The Accelerating Shift to Value Based Care

March 18, 2021
Today’s Agenda

Introduction

Drivers of the Accelerating Value Based Care Market

Major VBC Initiatives

- Direct Contracting Deep Dive

Data Applications within Value Based Care

Questions & Answers
Today’s Presenter

Dave Terry, CEO
Archway Health
## Archway Health Overview

**Headquartered in Boston with Offices in NYC**
- Founded in 2014
- **Healthcare Delivery & Payment Policy Experts** - dedicated to tracking the evolving payment landscape including overlap with other APMs, payment reform, CMS rulemaking, MACRA
- **Data Scientists and Actuaries** - Significant experience with population-based and episodic claims analysis for risk mitigation
- Insurance & Finance Experts
- Technologists and Product Developers

**Medicare Qualified Entity (QE) Status allowing access to 100% Part A, B and D claims**
- Archway analytical insights not available through program participation alone:
  - Top Performing Benchmarks
  - Peer comparisons
  - Analysis of patient populations beyond those attributed to the model

**Partnership with an A Rated insurance carrier to provide performance-based stop loss insurance**

**Extensive experience providing risk protection & care management for Medicare's Value Based Care programs**
- BPCI, BPCIA
- Oncology Care Model
- Next Generation ACO
- Medicare Shared Savings Program
- Comprehensive Kidney Care Choices
- Direct Contracting Entities
- Provider Excess of Loss (PEL)

**Trusted partner and proven track record in multiple CMMI programs**
- Dozens of provider partners in risk arrangements
- BPCI-A Convener with average savings of over 10% per episode to date
- OCM customers outperform the OCM participant pool
- Strong relationship with CMMI, including multiple successful program applications
Archway Health & Coverys Partnership

International A-Rated Carrier.

Top 5 MPL Carrier

Thousands of provider Customers

Tradition of Product and Underwriting Innovation.


Shared mission to improve healthcare through data & payment reform.

National Scope: VBC Innovator since 2014.

Track Record: Assisting providers to succeed in VBC Programs.

Robust team of healthcare reimbursement experts & data scientists.

Managed over 60,000 episodes, analyzed over 5 million.

Proprietary Predictive Modeling.

Note: A-Rating is held by Medical Professional Mutual Insurance Company and its underwriting subsidiaries.
Drivers of the Accelerating Value Based Care Market
VBC Drivers - Federal Deficit Growth

Federal Deficit Growth

[Graph showing Debt Held by the Public (% of GDP)]

- Civil War
- WWI
- WWII
- Great Depression

Actual | Projected

1793 1825 1857 1889 1921 1953 1985 2017 2049

0% 25% 50% 75% 100% 125% 150%
VBC Drivers - Federal Deficit Growth

The Urgency to Bend the Cost Curve

- Total healthcare spending is projected to top $3.6 trillion by 2026.
- Over a quarter of the federal budget is spent on Medicare, Medicaid, ACA, and CHIP.
- The 2019 Medicare Trustees Reports projects HI Trust Fund insolvency in 2026.

**VBC Drivers - CMS Priorities**

Medicare has stated they want all Medicare providers to be in a meaningful downside risk contract by 2025.

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare Advantage</th>
<th>Traditional Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>2022</td>
<td>25%</td>
<td>25%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>2025</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Health Care Payment Learning Action Network; CMS National Healthcare Trend
VBC Drivers - Changing Regulatory Environment

2020 Stark and Anti-Kickback Updates

Intent

“The transformation to a **value-based health care** delivery and payment system is heavily dependent on **physician engagement**” Seema Verma

“These new regulatory reforms will mean **better care**, including **innovative arrangements with digital technology**” Alex Azar

“We believe that **full financial risk** is one of the defining characteristics of a mature value-based payment system.” 85 FR 77511

“OIG’s new safe harbor regulations are designed to facilitate better **coordinated care** for patients, **value-based care**, and improved cybersecurity” Christi Grimm, OIG
### VBC Drivers - Changing Regulatory Environment

