



# **The Dollars and Cents of Value Based Care**

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**Chair: Rebecca Adkins**  
**SVP Population Health- Jefferson Health**

# Today's Objectives

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- Learn about ways to structure value-based business cases
- Understand finance cycles and basic concepts of value-based finance
- Understand what structures, teams, and skills you need to manage value-based finances
- Learn how different provider organizations manage value-based finance

# Financial Challenges in VBC



- Value based models often require upfront investments in clinical programming, technology, administration staff and other operations.
- ROIs may be uncertain or have a future payoff beyond one year budget cycles.
- Contracts and incentives can change from year to year.

# Rob Fields



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EVP and Chief Clinical Officer Beth Israel Lahey

# Getting to 2040

## *Strategies for Health System Sustainability*

Rob Fields, MD MHA  
EVP, Chief Clinical Officer, BILH

NAACOs Fall Conference  
*October 2025*



Beth Israel Lahey Health

# *The Challenges*

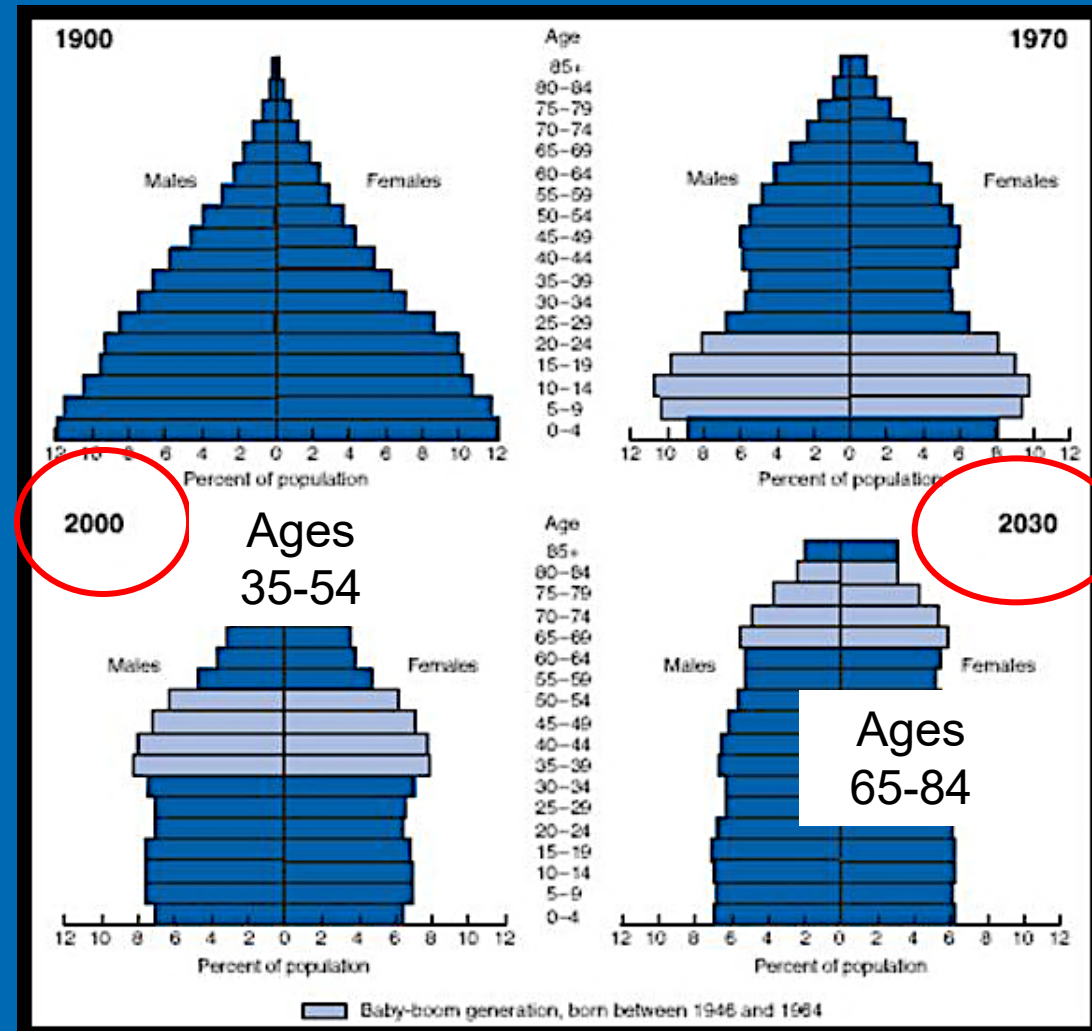
# 1. Shifting Demographics

## The “Squaring” of the Age Pyramid



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Age distribution becomes more evenly distributed increasing the average age of the population.



