Value Based Care

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PwC

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Value Based Care Point of View
Driven by the twin forces of risk shift and retail shift, payers and providers are under tremendous pressure to show value.

**Key Drivers…**

**Risk Shift**
Moving downstream from funders to delivery and consumers

**Retail Shift**
Growth of Individual and concurrent shift of supply formats

**Margin Pressure**
Need to manage costs and risk and prove value

**…Translating To…**

**Innovation**
Health systems developing new value propositions, care, financing and engagement models, diversifying and monetizing assets

**Convergence**
Health systems taking on the payor role

**Consolidation**
Health systems pursuing scale, system-ness, clinical and operational integration

**Transformation**
Health systems transforming their service lines, operating models, technology and culture

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The gradual shift to VBC provides greater opportunity for stakeholders to be directly accountable for clinical outcomes.

An aging demographic in the face of traditional, volume-based fee-for-service care delivery has contributed to rising healthcare costs, pressuring providers to demonstrate value (i.e., provide high quality care at lower cost).

<table>
<thead>
<tr>
<th>Volume Based</th>
<th>Value Based</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payment</strong>: Fee-for-Service</td>
<td><strong>Payment</strong>: Outcomes based</td>
</tr>
<tr>
<td>Providers reimbursed for number of interventions performed (e.g., lab tests, x-rays, procedures, etc.)</td>
<td>Providers reimbursed on health outcomes (i.e., was patient readmitted within 30 days? Did patient condition improve following intervention?)</td>
</tr>
<tr>
<td><strong>Incentives</strong>: Order/perform as many interventions as possible to maximize reimbursement</td>
<td><strong>Incentives</strong>: Keep patients healthy and reduce unnecessary interventions</td>
</tr>
<tr>
<td><strong>Focus</strong>: Individual patient episode</td>
<td><strong>Focus</strong>: Outcomes across continuum of care</td>
</tr>
<tr>
<td><strong>Role of Provider</strong>: Siloed approach based on specialty-driven interactions</td>
<td><strong>Role of Provider</strong>: Team-based across care continuum</td>
</tr>
</tbody>
</table>
Defining “Value” in healthcare has always been a contentious issue

Value in healthcare has been traditionally defined as increasing the Quality of care while decreasing cost of care per patient

Value = \frac{Quality}{Cost}

- Quality of care is a key driver of reimbursement in Value based care models.
  - Access: Availability, Timeliness and Capacity
  - Outcomes: Clinical, Operational and Throughput
  - Satisfaction: Patient, Provider, Payer
- New CMS Programs (MACRA, Bundles) tie reimbursement to Cost of Care

Quality = Access \times Outcomes \times Satisfaction

(Patient, Provider, Payer)

Cost = \frac{Total\ Cost\ of\ Care\ (Entity)}{Volume}

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Why Value Based Care is important NOW?

**Regulations & Policy**
- ACA has given rise to new structures and systems in support of **triple aim philosophy**, including:
  - MACRA
  - Center for Medical and Medicaid Innovation (CMMI)
  - Accountable Care Organizations (ACO)
  - Patient-Centered Medical Homes (PCMH)

**Consolidations and Financial Risk**
- Increasing costs and an aging population have pressured risk-bearing stakeholders to adopt Alternative Payment Model (APM) approach that incentivizes **high quality, high value** care
- Payers, physicians, and health systems are collaborating across care continuum to share risk and reduce overall costs – while improving care delivery

**Rise of Consumerism**
- Patients are seeking more choice, raising competitive pressures to drive satisfaction
- Consumers are demanding a better patient experience based on **timeliness, convenience, and price transparency** – all of which will have to be delivered for health systems to remain competitive

**Interoperability**
- Integrated EMRs allow the collection and synthesis of “big data” across disparate sources, uncovering new insights (both at individual and population level) to **better manage health outcomes**
- Technological advances enable more cost effective care management via **remote monitoring and telemedicine**

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Value Based Care opportunities across sectors