#### 2020 Stark and Anti-Kickback Updates

**Ranges of Risk**

<table>
<thead>
<tr>
<th>Full Risk</th>
<th>Meaningful Downside Risk</th>
<th>No Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>- OIG AKS Safe Harbor and CMS Stark Law Exception</td>
<td>- OIG AKS Safe Harbor and CMS Stark Law Exception</td>
<td>- OIG AKS Care Coordination Safe Harbors</td>
</tr>
<tr>
<td>- Greatest flexibility</td>
<td>- Provides flexibility in recognition of assumption of some downside risk</td>
<td>- CMS Stark Law Value-Based Arrangement Exception</td>
</tr>
<tr>
<td>- Nexus between remuneration and “Value-Based Purposes”</td>
<td>- Physicians and other participants must have meaningful downside risk req to receive VBC related payments</td>
<td>- Most restrictive because no assumption of risk</td>
</tr>
<tr>
<td>- Quality assurance program must protect against underutilization and assess quality (AKS only)</td>
<td>- Nexus between remuneration and certain “Value-Based Purposes”</td>
<td>- Remuneration must be used for value-based activities for target population</td>
</tr>
<tr>
<td>- Writing is not required (Stark only)</td>
<td>- Writing, but no signature required (Stark only)</td>
<td>- Monitoring or tracking outcome measures required</td>
</tr>
</tbody>
</table>

**Signed writing (both AKS and Stark)**
VBC Drivers - Changing Regulatory Environment

2020 Stark and Anti-Kickback Updates

Examples

Patient Tracking Technology Arrangement between participants in VBC

- One participant offers to provide a type of health technology to the other participant,
- The recipient uses the technology to track patient data to spot trends in health care needs and to improve patient care planning.
  - **Value based purpose**: spot trends in health care needs and improve patient care planning.
  - **Value based activity**: use of the health technology by the recipient.
Hospital pays physicians for Post-Discharge Meetings to improve care coordination

- The hospital requires post-discharge meetings with the physician who is primarily responsible for the care of the patient following discharge from the hospital.
- The hospital pays the physician for participating in these meetings.
  - **Target Patient Population**: patients who undergo lower extremity joint replacement procedures
  - **Value-Based Purpose**: to coordinate and manage the care of patients in the target population
  - **Value-Based Activity**: conducting post-discharge meetings
  - **Value-Based Enterprise**: Hospital and physicians responsible for post-discharge care of patients in the target population

**Examples**

VBC Drivers - Changing Regulatory Environment

**2020 Stark and Anti-Kickback Updates**
VBC Drivers - Provider Market Demand

1. Increasing provider investment, experience & capabilities
   - 50+ CMMI Programs
   - Commercial risk contracts - AQC, MA

2. Desire to diversify & smooth revenue coming out of COVID-19

3. Public & private market investment activities & valuations
   - Oak Street
   - Signify
   - Landmark
   - Agilon
Major VBC Initiatives
ACOs - Population Health Management

- Patients assigned to PCPs.
- Capitated payment structure.
- Focus on health & wellness.
- Management of downstream services.
- Owned & managed by health systems or large primary care groups.
Major VBC Initiatives - Accountable Care Organizations

ACO Contract Growth by Payer Type

1543 ACO Contracts

33 Million ACO Lives

Source: Leavitt Partners Center for Accountable Care Intelligence. *Note: Q4 numbers are current as of December 1, 2018.
### Major VBC Initiatives - Bundled Payments

**Specialist as Quarterback**

<table>
<thead>
<tr>
<th>Initial Hospitalization</th>
<th>SNF/IRF Care</th>
<th>Hospital Readmissions</th>
<th>Home Care</th>
<th>Outpatient Care</th>
</tr>
</thead>
</table>

- Patients attributed to specialists for a discrete condition.
- General time ranges from dates.
- Tied to specific clinical conditions.
- Almost all costs are included.
- One price paid to bundle owner.
- Qualifies as an APM within MACRA.
## Major VBC Initiatives - CMMI Programs