# 1. Shifting Demographics

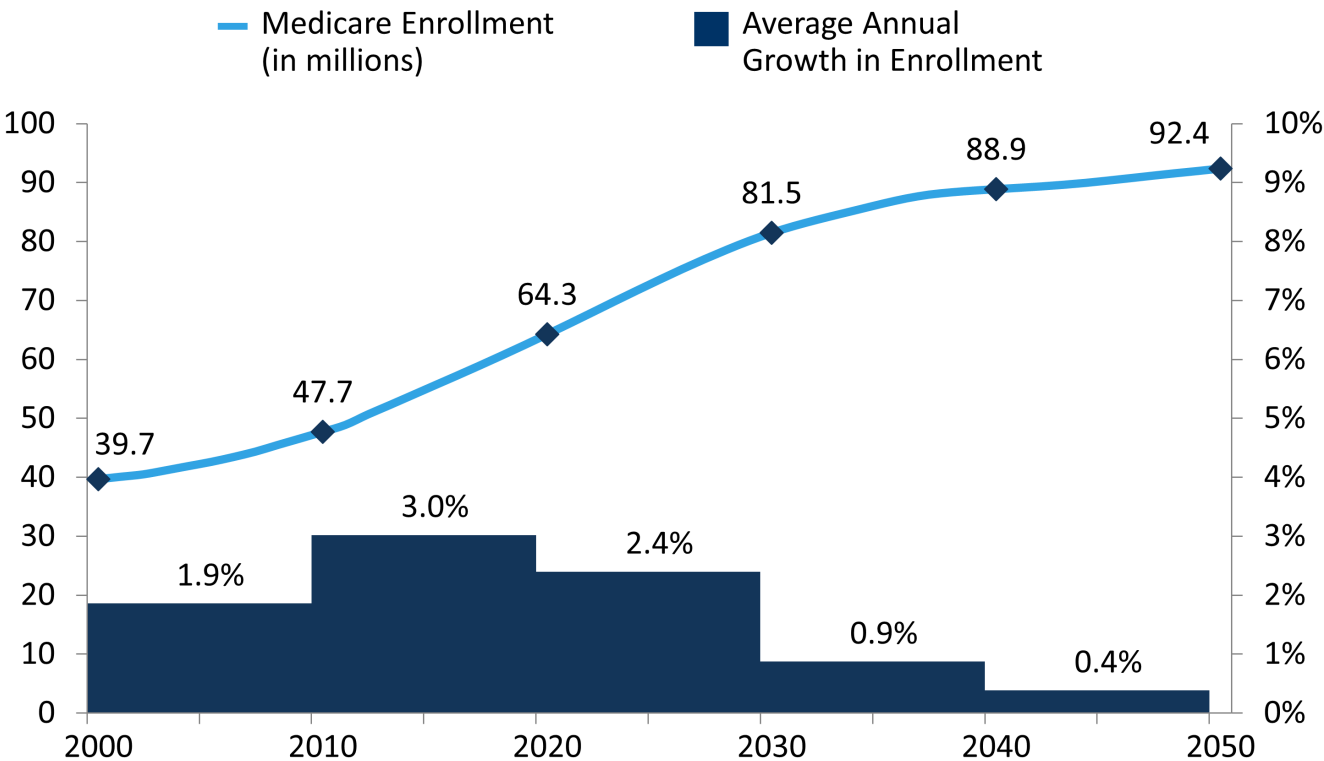
## Growth in Medicare enrollment



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**10K** new Medicare enrollees per day

### Projected Change in Medicare Enrollment, 2000-2050



SOURCE: 2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.





# 1. Shifting Demographics

## Specific Growth in Medicare Advantage

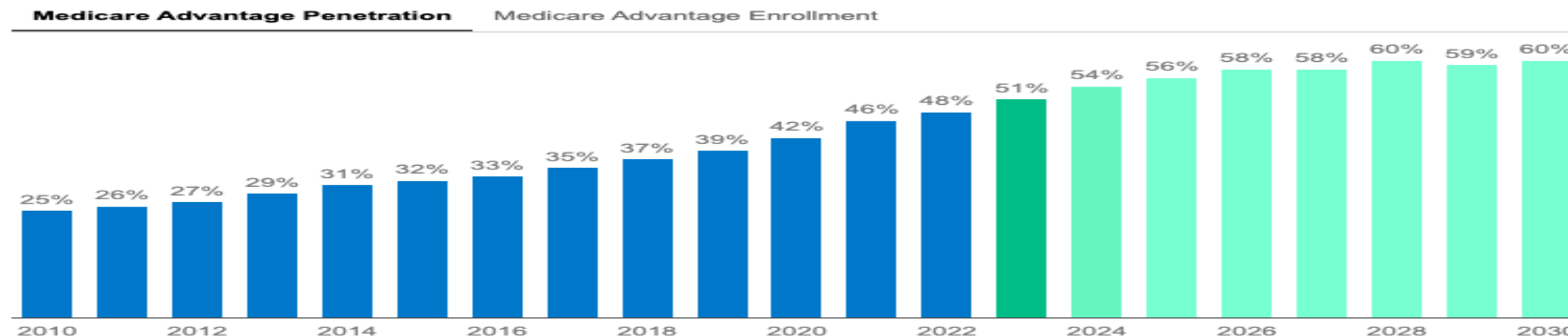


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While Medicare Advantage continues to grow in enrollment, net yield (after denials, etc.) of Medicare Advantage is 8-10% less than traditional Medicare (BILH experience).

