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# New-Era Planning Analytics: Assessing Population Health Management Market Opportunity

*Insights from Forum sponsor Kaufman, Hall & Associates*

By Daniel Majka, J. Patrick Smyth, and Nora Kelly

*In preparing to play a role in population health management, organizations should apply an expanded set of planning and projection analytics.*

Hospitals and health systems nationwide are working to determine how best to quantify their value position in a transforming healthcare industry. Beyond traditional analytics, organizations now also need to use more complex analytics to assess their position and performance in a broader context for population health management.

New-era planning analytics are internally *and* externally focused, and provide insights into two key dimensions: market evolution and organizational readiness for value-based care. Both the pace of change and the available metrics will vary by market, and analytics will continue to evolve. Examples of new-era analytics that organizations may use to augment traditional planning analytics include:

> Population health market opportunity
> Use-rate trends and opportunity
> Network integrity
> Referral risk
> Value position
> Total cost-of-care contribution
> Expanded view of profitability drivers

We explore the first analytic here.

Evaluating population health management opportunities is critical. The process answers important questions that clarify a market's advancement toward value-based care. Questions include:

> How do healthcare costs in the market compare to state and/or national averages?
> Does current and expected Medicare Advantage penetration indicate a growing opportunity?
> Does the organization have a critical mass of influenced lives with a payer that might be interested in partnering to share risk?

Evaluation of related data indicates how compelling the market opportunity is, and how best to position the organization to pursue the opportunity.

## Assessing Market Cost Position and Medicare Advantage Opportunity

Healthcare costs are one indicator of a market's position relative to population health management, using metrics such as risk-adjusted standardized per capita cost for Medicare beneficiaries. Relevant data can be found from sources such as the Centers for Medicare & Medicaid Services and the Dartmouth Atlas Project.

Providers and payers typically have evolved toward value-based care to a greater extent in low-cost markets than in higher-cost markets. For example, states such as California, Oregon, and New Mexico have some of the nation's lowest healthcare costs, given historically strong integration of payers and care delivery systems. With high-cost regions likely feeling more pressure to transition to value-based care, first movers toward lowering care costs in these areas will have an advantage.

Higher Medicare Advantage penetration is another indicator

that market participants are more evolved relative to population health management because plans and/or providers are paid a per-member per-month (PMPM) fee to cover all care provided to program participants. Enrollees also are more accepting of the management of their care. Markets with lower Medicare Advantage penetration may offer attractive opportunities for program participation under a range of revenue and risk models.

Assessing payer-provider positioning can help organizations determine payers' willingness to partner with them, based on whether a particular organization touches a critical mass of the health plan's enrollees. Hospitals and health systems should be able to quantify the lives they influence. For example, an organization that has 5,000 discharges annually from a particular health plan would have 77,000 influenced lives at the assumed rate of 65 discharges per 1,000-person population. Given a typical premium and an 85 percent medical loss ratio, the organization could estimate that those 77,000 lives generate about $185 million in costs for the health plan. If the organization can offer high value by reducing those costs, such figures might present a compelling case for the health plan to partner with the organization on a shared-savings or risk-based model.

## Shifting the Organization's View of Patients

Organizations should shift their analytical focus from patient volumes to influenced lives, and ultimately to managed lives. *Influenced lives* refers to patients who come to a hospital or health system for specific episodes of care via the emergency department, referrals, or self-selection. The costs and revenues relative to that care are generated within the organization, but the entity bears no responsibility for costs of care provided beyond its walls.

In contrast, lives in managed care arrangements are fully attributed. Providers typically receive PMPM payments, meaning revenue is fixed based on the population. Organizations are responsible for all costs of care provided within their systems and beyond (or a portion of total costs, depending on how financial responsibility is contractually distributed).

When done successfully, making the transition from volume to influenced lives, and then to managed lives, will significantly affect patient care volumes. At one end of the spectrum, greater numbers of patients and care episodes generate more revenue. At the other end, as those lives become managed, organizations are incentivized to improve care quality, provide more services to bolster patients' health status, and reduce non-value-added resource consumption. This approach ultimately generates savings for the health system.

## Developing a Point of View for the New Era

Hospitals and health systems should continuously track and quantify changes occurring in their markets. New-era planning analytics allow organizations to develop a range of potential outcomes related to those changes and assess the optimal timing for moving to value-based arrangements. Pursuit of opportunities should be based on the organization's data-informed point of view on where the market is headed and its role in that future market.

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**Daniel Majka**
is a managing director, Kaufman, Hall & Associates, Skokie, Ill. (dmajka@kaufmanhall.com).

**J. Patrick Smyth**
is a senior vice president, Kaufman, Hall & Associates, Skokie, Ill. (psmyth@kaufmanhall.com).

**Nora Kelly**
is senior vice president, Kaufman, Hall & Associates, Skokie, Ill., and is a member of HFMA's Southern California Chapter (nkelly@kaufmanhall.com).

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