**Providers**
- Develop new disease management programs and redeploy resources to more effectively deliver high value care
- Align physician incentives with patient engagement initiatives to improve preventive care offerings and reduce overall cost burden

**Payers**
- Diversify product portfolio by offering care management (including preventive) capabilities
- Identify partnership opportunities to leverage population health offerings
- Build narrow networks with high quality providers to more effectively manage risk

**Employers**
- Develop wellness programs, including behavioral and social, and closely monitor outcomes to assess ROI
- Offer targeted care interventions to high risk employees to better manage financial risk

**New Entrants**
- Create new patient-centric delivery models based on population health management principles to increase access for those most in need
- Develop personalized tech-enabled tools to empower self-management and decrease acute episodes (and costly interventions)
The need to demonstrate value has catalyzed the conceptualization of new and collaborative risk models.

### Collaboration Models

**Increasing Provider Risk**

<table>
<thead>
<tr>
<th>Description</th>
<th>P4P (Pay for Performance)</th>
<th>Gain Share / Risk Share</th>
<th>Bundles</th>
<th>Capitation</th>
<th>Full Risk Insurance Model (FRIM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Providers take on outcomes risk and are paid progressively based on improved care metrics (value based networks)</strong></td>
<td>Providers take on outcomes and financial risk by sharing gains and losses that are based on PMPM targets (value based networks)</td>
<td>Providers take on financial and outcomes risk for a well defined aggregated set of services (e.g., $/episode of care)</td>
<td>Providers assume actuarial risk for a population with a fixed PMPM amount (requires population health management)</td>
<td>Providers assume investment risk and assume complete financial as well as administrative responsibility for a patient population</td>
<td></td>
</tr>
</tbody>
</table>

**Example Arrangements**

- Bonuses for EBM adherence
- Withholds until process metrics are met
- Gain share when costs are below PMPM targets
- Deficit share when costs are above PMPM targets
- Single payment for well defined episode of care, including facility and all continuum of care fees
- Capitated arrangement for a regional Medicare population
- Provider sets up a health plan to serve regional population
- Provider partners with a payor on a JV

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MACRA: Financial Impact
How does CMS’ propagate VBC based payment programs?

*Multiple programs drive the shift towards Value Based Care*

**Determinants of Reimbursement**
- Quality
- Cost
- Practice Improvement
- IT Infrastructure

**CMS Value Based Programs**
- Pioneer MSSP ACOs
- Next Generation ACOs
- Comprehensive Care Joint Replacements
- Hospital Readmissions Reduction Program
- Hospital Acquired Conditions Reduction Program
- Bundled Payments for Care Improvement
- Annual Wellness Visits
- Transitional Care Management

**Aligned metrics and drives program alignment**
- Accountable Care Organizations
- Medicare Incentive Payment System
- Advanced Alternate Payment Models
- Bundles
- Wellness & Prevention
- MACRA
- MIPS
  - Quality
  - Resource Use
  - Clinical Practice Improvement
  - Meaningful Use
  - Qualifying APM Participant

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MACRA: Value Based Care’s key driver

The potential for ACA repeal leaves MACRA as the largest driver for Value Based Care

Final Rule Impacts to MACRA

- The 2018 final rule raises this bar to $90,000 in Medicare Part B charges and 200 patients annually
- Individual physicians and physicians in groups of 10 or fewer can band together virtually
- At least 8 percent of physician revenue has to be at risk to qualify
- Eligible clinicians achieve QP status based on a combination of participation in: Advanced APMs within Medicare fee-for-service; and Other Payer Advanced APMs offered by other payers

**Option 1 (MIPS Full Participation)**
- Report for a full year
- **Maximize** chance to qualify for positive adjustment
- Exceptional MIPS performers are eligible for additional positive adjustment each year for 6 years

**Option 2 (MIPS Partial Participation)**
- Report for 90 days, or less than a full year
- Report >1 quality measure, >1 improvement activity, or 5 required measures in ACI
- Avoid negative adjustment, and possibly receive incentive payment but assume neutral adjustment

**Option 3 (MIPS Minimal Participation)**
- Report 1 measure in Quality, 1 improvement activity or required measures in advancing care information performance for 90 days
- Avoid negative adjustment and possibly receive positive adjustment

**Option 4 (Advanced APM)**
- MIPS eligible who participate in Advanced APMs
- Qualify as QP if 25% of payments or 20% of patients are Medicare in your APM
- Receive 5% bonus
Although Year 1 reporting mandates put MACRA on the backburner, Year 2 mandates are much more involved.

