Managing Population Health:
A Strategic Playbook for Best-Fit Growth Opportunities

Mark E. Grube, Managing Director
Robert W. York, Senior Vice President
Brian P. Fuller, Senior Vice President
John P. Poziemski, Vice President

Kaufman, Hall & Associates, LLC
kaufmanhall.com
Table of Contents

Introduction .................................................................................................................. 2

Level 1. Understand and Organize Around Population Health Management ............. 3
  Population Health Management Defined .............................................................. 3
  The Care Management Imperative ........................................................................... 3
  Provider Roles with Population Health Management ....... 4

Level 2. Determine the Pace of Market Evolution ................................................... 6
  Level of Organization among Hospitals and Physicians.......................................... 6
  Employer Healthcare Benefits Structure ............................................................... 6
  Enrollment in Public Exchanges and Level of Insurance Product/Network Sophistication .......................................................... 6
  Amount of Vertical Collaboration and New-Entrant Activity .................................. 6
  Demand for Services ............................................................................................... 6
  Supply of Providers .................................................................................................. 7
  Regulatory Environment ......................................................................................... 7
  Pace of Change ........................................................................................................ 7

Level 3. Evaluate the Organization’s Position and Competence Gaps ....................... 7
  Clinical Integration .................................................................................................. 7
  Clinical Care Management ...................................................................................... 7
  Network Development, Configuration, and Relevance ............................................. 8
  Operational Efficiency .......................................................................................... 8
  Clinical and Business Intelligence and Actuarial Services ....................................... 8
  Purchaser Relationships and Managed Care Contracting ....................................... 8
  Financial Strength .................................................................................................. 8
  Brand Strength and Customer Service and Engagement ......................................... 8
  Leadership and Governance ................................................................................... 8

Level 4. Identify Potential PHM Market Opportunities .............................................. 9
  Patient Populations ................................................................................................. 9
  Insurance Landscape .............................................................................................. 9
  Benefit Design and Product Type .......................................................................... 10

Level 5. Determine the Scope of the PHM Network ............................................... 12
  Network Essentiality ............................................................................................... 12
  PHM Continuum of Care ....................................................................................... 13
  Network Performance and Outcomes ..................................................................... 14
  Network Adequacy .................................................................................................. 15
  Summary .................................................................................................................. 15

Level 6. Define a Contracting Strategy to Support PHM Opportunities .................... 17
  Defining Risk .......................................................................................................... 17
  Risk Contracting Options ....................................................................................... 17
  Strategic Risk-Contracting Opportunities .............................................................. 19
  Other Significant Considerations ........................................................................... 19

Level 7. Identify Appropriate Path for Your Organization—Build, Buy, or Partner? ... 20
  Identifying Most Likely Path .................................................................................. 21
  Identifying Potential Partners ................................................................................. 22

Concluding Comments .............................................................................................. 23

References .................................................................................................................. 23

Author Biographies ..................................................................................................... 24

About Kaufman Hall .................................................................................................... 25

© Copyright 2015 by Kaufman, Hall & Associates, LLC
Introduction

Due to its unsustainable costs, healthcare is moving to a new business model that centers on managing the health and care needs of patient populations through value- or risk-based care delivery and payment arrangements. Healthcare organizations will be required to participate in population health management (PHM), whether a major player or a minor one in their communities.

Managing the health/care needs of a population, and assuming the financial and clinical risk for doing so, represent a model that is profoundly different than the approach that has existed under the fee-for-service system in place in the U.S. since the 1950s. The new approach challenges healthcare leadership teams to re-evaluate their organizations’ market environment, redefine their operating scope, and build new capabilities in order to be successful going forward.

Healthcare executives and trustees who understand the PHM model and its implications for their organizations and communities will be better able to develop best-fit opportunities for participating in PHM.

This whitepaper aims to help leadership teams accomplish these goals through a structured process that provides detailed guidance on where, when, and how to assume a financially sustainable role in PHM. For those organizations that have started the journey, the paper helps their leaders determine the next strategies to pursue. A framework or roadmap (Sidebar 1 and Figure 1) guides readers through this whitepaper and the recommended process.

Sidebar 1. The Framework or Roadmap for Pursuit of PHM Opportunities

1. Understand and organize around population health management
2. Determine the pace of evolution in your market area
3. Evaluate organizational position and competence gaps
4. Identify PHM market segments and opportunities
5. Determine scope and scale of required PHM network
6. Define PHM contracting and network strategy
7. Identify the appropriate PHM path, i.e., build, buy, and/or partner

Source: Kaufman, Hall & Associates, LLC
Level 1. Understand and Organize Around Population Health Management

Population Health Management Defined

The term population health management is used in numerous ways. From the clinical view, PHM is:

1. The identification and surveillance of individuals at risk of developing disease, or those with chronic disease within populations, and
2. The intervention in early stages of disease processes in order to improve health outcomes and reduce costs by preventing illness or slowing progression of chronic illness to acute stages.

Population health management also considers the health outcomes of a group of individuals, including the distribution of such outcomes within the group.

From the services delivery view, population health management occurs when a healthcare system or network of providers works in a coordinated manner to improve the overall health, health outcomes, and well-being of patients across all defined care settings under risk-bearing arrangements. PHM has significant business and economics dimensions, which include responsibility for the quality and cost of defined care and for incentive structures that reward high performance related to such quality and cost.

The Care Management Imperative

PHM changes the demands on, and the relationships between, traditional industry participants, including hospitals, other providers, and insurers.

In the traditional business model in place up to this time, health systems and insurers typically have lived parallel lives. Health systems centered on functional competencies related to healthcare delivery, and insurers centered on competencies related to healthcare financing and distribution. Their technology platforms also have differed significantly, with medical records-focused technology used by health systems and claims-focused technology used by health insurers. Figure 2 provides more depth regarding the competencies of each.

Typically and traditionally, except for health systems that own their own health plan(s), most hospitals and health systems have not gained the competencies indicated in the blue box, but have deferred these to insurance companies.

Under the new business model, however, hospitals must demonstrate value to the market as part of a PHM construct. To meet PHM goals, patient care must be coordinated and managed across the continuum of care. This requires comprehensive care management, which includes development of healthy behaviors by populations in the community, management of chronic diseases in home and community settings, treatment of acute illnesses in hospitals, and provision of services in post-acute and home settings.

