Is your Organization Ready for Value-Based Payment?

Spring Managed Care Forum
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TODAY’S PRESENTATION

1. Current and Emerging Risk Sharing/Risk-Based (“RS-RB”) Models
2. Best Practice Financial/Benchmark Modeling and Impact on FFS
3. Key New Competencies Needed to Compete Under RS-RB Payments
4. Strategic Importance of Parallel Clinical Integration/Clinical Process Change
5. Organization Readiness at the Operational and Clinical Levels
7. Implementation Roadmap Development:
8. Lessons Learned
1. CURRENT AND EMERGING RISK SHARING / RISK-BASED (“RS-RB”) MODELS

The payer-provider contracting process has often been characterized as being adversarial vs. collaborative... absent finding a common means to demonstrate measurable value... both parties gamble with their respective futures.

1. POST-REFORM APPROACHES TO SUSTAINABLE MARGINS: SYSTEMS OF CARE / TRIPLE AIM

Future Go-To-Market

Physicians / Hospitals / Other
Payers
Administrators (Finance, PHM & IT etc.)
Consumers

Emerging Payments

Care Coordination
Population Health Management
Outcomes Data and Payments
Consumer Engagement
Aging and Overweight Populations, More Expensive Diseases to Treat, New Payment Models, Physician Shortages & Reduced ESI

How will providers and payers operationalize all of this?

KEY INITIATIVES
### 1. PAYER CUSTOMER REQUIREMENTS FOR VALUE: INCREASINGLY DEMANDING, NOT ASKING

<table>
<thead>
<tr>
<th>Fin. Class Segment</th>
<th>Today's Purchasing Behavior</th>
<th>Emerging Purchasing Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>» Cost driven – willing to trade access&lt;br&gt;» Accepts care management for lowered cost</td>
<td>» Intense focus on value – improved quality and service at reduced total medical expense&lt;br&gt;» Mixed views on shared savings &amp; CIN TME value&lt;br&gt;» General shift to consumerism... exchange population projected to be particularly price sensitive</td>
</tr>
<tr>
<td>Small Group</td>
<td>» Cost driven – willing to trade access&lt;br&gt;» Accepts care management for lowered cost</td>
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<tr>
<td>Mid Size</td>
<td>» High but variable cost sensitivity&lt;br&gt;» Prefer access... willing to trade for sig. cost reduc.&lt;br&gt;» Interest in patient engagement tools</td>
<td></td>
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<tr>
<td>Large Group</td>
<td>» Values consumer/member engagement&lt;br&gt;» Focus on total cost of care... supports COE</td>
<td></td>
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<tr>
<td>S/F HBP Public Sector</td>
<td>» Preference for access over cost reduction&lt;br&gt;» Cost sensitivity varies by municipality&lt;br&gt;» Union influenced</td>
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<tr>
<td>Medicare</td>
<td>» The most-value focused segment... best value</td>
<td></td>
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<tr>
<td>Medicaid</td>
<td>» Open, price-competitive, pilots underway&lt;br&gt;» Pay-for-performance on quality, CRGs/EAPGs</td>
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### 1. WHAT WILL MY PAYER CONTRACT PORTFOLIO AND PAYMENT MODELS LOOK LIKE IN THE FUTURE?

**Risk to Provider**
- Capitation/Global Comp
- Condition/Episode Bundling
- Fee-for-Service
- Performance-Based Programs
- PCP Incentives

**Member Attribution**
- <50% Revenues
- 50%+ Revenues
- G. Case & Episode Payments
- COE, Global Case Rates, Episodic Pricing + PBC
- Perf. Based Contracts (PBC)

**Integrated Care Systems/HEC**
- Capitation + PBC
- Shared Risk
- Shared Savings
- ACOS
- TME Shared Savings
- Narrow Network Products
- Networks of Care
- Carve-Out Specialty Services
- Episodic Prices
- Graduated/Transitional Risk
- Strategic Alliances/JVs