### MIPS Program

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>Meaningful Use of Certified EHR</th>
<th>Maximum MIPS Payment Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>+/- 4%</td>
<td>+/- 5%</td>
<td>+/- 7%</td>
<td>5% Lump Sum Incentive Payment</td>
<td>Excluded from MIPS</td>
</tr>
<tr>
<td>2017</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2019</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2020</td>
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<tr>
<td>2021</td>
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<tr>
<td>2022</td>
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<tr>
<td>2023</td>
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<tr>
<td>2024</td>
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<tr>
<td>2025</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2026 and later</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Eligible APMs

- Qualifying APM Participant
- 5% Lump Sum Incentive Payment
- Excluded from MIPS

### Reporting Flexibility

- Only penalized if providers don’t report on even a single metric
- Three reporting period options
- ACI reporting can be done in 2 ways

### Mandatory reporting for full year

- Providers penalized for performing below benchmarks (< 5%)
- Cost reporting at 10%
- Must report Stage 3 measures

### Year two reporting requirements are mandatory and stricter:

1. Mandatory reporting for Full Year
2. Mandatory reporting on Stage Three measures
3. Performance on cost measures becomes more important
4. Potential penalties increase

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MIPS Time and Cost Burden by Reporting Systems

Reporting on MIPS Measures involves considerable time and financial investments

- Quality reporting is the most expensive and the most time consuming activity
- Advancing Clinical Information and Practice Improvement do not mandate significant resource allocation

<table>
<thead>
<tr>
<th>Impact Area</th>
<th>Annual Burden (Per Year/Physician)</th>
<th>Quality</th>
<th>ACI</th>
<th>CPI</th>
<th>Total Burden</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMR Submission</td>
<td>Estimated Time</td>
<td>11 Hours</td>
<td>4 Hours</td>
<td>3 Hours</td>
<td>18 Hours</td>
</tr>
<tr>
<td></td>
<td>Estimated Cost</td>
<td>$725</td>
<td>$730</td>
<td>$550</td>
<td>$2205</td>
</tr>
<tr>
<td>Clinical Data Registry</td>
<td>Estimated Time</td>
<td>20 Hours</td>
<td>4 Hours</td>
<td>3 Hours</td>
<td>27 Hours</td>
</tr>
<tr>
<td></td>
<td>Estimated Cost</td>
<td>$1490</td>
<td>$730</td>
<td>$550</td>
<td>$2575</td>
</tr>
<tr>
<td>CMS Web Interface</td>
<td>Estimated Time</td>
<td>81 Hours</td>
<td>4 Hours</td>
<td>3 Hours</td>
<td>88 Hours</td>
</tr>
<tr>
<td></td>
<td>Estimated Cost</td>
<td>$6850</td>
<td>$730</td>
<td>$550</td>
<td>$8130</td>
</tr>
</tbody>
</table>

*These figures are based on estimates by CMS and may underestimate and/or not reflect the experience of every practice. Other studies show that time and costs may be higher*  
Source: Sample taken from Payment Model Evaluator from the American Medical Association: https://apps.ama-assn.org
A single provider can save approx. $1 Million on average by reporting on select measures in Year 1

Penalties closely follow the number of reporting providers and tie closely with historic performance/trends