Figure 2. The Distinct Historic Competencies of Health Systems and Health Plans/Insurers

Source: Kaufman, Hall & Associates, LLC

<table>
<thead>
<tr>
<th>Historic Health System</th>
<th>Historic Insurer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery System Competencies</strong></td>
<td><strong>Financing/Distribution System Competencies</strong></td>
</tr>
<tr>
<td>- Physician integration and alignment</td>
<td>- Claims management</td>
</tr>
<tr>
<td>- Care coordination and management</td>
<td>- Network management operations</td>
</tr>
<tr>
<td>- Information systems sophistication</td>
<td>- Product development</td>
</tr>
<tr>
<td>- Service distribution system</td>
<td>- Customer service and satisfaction</td>
</tr>
<tr>
<td>- Cost management/cost structure</td>
<td>- Marketing and communications</td>
</tr>
<tr>
<td>- Scale/essentiality</td>
<td>- Regulatory readiness</td>
</tr>
<tr>
<td>- Brand identification</td>
<td>- Actuarial services</td>
</tr>
<tr>
<td>- Payer relationships/contracts</td>
<td>- Business intelligence</td>
</tr>
<tr>
<td>- Financial strength/capital capacity</td>
<td>- Financial performance</td>
</tr>
<tr>
<td>- Risk management</td>
<td></td>
</tr>
</tbody>
</table>

**Technology/Infrastructure (Medical records-focused)**
A technology platform integrates the care management function. It includes infrastructure such as care coordination protocols, a patient-centric disease registry that can provide real-time patient care management and improvement, advanced analytics for patient segmentation and risk analysis, a predictive modeling and projections engine, and performance management tools (Figure 3). Effective care management has clinical components and business components (Figure 4):

- The **clinical components** include population-based chronic disease management; evidence-based practices; and claims and electronic medical record management and analytics that provide decision support and reporting related to claims, cost, utilization, and other critical information.

- The **business components** include network management and operations; business intelligence/actuarial services; and managed care contracting.

Conversations are occurring nationwide regarding who is going to “own” these care management competencies. Not typically historical strengths of either providers or health plans/insurers, these competencies will be required to effectively manage population health and the total cost of care.

In some instances, insurers are advancing their care management capabilities for specific patient populations, assuming full provider and plan risk for doing so. In other instances, sophisticated hospital systems with successful health plans are doing so.

Additionally, while strengthening their delivery competencies, some forward-thinking providers are developing or securing a partner to gain the clinical and business components that allow them to take on delegated risk contracts for certain patient populations. Organizations without the care management capabilities itemized in Figure 4 are planning to deliver care in another entity’s PHM network to that network’s membership base.

### Provider Roles with Population Health Management

Different types of providers are emerging and likely will continue to emerge, with variations in capabilities and functions in a PHM network. General categories reflect the organizations’ ability to incur risk in managing a population’s health—extending from no risk, as common in a fee-for-service system, to the ability to assume full prepaid payments and/or capitated risk.

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, either directly or through contracted services.
relationships, and assume full financial risk for doing so. To reduce healthcare costs, organizations playing this role will need to do more than they have ever done in the past, and in different environments and with new tools. Acute hospital care and traditional office-based primary care will not be enough. Disease surveillance, health assessment, health information exchange, and community-based patient engagement are among the new required capabilities, as described later.

Population health comanagers will provide a clinically integrated delivery network of defined scope, assuming risk for the population covered through a network owned by another entity that is receiving and administering the revenue. Affiliated organizations-major participants and niche providers, as described next—will be an essential part of the population health manager’s or comanager’s contracting platform, offering insurers and employers benefits that could include location, quality, and set of services, among others.

Even the largest U.S. healthcare providers currently do not directly provide the entire spectrum of care in their markets, but rather subcontract with providers to fill market and service coverage gaps (e.g., transplants). Population health managers and comanagers therefore will need to align with other providers. With size, scale, and financial resources, they will be positioned to accept and manage risk under population health contracts with governmental and commercial payers.

At the other end of the spectrum, some hospitals—such as critical access, small, and rural hospitals, and post-acute facilities—will be niche providers, who offer specified services to target populations under contracts, working within networks that are managed by larger entities. Not large enough to provide more global care to their patient populations under a value-based arrangement, the niche providers will need to ensure that they have the resources to offer specific “best-available-in-class” services in their communities. They will be important healthcare access points in their communities, but will not be critical players in broad health networks. Undifferentiated providers in competitive markets will be “price takers” whose success (and survival) largely will be dependent on their ability to manage costs at a level consistent with the requirements of price-sensitive contracts.

Single product participant and multiproduct participant roles in between will be assumed by other organizations. These community hospitals and health systems will work within a network managed by a population health manager or comanager to efficiently provide a single service or a portfolio of services to a select or broad range of patients. These providers will be critical components of PHM networks, but not large enough themselves to effectively manage the whole care continuum and its associated risks. Scale and resources will be required to provide the needed complement of cost-effective services with high-quality outcomes. Many providers—including large physician practices, hospitals, and healthcare systems—are actively looking for ways to improve care quality and reduce costs through partnership models with other providers along the continuum of services.

Effective population health management requires access and influence along the care continuum. The healthcare organization’s desired PHM role must be firmly grounded on its strategic-financial condition, its organizational competencies, and the readiness for PHM in its community, as described next.

Figure 5. Types of Providers within a PHM Model
Source: Kaufman, Hall & Associates, LLC

- **Prepaid/Capitated**
  - **Population Health Manager:** Integrated delivery system and health plan with the ability to provide and/or contract for a full continuum of services across all levels of acuity; well positioned to develop own insurance products and manage full plan-to-plan risk and direct contracting
  - **Population Health Comanager:** Regional provider organization, clinically integrated with other organizations, that capitalizes formation of a value-based delivery system and financing vehicle; well positioned to participate in PHM and risk-bearing arrangements, in a delegated and/or direct fashion
  - **Multiproduct Participant:** Provider organization that works within a network(s) managed by a Population Health Manager to provide a defined set of services in an efficient manner to serve a broad population base comprised of patients covered by public and private payers; critical role in future delivery system
  - **Single Product Participant:** Provider organization working within a network managed by a Population Health Manager to serve a specified and targeted service and/or population; these organizations will be critical components of narrow networks for specific plans/products
  - **Niche Participant:** Smaller niche providers, some of which may serve rural communities, that provide population access points; they face significant risk of commoditization

- **Fee-For-Service**
Level 2. Determine the Pace of Market Evolution

Understanding your market’s stage of development and how fast it is likely to adopt value-based care delivery and payment are critical in timing organizational initiatives. Service delivery areas are transforming at different speeds. Markets may be at a low or high stage of evolution toward value, based on whether the area has a low- or high-burning platform for change. An increasing pace of change is likely, even in markets with historically strong commitment to fee-for-service payment. This presents significant risk to all organizations, including the best-prepared ones.