<table>
<thead>
<tr>
<th>Provider Organizations</th>
<th>CMMI Programs</th>
</tr>
</thead>
</table>
| **Hospitals & Health Systems** | • MSSP ACOs  
                                • Geographic Contracting  
                                • BPCI-Advanced  
                                • OCM  
                                • CJR |
| **Primary Care Groups** | • **Direct Contracting**  
                                • Primary Care First  
                                • MSSP ACOs  
                                • MACRA |
| **Specialty Groups** | • BPCI-Advanced  
                                 • Oncology Care First  
                                 • ESRD Treatment Choices  
                                 • Kidney Care Choices  
                                 • Radiation Onc Model  
                                 • Emergency Treat & Transfer  
                                 • MACRA |
| **New Entrants** | • Chronic care management  
                                • ACOs  
                                • Specialty Carve-Outs |

- **Orthopedics**
- **Cardiologists**
- **Oncologists**
- **Nephrologists**
- **Emergency Medicine**
- **Radiation Oncology**

- **MA Sub-contractors**
- **Private equity-backed specialty providers**
- **Big tech players**
VBC Drivers - CMMI Phase II

1. Fewer, bigger programs
   - Limit program overlap
   - More program clarity

2. More up and downside risk
   - Downside risk drives improved performance

3. ACOs “with bundles underneath”

4. Shift from voluntary to mandatory
   - Moving to VBC as payment policy
   - 90 day DRGs?
   - Shift from FFS to global and sub-cap arrangements?
Direct Contracting Deep Dive
Medicare Direct Contracting - Risk Options

Risk Options

Professional
- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 50% shared savings/shared losses with CMS
- Primary Care Capitation (PCC) equal to 7% of total cost of care for enhanced primary care services

Global
- ACO structure with Participants and Preferred Providers defined at the TIN/NPI level
- 100% risk
- Choice between Total Care Capitation (TCC) equal to 100% of total cost of care provided by Participant and Preferred Providers, and PCC

Geographic (proposed)
- Would be open to entities interested in taking on regional risk and entering into arrangements with clinicians in the region
- 100% risk
- Would offer a choice between Full Financial Risk with FFS claims reconciliation and TCC

SUSPENDED
# Medicare Direct Contracting - Global Risk Model

## Game Changing Attributes

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Prospective Payment ACO Model</strong></td>
<td><strong>Monthly PMPMs paid to Direct Contracting Entity (DCE)</strong>&lt;br&gt;○ Moves Medicare FFS patients into risk model&lt;br&gt;○ Most attribution will be Primary Care driven</td>
</tr>
<tr>
<td><strong>2. Not a Shared Savings program</strong></td>
<td><strong>DCE keeps all savings and responsible for all losses</strong>&lt;br&gt;○ 2% initial discount&lt;br&gt;○ 25% Up &amp; Down Risk Corridor</td>
</tr>
<tr>
<td><strong>3. Significant Incentives for Specialty Risk Arrangements</strong></td>
<td><strong>Specialty PMPMs flow to DCE if they have downstream specialty partnerships</strong>&lt;br&gt;<strong>DCE success will require partnerships with high performing specialists</strong></td>
</tr>
</tbody>
</table>

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**Direct Contracting Structure**

**Contract between CMS and DCE**
- Prospective PMPM payment
- PMPM based on Participant Provider partnerships
- Annual Full Cap Benchmark

**Direct Contracting Entity**
- Full Up/Down Risk
- Quality Withholds
- Annual Reconciliations

**Primary Care Participant Providers**
- Required Contracts
- Determine alignment
- Drives Primary Care cap payments

**Primary Care Participant Providers**
- Responsible for quality
- Paid by DCE
- Need to get to 5,000+ lives to start

**Cardiac Care**
- Determines alignment
- Drives Specialty Cap payments
- Paid by DCE

**Musculo Skeletal**
- Preferred Providers
- Doesn’t drive alignment
- Can drive specialty Cap payments
- Can be paid by DCE

