Webinar 1 Issue Brief:
A Framework for Population Health Management

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Introduction

Governance and leadership teams of California’s hospitals and health systems must have the knowledge and skills needed to succeed under population health management (PHM). To help ensure success, California Hospital Association, in collaboration with Kaufman, Hall & Associates, LLC, is offering this five-part program titled “Population Health Management.” The program provides participants with an understanding of the key components of PHM. Each module features an Issue Brief and webinar for executives and professionals in a wide range of organizations.

This Issue Brief and its associated webinar launch the series. They provide an overview of PHM and a framework for its pursuit by hospitals and health systems. Subsequent Issue Briefs and webinars will offer detail on PHM business imperatives, clinical priorities, technology requirements, and leadership roles, metrics, and structures.

For additional information about the program visit: www.calhospital.org/population-health-web.

“Population health management is the direction health care is moving. Those who commit early to building the competencies and infrastructure required to advance population health can position or reposition themselves to achieve a sustainable role. Whether you are already immersed in PHM or just formulating your strategy, this program provides practical, boots-on-the-ground tools. I encourage all hospital leadership teams — from small, rural facilities to large urban hospitals — to consider participating in this program.”

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Webinar 1 Issue Brief: A Framework for Population Health Management

From Providing Care to Managing Health

A major transformation is underway in health care, as the nation moves to enhance patient care quality, access, and experience, and reduce costs. Significant change is being driven by a variety of forces, including nontraditional competitors, increasing consumerism, innovative technology, changing workforce demands, and intense pressures from employers and public and private payers, which signal the unsustainability of health care’s volume-based business model.

The nature of such change is now more revolutionary than evolutionary, threatening and transforming business as usual for all participants. In particular, hospital-centric service delivery likely will not meet the ease-of-access and lower-cost requirements of consumers who are shopping for health services much as they would retail purchases. Such consumers, employers, and other stakeholders are moving the health care marketplace with lightning speed from the patient sick-care model to a consumer- and population health management-focused model.

The term “population health management” as used throughout this Issue Brief is defined on the following page.

Five Drivers of the Population Health Management Imperative

1. Macroeconomic issues are driving real change: The long-run economic health of the nation depends on having a less costly, and more efficient and effective health care delivery system. Triple Aim goals of achieving better care for individuals, better health for populations, and lower per capita costs are front and center. Coordinated care management for identified populations has a proven track record of meeting these goals.

2. Employer and insurance markets are transforming: Employers are moving employees from defined benefit to defined contribution, high-deductible health plans (HDHPs); insurers are moving to performance-based payment arrangements. Public exchanges, as mandated by the Affordable Care Act, are accelerating the spread of HDHP-like plans.

3. Consumerism is increasing: HDHPs put decisions regarding health care purchases firmly in the consumer’s court, effectively changing health care from a wholesale transaction to a retail transaction in a more transparent market shaped to meet customer needs. Employers, providers, payers, and consumers are looking for improved health care value.

4. Well-funded competitors are emerging: New and nontraditional entities are blurring the lines and roles of industry stakeholders. Insurers and retail pharmacies are moving into the care-provision space. Health systems are acquiring health plans or partnering to achieve insurance capabilities. Vertical and horizontal consolidation is reshaping the industry, creating very large, well-capitalized entities that can organize care delivery for population health management.

5. Innovative technology is changing care delivery: Virtual/telehealth companies and mobile apps are redefining access to the health care experience and its costs. Web, mobile, and other technology-driven offerings shift health and care services from inpatient and outpatient facilities to in-home “anywhere care and anywhere health.”

Source: Kaufman, Hall & Associates, LLC
The Rationale and Vision for Population Health Management

California is at the forefront of this transformation by virtue of its size and unique demographic profile. The economic realities of these factors, coupled with the longstanding prevalence of health maintenance organizations (HMOs), have spurred the state’s historical vanguard role in integrating the delivery and financing of health care services. Key models that emerged over time include delegated risk models for organizing care delivery, such as those led by large independent practice associations (IPAs) comprised of individual and small-group physicians. Early development and sustained prevalence of HMO insurance by Kaiser Permanente and other commercial insurers, as well as managed care initiatives of large employers and CalPERS, have spanned many decades.