<table>
<thead>
<tr>
<th>No of Physicians</th>
<th>Potential penalties Year 1</th>
<th>Potential penalties Year 2</th>
<th>At Risk Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000 physician and above</td>
<td>$709,1669.96</td>
<td>$12,457,301.76</td>
<td>$18,272,471.13</td>
</tr>
<tr>
<td>500 to 1000 physicians</td>
<td>$169,3108.66</td>
<td>$3,534,569.92</td>
<td>$4,922,919.02</td>
</tr>
<tr>
<td>200 to 500 physicians</td>
<td>$277,110.18</td>
<td>$444,407.92</td>
<td>$671,638.27</td>
</tr>
<tr>
<td>50 to 200 physicians</td>
<td>$166,683.23</td>
<td>$388,965.76</td>
<td>$525,646.01</td>
</tr>
<tr>
<td>0 to 50 physicians</td>
<td>$40,627.08</td>
<td>$62,909.64</td>
<td>$96,223.85</td>
</tr>
</tbody>
</table>

- Larger hospitals will have to lose out on greater sums of money
- The distribution of expected penalties is normal and centers around a median of $1 million across a cohort of 1200 providers nationwide
- This curve will shift to the right as the uninsured population enrolls in Medicare and other government sponsored programs. (Median moves to $1.7-2.1 Million)

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An Example of Typical Primary Care Practices

On average, physicians get 19% of their total revenues from Medicare:

- Average visit charge = $70
- Medicare pays $49 per visit
- Assuming an average per Medicare patient annual revenue of $200

<table>
<thead>
<tr>
<th>Total Medicare Patients @50% of panel size</th>
<th>1200</th>
<th>1800</th>
<th>2500</th>
<th>4800</th>
<th>10,000</th>
<th>25000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Total Medicare Revenues @$200/pt./yr.</td>
<td>$120,000</td>
<td>$180,000</td>
<td>$250,000</td>
<td>$480,000</td>
<td>$1,000,000</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>4% incentive or penalty</td>
<td>$4800</td>
<td>$7200</td>
<td>$10,000</td>
<td>$19,200</td>
<td>$40,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Physician payment/penalty</td>
<td>$4800</td>
<td>$7200</td>
<td>$5,000</td>
<td>$4,800</td>
<td>$5,000</td>
<td>$12,500</td>
</tr>
</tbody>
</table>

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*Citation: “CMS Reveals Medicare Physician Pay Data” – Modern Healthcare, April 9, 2014*
Value Based Care (VBC)
VBC Programs focus on six key dimensions, necessitating more effort and strategy to participate successfully.

As part of Medicare’s efforts to improve care quality and efficiency, value based care includes both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule (PFS).

1. Care Coordination
   - Patient activation
   - Infrastructure and processes

2. Clinical Quality
   - Care type (preventive, acute, post-acute, chronic)
   - Diagnosis

3. Population Health
   - Health behaviors
   - Access
   - Physical and social data
   - Health status

4. Cost Reduction
   - Cost
   - Efficiency
   - Appropriateness

5. Person Centric Care
   - Patient experience
   - Caregiver experience
   - Preferences

6. Safety
   - All-cause harm
   - HACs
   - HAIs
   - Unnecessary care
   - Medication safety

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Multiple stakeholders in the healthcare value chain are impacted by VBC Programs, depending on the nature and scope of risk sharing agreements and involvement in care delivery.

Employers and government are contracting more directly with care providers causing health insurers to increase their demands for **value-based outcomes** and are introducing new payment models that include at-risk payments and bonuses based on measurable outcomes.

Stakeholders will have to mitigate performance risks as VBC will enable distribution of risk across multiple groups.

Stakeholders will have to be more aware of the costs, driving them towards better value for their healthcare dollars and a wider variety of treatment alternatives.

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What does VBC mean for all industry stakeholders?

Stakeholders will experience varied impact on bottom lines, which will be staggered depending on legislative timing and impact on value chain.