Analysis of seven market characteristics indicates market readiness for PHM and how quickly the market is evolving:

**Level of Organization among Hospitals and Physicians**

Indicators of the degree of organization among providers in a market area typically include the extent of hospital consolidation, physician group size, provider network size, degree of clinical integration, and geographic coverage/number of covered lives by entities in the region. As markets change, physician referral patterns increasingly will be influenced by financial incentives offered through bundled pricing, shared savings programs, and other value-based payment models. Hospitals could quickly lose referrals to lower-cost facilities, whether such facilities are a traditional competitor or one new to the market.

**Employer Healthcare Benefits Structure**

The shift of employees into high-deductible/consumer-driven health plans that are available through traditional insurers and private exchanges is boosting transparency, along with cost sensitivity. Employers are encouraging patients to be consumers and shop for the highest-possible value healthcare services, using newly available tools and information. Quickly evolving markets have a high penetration of consumer-driven healthcare purchasing.

**Enrollment in Public Exchanges and Level of Insurance Product/Network Sophistication**

Enrollment in public exchanges and high deductibles available through tiered-benefit programs also are increasing the level of consumerism and price sensitivity. In many regions, payers are forming tiered or narrow networks for both exchange and traditional insurance offerings, with a focus on lower costs and increased care management.

**Amount of Vertical Collaboration and New-Entrant Activity**

Vertical networks that pair providers and payers typically use integrated care models with new, value-based incentive structures for the financing, delivery, and clinical patient care management. Network inclusion or exclusion has or can have major implications for hospitals and health systems in the covered area. New market entrants, such as private equity firms, retail companies, and players from other industries have the potential to disrupt markets in significant ways.

**Demand for Services**

Lower utilization of inpatient services, shifting demand for ambulatory services, and web or mobile-based services will force providers to reposition themselves. Notwithstanding population aging trends and the newly insured, considerable hospital inpatient utilization is “vulnerable”—i.e., likely to decline further as costs are reduced in healthcare. This includes inpatient admissions that should not occur if patients are better managed in ambulatory and home settings, and shorter hospital stays and reduced readmissions for Medicare patients. Hospital outpatient services are particularly vulnerable to new competition that offers lower-priced services more conveniently.
Supply of Providers

If the number of hospitals, beds, and physicians in a region is too high, providers will experience significant “pricing and/or reimbursement pressure” as utilization falls and demand shifts to ambulatory settings and virtual care delivery. When there is an oversupply of providers, pricing pressure also results from provider willingness to take on discount fee-for-service arrangements in order to guarantee patient and referral volume.

Regulatory Environment

Federal and state legislation and regulations materially affect the way providers conduct business, at times slowing the pace and degree of change. Providers operating in localities where regulatory factors are more abundant and limiting are often challenged in building the structures and relationships necessary to drive value-based care delivery.

Pace of Change

All of the seven market elements described here need not be working at the same time to shift a market rapidly for area providers. In some markets, initiatives by one type of stakeholder move the needle significantly. In other areas, new market entrants or new regulations begin and accelerate the process. A single decision by a physician group, payer, or employer can weaken or completely undercut a health system’s efforts to gain market share through clinical network development, targeted community outreach, or other initiatives. Payers and other contracting entities are developing narrow-network arrangements, from which other providers will be tiered-out or otherwise excluded through steerage to competitive providers.

As described next, an organization’s competencies will be critical to its future positioning to manage population health.

Level 3. Evaluate the Organization’s Position and Competence Gaps

Strengthening existing competencies itemized in Figure 2, and developing new competencies itemized in Figure 4 gives hospitals and health systems additional flexibility to make the considerable changes required to participate in PHM. Each of the nine capabilities highlighted below is important, but usually a few capabilities require significant focus in order to establish the organization's value for payers, employers, consumers, and other stakeholders.

Clinical Integration

Clinical integration is the extent to which patient care services are coordinated across people, functions, activities, processes, and operating units so as to maximize the value of services delivered. Clinical and economic alignment of physicians, nurses, and other providers across the care continuum furthers organizational goals around quality improvement, cost reduction, and strategic and financial sustainability. Considerations include shared hospital/provider incentives, and relationships between physicians and other care team members.

Clinical Care Management

To be compelling to purchasers and maintain strong operating performance, hospitals must achieve high quality and consistent care outcomes. Team-based, coordinated care delivery improves quality metrics, reduces readmission rates, and enables achievement of other quality and outcomes objectives. Clinical considerations include chronic disease management programs and use of evidence-based practices and protocols to better manage/coordinate patient care, especially for high-risk, high-use patients.
A quality and care management infrastructure has an enterprise-wide decision support and reporting function, enabling the successful access, collection, analysis, and interpretation of claims, costs, and utilization information. Also included are incentive systems to reward providers for documented superior quality, outcomes, and consumer experience.

Network Development, Configuration, and Relevance
A robust network—including hospitals, physicians, post-acute providers, and other delivery system partners—builds and sustains a competitive advantage. A specific organization may be providing the full continuum of services or participating as a single-product, multiproduct, or niche provider in a network offered by another entity. Issues that require consideration include breadth of specialist and primary care offerings, relative size of operations, referral sources, scope of geographic coverage, and overall network accessibility.

Operational Efficiency
Operational efficiency is required for sustainable financial performance in the short term and the ability to compete on price and quality dimensions in the long term. Considerations include operating cost, structural costs, service rationalization, and clinical variation.

Clinical and Business Intelligence and Actuarial Services
Collecting, analyzing, and using clinical and business data are critical to setting appropriate goals and intervention targets and to performance management. Considerations include acquisition of clinical and administrative tools, ongoing data collection and management, data analytics, and the integration of findings with organizational plans. Actuarial expertise is required for sustainable risk management.

Purchaser Relationships and Managed Care Contracting
Organizations that drive innovative network development typically contract with large employers, municipalities, and/or health plans to enhance their brand and essentiality broadly. Considerations include: size and scope of current contracting arrangements; the level of customer service and engagement; and ability to accept and distribute risk, risk-based incentives, and prepaid claims.

Financial Strength
Strong cash flows and a sound balance sheet enable organizations to make the necessary investments to transform and compete, while managing overall enterprise risk. Considerations include operational performance and balance sheet strength, as assessed through capital capacity and financial/credit analyses.

Brand Strength and Customer Service and Engagement
Organizations need to ensure their differentiation and recognition in the market as a respected entity, associated with high quality and service excellence. The new retail focus in a consumer-driven environment requires organizations to engage the patient at every stage, building and maintaining strong brand presence.