### Medicare Advantage Enrollment and Projections

Medicare Advantage Enrollment 2010-2023 & Projected Enrollment 2024-2030  
(As a share of the eligible Medicare population)



NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023. Using the CBO baseline, Medicare enrollment is based on individuals who are enrolled in Part B, which is designed to include only individuals who are eligible for Medicare Advantage and exclude those who have Part A only and cannot enroll in Medicare Advantage. However, it may include some individuals who have Part B only and also are not eligible for Medicare Advantage.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023. Enrollment numbers from March of the respective year. Projections for 2024 to 2030 are from the May CBO Medicare Baseline for 2023. • PNG

**KFF**

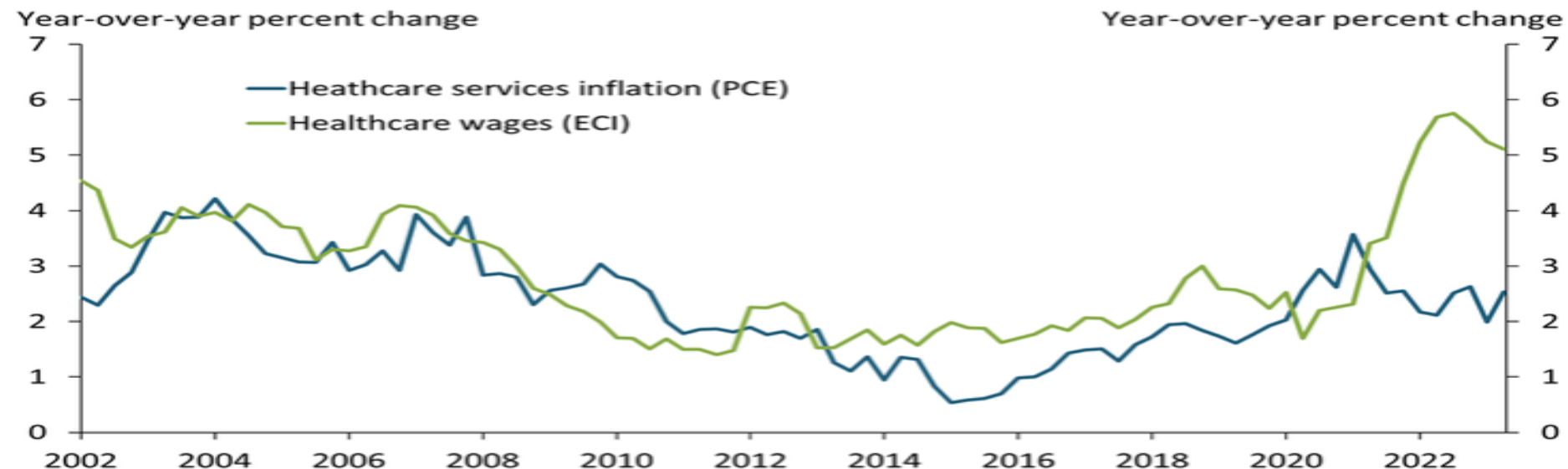
## 2. Labor and Supply Chain Inflation

### Ongoing effects of the pandemic



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Post pandemic labor and supply chain inflation have outpaced reimbursements causing major cost management concerns.



Note: PCE (Personal Consumption Expenditures Price Index) is a measure of price changes; ECI (Employment Compensation Index) is a measure of changes in employee compensation and includes employee benefits.

Sources: U.S. Bureau of Economic Analysis (BEA) and U.S. Bureau of Labor Statistics (BLS).

Taken from the Federal Reserve Bank of Kansas City: <https://www.kansascityfed.org/research/charting-the-economy-archive/rising-labor-costs-in-the-healthcare-sector-are-poised-to-buttress-services-inflation/>

### 3. Shifting and Shrinking Commercially Insured Population

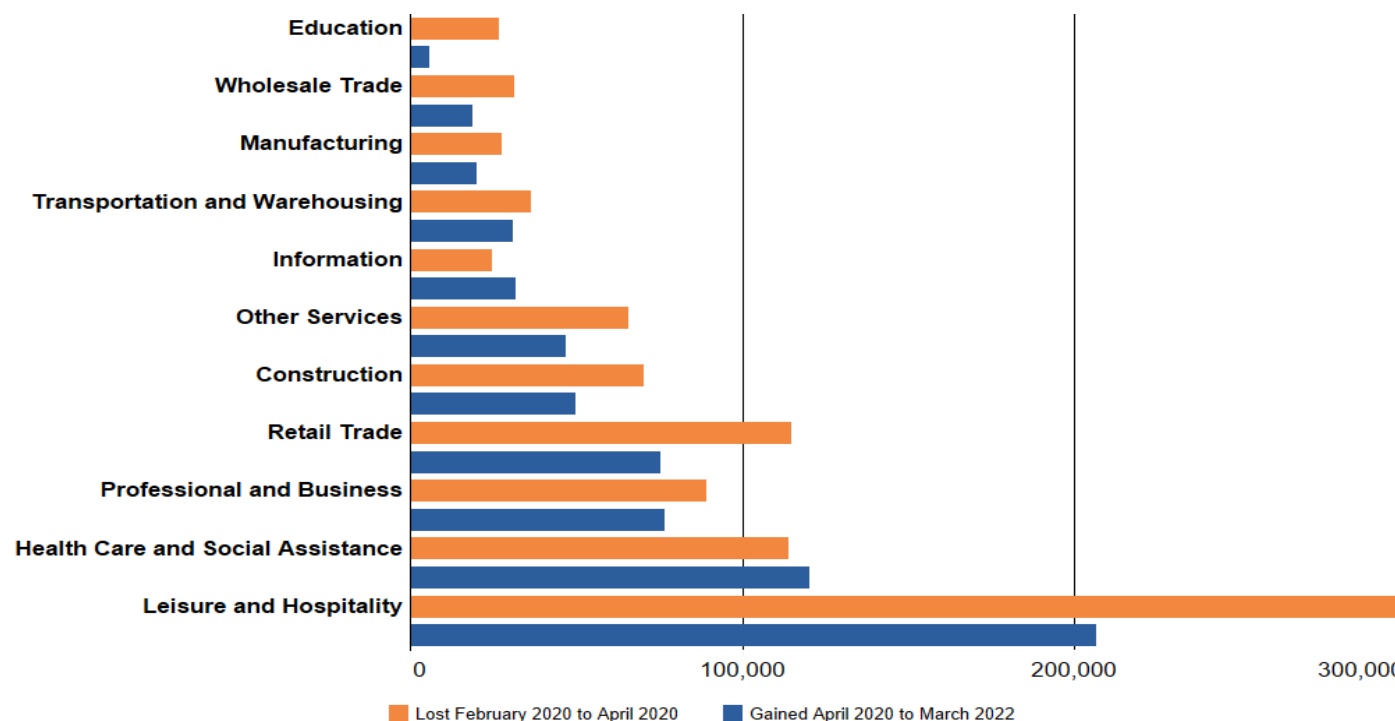
#### Ongoing recovery in higher tax states



