about population health, yet to ignore the socioeconomic factors that contribute to disproportionate health impact. 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.

7. Organizations are expanding their presence across the care continuum

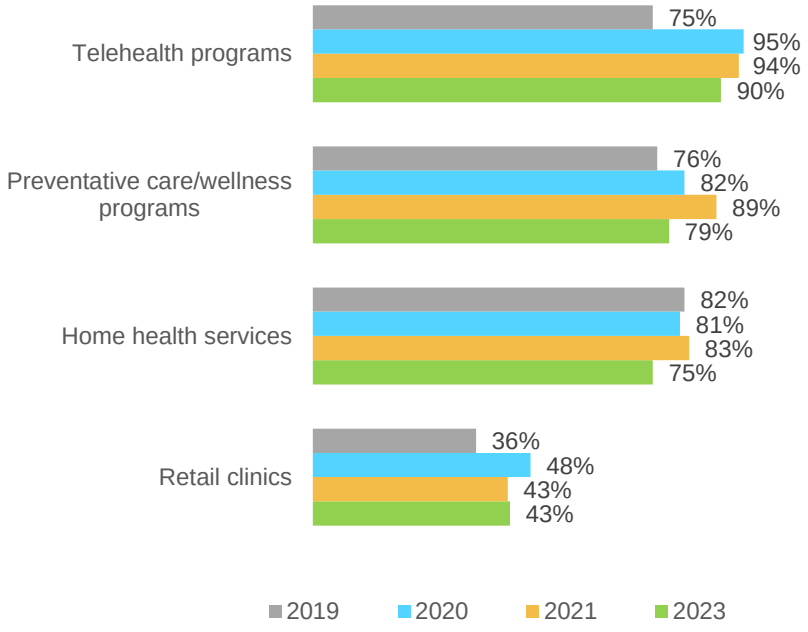
Achieving lower costs and better health outcomes requires ensuring that patients get the right care, at the right time, and at the right place in a given patient's care journey. Recognizing this, many hospitals and health systems have acquired or partnered with organizations that provide services at various points in the continuum (see Figure 14).

Figure 14: Coverage across the continuum through partnerships and acquisitions: 2023



After reported involvement across the continuum remained relatively stable in the early years of this survey, significant changes occurred in 2020. Increased ownership of telehealth programs, preventative care/wellness programs, home health services, and retail clinics were all reported. As noted in Figure 15, these changes have begun to level-off or even decline slightly in 2023. Reported ownership of or partnerships with home health services fell by 8% in 2023, while preventative care/wellness programs decreased from 89% to 79%. Involvement with retail clinics and telehealth programs was mostly unchanged.

Figure 15: Coverage across the continuum through partnerships and acquisitions: 2019-2023

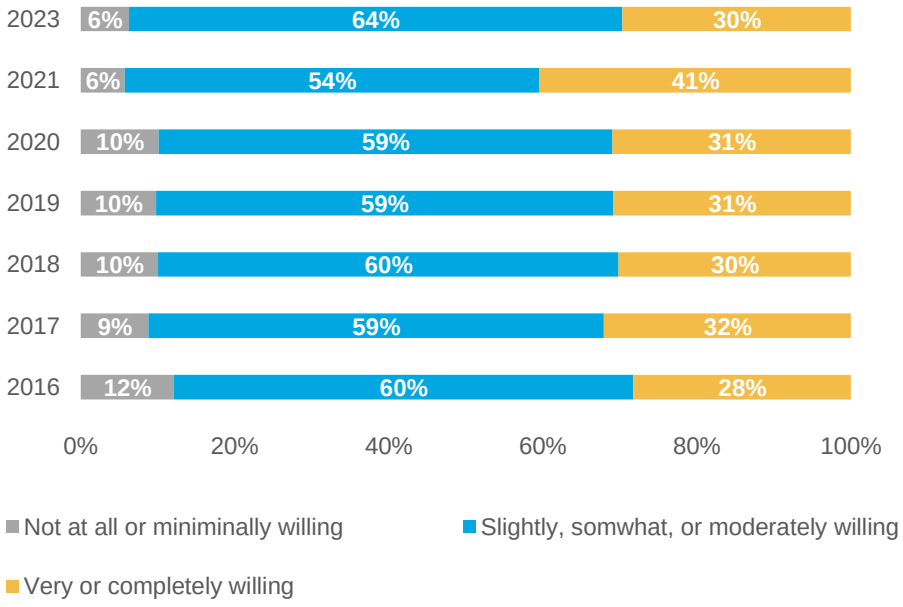


Covid-19 was undoubtedly a main driver of these changes in 2020, especially with regards to telehealth and home health services – capabilities that have been critical to reaching and treating patients, and also cost-effective services that stand to play a significant role in population health. Their drop in use in the third year since the onset of the pandemic may indicate regression towards a pre-pandemic norm that is, in fact, a step backwards.

We see similar results in regards to payers perceived williness to engage in risk-based contracts, something we've explored since the onset of this survey without any notable changes from 2016-2020. However, 2021 revealed a 10% increase in payers being reported as "very" or "completely" willing to enter into agremeents with payments tied to outcomes. However, results

from 2023 show that payer willingness to enter risk-based agreements has reverted to near pre-pandemic levels.

Figure 16: Reported payer willingness to engage in risk-based agreements reverts to near pre-pandemic levels



Payers continue to be reported as no better than “moderately willing” to engage in risk-based contracts more often than not.

Accelerating the Journey

Judging by the tone of public media, a significant change in the priorities and processes that underly our healthcare system is seriously overdue. From our perspective, population health represents a real opportunity for providers to address the growing dissatisfaction with our healthcare system. Not only is there potential to improve 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 this 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. At the same time, healthcare leaders have been forced to focus on operational challenges brought about by the pandemic, making the decision to transition to population health that much more difficult. As a result, most organizations have done little more than experiment with this new business model.

At the same time, calls for greater healthcare value have not slowed. Frustrated with the intractable rise of premiums and deductibles, consumers and employers continue to press payers to moderate costs. 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 the market's traditional players trapped in gridlock, new players are getting involved, ranging from innovative startups with focused solutions, to massive entities with robust capabilities such as Amazon and Walmart. At the same time, politicians are taking action: the passing of the Inflation Reduction Act is sure to spur change, but whether or not it benefits consumers as its authors have promised remains to be seen.

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 has 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 on 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, 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 bore the brunt of the infection. Disadvantaged populations and many "essential workers" experienced a disproportionate share of infections and deaths. And these subpopulations made it that much harder to bring the pandemic 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 serious damage 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?

We continue to be hopeful.