Leadership and Governance
Deep bench strength of clinical, administrative, and governance leadership drives operational and strategic change. Considerations include current and prospective physician leadership, administration depth and succession, incentive design, and board healthcare expertise.

An organization’s identification of opportunities to manage population health, as described next, should be based on its competitive strengths and weaknesses in each of these nine competencies.
4. Identify Potential PHM Market Opportunities

Following the learning and analyses of the context-setting stage described in the first three sections, the key challenge of this fourth stage is the critical task of identifying the organization’s value proposition, i.e., where it wants to enter or expand its presence in the PHM arena.

The strongest of organizations will be looking for opportunities that span both delivery and financing functions, covering the whole care continuum. They will do so through operating a risk-bearing network that includes contractual arrangements with organizations to cover specific services.

Most hospitals and healthcare systems will be looking for PHM opportunities that will enable growth solely as a delivery system, providing defined services to a specific population under contract with another entity that operates a risk-bearing network.

Other organizations will pursue opportunities that combine pieces of delivery and financing functions.

Identification of potential PHM opportunities is complex work, involving variables related to the patient population, the overall insurance market, and available types of insurance products.

Patient Populations

Patient populations can be defined or segmented in many ways. Definitions that focus on health-risk category are common. For example, a segment defined as “patients with multiple chronic conditions and co-morbidities” represents a high-risk population across payer classes.

Most organizations need to gain experience in caring for patient populations under value-based arrangements, and high-risk populations are a common starting point. Another way organizations are starting is to manage the care needs for their own employees through self-insured or risk-sharing arrangements.

Patient populations can and should be segmented and considered by how they are insured—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 HMO, PPO plans, or other types of plans.

Insurance Landscape

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

For sophisticated organizations, the goal of such analysis is to learn what opportunities might be available to build, buy, or partner with another entity to offer an insurance product to a defined covered population.
For other organizations, the goal is to identify which plan(s) might be a good one(s) with which to participate in PHM contracting arrangements, and thereby gain some “blue box” experience, as outlined in Figure 2, assuming risk for a patient population. For each insurance product type, described later, 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 individuals who receive care under commercial insurance provided by their employer. Organizations just beginning with PHM might wish to consider targeting “high-risk” populations across payer classes. Or, on even a more pragmatic level, they could consider targeting high-risk segments in particular payer plans that offer opportunity to gain PHM experience.

In some areas of the country, the insurance market is highly fragmented, with many commercial insurers competing under predominantly fee-for-service arrangements, and a large proportion of self-insured companies. In other areas of the country, commercial managed care penetration is higher and the number of insurers and self-insured companies more limited.

Managed Medicaid and Medicare Advantage programs may be widespread or in early stages of adoption, but can be expected to grow in most areas. Similarly, private plan premiums in some regions may be higher or lower than in other regions and on the way up or down based on how aggressive commercial carriers get with their pricing strategies.

The following factors in a market typically produce a more promising landscape for PHM opportunities:

- Commercial carriers experience positive margins on small- and large-group products
- Public plan reimbursement is stronger than average
- The market is gradually moving towards managed care products and services with apparent increasing willingness to entertain risk contracting discussions

Insurance types can be evaluated to identify high-level opportunities. Types may include commercial ACO programs, self-insured employer-directed programs, private exchanges (both fully insured and self-insured), public exchanges, Medicare Advantage, Managed Medicaid, and others.

Next, criteria related to specific products can be layered in, including, for example, 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 look like an opportunity, per-member-per-month (PMPM) capitation rates in the region can be compared to other metropolitan areas of similar size and other counties of similar size. A close look at capitation rates as a percentage of fee-for-service reimbursement enables identification of whether there might be upside potential for an organization that effectively manages patient care and reduces utilization. For example, if capitation rates are more than 100 percent of fee-for-service rates, the opportunity could be promising based on the organization’s ability to coordinate patient care and reduce costs.

**Benefit Design and Product Type**

Design of individual benefit plans offered by payers also varies and has a significant effect on the 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 types of products will be more or less attractive to an organization based on what it can achieve.

For example, one leading organization in a geographic region participates in various plans with different benefit designs. It has its own employee insurance plan for which it manages all clinical and financial risk. It also participates in the Medicare Shared Savings Program, and has contracts with commercial HMO and ACO plans. With its employee insurance plan, the organization achieved ED visits per 1,000 of 104, but for patients attributed under the Medicare Shared Savings Program, ED visits per 1,000 was 346. Readmission rates ranged from about 5 percent to more than 11 percent, based on the specific contract.8
Figure 6. Sample High-Level Summary of PHM Opportunities by Type of Insurance Product
Source: Kaufman, Hall & Associates, LLC

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Size</td>
<td>—</td>
<td>✗</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✗</td>
</tr>
<tr>
<td>Growth Potential</td>
<td>—</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>MCO Penetration</td>
<td>✗</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Revenue Opportunity (Premium $)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✗</td>
<td>✓</td>
<td>—</td>
</tr>
<tr>
<td>Profitability</td>
<td>✗</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>✗</td>
<td>—</td>
</tr>
<tr>
<td>Regulatory/Reform Environment</td>
<td>—</td>
<td>✓</td>
<td>✓</td>
<td>✗</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Population Health Risk Profile</td>
<td>✓</td>
<td>✓</td>
<td>—</td>
<td>✗</td>
<td>—</td>
<td>◀</td>
</tr>
<tr>
<td>Overall</td>
<td>—</td>
<td>✓</td>
<td>—</td>
<td>◀</td>
<td>✓</td>
<td>—</td>
</tr>
</tbody>
</table>

Figure 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 through reduction of utilization compared to baseline fee-for-service models. Medicare Advantage presents a particularly important opportunity in that utilization for this population has an inherently higher use-rate starting point, and thus more room to show early improvements in use-rate reduction.

Identification of viable PHM opportunities for hospitals and health systems is complex work, which must be data-driven, market-specific, and realistic. The organization’s 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. The next sections describe that planning process.
5. Determine the Scope of the PHM Network

Effective and sustainable population health management requires the design of a high-performance provider network. Sophisticated organizations that can provide services across the continuum of care functioning as population health managers will face critical decisions related to scope and scale of their network. Single product participants and multiproduct participants will not be forming the networks themselves, but will want to be essential in their line(s) of business in order to avoid being excluded from future networks. Their brand name, the quality and outcomes of services provided, and their costs need to be ultra-competitive so that they are viewed and continued to be viewed as providers critical to the network.

In moving away from fee-for-service care delivery and financing models, organizations must 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 under a PHM construct. Specific criteria include:

- Network essentiality (size/scale)
- PHM care continuum (breadth/depth)
- Network performance and outcomes
- Overall “network adequacy,” as defined by key regulators and/or payers

Although these criteria are not mutually exclusive, each has certain nuances that will be important for hospitals and health systems to understand and evaluate.