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Slower post-pandemic recovery for jobs due in part to the economic trends and geographic migration.

**21%**  
**Reduction** in  
employment from  
March-April 2020. < 71%  
recovery by April 2022



<https://www.osc.state.ny.us/reports/osdc/new-york-citys-uneven-recovery-analysis-labor-force-trends>

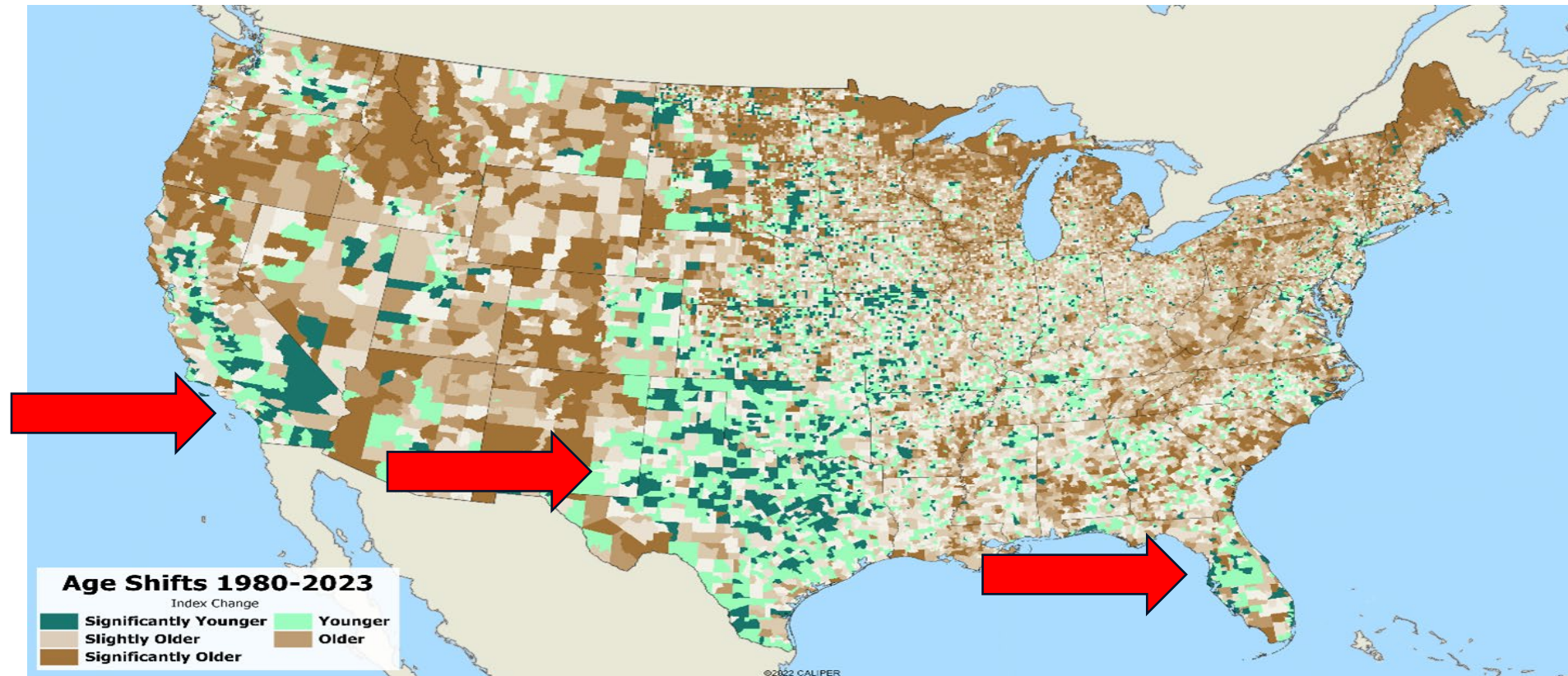
### 3. Shifting and Shrinking Commercially Insured Population

#### Ongoing recovery in higher tax states



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Geographic migration out of the Northeast to lower tax states has hurt the tax base and healthcare operating margins.



