identifying PHM market and network opportunities

Organizational strength will determine differences in strategies for population health management (PHM): The strongest organizations will create the PHM networks, and other organizations will look to participate in those networks.

The transition of U.S. health care to a system focused on managing population health presents significant opportunities and challenges for hospitals and health systems. A seven-process framework—illustrated in the exhibit on page 2—can guide organizations on how to assume a financially sustainable role in population health management (PHM), including determining when and where to focus this effort. This discussion focuses primarily on the fourth and fifth processes within this framework, through which organizations define which patient populations they will serve and how they will serve them. It should be noted, however, that an organization cannot effectively perform these processes without first laying the groundwork with a rigorous evaluation and analysis, which constitute the preliminary phase of the framework. (The processes making up this initial phase are discussed in the sidebar on page 4.)

Identifying Potential PHM Market Opportunities

Identifying entry and/or expansion points into the PHM arena is complex and critical work. The strongest organizations will seek opportunities that span both delivery and financing/insurance plan functions across the whole care continuum. Most hospitals and healthcare systems, however, will be looking for PHM opportunities to contract with other entities to deliver defined services, thereby fostering delivery system growth. Other organizations will be looking for a mix of the two.

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Key variables related to opportunities include the patient population, the overall insurance/employer market, and available types of insurance products.

**Patient populations.** Patient populations should be segmented for consideration by their type of insurance coverage, with segments including Medicare (traditional or Medicare Advantage), Medicaid (traditional or Managed Medicaid), dual eligible for Medicare and Medicaid, and commercial plans through employers or public/private exchanges using HMOs, PPO plans, or other types of plans. A common initial strategy for many organizations is to focus first on managing the care needs for their own employees through self-insured or risk-sharing arrangements.

Each segment can be further stratified according to the health-risk categories of patients. For example, a segment defined as “patients with multiple chronic conditions and comorbidities” represents a high-risk population across each of the segmented payer classes. Organizations that need to gain experience in caring for populations under value-based arrangements commonly start with this segment.

**Insurance/employer landscape.** The speed of new developments in the employer and insurer markets, which varies by region, will have considerable impact on the opportunities available to hospitals and health systems. In areas where employers are shifting employees into defined-contribution, high-deductible health plans, narrow and tiered networks that limit patients’ choices of hospitals and physicians are more common. Many public and private exchanges also offer such networks, which appeal to price-sensitive consumers who are willing to trade breadth of provider choice for lower premiums and copayments. The key question for a hospital is whether it will be included in or excluded from the network.

Large area employers may be receptive to direct contracting with healthcare providers for specific services or a full scope of services under risk-based arrangements. Small and mid-size employers may be looking to move their employees into the public exchange or some type of private exchange in which hospitals could participate as part of the defined network. Benefits consultants and brokers can help providers gain an understanding of the local employer and insurer universe.
Detailed analysis of the health insurance landscape in local communities and the region is recommended, with a close look at the following elements:

> Types of commercial fee-for-service arrangements and volume by payer and plan
> Types and penetration of managed care arrangements
> Types of self-insured employer-directed programs and attributed patients
> Pricing of premiums for private and public plans
> Presence of tiered or narrow health plan networks
> Enrollment in public and private exchanges by plan type

The value of such an analysis for sophisticated organizations is in discovering what opportunities might be available to build, buy, or partner with another entity to offer an insurance product to a defined covered population. Other, less-sophisticated organizations can benefit from identifying which plan or plans might be a good partner for a PHM contracting arrangement, from which the organization could gain experience in assuming various levels of risk for a patient population. For each insurance product type, service needs vary based on population health-risk profiles. For example, Medicare beneficiaries who receive care under private managed care arrangements have a higher health-risk profile than do individuals who receive care under commercial insurance provided by their employers.

Managed Medicaid and Medicare Advantage programs may be scattered or in early stages of adoption, but can be expected to grow in most areas. The level of concentration and competition in the private managed care insurance markets will likely influence the aggressiveness of the pricing strategy and premiums for commercial plans.