**Population Management**
- Hospital/Office
- Collaboration
- Integrated System

**Source:** Navigant Best Practices
2. **BEST PRACTICES FINANCIAL / BENCHMARK MODELING AND IMPACT ON FFS**

<table>
<thead>
<tr>
<th>Margin Levers Modeled</th>
<th>E.G., Variables To Be Modeled</th>
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</table>
| **Utilization Rate and Mix** | » Identify high risk patients and reduce avoidable utilization.  
» Steer patients to appropriate site of care. Share savings potential from Payer |
| **Volumes** | » Increase the number of managed lives under contract to drive more PMPM revenues  
» Spread fixed costs over larger revenue base |
| **Unit Cost** | » Reduce underlying cost structure to improve margin position |
| **Payer Payments** | » Make decisions with fact base on impact of discounts for steerage vs. locking in current payment rates |
| **Shared Savings** | » Retain negotiated % of shared savings  
» Establish internal savings distribution formula that aligns hospital physician incentives |

**2. MODELING IMPACT OF RB-RS ARRANGEMENTS IS CRITICAL TO NEGOTIATING SUCCESS**

To assess the potential financial impact of value based payment arrangements such as commercial shared savings contracts, determine the margin/revenue impact on FFS revenues as well as potential avoidable costs/utilization with each major payer... financial/analytical models must be built.
### 2. LEVERS FOR SAVINGS ARE OFTEN NOT OBVIOUS

**Largest $$ savings from FFS... Avoidable readmissions, 1 day stays and E/D use**

<table>
<thead>
<tr>
<th>Margin Levers Modeled</th>
<th>Downstream Issues to Manage</th>
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<tbody>
<tr>
<td><strong>Utilization Rate</strong></td>
<td>How is the avoidable utilization? Where can we shift patients to lower cost care sites/lower cost service mix? Where should we consider clinical process changes?</td>
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<tr>
<td><strong>&amp; Mix</strong></td>
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<tr>
<td><strong>Volumes</strong></td>
<td>How exactly will we grow lives in partnership with payers? What, if any, underlying discounts do we need to give to steer/retain volume?</td>
</tr>
<tr>
<td><strong>Unit Cost</strong></td>
<td>Which Value Imperatives need to be accelerated to get unit costs down? Greatest synergistic opportunities... admin &amp; clinical?</td>
</tr>
<tr>
<td><strong>Payer Payments</strong></td>
<td>What discount rate, if any, will you give the payer? Pricing strategy by service area/service line?</td>
</tr>
<tr>
<td><strong>Shared Savings</strong></td>
<td>How do we distribute savings? What metrics, what targets, what weights? Impact if we expand physician network, grown lives?</td>
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### 2. PAYER RS-RB CONTRACTING KEY DUE DILIGENCE STEPS (COMMERCIAL & MA SHARED SAVINGS EXAMPLES)

- Acquire Payer Commercial and Medicare Advantage paid claims, to model anticipated revenue and margin impact of expected utilization reductions:
  - Shared Savings Calculations
  - Covered lives and attributed lives by product
  - Medical Expenses
  - Medical Trend Target(s)
- Assess Payer contracts and recommend modifications/counter-proposed on:
  - Shared Savings Calculations
  - Risk Adjustment and Mitigation Best Practices
  - PMPM Trends and Targets as well as Quality Metrics
  - Contract Language (very different from FFS contracts)
- Acquire Payer claims data for attributed lives and TME... model anticipated revenue impact for each negotiable item:
  - Shared Savings Calculations
  - Avoidable Costs and Utilization
  - Care Management/Coordination/Navigation Fees
3. **Key New Competencies Needed to Compete Under RS-RB Payments**

WHAT CAPABILITIES DO SYSTEMS NEED TO ADD TO BE SUCCESSFUL UNDER RS-RB PAYMENT MODELS?

- Practice Variation
- Improvement Metrics
- Analytic Tools
- Population Management
- Change Management
- Predictive Modeling
- Member Attribution
- Integrated Care Systems/HEC
- Cost of Care Reduction
- Physician Leadership
- Strategic Leadership
- Clinical & Operating Efficiency
- Quality Improvement Focus
- Clinical Decision Support Systems
- Comprehensive Improvement Metrics
- Care Coordination
- EBM
- Standardized Processes
- Member Engagement
- Reduction of Avoidable Costs
- Reporting / Tracking Tools
- Payment Distribution Process
- Focus on Prevention
- Outcomes Based Metrics
- Clinical & Financial Integration
- Organization Leadership/ Governance Structure