Taken from Applied Geographic Solutions: <https://appliedgeographic.com/2023/07/aging-population-and-migration/>

## 4. Shifting Service Mix

### Push for outpatient procedural services



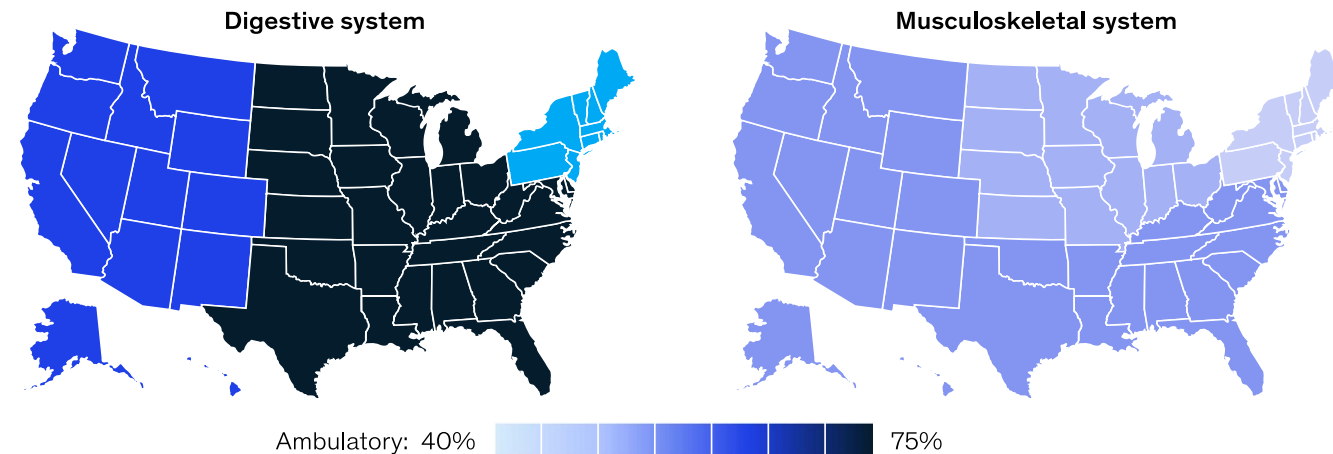
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Service lines that traditionally created operating margin for hospitals are moving aggressively to the outpatient realm.

**3%**  
**Reduction**

**n** in hospital share  
of revenue from 47%  
(2019)- 44% (2025)

Regional variation in the prevalence of ambulatory care exists even within specific specialties.



McKinsey  
& Company

<https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/the-future-of-us-healthcare-whats-next-for-the-industry-post-covid-19>

Every variable in the sustainability function is negatively impacted by these trends.

*f*

(revenue – cost) \* capacity

efficiency

# *Elements for Sustainability* *(selected strategies)*



# 1. Making Medicare Sustainable

## Redefining the economic AND the operational model



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### Two Primary Goals

We need to both 1) move to **risk-based economic models** for Medicare members and 2) lower the cost of delivering that care via **technology, team-based models** and breaking the “standard” brick and mortar model.

### Risk-based Economy

- Value-based models of care based on % of premium
- Reduces the incentive fit care into older models with negative margin
- Capacity constraints at the hospitals currently are aligning with the demand destruction this creates.

*Clinically integrated network strategies to support this work.*

### Technology-enabled, team-based models of care

- Remote patient monitoring, wearables, and other technology managed “centrally” without the need for brick and mortar appointments
- Growth in home-based care models
- New team members taking a larger role (e.g. pharmacists, ambulatory nursing, community health workers)