**Cancer Care**
- Required optional Participant Providers
- Determines alignment
- Drives Specialty Cap payments
- Paid by DCE

**Diabetes Chronic**
- Preferred Providers
- Required optional Participant Providers
- Determines alignment
- Drives Specialty Cap payments
- Paid by DCE

**Neuro**
- Required optional Participant Providers
- Determines alignment
- Drives Specialty Cap payments
- Paid by DCE

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### Direct Contracting Economics - Global Budget

**Medicare FFS Beneficiaries** | 5,000
---|---

**Direct Contracting Budget** | $51,480,000 | $858

<table>
<thead>
<tr>
<th>Capitation Payments</th>
<th>Full Budget</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>$2,700,000</td>
<td>$40 - $50</td>
</tr>
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</table>

**Specialty Care**

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Full Budget</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td>$10,002,000</td>
<td>$167</td>
</tr>
<tr>
<td>Diabetes/Endocrine</td>
<td>$6,084,000</td>
<td>$101</td>
</tr>
<tr>
<td>Other Chronic Care</td>
<td>$4,182,000</td>
<td>$70</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>$4,872,000</td>
<td>$81</td>
</tr>
<tr>
<td>Neurology</td>
<td>$3,972,000</td>
<td>$66</td>
</tr>
<tr>
<td>Cancer</td>
<td>$3,546,000</td>
<td>$59</td>
</tr>
<tr>
<td>Respiratory</td>
<td>$3,438,000</td>
<td>$57</td>
</tr>
<tr>
<td>GI/Digestive</td>
<td>$2,592,000</td>
<td>$43</td>
</tr>
<tr>
<td>Mental Health</td>
<td>$1,638,000</td>
<td>$27</td>
</tr>
</tbody>
</table>

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Direct Contracting - Quality Metrics

Proposed Quality Measure Set

Claims-based Measures
- Risk-Standardized, All Condition Readmission
- All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- Advanced care plan
- Days at home (proposed – to be developed)

Patient Experience Survey
- CAHPS® for ACOs survey

*CAHPS®, stands for Consumer Assessment of Healthcare Providers and Systems, is a registered trademark of the Agency for Healthcare Research and Quality
Medicare Direct Contracting - Waivers & Enhanced Benefits

Care Management Enhancements for DC Participants

- 3-day SNF rule waiver
- Telehealth expansion
- Homebound requirement waiver
- Post-discharge home visits
- Care management home visits
- Cost sharing for Part B services
- Chronic disease management reward program
- Concurrent care for beneficiaries who elect hospice benefit

Patient Engagement Incentives

- Vouchers for OTC medications
- Prepaid transportation vouchers
- Items and/or vouchers to support chronic disease management
- Wellness programs
- Electronic alert systems for patients with dementia
- Meal program vouchers
- Medication reminder apps, calendars or other methods
- Dental care vouchers

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# Medicare Direct Contracting - Global Risk Model

## Keys to Success

### Primary Care
- Ability to transition from FFS to Capitation
- Expanded PCP panel size
- Greater use of Care Extenders
- Patient engagement & Telemedicine
- Patient risk segmentation
- Chronic care management
- **Participant/Preferred partnerships with High Quality Value Based Specialists**
- Risk financing & Stop-Loss

### Specialty Care
- **Preferred referral partnerships with DCE’s**
- Ability to use data to demonstrate great outcomes at value based prices
- **Ability to take and manage risk**
  - Pay for Performance
  - Bundles
  - Carve-Outs
- Easy access
- Collaborative, high quality hospital and post-acute partners
- Integrated patient engagement tools

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# Medicare Direct Contracting - Benefits for Participants