Source: Navigate Best Practices
3. **REVENUE & EXPENSE MANAGEMENT: EXAMPLE - VALUE OF CONTRACT MODELING CAPABILITIES**

### Increasing Clinical Integration and Financial Risk Levels / Complexity

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Shared Savings</th>
<th>Bundled Payment</th>
<th>Accountable Care Organization</th>
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<tbody>
<tr>
<td>Overview</td>
<td>Utilization Reductions Shared Between Payer and Provider – Incenting Quality over Quantity</td>
<td>One payment per Defined Episode – Movement Away from Utilization Based Reimbursement</td>
<td>Population Based Care that Rewards Integration, Quality, Outcomes and Efficiency</td>
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<tr>
<td>Designed to Promote</td>
<td>Cost Reduction</td>
<td>Cost &amp; Utilization Reduction</td>
<td>Value</td>
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<tr>
<td>Care Coordination</td>
<td>Encouraged</td>
<td>Required</td>
<td>Required</td>
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<tr>
<td>Quality Standards</td>
<td>Optional</td>
<td>Optional</td>
<td>Required</td>
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<tr>
<td>Physician Alignment</td>
<td>Must Align to Achieve Savings</td>
<td>Must Align to Achieve Savings</td>
<td>Required</td>
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Source: Navigant Best Practices

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4. **STRATEGIC IMPORTANCE OF PARALLEL CLINICAL INTEGRATION/Clinical Process Change**
4. TWIN PILLARS TO SUCCESS UNDER CURVE 2 PAYMENT MODELS

High Efficiency Health Care

- Manage Financial Risk
- Coordinate and Manage Patient Populations
- Patient and Physician Engagement
- Infrastructure / Operational Alignment
- Clinical Integration / Care Model Redesign
- Increases Value, Equitable & Sustainable

Source: Navigant Best Practices

4. OUR PRICING, PRODUCT, CARE DELIVERY MODEL DESIGN LEVERS TO TRANSITION FROM CURVE 1 TO CURVE 2

- What Pricing Strategy?
  - FFS + P4P
  - Shared Savings
  - Episodic Bundling
  - Full Risk
  - IP/OP Increase vs. Decrease?

- Absent Parallel Clinical Integration/Clinical Process Change with Payment Model Change... How Will You Manage Risks?

- What Network Partners?
  - Physician, Hospitals & Other

- Which Products and Which Payers?
  - Commercial Group
  - ACOs & Other
  - Medicare Advantage
  - Managed Medicaid

- What Time Line?
  - Y1
  - Y2
  - Y3
  - Y4

Source: Navigant Best Practices

Management of Pricing, Product, Network, Operational, Clinical, Financial, Distribution Channel and Competitive Risks?
Prioritizing areas of focus based on payment model and areas of need:

**Shared Savings**
- Physician-Hospital relationships (e.g., IPA, self-employed)
- Governance model (e.g., dyad leadership)
- Chronic disease management and practice variations

**Bundles**
- PAC facility preferred partnerships and associated workflows
- Implant and DME cost benchmarking
- Pre-op risk management (e.g., glycemic control)

**ACO**
- High-risk patient management
- Demand matching across network
- Pharmacy utilization

**Cross-cutting Quality & Performance Metrics and Variation Analysis**

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**4. COMMON ANALYTICS BASE LINKS CLINICAL AND PAYMENT TRANSFORMATION**

**FINANCIAL BUDGETING & PLANNING FOR RISK CONTRACTS: E.G. BUILDING PMPM BUDGETS BASED ON AVOIDABLE COST ANALYSIS**

Illustration: PMPM Savings Opportunities

Cost and Utilization Reductions Achieved Through Care Coordination and Clinical Process Change

Current PMPM: $410

Projected PMPM: $360

Source: Navigant Best Practices
4. TWO KEY WORKSHOPS GUIDE CLINICAL TRANSFORMATION AND DRIVE CLINICIAN ENGAGEMENT

**Workshop Type #1: SCAMPs**

- Standardized Clinical Assessment and Management Plans (SCAMPs)
- Utilized to dive into clinical decisions with high impact on outcomes and costs. Key to:
  1. Evidence-based care customized to treatment patterns
  2. Physician engagement and buy-in

**Workshop Type #2: RIEs**

- Rapid Improvement Events (RIEs)
- Aimed at improving flow through operational bottlenecks or key process misalignments
  1. Focus on early consideration of "root cause analyses"
  2. Inter-disciplinary approach to improvement
  3. Allow for optimal buy-in and adoption into practice.