Four factors in a market tend to create a more promising landscape for PHM opportunities:

> High utilization rates and costs per discharge, representing opportunities to lower both trends
> Employers that are highly sensitized to healthcare costs and willing to make significant changes to their healthcare benefit designs
> A market movement toward managed care products and services, with evidence of an increasing willingness to entertain discussions of risk contracting
> The presence of new competitive dynamics, such as benefit design changes for state employees or new insurer/plan entrants

Each insurance segment can be further evaluated to identify high-level product opportunities, possibly including commercial ACO programs, self-insured employer-directed programs, private exchanges (both fully insured and self-insured), public exchanges products, Medicare Advantage, Managed Medicaid, and others.

The organization then can layer in criteria related to these specific products, such as enrollment size, growth potential, managed care penetration, revenue (premium) opportunity, profitability, regulatory/reform environment, and population health risk profile.

For example, if Medicare Advantage programs seem to present an opportunity, per-member-per-month capitation rates in the region can be compared with those in other metropolitan areas of similar size and other counties of similar size. By looking closely at capitation rates as a percentage of fee-for-service payment, an organization can determine whether it can gain an upside benefit from effectively managing patient care and reducing utilization. For example, if capitation rates are more than 100 percent of fee-for-service rates, there could be a promising opportunity, depending on the organization’s ability to coordinate patient care and reduce costs. To fully comprehend the opportunity, however, the organization must thoroughly evaluate issues related to how capitation rates are set and what each plan is paid.

**Benefit design and product type.** Individual benefit plans offered by payers vary, and the extent to
Laying the Groundwork for PHM

Performing a rigorous evaluation and analysis is critical to successfully identifying opportunities to manage population health and determining the network scope and scale needed to realize those opportunities. Such an effort constitutes the first broad phase of the population health management (PHM) development framework, during which healthcare leaders gain an understanding of the roles providers will play in PHM, how quickly the transition to that model is occurring in their markets, and the extent to which their organization possesses the specific competencies required to deliver high-quality care to a specific population while managing the population’s total cost of care. This analytical phase comprises three processes.

Organize around PHM. To achieve effective and efficient PHM, health systems and provider networks will need to work collaboratively to improve the overall health, health outcomes, and well-being of patients across all defined care settings under risk-bearing arrangements.a

Different organizations will play different roles in PHM, reflecting their ability to incur and manage risk, and based on numerous factors, such as their care management capabilities, scale, and points of access/consumer interface.

Some large healthcare systems will be functioning as population health managers that provide a full continuum of services at competitive prices across acuity levels for regional populations. Assuming full financial risk, they will do this either directly with employers or through contracted relationships with insurers.

At the other end of the risk spectrum, some hospitals—such as critical access and rural hospitals, and post-acute facilities—will be niche providers. These organizations will offer specified services to target populations, working under contracts within networks that are managed by larger entities. Specialty providers also may function in this role, assuming some level of risk for specific services (e.g., cancer bundles) or populations (e.g., children). The exhibit at right defines the five key types of providers within a PHM model. The roles of each provider are summarized in the exhibit on page 5.

An organization’s desired role must be firmly grounded on its strategic-financial condition.

Determine market stage. Service delivery areas are moving toward value-based care delivery and payment at different rates. Their stage of development varies based on factors including employer/purchaser movement toward defined healthcare benefits; level of organization among hospitals and physicians; enrollment in public exchanges; insurance product/network

Source: Kaufman, Hall & Associates, LLC

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which plans differ will have a significant effect on an organization's ability to move the PHM needle on indicators such as admissions per thousand, length of stay, and readmission rates. Care delivery or assumption of risk for particular benefit design or product type will be more or less attractive to an organization based on what it can achieve.

The exhibit on page 6 provides an example of a high-level look of opportunities for one organization by type of product. Critical to success in each product area will be the organization's ability to produce managed care savings by reducing utilization compared with baseline fee-for-service models. Medicare Advantage presents a particularly important opportunity in that for the use rate for this population is inherently higher to begin with, allowing more room for early improvements in use-rate reduction.