Common payment systems in California — such as capitation and global budgeting — focus on quality, access, and cost, thus aligning the systems with the emerging population health/value-based care construct. Value-based arrangements, as pursued at the national and state level by public and private payers, reward providers for meeting quality and outcome targets while lowering costs, and penalize providers that don’t meet such goals. The Centers for Medicare & Medicaid Services (CMS), the nation’s largest payer whose payments constitute a significant portion of most hospital revenue streams, aims to ensure that value-driven “alternative payment models” constitute 50 percent of its payments by year-end 2018. A consortium of major providers and commercial insurers recently targeted an even higher goal of 75 percent by 2020.

The Definition of Population Health Management

Population health management has many definitions, but the most succinct defines PHM as an approach to improving health and the quality of care delivered while managing the cost of care. Other definitions appearing in the professional literature address PHM’s clinical and service-delivery considerations and can offer a helpful starting point for hospital positioning/repositioning strategies as described in this Population Health Management program.

The clinically oriented definition: “PHM considers the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” It encompasses the following:

- The identification and surveillance of individuals at risk of developing disease or those with chronic diseases
- Interventions in early disease stages to improve health outcomes and reduce costs by preventing illness or slowing progression of chronic illness to acute stages

The service delivery-oriented definition: “Population health management occurs when a health care 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.” The health care system or network of providers may work under contractual arrangements with another entity, such as an insurer.

Three factors are critical to the success of the PHM model:

- A clinically integrated physician network
- Incentive structures that reward high performance
- Risk contracts

This Issue Brief provides detail on each factor.

Note: “How a “group of individuals” is identified varies based on whether a public health agency, provider organization, government or commercial payer, or other stakeholder is defining the “grouping.”

Population health management thus is the business challenge and opportunity for tomorrow’s hospitals and health systems, and the means to transform health care from a silo-like treatment of services to coordinated care across the care continuum. PHM is the direction health care is moving, so simply stated, if participating in Medicare or Medicaid, all hospitals and health systems in California and nationwide are in the PHM business. Those that commit early to building the competencies and infrastructure required to advance population health can position or reposition themselves to achieve a sustainable role in this paradigm. Organizations that stand on the sidelines hoping that solely the old model will endure will be excluded from delivery networks and/or contracts. Such organizations are likely to find their financial and clinical strength — and their market presence — diminishing as competitors reshape the delivery system in their communities.

Key Competencies

PHM has significant business and economic dimensions for hospitals and health systems. These include responsibility for physician engagement; quality, access, and cost of care; incentive structures that reward high performance related to these measures; and patient and family education/engagement on healthy behaviors and lifestyle.

To meet and sustain PHM goals of coordinated and managed care across the continuum, hospitals and health systems must have strong capabilities in nine areas. These areas are particularly important to establishing the organization’s value to consumers, payers, clinicians, employers, and other stakeholders. A brief description of each follows.

- **Network strength (development, configuration, and relevance):** A robust network — with hospitals, physicians, post-acute providers, and other providers — has an appropriate breadth of specialist and primary care offerings, scope of geographic coverage, and overall accessibility.

- **Clinical integration (CI):** Patient care services that are coordinated across people, functions, activities, processes, and sites maximize the value of services delivered. Clinical and economic integration/alignment of physicians, nurses, and other providers across the care continuum furthers organizational goals around quality improvement, cost reduction, and strategic and financial sustainability. CI typically is achieved through the use of strong incentive structures and contracting mechanisms that reward improvements related to these metrics.

- **Operational efficiency:** Considerations include operating costs, structural costs, service rationalization, and clinical variation.

- **Clinical care management:** This is characterized by team-based, coordinated care delivery that includes utilization management, referral management, transitions of care, chronic disease management programs, and use of evidence-based practices and protocols to better manage patient care, especially for high-risk, high-use patients.

- **Clinical and business intelligence:** To set appropriate goals and intervention targets, clinical and business data must be collected, analyzed, and applied.

- **Financial strength:** Strong cash flows and a solid balance sheet enable organizations to invest in what is needed to compete, while managing overall enterprise risk.

“Business model disruption leaves a changed market in its wake, positively transforming businesses that can make the shift to a new model, reducing the relevance of many businesses that stick with the old model, and forcing the most vulnerable entities out of business.”

Kenneth Kaufman and Mark E. Grube
• **Purchaser relationships (and managed care contracting):** Considerations include size and scope of arrangements, level of consumer engagement, strategic pricing, and ability to accept and distribute risk, incentives, and prepaid claims.

• **Customer service and consumer engagement:** Differentiation and recognition in the market is achieved through consumer engagement and strong brand presence.

• **Leadership and governance:** Deep bench strength of clinical, administrative, and governance leadership drives operational, strategic, and cultural change.