5. ORGANIZATION READINESS PLANNING AND ASSESSMENT PROCESS AT THE OPERATIONAL AND CLINICAL LEVELS
5. KEY FRAMING QUESTIONS: PREPARING FOR PAYMENT AND CLINICAL TRANSFORMATION CHANGES

1. Longer term, how sustainable is our current FFS payment model?
2. If we move away from our FFS to an early stage value-based payment models -- how do we minimize the risk of margin erosion?
3. To optimize our net revenue/payment yield part of the margin equation:
   a) What employer, geographic and payer LOB’s should we target?
   b) What steerage/keepage opportunities exist and how do we best avoid cannibalizing our higher payments with the same patients?
4. To optimize the labor/non-labor cost part of the margin equation:
   a) What types of avoidable costs and utilization need to be removed?
   b) What types of administrative costs can be reduced?
   c) Which incentives need to change, if any, to achieve the above?
5. What operational and clinical process changes do we need to make to be successful under value-based payments?
6. What risks do we need to plan for and manage?

5. YOUR OPERATIONAL AND CLINICAL READINESS FOR VALUE BASED PAYMENTS STARTS WITH A RISK ASSESSMENT

Summary of Risks – Population Health Management & Risk Based Contracting

- Plan for Risks
- Invest in Capabilities to Avoid/Mitigate Risks
- Timelines are Important
- Develop Detailed Implementation Plans & Execute
- Manage Risks Across care Continuum
- Performance Accountability
- Start in… When?
- Alignment w/ Strategic Plan
- Results to Report Across Formal PMO Process
5. READINESS RATINGS: PERFORMING A FINANCE/CONTRACTING/INFRASTRUCTURE GAP ASSESSMENT

<table>
<thead>
<tr>
<th>Risk-Based Contracting</th>
<th>Current State Assessment</th>
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<tbody>
<tr>
<td>Revenue &amp; Expense Management</td>
<td>(\text{Unprepared with No Plans})</td>
</tr>
<tr>
<td>Financial Budgeting and Planning for Risk Contracts</td>
<td>(\text{Ready for Success})</td>
</tr>
<tr>
<td>Managed Care Contracting</td>
<td>(\text{Plans for Developing Capabilities})</td>
</tr>
<tr>
<td>Funds Flow, Rewards &amp; Incentives</td>
<td>(\text{Unprepared with No Plans})</td>
</tr>
<tr>
<td>Overall Risk &amp; Financial Management</td>
<td>(\text{Plans for Developing Capabilities})</td>
</tr>
<tr>
<td>Health Information Technology/Information Systems</td>
<td>(\text{Ready for Success})</td>
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Note: The same type of readiness assessment would be performed on Clinical Delivery Operations, Provider Network Care Continuum, Market and Product Strategy and Unified Analytics-IT-Infrastructure. All areas combined, define organizational readiness for population health management and risk-based contracting.

5. MOVING TOWARD MANAGING POPULATIONS SHIFTS THE STRATEGIC IMPERATIVE TO HIGH SYSTEM PERFORMANCE

Organizational elements complement functional capability building:

- **Physician/Hospital Alignment**
  - Performance based on best practice benchmarks
- **Cost Restructuring**
  - Efficient utilization of overhead in organization is mission critical
- **Coordinated Care Continuum**
  - Clinical integration and care management has to be coordinated across the entire continuum of care
- **Care Management/Reimbursement Risk**
  - Management of variability in underlying utilization and costs in providing clinical services to patients

Pathway Toward High-Performance
5. A PHYSICIAN ALIGNMENT READINESS ASSESSMENT WILL CLARIFY NEXT STEPS

Stage 1 “Traditional”
- Independent MD
- Individual Practice Mgt.
- Limited Physician/ Hospital Trust
- Economic Focus to Relationships

Stage 2 “Early Integration”
- Groups: Mostly Single Specialty Practices
- Emerging Collaboration - Physicians Understand Beyond Economics

Stage 3 “Mature Integration”
- Mixed Employed/Private Model
- Clinical Standards
- Strong Relationships
- Some Clinical Integration