Additionally, the four criteria will need to be looked at on a population-by-population and insurance plan basis—for example, Medicare, Medicaid, commercial, insurance exchange, and others. Although factors may overlap across populations, each population will have unique healthcare demands and risk factors that are driven by demographics, socioeconomics, and a variety of other conditions and considerations. These different demands will need to be accounted for because different service and network requirements must be met.

For example, the Medicaid population, whether covered through Managed Medicaid or the traditional program, has higher demand for behavioral health services. A PHM network for this population must have significant behavioral health offerings.

Description of the four network criteria follows.

**Network Essentiality**

After the organization has identified PHM market opportunities, an evaluation of the “baseline essentiality” of its current provider network is needed. Successful organizations bring to defined opportunities an attributable population and a competitive (or at least minimum threshold) cost and quality profile for services that can be provided as part of a delivery network. Each population has different service and coverage requirements depending on geographic concentration, utilization and referral patterns, insurance coverage requirements/restrictions, and other factors.

Network essentiality in many instances is tied to an organization’s primary care physician (PCP) network, and measured based on the population that can be attributed to the provider network/delivery system. Without the PCP network in place, it will be difficult to achieve required cost and quality performance or to secure the attributable population. The larger the population an organization captures/covers, the more essential it likely is in the new PHM paradigm.

Under some insurance models, patients actively select a health system to which they want to be attributed. For example, patients who choose a Medicare Advantage (MA) plan know which providers are in the MA network. In contrast, patients with traditional Medicare coverage may get attributed to a health system based on their primary care physician, but are not required to use only that health system.
Organizations also will need to consider influenced lives—patients referred by physicians not affiliated or owned by the health system—and incidental lives, defined as self-referred patients.

Whether individuals access the organization through controlled, influenced, or incidental means, each source of patients increases the organization’s attributable population, which helps to increase the organization’s service or network attractiveness. Essentiality is then enhanced by customer service and patient engagement initiatives that help grow and retain the managed population base.

**Figure 7. A New View for Engaging and Managing Population Segments along the Health-Risk Continuum**

Source: Kaufman, Hall & Associates, LLC

**PHM Continuum of Care**

In a risk-bearing environment, understanding and evaluating the continuum of care becomes even more critical for provider organizations. Care interventions and their benefits for patient populations vary along the health-risk continuum (Figure 7). For example, care navigators can be of greatest benefit in managing diseases, reducing costs, and improving quality of life of patients with complex chronic and critical conditions.

In PHM models, strategic focus of hospitals and health systems is moving away from traditional care settings—i.e., acute care and specialty care—and towards a broader set of clinical-service sites and modalities (including virtually).
with associated lower-cost alternatives covering primary care, post-acute care, ancillary services, ambulatory care, and others (Figure 8).

Many providers may prefer to “build out” these care settings over time, but most organizations find this cost prohibitive and will lack the operational expertise to execute new-setting strategies in the near term. Organizations expecting to be population health managers will develop relationships and partnerships with organizations in the market that can play a meaningful role in the network, whether operating under a fee-for-service or value-based arrangement. Collaborative models likely will include a combination of employed, affiliated, and independent contractors in the specific region.

Network Performance and Outcomes

To develop a successful continuum-of-care strategy, an organization must be able to manage and monitor performance across the continuum, whether through employed/owned, affiliated and/or partnered entities. Performance is measured with quality and outcomes indicators, and overall health status of the managed population(s), as specified in contractual arrangements.

Performance also will be monitored against specific per-member-per-month medical cost targets in the risk contract. Additionally, current/future network partners will need to be monitored based on key selection and participation criteria, including utilization of technology, quality standards and protocols, capacity to care for current/future populations, and other factors that ensure they are a good fit for the organization’s PHM initiatives. Figure 9 provides a piece of one organization’s criteria scorecard for physician network participation.

---

**Figure 8. Population Health Management: Coordinating Care in the Continuum of Settings**

_Source: Kaufman, Hall & Associates, LLC_
Network Adequacy

Network adequacy refers to an entity’s ability to deliver the benefits promised under the terms of a contract by providing reasonable access in a delineated service area to a sufficient number of in-network primary care and specialty physicians, hospital services, and other specified services. At the most basic level, the service area is the geographic area in which a plan and/or risk-bearing provider furnishes access to the continuum of services. Regulations typically provide the baseline or starting point for network adequacy (Sidebar 2). 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 will need to be thoughtful about whether they are able to build, contract for, and deliver an appropriate network, given each population’s variable set of requirements.

Summary

Designing a robust provider network will be critical for the future success of PHM strategies. As organizations determine the right size and scale for their 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 capture a critical mass of patients/populations, thus making it harder to spread the risk for managing these populations.

Network design adequacy also is an important component of health plan offerings for the marketplace, and will impact the ultimate pricing and economics of programs undertaken by insurers and provider delivery networks. Additionally, network definitions are dynamic. As care delivery 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 bricks and mortar facilities and clinics to virtual delivery mechanisms.
Sidebar 2. Network Regulations

The Affordable Care Act established the first national standard for network adequacy in commercial insurance. The Act requires “Qualified Health Plans” sold on the health insurance marketplaces to maintain a provider network that is “sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without delay.” (a)

Also required are inclusion of essential community providers to serve predominantly low income and medically underserved individuals, and the availability of providers to new patients. Additionally, the Act defined an “Essential Health Benefits” (EHB) package, which together with the network adequacy standards determines the delivered care and its ease of access.

As noted in one report,(b) however, network adequacy standards under federal rules give states and insurers considerable flexibility in interpreting what would constitute “sufficient” numbers and types of providers that can deliver covered benefits without “unreasonable delay.” States differ in their approaches to regulating the adequacy of health plan networks, often based on their fiscal need to control costs, balancing this with access requirements.

Some, but not all states, have adopted the National Association of Insurance Commissioners Model Act, which applies to any benefit plan that requires, or creates incentives for a covered person to use healthcare providers managed, owned, under contract with, or employed by the health insurance issuer. The Act requires covered health plans to maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. (c) In many states, adequacy requirements historically have applied under this Act only to HMO and not to other managed care products such as PPOs.

Most states have broad standards requiring health plans in the private insurance market to have a “robust” or “sufficient” network. (d) Medicaid Managed Care Plans, which now cover nearly 50 million people through some form of privately owned managed care, either on a voluntary or mandatory basis, (e) are required to provide timely access to a range of preventive, primary, and specialty care services, including in-network and out-of-network providers.