Some of these functions historically have been “housed” in the provider domain, while insurers traditionally managed other functions. Care management responsibilities often lie in between the two domains, historically resulting in fragmented care management capabilities (Figure 1).

**FIGURE 1:** The Distinct Historic Competencies of Health Systems and Health Plans/Insurers

PHM changes the demands on, and the relationships between, traditional industry participants. Comprehensive care management is required to meet PHM goals. This function spans the 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, ambulatory, and home settings.
Comprehensive care management has *clinical components*, such as use of evidence-based practices, and claims and medical record management and analytics. The latter provides clinical decision support related to quality, outcomes, cost, utilization, and other information critical to health and healthy behaviors by defined populations in the community. Comprehensive care management also includes *business components*, such as delivery network management and operations, business intelligence and actuarial services, and contracting arrangements (Figure 2).

Ownership of these care management competencies historically has varied depending upon the contractual arrangements and related level of performance and/or financial risk that the particular insurer and health system chose to assume for the population served.

**FIGURE 2:** *The Clinical and Business Components of Effective Care Management*

In some instances, physician organizations, including IPAs, have developed their own sophisticated care management infrastructures as they assume responsibility for the total cost of care for a population segment. In other instances, insurers have advanced their own care management capabilities for specific populations, assuming full provider risk and insurance risk for doing so. See “Types of Risk Assumed by Hospitals and Health Systems,” page 7.

For example, in California under the Coordinated Care Initiative, health plans are assuming insurance risk (and provider risk in those instances when there are not subcapitation arrangements with providers) to provide dual eligibles and Medi-Cal beneficiaries with access to covered medical, behavioral, and long-term care services. The plans receive monthly capitation payments from CMS and the state, but providers might be paid on a fee-for-service (FFS) or capitated basis.

Today, many sophisticated hospital systems that want to manage the total cost of delivered care are developing or enhancing such capabilities through partnership or affiliation arrangements with a health plan, a risk-bearing provider organization, and/or a managed care company. A Knox-Keene license is required of health systems to contract with California health plans and assume full delegated risk for services.
For example, Dignity Health Provider Resources, recently formed by Dignity Health, is seeking a limited Knox-Keene license to contract with California health plans and assume delegated risk for professional, hospital, and other covered services across the spectrum of a patient’s care.9

MemorialCare Health System, an integrated delivery system in Los Angeles and Orange Counties, with six hospitals, robust physician and outpatient networks, and a Knox-Keene licensed health plan of its own,10 has secured numerous partnerships with both insurers and providers. It is one of seven health systems that have partnered with Anthem Blue Cross to launch Vivity, a fully insured HMO product for the large-group market in Southern California. The hospitals receive discounted FFS payments from Anthem, share financial gains and losses for the total cost of care through Vivity, and compensate affiliated physicians through capitated payment arrangements.11

Given Managed Care, PHM Prospects and Progress in California

At what stage is California, its health care providers, and other stakeholders in managing population health?

California has a long track record of providing “managed” health care that is more efficient and coordinated than what occurs in the rest of the nation. Federal and state legislation — the HMO Act of 1973 and the Knox-Keene Health Care Service Plan Act of 1975 — encouraged risk-based models, which involve health plans, physicians, hospitals, and other providers in active care management. These models, the early presence of Kaiser Permanente,12 the development of large medical groups, and the formation of integrated health care delivery systems hastened capabilities to manage the total cost of care for specific populations.

Types of Risk Assumed by Hospitals and Health Systems

Risk in PHM contracting arrangements for hospitals and health systems falls into two categories:

• **Provider risk** is assumed by the entities delivering health care services, and includes two types:
  - **Clinical or performance risk**, which is the ability to deliver patient care that exceeds the targets for safety, quality, compliance, and other measures defined in the risk contract with the payer
  - **Utilization or financial risk**, which is incurred by a provider organization through acceptance of a fixed payment in exchange for the provision of care anticipated to have an expected level of utilization and cost

• **Insurance or plan risk** is assumed by hospitals and health systems that have their own insurance plans, with “ownership” of the members and the overall cost of plan administration and/or care delivery. Hospital- or insurer-owned plans that are contracting with providers for the provision of care under capitated arrangements are not technically taking on provider risk.

Source: Kaufman, Hall & Associates, LLC

“Many sophisticated hospital systems that want to manage the total cost of delivered care are developing or enhancing care-management capabilities through partnership or affiliation arrangements.”

Jody Hill-Mischel and Mark E. Grube