Stage 4 “Advanced Integration”
- Large, Diverse Network
- Fully Aligned Hospital/Physician Leadership
- Roles Well Defined
- Robust CI

Stage 5 “Future Vision”
- Large, Diverse Network
- Fully Aligned Strategic Physician Leadership

5. QUANTIFYING THE SIZE OF THE PERFORMANCE GAP: WHERE ARE YOUR PHYSICIANS TODAY?

Required Movement toward Best Practice Performance Expectations
- Evaluation of the current financial and operational gaps
- Best practice performance targets established in coordination with incumbent physician and administrative leaders
- Reliance upon legacy and/or performance expectations will hinder achieving high performance

Models that represent the varying degrees and types of affiliations
5. **Maximizing Physician Engagement is a Key Success Factor in Clinical Transformation**

<table>
<thead>
<tr>
<th>Both Payer &amp; Integrated DS</th>
<th>Payer Support Programs</th>
<th>Integrated DS Services</th>
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<tbody>
<tr>
<td>Shared Savings</td>
<td>Direct Invest.</td>
<td>EMR/MU</td>
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<td>PCMH</td>
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<td>Program Support</td>
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<td>CCRN</td>
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Integrating DS Affiliated PCPs

- Practice Characteristics - # Physicians, Specialties, Patient Panel Size, Geography
- Practice Population Management Capabilities
- Practice Patient Needs

- Customized Engagement Opportunities for Physicians & Practices

6. **Critical Success Factors: Population Health and Care Delivery Models for RS-RB**
### 6. Evaluate Your Organization Against Milestones for Each Population Health Capability

<table>
<thead>
<tr>
<th>Building Block</th>
<th>Goal</th>
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<tbody>
<tr>
<td>1. IT Systems &amp; Analytics</td>
<td>Enable population health through world class tools and technology &amp; data reporting</td>
</tr>
<tr>
<td>2. Quality &amp; Performance Improvement</td>
<td>Utilize data to inform QI / PI initiatives in order to achieve system wide quality goals</td>
</tr>
<tr>
<td>3. Physician Leadership &amp; Alignment</td>
<td>Achieve physician partnership to ensure access and to create and operate high quality delivery model</td>
</tr>
<tr>
<td>4. Care Coordination &amp; Management</td>
<td>Coordinate care across the continuum to deliver an efficient and cost effective delivery model</td>
</tr>
<tr>
<td>5. Finance/Underwriting</td>
<td>Achieve financial model alignment to incentivize and reward success in population health</td>
</tr>
<tr>
<td>6. Contracting &amp; Network Development</td>
<td>Contract with specific payers and employers to grow lives, manage risk and achieve financial targets and develop a provider network to manage lives within the care model</td>
</tr>
<tr>
<td>7. Patient Engagement</td>
<td>Engage patients in care decisions to maintain healthy populations and improve health of sick patients</td>
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**Key Benefits**

<table>
<thead>
<tr>
<th>IT Systems &amp; Analytics</th>
<th>Quality &amp; Performance Improvement</th>
<th>Physician Leadership &amp; Alignment</th>
<th>Care Coordination &amp; Management</th>
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</thead>
<tbody>
<tr>
<td>Enable population health via world class tools &amp; data reporting</td>
<td>Utilize data to inform QI / PI initiatives to achieve system wide quality goals</td>
<td>Achieve physician partnership to create high quality delivery model</td>
<td>Coordinate continuum of care to deliver cost-effective delivery model</td>
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</tbody>
</table>

- Process to evaluate the health needs of specific population*
- Goals to evaluate performance for ambulatory quality and hospital quality initiatives
- Quality and Patient Sat Metric Library*
- Mechanisms in place to standardize reporting of clinical and quality performance*
- Process to integrate results to current QI/PI initiatives and define additional initiatives*
- Physician leaders with the credibility and expertise to lead
- Aligned network of physicians
- Physician partners willing to change
- Incentive models that align MD behavior with plan design*
- Tech adoption agreement with affiliate MDs*
- Clear performance expectations for MDs in quality programs*
- Measure against specified targets*
- Physicians engaged in designing care coordination model*
- Risk stratification process assigns specific providers*
- Transition of Care value streams
- Case management / clinical protocols for high volume diseases
- Standardized process for patient handoffs
- Physician office connectivity*
- Care coordination performance using standard metrics*