*Extension beyond physicians and clinics only.*



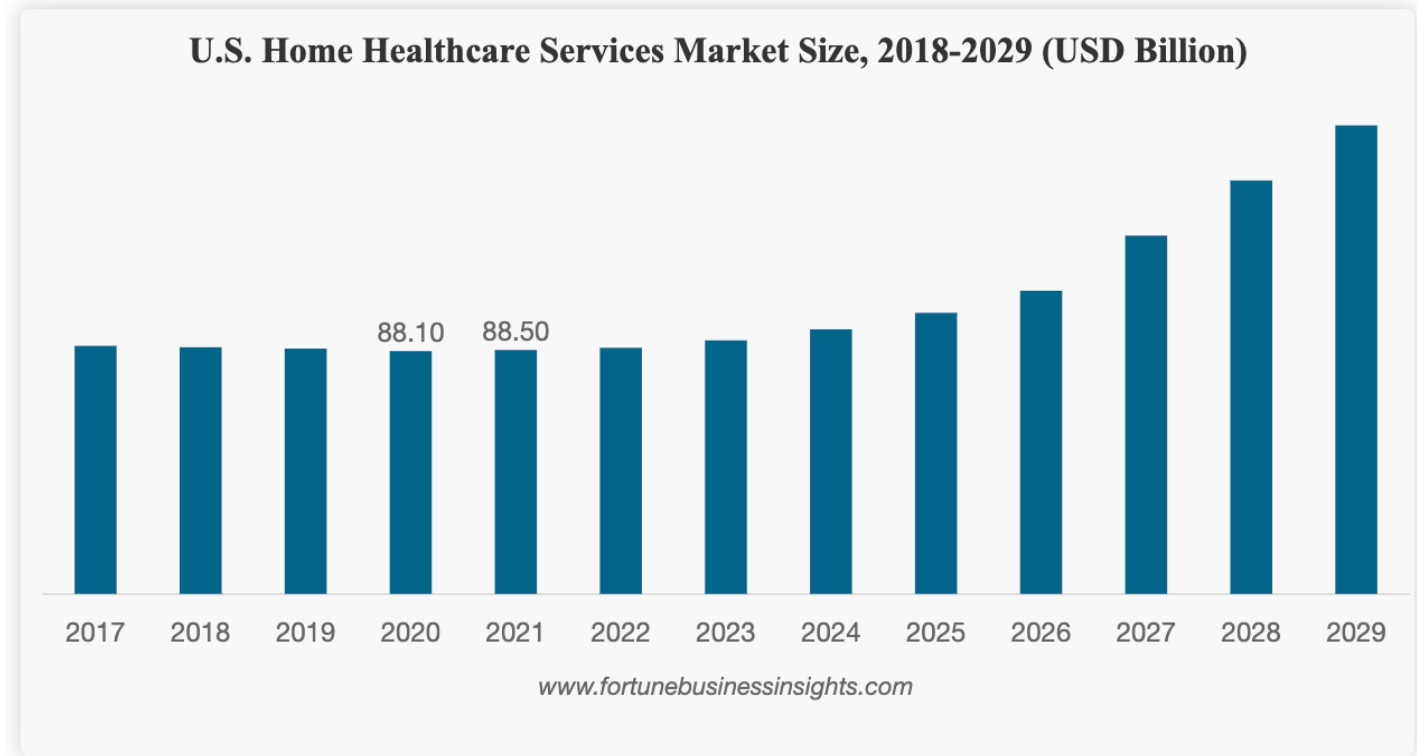
## 2. Developing Alternative Sites of Care

### Investing in the shift to ambulatory and technology



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- Ambulatory surgical center growth
- Continued growth **hospital at home** volume
- Growth and investment in **remote patient monitoring, virtual cardiac rehab** and other home-based technology as a shared service
- **Home infusion** and general home health



<https://www.fortunebusinessinsights.com/u-s-home-healthcare-services-market-105568>

# Thank You!



# Dustin Ottemiller

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VP Finance Jefferson Health

# The Dollars and Cents of Value Based Care

Dustin Ottemiller  
October 10, 2025







## Thomas Jefferson University

200+

Graduate and undergraduate programs

77,000+

Alumni

17

NCAA Division II teams

8,300+

Students (full/part time)

Over  
\$200 million

In applied, basic, clinical and scholarly research

1,000+

Patents for new drugs, software innovations, medical devices and diagnostic tools

Data is FY24 - updated January 2025



## Jefferson Health

4,350

Employed physicians

32

Hospital campuses

700+

Sites of care

13,600+

Nurses (full/part time)

4

Magnet® designated locations

4

Pathway to Excellence® designations

2,500+

Advanced Practice Clinicians

8.8+ million

Outpatient visits (hospital and physician)

Data is FY24 - updated April 2025



## Jefferson Health Plans

362,000+

Total members

40+

Years of service

316,000+

Medicaid members

750

Employees

13,000+

Medicare members

20,000+

CHIP members

13,000+

Individual and family plans

Data is 12/24 - updated January 2025



# Value-based business case

## Resource Requirements

- Clear income statement presentation
- Is capital required?
- Are incremental operational resources needed?
- What are the execution risks?
- Alternatives evaluated?

## Financial Impact

- **Clear income statement presentation**
- What does this mean for financial performance versus budget?
- How is revenue (or expense savings) modeled?
- Organizations revenue recognition risk tolerance?
- Does this consider the long-term financial plan?

## Strategic Fit

- ***Clear income statement presentation***
- Is this aligned with the mission?
- Does this consider asset rationalization or expansion plans?
- Are other organizational partnerships considered?

## Real World Example: ED decanting

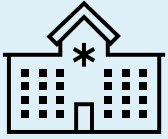
**Situation:** Hospital ED's at capacity; High volume of low acute medical admissions;  
High readmission rate

**Background:** Lack of experience in home care; Post acute not part of core strategy;  
Multiple payers with value-based/at-risk arrangements

**Action:** Buy vs. build; Speed to execution considerations;  
**Financial analysis to justify value proposition**

**Result:** Vendor partnership; Pilot with targeted patient populations

# Real World Example: ED decanting financial considerations



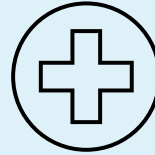
## Facility

Alignment on assumptions:

- Pilot volumes
- Backfill of reduced volume

Decanted margin impact

Medicare Cost Report



## Population Health

Value-based revenue gains

- ACO distribution policies

Full risk patient cost avoidance

Readmission cost/quality



## System

*Bottom line impact*

Fiscal year alignment

Revenue recognition timeline

Budget variances





# Wade Brosius

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Chief Medical Officer Pottstown Medical Specialists



# Jefferson

HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

[Jefferson.edu](https://jefferson.edu) | [JeffersonHealth.org](https://jeffersonhealth.org) | [JeffersonHealthPlans.com](https://jeffersonhealthplans.com)

# **The Strategic Imperative: Integrating Diabetes Education for Financial Sustainability**

A Value-Based Care Approach  
for Independent Multi-Specialty  
Group Practices

**Wade A. Brosius, DO**  
**CMO, PMSI**  
**10/9/2025**

# The Financial Challenge of Independent Multi-Specialty Groups in the Value-Based Care Era

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**Problem:** Independent multi-specialty groups face significant financial pressure as the healthcare landscape shifts from fee-for-service (FFS) to value-based care (VBC).