<table>
<thead>
<tr>
<th>Stakeholder Impact</th>
<th>Provider Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Providers must perform well in order to avoid penalties and for the opportunity to receive bonuses</td>
</tr>
<tr>
<td></td>
<td>Payments are adjusted positively, negatively, or not at all based on participation and performance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stakeholder Impact</th>
<th>Large IDN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Large IDNs rely on physician referrals, therefore it is in their best interest to ensure all providers and practices, employed or not, remain healthy</td>
</tr>
<tr>
<td></td>
<td>If independent providers are unable to remain solvent in their transition to more risk, large IDNs may have the first opportunity to employ them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stakeholder Impact</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>VBC will provide more incentives to hospitals and provider organizations to seek out risk-sharing arrangements with commercial, MA, and Medicaid plans</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stakeholder Impact</th>
<th>Pharma Life Sciences</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pharmacists will be responsible for taking part in value-based care and becoming part of the care team</td>
</tr>
<tr>
<td></td>
<td>Payers will want to create risk-based contracts for medications based on outcomes</td>
</tr>
</tbody>
</table>
Strategic positioning
Effective VBC strategy requires a mindset of fundamental transformation and continuous improvement
Strategic positioning should be informed by available capital, partnerships, integration, technology, and market penetration.

<table>
<thead>
<tr>
<th>Influencers</th>
<th>Considerations for Gradual Transition</th>
<th>Considerations for “Big-Bang” Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Available</td>
<td>• Ability to invest only in quality checks and care delivery workflow improvements</td>
<td>• Ability to invest holistically in back-office administrative capabilities that can scale across populations</td>
</tr>
<tr>
<td>Partnerships</td>
<td>• Reluctance to partner with payers and end-to-end third party administrators</td>
<td>• Willing to partner with payers who can bring end-to-end capabilities to the table</td>
</tr>
<tr>
<td></td>
<td>• Willingness to partner with point solution vendors</td>
<td>• Good partnerships with BPO vendors who bring end-to-end capabilities to the table</td>
</tr>
<tr>
<td>Level of Integration</td>
<td>• Non-integrated EHR deployments</td>
<td>• High level of integration across the care delivery suite of solutions as well as financial integration</td>
</tr>
<tr>
<td></td>
<td>• Manual integration and warm hand-offs available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• IPAs not fully integrated across</td>
<td></td>
</tr>
<tr>
<td>Current Technology</td>
<td>• Moderate electronic management of care delivery</td>
<td>• High level of automation and electronic management of care delivery</td>
</tr>
<tr>
<td></td>
<td>• Revenue cycle operations are manual across certain facilities</td>
<td>• Revenue cycle management is largely automated with minimal manual intervention</td>
</tr>
<tr>
<td>Market Positioning</td>
<td>• System is market leader and has leverage across payers</td>
<td>• System is not a leader and is at risk of losing further patient flow to the competition</td>
</tr>
<tr>
<td></td>
<td>• Strong relationships across payor landscape</td>
<td>• System is at risk of being narrowed out of the network</td>
</tr>
</tbody>
</table>

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Creating quality management capabilities is critical for responding to the expectations of the changing market.
WHERE DO I START?: The first step in moving to VBC is defining strategies based on appetite and preparedness for risk sharing.

<table>
<thead>
<tr>
<th>Spectrum of Risk</th>
<th>Increasing Coordination, Commitment, and Risk for Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>Fee for Service with Incentives</td>
</tr>
</tbody>
</table>

**Strategic positioning to succeed in Value Based Arrangements can be assessed using the core drivers of reimbursement as guidelines**

- ✔ Historical strong areas of Quality
- ✔ Use of CMS Certified EMR’s
- ✔ Practice setup and workflows
- ✔ Areas of operational excellence and low cost
- ✔ Overall Health Status Risk
- ✔ Selection Risk
- ✔ Investment Risk

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HOW DO I OPTIMIZE PERFORMANCE?: Determine your gaps and opportunities for improvement and readiness

**Payment Models & Performance Scenarios**

- Benchmark financial and quality performance against regional and national peers
- Co-develop five scenarios of potential VBC payment models and estimate performance under each scenario based on specified assumptions