Identification of viable PHM opportunities for hospitals and health systems should be data-driven, market-specific, and realistic. The

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Contracted Participant</th>
<th>Single-Product Participant</th>
<th>Multiproduct Participant</th>
<th>Population Health Comanager</th>
<th>Population Health Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk/Payment Model</td>
<td>None, FFS payment</td>
<td>Blend/episodic</td>
<td>Blend/episodic</td>
<td>Full or partial provider risk; unlikely to take on health plan risk</td>
<td>Full provider risk; may take on health plan risk</td>
</tr>
<tr>
<td>Clinical Integration</td>
<td>No</td>
<td>Maybe</td>
<td>Likely</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Network Adequacy/ Market Essentiality</td>
<td>Low</td>
<td>Low</td>
<td>Low to moderate</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>Insurance License Ownership</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Maybe, but not required</td>
<td>Limited or regular license</td>
</tr>
<tr>
<td>Membership Ownership</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Maybe, but unlikely</td>
<td>Yes</td>
</tr>
<tr>
<td>Examples</td>
<td>• Critical access hospital</td>
<td>• Academic medical center</td>
<td>• Integrated delivery system</td>
<td>• IPA</td>
<td>• Clinically integrated network</td>
</tr>
<tr>
<td></td>
<td>• Safety net hospital</td>
<td>• Children's hospital</td>
<td>• IPA</td>
<td>• Clinically integrated network</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Community hospital</td>
<td>• Specialty hospital</td>
<td>• Community health system</td>
<td>• Integrated delivery system</td>
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<tr>
<td></td>
<td></td>
<td>• Senior independent practice association (IPA)</td>
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</table>

Source: Kaufman, Hall & Associates, LLC

Evaluate the organization’s position and competency gaps. Nine capabilities are important for PHM, but usually a few capabilities require significant focus in order to establish the organization’s value for payers, employers, consumers, and other stakeholders. The competencies are clinical integration; clinical care management; network development, configuration and relevance; operational efficiency; clinical and business intelligence and actuarial services; purchaser relationships and managed care contracting; financial strength; brand strength, customer service, and engagement; and effective leadership and governance.

Based on an objective evaluation of these competencies, organizations should develop and implement strategies aimed at strengthening existing competencies, and building, buying, or partnering to establish new competencies as needed. An organization’s identification of opportunities to manage population health, as described next, should be based on its competitive PHM strengths and weaknesses.
organizational PHM strategy should be objectively defined within its integrated strategic-financial plan so that risk is effectively managed as the organization transitions to value-based payment mechanisms under a PHM construct.

**Determining the Scope of the PHM Network**

Effective and sustainable PHM requires the design and continuance of a high-performance delivery network that covers the care continuum under an optimized contracting strategy. Sophisticated organizations will develop and control such optimized networks; other organizations will look to participate in such networks.

In moving away from fee-for-service care delivery and financing models, organizations should scrutinize their provider networks in a different light. Although many of the traditional strategic criteria for a viable network still apply (e.g., demand for services, access points and footprint, competitive market positioning), additional criteria will be needed for a high-performance network for managing population health. Specific criteria include:

- Network essentiality and PHM care continuum
- Network adequacy
- Service distribution right-sizing
- Delivery network growth strategy
- Organizational agility

These five criteria for a high-performing delivery network are not mutually exclusive, but each has certain nuances that will be important for hospitals and health systems to understand and evaluate.

In particular, the criteria will need to be assessed on a population-by-population basis as determined by type of insurance, whether Medicare, Medicaid, commercial, insurance exchange, employer, or other insurance products. Each population likely will have unique demand and risk factors driven by demographics, socioeconomic, and a variety of other considerations, which will need to taken into account to meet different service and network requirements.

For example, the Medicaid population typically has higher demand for mental health services and social services and higher physical healthcare needs. A PHM network for this population should have, or be aligned with, a network of providers and agencies that are capable of integrating these...
key functions into the care model. This care model also should be adaptable to changes in eligibility criteria and requirements and the evolving needs of the population segments.

That said, here are key considerations with respect to each of the five network criteria.

**Network essentiality and PHM care continuum.**

Network essentiality is determined by healthcare purchasers based on the scope and scale of the delivery network. To be considered essential, a network must provide the breadth and depth of care desired by the purchaser, and be able to handle the projected volume of patients.

Network essentiality to the purchasers of care is usually tied to an organization’s primary care provider network and/or geographic presence, and it is measured based on the population that can be attributed to the provider delivery network. The larger the population captured or covered by an organization, the more essential the network will likely be with respect to PHM.