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**Context:** FFS models reward volume, while VBC models reward patient outcomes, quality, and cost-efficiency.

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**Current State:** Without a dedicated focus on chronic disease management, practices are at risk for penalties, missed shared savings, and declining revenue streams under VBC contracts.

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**Hypothesis:** A dedicated Diabetes Education Department is a strategic asset, not a cost center, essential for improving patient outcomes and securing financial success.

# PMSI By the Numbers

## Measuring Success: Metrics to Support ROI

- **Total Patient Population:** 130,000 Patients
- **Total Practices:** 10 (5 Primary Care, 5 Specialty)
- **Total Providers:** 30 Providers (23 Primary Care, 7 Specialty)
- **Diabetes Education Dept Providers:** 5
- **Total Diabetic Patient Population:** 14,300
- **Patients Enrolled in Diabetes Education:** 1,000
- **Individual Education Visits (Annual):** 600
- **Group Education Visits (Annual):** 12
- **DPP Patients seen (Annual):** 70
- **CGM Placements (Annual):** 350
- **In-Office Retinal Screens Performed (Annual):** 1,400
- **Insulin Pumps Managed (Annual):** 95

# Building the Diabetes Education Department

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## Our Proposed Solution: A Multidisciplinary Department

- **Certified Diabetes Care and Education Specialists (CDCES):** Leads patient education, develops care plans, and ensures adherence to national standards.
- **Registered Dietitian (RD):** Provides Medical Nutrition Therapy (MNT), crucial for managing blood glucose and weight.
- **Diabetes Prevention Program (DPP) Coordinator:** Manages the evidence-based program to prevent or delay the onset of Type 2 Diabetes.
- **Focus:** A collaborative approach to empower patients with the knowledge and skills needed for self-management.

# Value-Based Focus & ROI Calculation

- **From Cost to Investment: A Clear Return on Investment (ROI)**
- **Investment (Estimated Annual Costs):**
  - CDCES Salary: \$135,000
  - RD/CDE Salary: \$80,000
  - DPP Coordinator Salary: \$60,000
  - Admin: \$50,000
  - **Total Estimated Employee Cost: \$325,000**

# Value-Based Focus & ROI Calculation (cont.)

## Expected Benefits (ROI):

- **Reduced Hospitalizations:** A major driver of cost savings. A single hospitalization for a diabetes-related complication can cost \$10,000+. A 1-2% reduction in hospitalizations for a patient panel can cover department costs.
- **Fewer ER Visits:** Diabetes education leads to better glucose control and less severe events.
- **Shared Savings:** Improved HEDIS scores and better patient outcomes directly translate to a higher percentage of shared savings in VBC contracts.
- **Increased Patient Retention:** Engaged and healthier patients are more likely to stay with the practice.
- **Simplified ROI Formula:**  $(\text{Financial Benefits} - \text{Total Costs}) / \text{Total Costs} = \text{ROI}$



# Summary & Conclusion

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## A Strategic Investment for Long-Term Success

- **Key Takeaway:** A dedicated Diabetes Education Department is the cornerstone of a successful VBC strategy for an independent multi-specialty group.
- **Patient Impact:** It empowers patients, improves their quality of life, and reduces long-term health risks.
- **Financial Impact:** It directly contributes to financial sustainability by reducing healthcare costs, improving quality metrics, and securing shared savings.
- **Call to Action:** Implementing this department is not just good for patients; it's a critical investment in the future of our practice.



# Jessica Walradt

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VP Finance/Value Based Contracting Northwestern Medicine