Health services delivery networks applying to provide Medicare beneficiaries coverage under a commercial Medicare Advantage plan must demonstrate that they are able to provide current and potential beneficiaries with adequate access to providers and facilities through their own network. Adequacy of access typically is defined according to specific criteria identified by the Centers for Medicare & Medicaid Services related to the applicant’s number of providers and facilities, and maximum travel time and distance for a defined percentage of beneficiaries to at least one provider/facility for each specialty type. (f)

Regulations are complex and definitions may lack clarity, but an entity assuming risk for a patient population is not likely to be able to obtain licensure to sell and distribute its product and services in the marketplace without an adequate delivery network of providers and facilities.

Level 6. Define a Contracting Strategy to Support PHM Opportunities

The movement towards value-based care under a PHM construct is not a “one-size-fits-all” mandate. Organizations can take and are taking incremental steps towards managing the total cost of care (i.e., assuming full provider risk) in a “budgeted care” or “prepaid” contracting environment.

A spectrum of provider risk options exist that should be closely evaluated to ensure that the risk model appropriately aligns with both an organization’s capabilities and the stage of evolution in its market. Each subsequent risk model will require greater integration of care delivery and financing components. Integration ensures access to real-time data and analytics to further improve the organization’s PHM care management and care delivery model.

Additionally, some organizations—generally those further along the pathway towards full risk—may also decide to take on insurance risk in addition to provider risk. These organizations may do so for reasons including the following:

- To accelerate the journey towards PHM capabilities and managing the total cost of care
- To enhance the care management “glue” and tighten integration of the organization’s financing and care delivery components
- To expand geographically beyond its existing delivery system footprint
- To diversify revenue sources with access to the full insurance premium dollar

Leadership teams must start moving their contracts to risk-based arrangements to gain critical experience in meeting Triple Aim objectives of improved health, enhanced outcomes, and lower costs. Inaction or inadequate action could impair the organization’s ability longer term.

Defining Risk

The path towards population health management is defined by the risk model chosen by the organization as a starting point. In the healthcare delivery and financing context, risk generally can be considered in two categories:

- **Financial risk**: Financial risk is incurred by a provider organization through acceptance of a fixed payment in exchange for the partial or total care of an identified patient population at a specified quality level. These terms are defined in the risk contract. Financial risk represents the uncertain financial net gain or loss that an organization experiences after incurring the care-provision costs.

- **Clinical risk**: Clinical or “performance risk” is the ability of the provider’s network to deliver patient care that exceeds the benchmark level of cost and quality specified in the risk contract with the payer. The ability to manage a patient throughout the continuum of care will directly impact the organization’s financial return on the contract.

Each risk type must be assessed by the organization. Providers may assume downside financial risk for not meeting targeted population health measures, for costs above expenditure benchmarks, and for not meeting quality thresholds. Conversely, upside financial incentives will accrue when providers exceed the population health measures, achieve a lower cost of care than target levels, and exceed quality thresholds.

Risk tolerance reflects the organization’s capacity to manage both types of risk without endangering its strategic, operational, or financial performance. Different organizations have varying capacity and tolerance for risk.

Risk Contracting Options

A hybrid of payment mechanisms is emerging, incrementally shifting payment from fee-for-service to the value, risk-based arrangements described here in order to better manage population health and lower healthcare costs.
Fee for Service (FFS): The predominant model historically, under FFS arrangements, providers are paid for the quantity and intensity of care delivered. Because payment is not dependent upon the quality or cost of care delivered, the provider has neither performance risk nor financial risk. Providers benefit from increases in the number of patients seen and in the number of tests and treatments provided to each patient.

Pay for Performance (P4P): Hospitals, physicians, or other providers receive bonus payments to their FFS reimbursement or have a portion of their pay withheld based on whether they meet preset performance targets. Targets may relate to quality, cost effectiveness, or efficiency of care, or other factors.

Shared Savings: The shared savings model offers incentives for providers to reduce healthcare spending for a defined patient population by giving providers a percentage of net savings realized as a result of their efforts to reduce the care costs. Over the long run, shared savings are difficult to sustain because the savings pool is finite and extracting incremental savings as care improves will be challenging.

Case Rate (Episode-of-Care or Bundled): Providers are paid a fixed amount for services required by a patient for a specific procedure or condition, such as a total knee or hip replacement. Providers benefit from the savings they generate through improved efficiencies in care delivery, but payers are likely to provide lower upfront payments for each episode of care as efficiencies improve. Providers are at risk for the cost of care delivered if it exceeds the predetermined payment amount, but continue to benefit from seeing a greater volume of patients.

Partial Risk: Under partial capitation or partial risk, a provider typically takes on full financial and clinical risk for a specified set of services (for example, acute care services, but not professional services), receiving a single fixed payment for that set of services.

Shared Risk: Providers share with the payer both positive and negative financial risk depending on whether the cost of care exceeds the pre-specified payment amount. The level of savings (or losses) depends on the negotiated arrangement between the provider and the payer, typically as a percentage of the total premium dollar or as a proportion of the cost overruns. Because providers take on more downside risk in this model, various contracting mechanisms are often used to limit the provider’s financial exposure. These include stop-loss insurance (provider pays a fixed fee to another insurer to accept the risk beyond a specified amount), risk corridors that limit upside and downside risk, and carve-outs for patient populations where the clinical risk may be more difficult for the provider to manage.

Full Risk: Under full-risk “capitation” arrangements, providers receive a single fixed amount per patient per month, or periodically receive a predetermined percentage of the premiums that patients pay to insurers. Providers are able to keep any savings if costs are below the capitated amounts, but are responsible for any cost overruns. Global capitation payments cover all patient services, while partial capitation payments cover only a specified portion of services. The entity contracting with the payer must have downstream network contracts, covering the specified continuum of care. Cost savings, after administrative fees, can be distributed per contract agreement.

Provider-Sponsored Insurance: With provider-sponsored insurance, the provider manages not only the total cost of care (full provider risk) but 100 percent of the financial risk for insuring the patient and controlling the full premium dollar. Provider-sponsored insurance represents the greatest level of financial and clinical control because the provider organization controls the clinical aspects of care and care financing and administration.

Figure 10 illustrates the range of arrangements on the risk continuum.
Strategic Risk-Contracting Opportunities

Like PHM opportunities, not all risk contracts are created equal. Hospitals and healthcare systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements under PHM. A healthcare organization’s risk-contracting strategy should be part of its comprehensive business plan. This provides the documentation and analysis necessary to validate capital decision making related to risk contracting and the scope of PHM.