Network essentiality and PHM care continuum. As organizations determine the right breadth for their network, trade-offs will be apparent. The broader the network, the harder it typically is to manage performance—especially without vested and aligned partner entities. However, the narrower the network, the harder it will be to manage a critical mass of patients/populations, thus also making it harder to spread the risk for managing these populations.

Network adequacy. This criterion refers to sufficiency of access to in-network primary care and specialty physicians, hospital services, and other specified continuum of care services in a delineated service area. At the most basic level, the service area is the geographic area in which a risk-bearing provider and/or health plan furnishes access to the continuum of services.

In many instances, service area and network adequacy standards are driven by national and state laws and regulations, which vary depending on the regulator. Adequacy will depend on the population served, so health systems should carefully consider the extent to which they can build, contract for, and deliver an appropriate network, given each population’s specific requirements.

Network definitions are dynamic. As care delivery shifts to consumer-driven virtual offerings, providers, purchasers, and regulators alike will attempt to determine how to change historical network definitions from bricks-and-mortar facilities and clinics to virtual delivery mechanisms.

**Service distribution right-sizing.** To succeed under value-based arrangements, many health systems must systematically reconfigure their networks so

The exhibit on page 8 illustrates an example of the care-continuum delivery capabilities of a regional health system. The system has well-developed delivery capabilities with all services except for post-acute and transitional care. Acquisitions or partnerships would be needed to fill these care needs.
they are highly efficient, deliver consistent quality across all sites, and manage patients in the least-intensive setting possible while still providing the necessary level of care. A critical focus will be to eliminate unnecessary duplication of services.

Proactive providers are working hard to determine the best combination and location of services and programs across inpatient and outpatient sites, and across virtual services, such as telehealth. Increasingly multichannel access strategies must be deployed and different care models constructed to meet the unique needs of specific population segments. For example, working individuals will likely prefer access channels that reduce time away from the workplace and, therefore, are likely to be particularly receptive to telehealth, urgent care, and clinics with evening and weekend hours.

The potential rewards can be significant for organizations that get the right mix. Such rewards may include:

- A dramatic reduction of fixed costs associated with physical assets
- More productive use of clinicians’ time
- Increased convenience and reduced prices for consumers

Reconfiguring a delivery network is a multiyear transformational process that should be guided by a clear blueprint of the changes to be made, the key interdependencies, the sequence of changes, and the potential challenges. Physician partnership in the transformation process is critical.

**Delivery network growth strategy.** As PHM-based value arrangements reshape utilization, most
hospitals and health systems will need to expand their attributed or accessible managed populations to support organizational infrastructure and associated costs. Growth typically requires geographic expansion through strategic partnerships or affiliations with employers, providers, or health plans.

Partnering activity among providers and health plans is bourgeoning nationwide. Affiliations among systems in nonadjacent geographic markets also are proliferating, with key goals being to increase efficiencies through streamlined back-office or administrative functions and to expand the market footprint.

Absent growth in the number of attributed lives, organizations should aggressively realign their operations to ensure financial stability. Efficiency is required of providers in all value-based contracting arrangements.

Organizational agility. Designing a robust provider network will be critical for the future success of PHM strategies. As organizations determine the right size and scale for a network, trade-offs will be apparent. The broader the network, the harder it typically is to manage performance—especially without vested partner entities that share the same vision. However, the narrower the network, the more difficult it will be to appeal to and capture a critical mass of patients/populations, thus making it harder to spread the risk for managing these populations.

But network definitions are dynamic, making PHM service delivery opportunities fluid as well. As care shifts to virtual, non-facility-based offerings, providers, payers, and regulatory agencies alike will be trying to determine how to change historical network definitions from brick-and-mortar facilities and clinics to virtual delivery mechanisms.

The role of hospital and health system leaders now centers on building organizational agility—or what the Stanford Graduate School of Business Professor Charles O’Reilly calls “organizational ambidexterity”—defined as the ability to nimbly operate current business while simultaneously preparing for changing or new conditions. In all likelihood, many levels of the seven-level framework will need to be revisited regularly, including the definition of a health system’s best-fit opportunities to manage population health and the network scope and scale needed to realize those opportunities. Change will be a constant in health care going forward under the PHM model, and organizational agility will be critical for responding to that change.


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