<table>
<thead>
<tr>
<th>Category</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| **Revenue Growth**                        | • Improved reimbursement for primary care  
• Access to downstream specialty care funds |
| **Improved Cash Flow**                    | • Consistent monthly cap payments                                         |
| **Opportunities to Improve Patient Care** | • Upfront cash for investments in care management  
• Improved care coordination  
• Care management waivers  
• Patient engagement incentives |
| **More Control**                          | • All healthcare dollars flow through primary care  
• Access to comprehensive market data |
| **Greater Independence**                  | • Greater ability to recruit & retain vs competitors                      |
| **Prepare for More VBC Contracts**        | • CMMI programs are great starting points  
• Opportunities to expand into MA & Commercial risk |
Data Applications within Value Based Care
# Data Applications within VBC - Risk Assessment

<table>
<thead>
<tr>
<th>Elements of Risk</th>
<th>Key Decisions &amp; Actions</th>
</tr>
</thead>
</table>
| **1. Programmatic Risk** | - Which programs to participate in?  
- Programs to avoid?  
| **2. Provider Performance Risk** | - Build care management infrastructure.  
- Drive improvements in quality & cost.  
- Develop preferred provider networks.  
| **3. Insurance Risk** | - Fully understand risks & opportunities.  
- Protect downside.  
- Match risk tolerance with deductible.  

**Deep understanding of the rules, incentives, & biases within all VBC programs.**

**Knowledge of provider performance, capabilities, quality, and cost.**

**Traditional actuarial risk associated with volume, historical experience, outlier rates, etc.**
Some providers have more experience than their peers.

Number of Knee Replacement Surgeries for Different Providers

Unique Providers in the state of Massachusetts (Surgeons)

Surgeons who perform a lot of surgeries

Surgeons who perform fewer surgeries

Which provider would you want to perform your surgery?
Some providers have better outcomes than their peers.

**Frequency of Complications and Other Quality Metrics for Knee Replacement Surgeons**

<table>
<thead>
<tr>
<th></th>
<th>Frequency of complications within 30 days</th>
<th>Frequency of ER visits within 30 days</th>
<th>Frequency of readmissions within 30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example High Quality Provider</td>
<td>26%</td>
<td>5%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Example Low Quality Provider</td>
<td>31%</td>
<td>17%</td>
<td>10.4%</td>
</tr>
</tbody>
</table>

Which provider would you want to treat your employee or your family member?
Quality and Price are Generally Uncorrelated

Step 1: Benchmark High Quality Physicians
- Trended Episode Payment: $39,626
- Anchor Facility Payment: $28,076
- Anchor Physician Payment: $5,281
- PAC Payment: $6,318
- Readmission Rate: 3%
- ER Outpatient Rate: 6%

Step 2: Analyze Historical Episodes for Employer
(Based on historical claims data provided by employer)

Step 3: Estimate the Opportunity for Savings
(Based on analysis of historical employer spend against high-value benchmark)

- Number of Episodes: 18
- Total Episode Payment: $871K
- Total Saving Opportunity: $166,845
- Total Anchor Facility Saving: $40,708
- Total Anchor Physician Saving: $5,615
- Total PAC Saving: $120,523
- % of Saving: 19%

**Lower Joint Replacement Example**

Episode Name: Major joint replacement of the lower extremity

Physician Rank | Physician Name | Facility | Physician Volume | Facility Volume |
--- | --- | --- | --- | --- |
Top 25% | Medium | High | Medium | High |
25%-60% | High | Med | Low | Med |
50%-75% | Low | Med | Low | Med |
Bottom 25% | Low | Low | Med | Low |
<10 Patients | Null | Null | Null | Null |
Data Applications within VBC - Network Development

MA Commercial Joint Replacement Episodes
*By episode cost & surgeon quality rating*

- **Low Value Quadrant**
- **High-Value Quadrant**

**Average Episode Cost**

**Surgeon Quality Rating**
Data Applications within VBC - Variability
Data Applications within VBC - Moving the Curve

Benchmark Opportunity
Tailored to program requirements
DCE characteristics

Risk Reduction
Quantify impact
Pass through to DCE

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