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* = Plan & provider requirement

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Governance: To ensure appropriate decision rights and accountability.
**Goal**

Achieve financial model alignment to incentivize and reward success in population health

Contract with specific payers and employers to grow lives, manage risk and achieve financial targets and develop a provider network

Engage patients in care decisions

**Key Elements**

- Financial model alignment across facilities and professionals*
- Appropriate metrics to quantify population health performance*
- Relevant dashboards to monitor performance on ongoing basis*
- Mechanisms to integrate financial analytics into budgets*
- Actuarial capabilities
- Communication process to share results with stakeholders*
- CDM mappings and cost accounting system utilized as inputs into financial model
- Transparent funds flow and distribution process*
- Aligned contracting priorities with financial / budget model to manage transition to risk*
- Aligned payment models to incent performance*
- Internal alignment with key internal teams
- Employer specific partnerships to deliver new lives*
- Appropriate number of clinical resources*
- Ownership or strategic partnerships for aligned providers across continuum *
- Include ancillary providers*
- Aligned IT infrastructure across partners *
- Patient portal to engage patients*
- Communication process that presents clinical knowledge understandably*
- Training program on engaging and communicating with patients to create a sacred encounter
- Tools for nurse care managers to assess patient barriers
- Partnerships with community stakeholders
- Standard process for gathering pt. survey results*
- Shared decision-making process accounting for each patient’s unique needs*

**Governance:** To ensure appropriate decision rights and accountability.
6. ANALYTICS DRIVE DIRECT VALUE CAPTURE – PATIENT FLOWS

Illustration: Joints 30 Day Post

6. ANALYTICS ENABLE EFFICIENT & TARGETED RE-DESIGN – PHYSICIAN VARIATION ILLUSTRATION

Post Acute Care Costs by Physician
7. **IMPLEMENTATION ROAD MAP DEVELOPMENT:**

- FINANCIAL/IT/OTHER ADMINISTRATIVE AND OPERATIONAL CAPABILITIES
- ORGANIZATIONAL RE-DESIGN AND GOVERNANCE
- PHYSICIAN ENGAGEMENT AND COMMUNICATION
- TRANSITIONS IN CARE
- HOW PHYSICIANS CAN CLOSE THE PERFORMANCE GAP
- KEY RISK MITIGATION ISSUES TO ADDRESS

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<thead>
<tr>
<th>Road Map Component</th>
<th>M1</th>
<th>M2</th>
<th>M3</th>
<th>M4</th>
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<th>M7</th>
<th>M8 +</th>
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<tbody>
<tr>
<td>1. Executive Oversight</td>
<td>Monthly Operating Reports</td>
<td>Governance and organizational model alignment</td>
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<tr>
<td>2. Finance &amp; Managed Care Contracting</td>
<td>Risk Contract Budgets</td>
<td>Funds Flow &amp; Success Metrics</td>
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<td>Preferred Pricing Methodology</td>
<td>Payer Specific FFS Negotiations &amp; Execution</td>
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<td>Payer Negotiations for Risk Contracts</td>
<td>Direct Employer Strategy</td>
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<td>4. Provider Network Contracting</td>
<td>Credentialing/Signing Providers</td>
<td>Joint Contracting with Payers for RS-RB Payments / Delegated Risk</td>
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<td>Data Sharing &amp; Reporting</td>
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<td>5. Clinical Delivery Operations</td>
<td>Medical Home, Disease Mgmt. &amp; Clinical Programs/Protocols</td>
<td>Population Health Management</td>
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<td>Medical Management at Clinic Level</td>
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<td>6. Unified Analytics &amp; Infrastructure</td>
<td>Avoidable Cost/Utilization</td>
<td>Provider Network Modeling &amp; Funds Flow</td>
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<td>Predictive Modeling</td>
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7. ESTABLISH A POPULATION HEALTH ROADMAP TO HIT THE MILESTONES AND ACHIEVE SUCCESS

Navigating the roadmap along these key components requires:

1. Sustained leadership across components of health system
2. Analytics to identify opportunities, prioritize, and measure performance
3. Definition of near-term → long-term value capture
   - Near-term: generic vs. branded prescribing, PAC routing
   - Mid-term: Post-acute care refinement, readmissions
   - Long-term: comprehensive care management
4. Systematic processes for workflow development
   - Rapid Improvement Events (RIEs) for inter-disciplinary bottlenecks and cost drivers
   - E.g., SCAMP (Standardized Clinical Assessment and Management Plan) development for key areas of need (post-op infections, prosthesis/implant infections, etc.)
   - Care Management function development

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8. LESSONS LEARNED
8. LESSONS LEARNED FROM VALUE-BASED PAYMENT AND CLINICAL PROCESS CHANGE INITIATIVES

» When you change your core payment model and provide incentives to modify practice behavior to focus on optimal care with the lowest cost mix of services... you must also address how prepared your organization is prepared to manage clinical, operational, financial and competitive risks. For example:

› Are our analytics capabilities aligned to track/report/manage risk?
› Do we have the right configurations in our “Network” to navigate patients “in-network” and draw “shared savings” from other providers in the market beyond our own organization?
› Are our Finance/Accounting/Billing/IT operations prepared to manage value-based payments and associated performance metrics?
› How will we risk stratify patients and what clinical process changes will we need to make to manage high and moderate risk patients?
› How do we need to structure our organization to achieve results? Who will lead the change?
› How are we doing relative to our competitors and to systems in similar markets on contracting? On quality? On staffing and productivity?

8. PREPARING FOR THE FUTURE: INTEGRATED CLINICAL AND PAYMENT TRANSFORMATION

"The best way to predict the future is to invent it." – Alan Kay

"The future belongs to those who see possibilities before they become obvious." – John Sculley

“All organizations are perfectly designed to get the results they are now getting. If we want different results, we must change the way we do things.” – Tom Northrup

What clinical and operational changes does your organization need to address to serve patients, retain the best staff and remain a financially sustainable organization in the post 2014 ACA business environment?
TODAY'S PRESENTERS

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Chris is a senior healthcare executive with over twenty-eight years of operations, finance, managed care/contracting, M&A, strategic alliance and new business development experience across hospital, physician organization, post-acute care and health plan industry verticals. More recently, Mr. Kalkhof has worked on varied planning, development and implementation initiatives associated with post-reform care delivery and financing models designed for business model sustainability.

Since joining Navigant, Chris has worked with some of the leading academic medical centers, health systems, health plans and medical groups around the country on the following strategic initiatives:

- Operational readiness for population health management and risk based contracting and strategy alignment
- Comprehensive managed care reimbursement benchmarking to support/revise pricing strategy and service line care continuums
- Commercial global case rate and episodic pricing model development and shared savings payment models for payer contract strategy development and negotiations, along with concurrent clinical transformation initiatives
- Best practices contract and rate amendment language for national health systems and payers
- Strategic alliance and joint venture development between health plans and provider organizations which cover product, value-based reimbursement, network composition, distribution channels and partnership zones
- M&A due diligence support of provider and health plan acquisitions

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As a Managing Director in Navigant's Healthcare practice, Dr. Amol Navathe serves as a practicing physician, health economist and engineer with expertise in the utilization of advanced health data analytics and technology to improve healthcare delivery. He serves a diverse client base of payer, provider, and government clients on transformational payment and care delivery issues. His pioneering work on utilizing claims and clinical data to re-engineer the fundamental processes of care offers clients exceptional business, operational and patient management efficiency expertise.

Dr. Navathe has applied his skills to delivery transformation and innovations, federal policy for health data infrastructure development, and the study of physician and hospital economic behavior. Through his extensive thought leadership, he is the founding co-editor-in-chief of "Health Care: The Journal of Delivery Science and Innovation." He is also the founding director of the Foundation for Healthcare Innovation.

Having served as Medical Officer and Senior Program Manager for the Office of the Secretary Department of Health and Human Services, Dr. Navathe led the $1.1 billion Comparative Effectiveness Research (CER) program. He is regarded as one of the chief architects of the nation's CER and research data infrastructure strategy.

Dr. Navathe led a $19M data infrastructure to create a multi-payer multi-claims database (MPCD), which promotes CER. He has led delivery systems to improve management of high-risk and high-cost patients through predictive analytics and brings his CER knowledge to driving evidence-based care.