# The Dollars and Cents of Value Based Care

Northwestern Medicine

October 10, 2025



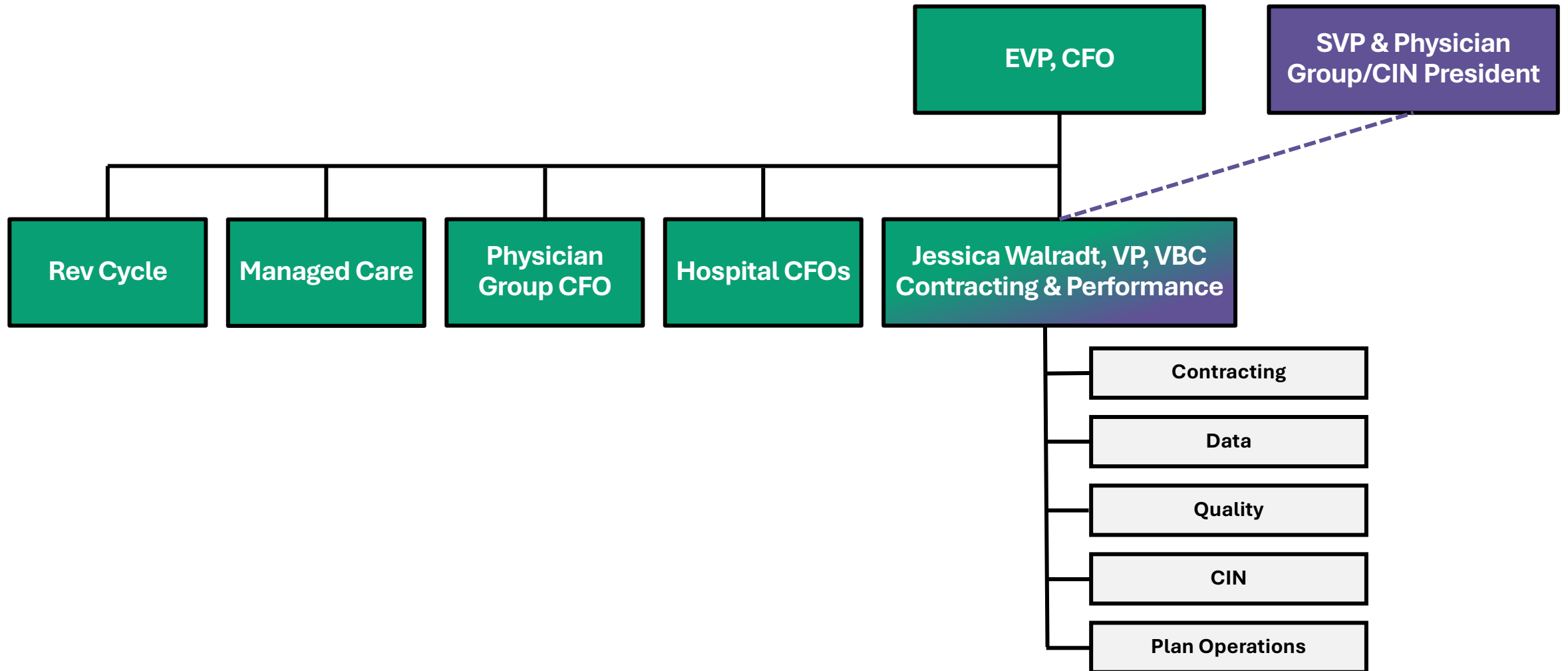
## **Northwestern Medicine**

- 1 AMC located in downtown Chicago
- 2 multi-specialty employed group practices (~2800 employed physicians)
- 11 hospitals

## **Northwestern Medicine ACOs**

- 2 MSSP ACOs; ~82,000 assigned beneficiaries
- 12 EHR vendors
- Reported eCQMs in 2023 and 2024

# Organizational Structure



# Calculating a Return on Investment (ROI)

## Types of Revenue

❖ FFS Revenue

❖ Direct Incentive

❖ Downstream Shared Savings

## Challenges of Building an Effective VBC Business Case



**Complex payment methodologies:** Most organizations participate in multiple VBC models with varying payment methodologies. Within organizations, most individuals do not work with/understand VBC benchmark and performance calculations.

- **Robust assessment can require program evaluation SME**



**Time lag between intervention and ROI:** Can take one to five years for the impact of an intervention to materialize in an ROI.



**Multiple competing priorities:** Integrated health systems balance multiple strategic priorities; many with near-term, widely understood ROIs.



# Addressing Challenges

## Challenge

## Mitigation Strategies

### Complex Payment Methodology

- ✓ Simplify messaging; omit unnecessary details
- ✓ Identify necessary stakeholder engagement prior to pitching ultimate decision maker
- ✓ Beware of “too good to be true” scenarios

### Time Lag

- ✓ Identify real-time process metrics
- ✓ Robust due diligence to substantiate intervention will work as designed

### Competing Priorities

- ✓ Demonstrate how intervention aligns with broader organizational priorities
- ✓ Demonstrate that optimization strategies with current resources have been exhausted
- ✓ Do not be deterred by an initial “no”

# Example: Pharmacy

## Direct Incentive

Category	\$
Med Adherence MA Star Rating Incentive Opportunity	\$580K
PharmD	(\$190K)
Pharm Tech	(\$90K)
Surescripts Data	(\$259K)
<b>Net</b>	<b>\$41K</b>

*Reasonably confident in ability to cover expenses via incentive earnings alone*

## Downstream Shared Savings

Population	# of Members	PMPM Expense
<b>0 Rx Gaps</b>	4,129	\$1,026
<b>≥1 Rx Gap(s)</b>	915	\$1,536
<b>Difference</b>	<b>3,214</b>	<b>\$510</b>

### Necessary Assumptions:

- ☐ Number of impactable patients
- ☐ % of gaps closed
- ☐ Hold other factors constant
- ☐ % shared savings

**\$5M - \$9M**  
**Shared Savings**



# Pop Health Pharmacy Outreach Optimization

	Staff	Patient Outreach Strategy	# Patients Reviewed	# Patients Outreached
Historical	1 PharmD	<ul style="list-style-type: none"><li>Reactive, manual review of payer lists</li><li>MyChart active only</li></ul>	1,000	500
Current	1 PharmD	<ul style="list-style-type: none"><li>Automated list in Epic</li><li>MyChart active only</li></ul>	5,600	2,800
Future	2 PharmD & 1 Pharm Tech	<ul style="list-style-type: none"><li>Automated list in Epic</li><li>MyChart &amp; Non MyChart</li></ul>	16,800	8,400