**Capabilities Inventory & Opportunity Analysis**

- Refine and customize the pop health & VBC capability model to your imperatives
- Conduct a capability inventory, maturity assessment and gap analysis across each capability area
- Assess ecosystem of vendors, applications, integration points, and data stores

**Future Operating Model Design**

- Design optimized target state business / clinical operating model (people, organization, information) and inform technology needs
- Design future state application, integration, and information models
- Identify technology and operational gaps; provide guidance on solution options

**Activities**

- **Benchmarking Analytics & Scenario Analysis**
  - Identifies relative strengths, weaknesses, and opportunities of in deployment of a VBC strategy
  - Identifies further areas for improvement around quality, cost, utilization, and other key performance drivers

- **Population Health & VBC Capability Model**
  - Provides a clear current state assessment and set of opportunities for positively impact clinical, business, and technology performance under various VBC scenarios

- **Population Health & VBC Reference Architecture**
  - Provides the vision of where you need to be in the future from a VBC perspective
  - Drives alignment between strategy, clinical, finance, operations, and technology organizational areas
Conduct a Capabilities Analysis to meet your VBC objectives…and then do a gap analysis
Capability stacks should optimize and be able to sustain a Value Based Care Operating Model

An effective operating model is characterized by key components:

- **Financial Incentives**, enable preparation and deployment of appropriate reimbursement strategies
- **Decision making and governance**, ensuring accountability and timely decisions are made to drive operations
- **Organizational effectiveness**, ensuring the right skill sets and leaders are in place
- **Processes and metrics**, identifying key processes within the organization with comprehensive performance dashboards
- **Tools and technologies**, core technologies and tools that enable or drive business process
- **Assets and Capabilities**, maximize access to members, talent, and technology
DON’T Think in Silos: There are significant synergies across VBP program components that can be capitalized with cohesive design and execution

1. **Patient Engagement and Care Delivery**
   - Flag patients qualifying for CCM during Wellness or Transitional Care Management (TCM) visits and introduce program during visit
   - Promote office visits (for improved risk score documentation) during monthly non face-to-face CCM interaction with patient
   - Verify relevance/completeness of care plan (a key CCM requirement) during HCC chart prep and complete it during/after visit

2. **Program Analytics**
   - Manage analytics for risk adjustment, Wellness, TCM, and CCM concurrently - leverage CCM list to identify potentially missing/inaccurate diagnosis codes (relevant for risk adjustment) and leverage risk adjustment process to refine patient eligibility (relevant for CCM and TCM)
   - Identify “high risk” patients or candidates for TCM through all processes and target for more intensive care management programs

3. **Financial Management**
   - Manage financial tracking process around potential revenue uplift from all programs concurrently since they cover similar populations
   - Perform impact estimation due to each component more granularly
   - Build revenue cycle and billing processes concurrently to drive compliance, accuracy and timely reimbursement
Value Based Care Business Models
Overview: Strategies for successful Value Based Care initiatives

Successful healthcare value management will employ non-traditional strategies and solutions to how care is delivered and paid for in fulfilling the objectives of its Triple Aim

**Enablers:**

- **Data warehousing, analytics, and web-based platforms** to assimilate and generate “big data” informed population-level insights to assist on-the-ground clinical decision making
- Remote monitoring and rigorous tracking of **biometric parameters** (i.e., hemoglobin A1C) as well as e-reminders and other such alerts to encourage high value preventative interventions (e.g., wellness programs, immunizations, cancer screenings)

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**Provider-driven**

- Employ clinician-led outreach and standardized treatment approaches across the delivery spectrum (i.e., primary, specialty and post-acute care) to close care gaps and reduce utilization of high cost services

**Payer-driven**

- Incentivize transition from fee-for-service to value-based care models that promote quality over quantity

**Patient-centered**

- Proactively identify at-risk populations to help prioritize high value care priorities
- Encourage disease self-management to lower costs and improve health outcomes

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Provider networks who better coordinate services across the delivery spectrum and proactively intervene earlier in a patient’s care pathway will achieve greater patient engagement -- and healthier populations. These providers can then expect ROI from less costly admissions, decreased LOS, improved medication adherence (e.g., upon discharge), and decreased readmissions.