The PHM contracting arrangements that organizations decide to pursue must be based on solid quality, cost, outcomes, and other performance data, as described later. Reliable data are critical to negotiations with insurers and other healthcare purchasers and to the operation of value or risk contracts.

The strategic value of entering into provider risk arrangements is significant for both hospital providers and insurers. Hospitals have the opportunity to gain at new set of core competencies and capabilities that will be required for future success in evolving value-based and managed care environments. Additionally, many of these contracting arrangements involve narrow network-type agreements that will guarantee preferred providers access to market-based population segments, ultimately supporting current and future business models. A value-based approach to care delivery and financing also provides the opportunity to strengthen the organization’s mission and commitment to the community.

From a payer perspective, many insurers are now expanding their value-based payment agreements in order to provide more affordable options to individuals and groups that are purchasing health insurance at local, state, regional, and/or national levels.

For example, approximately 20 percent of BlueCross BlueShield’s total spending is through value-based care arrangements. UnitedHealthcare expects that 50 to 70 percent of its commercial members will benefit from value-based contracting in 2015. WellPoint will transition 75 percent of its physician practices from visit- to value-based reimbursement over the next three years.10

By aligning with high-value and/or high-performance health system networks, these insurers are able to leverage the brand of existing provider networks, while simultaneously creating a product that can potentially be priced competitively or ahead of the market.

Other Significant Considerations

The assumptions of risk will have other implications that hospitals and health systems will need to consider.

Financial Reporting. From a financial reporting perspective, assuming risk contracts will require changes to the way the organization recognizes revenue and accrues liabilities over time. The cash and financial impact of these accruals could significantly impact the organization’s financial performance and should be incorporated in planning activities.

Capital Reserve Requirements. Varying by contract, capital reserve requirements include regulatory reserves (state and federal) and financial reserves. The latter are intended to offset an organization’s future operating exposure to contract-based risk, such as higher-than-anticipated costs. If an organization’s use of capital reserves diminishes its liquidity to the point of triggering debt covenants, its credit rating may be at risk. A lower credit rating increases the cost of capital for the organization going forward.

Actuarial Considerations. Relevant actuarial issues include the number of patients covered by the contract, risk adjustment, cost, pricing, benefit design, the required upside and downside payment, and stop-loss insurance and reinsurance. These issues are interrelated, so they must be assessed together to ensure positive financial results for healthcare providers.
Cost Data. Data on cost (unit and case) for the services for which the hospital or healthcare system assumes risk will drive the evaluation of the healthcare organization’s performance under a risk-based contract. The availability and accuracy of such data are of utmost importance. Hospitals and healthcare systems must know their current cost of care, as well as the care costs of partners that will be sharing risk. A quick response to high-cost “outlier activity” will be required to meet expected financial targets.

Cost-Accounting Systems and Predictive Analytics. Many hospitals and healthcare systems will need to acquire more robust, cost-accounting systems that allocate costs—either directly or through a proven, established formula—to the products and services provided. This will require many decisions about what data to capture and how to capture them. Hospitals and healthcare systems that assume full risk for a patient population must have sophisticated analytics, informatics, and predictive modeling capabilities related to overall population health and high-risk subsets.

Data Sharing. Data sharing between payers and providers is essential to tracking organizational performance of key measures covered by a contract. Hospitals and physician practices historically have had access only to data on their own patients, with no comprehensive view of care and cost trends in their communities.

Risk-based contracts secured by hospitals and healthcare systems should grant access to data from payers and other healthcare providers on the populations to be served. Data sources include inpatient and outpatient claims, medical records, pharmacy, and lab and test results. Healthcare organizations that subcontract with other providers must routinely share data and analyses with partnering entities to ensure transparency in measuring subcontractor performance.

Level 7. Identify the Appropriate Path for Your Organization—Build, Buy, or Partner?

Hospitals and healthcare systems should explore options for achieving PHM expertise, whether doing so via each or a combination of the following means:

- Building competencies and capabilities internally
- Buying or purchasing access to certain competencies or services from another entity
- Partnering with another entity to gain access to required competences

To participate in population health management in a significant way, most hospitals and health systems will need to use the latter two approaches. Whether building, acquiring, or partnering with another entity to develop capabilities and network components, the decisions are complex, interrelated, and highly market- and organization-specific.
Identifying the Most Likely Path

Build, buy, and/or partner options should be considered based on the organization’s objectives, its current capabilities, the required time frame for obtaining the needed capabilities (the “development window”), and resource requirements, including time, cost, and leadership for pursuing the options.

A decision tree, as illustrated in Figure 11, highlights the key questions required to identify build, buy, or partnership objectives:

1. Does the organization need health plan capabilities to achieve its vision?
2. If yes, does it need full or selected health plan capabilities?
3. Which products should the organization focus on? Near term?
4. How broad does the health plan coverage need to be and how broad is it today?
5. Is the organization better off building, buying, or partnering to obtain the capabilities needed to provide the product to the intended market?

A framework, such as illustrated for a health system in Figure 12, can be helpful as a next step. For this organization, a strategy of building further competencies would be appropriate to achieve greater clinical and physician alignment, network development, and operational efficiency, furthering its solid foundation. Buying or partnering would be appropriate for obtaining care management capabilities and clinical and business intelligence—areas where the health system is weak, the development window short- to medium-term, and the resource requirements moderate to high.

Figure 11: Strategic Planning Decision Tree
Source: Kaufman, Hall & Associates, LLC

Figure 12. Framework for the Build, Buy, or Partner Decision
Source: Kaufman, Hall & Associates, LLC

<table>
<thead>
<tr>
<th>Strategic Driver</th>
<th>Current Capabilities</th>
<th>Development Window</th>
<th>Resource Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical and Physician Alignment</td>
<td>Moderate</td>
<td>Short Term</td>
<td>High</td>
</tr>
<tr>
<td>Care Management Capability</td>
<td>Weak</td>
<td>Short/ Medium Term</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Clinical and Business Intelligence</td>
<td>Weak</td>
<td>Short/ Medium Term</td>
<td>Moderate/High</td>
</tr>
<tr>
<td>Network Development</td>
<td>Moderate</td>
<td>Medium Term</td>
<td>High</td>
</tr>
<tr>
<td>Operational Efficiency</td>
<td>Moderate</td>
<td>Short/ Medium Term</td>
<td>Moderate</td>
</tr>
</tbody>
</table>
Identifying Potential Partners

Potential partners for hospitals and health systems could include many different types of entities, including health plans, health systems, management services organizations, and other types of traditional and nontraditional service companies. Figure 13 indicates the wide range of health plan services that a hospital system might be looking for, given a wide range of objectives.