**Clinically integrated and data-driven providers**

- Shift from fee-for service to value-based care models
- Emphasis on team-based care
- Focus on data-driven, evidence-based medicine, leveraging both clinical and non-clinical attributes (e.g., environmental, social)
- Coordinated care across the continuum (e.g., from diagnosis to rehabilitation)
- Evidence-based research integrated into clinical decision making

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Payer-driven strategies in population health management

To manage the increased costs associated with an aging population, payers are adopting value based care models and alternative payment approaches to share the risk burden with providers (e.g., ACOs and Bundled Payments).

Payers are also addressing continuity of care and patient experience with models such as the Patient Centered Medical Home (PCMH), a care delivery model where primary care physicians coordinate patients’ comprehensive care needs across prevention, acute episodes, and chronic disease management.

- Introduce increasing levels of risk gradually, regularly assessing for provider and practice readiness
- Investing in care management capabilities
- Tailor measures to performance improvement goals of physician practices
- Develop actionable performance metrics, to include patient satisfaction and clinical outcomes measures
- Initiate payer-provider engagement to drive improvement and share best practices
- Provide cost and quality information at individual clinician level
- Ensure payment incentives address both individuals and practices

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Patient-centered strategies in population health management

Successful Value-based care initiatives acknowledge patients as integral stakeholders in the healthcare system. Empowered patients will proactively monitor their conditions and engage with providers in active disease management, earlier and more often. This allows providers to better target those patients at higher risk – and realize cost savings through more effective resource deployment.

Empowered Patients

Developing a robust patient engagement strategy is integral to population health management:

- Delivers better patient experience (quality, satisfaction)
- Improves health of populations
- Reduces cost of care

Understanding condition/illness

Information sharing with providers

Shared decisions integral to care plan

Informed and educated patients

Collaborative information gathering

Data capture through home health devices

Shared decision making

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Abhi Sharma, MD

Bio

Abhi is a Manager in Provider practice and specializes in Population Health and Value Based Care strategy. Dr. Abhi practiced Emergency Medicine and also has 7+ years of experience in population health and risk sharing strategy with a focus on optimizing value-based care delivery across both the commercial and public sector organizations. Dr. Abhi has worked extensively on clinical quality audits, provider growth strategy and patient engagement projects, including risk stratification strategy, physician enterprise management, market entry assessment, competitive analysis and benchmarking and commercial due diligence primarily across the public private continuum.

Education

• MPH (Health Care Management), The TH Chan School of Public Health, Harvard University, Boston, MA
• MBA (Strategy and Finance), The Fuqua School of Business, Duke University, Durham, NC
• MD (Emergency Medicine), Government Medical College, Dharmasala, India
• Certified Health Finance Professional, Healthcare Financial Management Association, IL

Relevant Experience

• Conceptualized and developed data/business requirements and functionalities for PwC's MACRA Preparedness Tool
• Clinical lead for a provider quality audit to benchmark and optimize strategy Vs national reporting standards
• Optimized data collection architecture and created data prioritization tool for a multistate faith based system
• Led assessment of clinical quality improvement strategy and development of quality reporting dashboard for one of the biggest faith based provider in the United States
• Designed Electronic Clinic Quality Metrics (eCQM) reporting strategy roadmap for an Austin based provider system
• Designed models of care to reduce healthcare disparity between rural and urban populations by incorporating telehealth access into the care delivery network of the largest healthcare system in the U.S.
• Led synergy analysis for utilization and care management functions at one of the biggest payer merger in the US
• Designed pre-acquisition clinical and quality diligence methodology for a Medicare plan in the state of Louisiana
• Developed value based population health capabilities and financial models for a faith based provider system in TN
• Designed models of care to reduce healthcare disparity between rural and urban populations by incorporating telehealth access into the care delivery network of the largest healthcare system in the U.S.