For each partner type and identified entities within each partner type, organizations should evaluate the comparative:

- Cultural fit, including shared mission, values, beliefs, and PHM vision
- Ability to strengthen required capabilities
- Ability to grow and diversify the organization’s current business portfolio based on the identified PHM market opportunities

Again, an evaluation framework, such as Figure 14, can be used to highlight findings.
Figure 15. Partnership Integration Continuum
Source: Kaufman, Hall & Associates, LLC

<table>
<thead>
<tr>
<th>Degree of Integration</th>
<th>Low</th>
<th>50/50 Partnership</th>
<th>Minority Interest</th>
<th>Joint Venture</th>
<th>Leverage Existing Arrangements</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Sale to Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50/50 Partnership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minority Interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Venture</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leverage Existing Arrangements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As with merger/partnership arrangements in all industries, the degree of integration desired by the partnering organizations ranges from low to high along a spectrum of ownership interest (Figure 15).

Partnership terms to consider include the following: governance/equity-sharing, contract period, risk-sharing arrangements, branding, partnership exclusivity, start-up costs, provider network development, role of provider network in sales/enrollment process, management team, product expansion opportunities, geographic expansion opportunities, and other items.

Concluding Comments

The nation is moving to a care delivery and payment model based on population health management. Hospitals and health systems need to make early stage investments in this new model and be aware that a positive return on investment may take a number of years to achieve, in some instances 5 to 10 years. Partnerships likely are required to cover new services and/or geographies. Understanding the PHM model and its implications for organizations and communities are critical to an organization's pursuit of best-fit PHM opportunities. Use of the seven-stage roadmap can help guide the nation's hospitals and health systems.

References

Author Biographies

Mark E. Grube, Managing Director
mgrube@kaufmanhall.com

Mark Grube, a Managing Director, leads Kaufman Hall’s Strategic Advisory practice, which provides a broad array of strategy-related services to regional and national healthcare systems, academic medical centers, community hospitals, and specialty providers nationwide. Mr. Grube has more than 25 years of experience in the healthcare industry, as a consultant and as a planning executive with one of the nation’s largest healthcare systems.

Mr. Grube is a frequent speaker and author on healthcare strategy topics and has published dozens of articles and white papers. He is a three-time winner of the Helen Yerger/L. Vann Seawell Best Article Award from the Healthcare Financial Management Association (HFMA).


Mr. Grube received an M.B.A. from the University of Chicago Graduate School of Business and a B.S. in Economics, magna cum laude, from Bradley University.

Robert W. York, Senior Vice President
ryork@kaufmanhall.com

Rob York is a Senior Vice President of Kaufman Hall and leader of the Population Health Management division in the firm’s Strategy practice. He provides strategic services for a range of healthcare clients, including large healthcare systems, public/safety-net providers, academic medical centers, and community hospitals.

Mr. York’s responsibilities focus on developing strategies to help providers remain relevant and viable in the new healthcare environment. Such strategies are based on rigorous market analysis, population and payer segment and demand analysis, and strategic partnership evaluation.

He regularly speaks to Boards and at meetings of professional societies, and has published numerous articles in industry journals, including Health Affairs, Spectrum, and Strategic Financial Planning.

Mr. York has a B.S. in Business Administration with honors from the University of Arizona and an M.B.A. from the University of Notre Dame.

Brian P. Fuller, Senior Vice President
bfuller@kaufmanhall.com

Brian Fuller is a Senior Vice President with Kaufman Hall and a member of the firm’s Strategy practice. Mr. Fuller provides strategic planning assistance to hospitals and health systems nationwide, focusing on development of integrated strategic financial plans, strategic options identification and evaluation, and organizational and governance model restructuring to position health systems for continued future success.

Prior to joining Kaufman Hall, Mr. Fuller spent more than 15 years in the strategy practices at Navigant Consulting, Sg2, Tiber Group, and Medimetrix Consulting, where he advised leading provider organizations on a wide variety of strategic topics.

Mr. Fuller has authored numerous articles published in healthcare professional journals, including hfm, Spectrum, Trustee, and Health Planning TODAY. Mr. Fuller is a frequent speaker at industry conferences and facilitator of health system Board retreats.

Mr. Fuller has an M.B.A. with a Health Sector Management concentration from the Fuqua School of Business at Duke University and a B.S. in Business Administration from The Ohio State University.

John P. Poziemski, Vice President
jpoziemski@kaufmanhall.com

John Poziemski is a Vice President of Kaufman Hall and is based in the firm’s Los Angeles office. A member of the Strategy practice, Mr. Poziemski focuses specifically on integrated strategic and financial planning, strategic options evaluation, mergers and acquisitions, and value-based transformation initiatives, working primarily with provider organizations in the western region.

Prior to joining Kaufman Hall, Mr. Poziemski worked at Sg2, where he was a member of both the solutions and consulting teams. While at Sg2, he managed a variety of consulting engagements and business-development activities focused on clinical program development and physician integration strategy.

Mr. Poziemski is a regular presenter at industry conferences and board retreats.

Mr. Poziemski has a B.S., with honors and distinction, from the University of Illinois at Urbana-Champaign.
About Kaufman Hall

Kaufman, Hall & Associates, LLC (“Kaufman Hall”) was founded in 1985. Since our inception 30 years ago, Kaufman Hall has been dedicated solely to providing consulting services and software tools to the healthcare services industry. It is one of the most respected management consulting and software firms in healthcare. With the key acquisition of Axiom EPM in 2014, the firm expanded its breadth of industries and software capabilities to include enterprise performance management industry solutions for banking, healthcare, higher education, insurance, retail, and manufacturing.

The firm’s original mission remains its current mission: To enable client organizations to reach their full business potential through the provision of high value, financially centered, consulting services and software products. The emphasis has been and always will be on services and products that enable clients to be fully self-sufficient in meeting their strategic, financial and capital goals.

Through the years, the company has developed expertise in several integrated service and software areas. Service areas include financial advisory services to debt and derivative transactions; strategy-related advisory services; preparing and implementing strategic, financial, and capital plans; designing and implementing comprehensive capital allocation processes; and assisting in the evaluation, structuring, and negotiation of merger, acquisition, joint venture, and divestiture transactions.

Related software solutions include: budgeting and forecasting, capital planning, decision support and analytics, performance reporting, and long-range planning, and Enterprise Performance Industry Solutions for banking, healthcare, higher education, insurance, retail, and manufacturing.

Kaufman Hall operates a national practice with a staff of more than 260 professionals located in Chicago, Atlanta, Boston, Los Angeles, New York, and Portland.