Roundtable Panel Discussion: *Perspectives of Chief Financial Officers (CFOs) / Chief Executive Officers (CEOs) on Reducing Barriers to Participation in PB-TCOC Models*

Panelists:

Subject Matter Experts

- **Christopher Crow, MD, MBA** – Chief Executive Officer and Co-Founder, Catalyst Health Group
- **Chase Hammon, MBA** – Chief Financial Officer, Duly Health and Care
- **Jessica Walradt, MS** – Vice President, Finance, VBC Contracting & Performance, Northwestern Medicine
- **Brock Slabach, MPH, FACHE** – Chief Operating Officer, National Rural Health Association (NRHA)
- **Michael Barbati, MHA** – Vice President of Government Programs, Enterprise Population Health, Advocate Health

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Christopher Crow, MD, MBA

Chief Executive Officer and Co-Founder, Catalyst Health Group

Christopher Crow, M.D.

CEO & Co-Founder of Catalyst Health Group

Board-certified Family Physician

Background

Dr. Christopher Crow leads **Catalyst Health Group**, a healthcare innovation ecosystem, whose purpose is to Help Communities Thrive and is comprised of:

- **Catalyst Health Network**, a group of 800 primary care providers in Texas focused on value-based care
- **Catalyst Care Connect**, an MSO that provides professional, non-clinical services to primary care practices
- **Catalyst Physician Group**, the largest independent primary care practice in Texas with 150 PCPs

Catalyst serves more than **one million patients** through **800 providers** in the Dallas/Fort Worth Metroplex, the Texas Panhandle and East Texas, and has seen nearly **$500 million** in savings for the communities served since 2015.

Affiliate companies:

- **Stellus Rx**: A national tech-enabled service company offering personalized pharmacy support as an extension of the clinical care team
- **Lightpath Health:** Nonprofit organization offering team-based primary care services to the uninsured

Additional Notes:

- A practicing physician for 12 years and founded Village Health Partners, one of the first Level 3 NCQA patient-centric medical homes
- Awarded Healthcare Innovator of the Year by D CEO Magazine, and multiple years as a top 500 CEO
- Awarded 2024 Robert Graham Award from the American Academy of Family Physicians

Catalyst HEALTH GROUP

Barriers to participating in PB-TCOC models

01

Financial Incentives

FFS is an incongruent payment model for TCOC. It creates a physician mindset and operational model that values throughput not outcome.

02

Actionable Data

Disparate data sources for patient populations are not aggregated for physicians and patients to easily glean actionable insights to act on, proactively and reactively.

03

Cash Flow

It often takes multiple years to transform patient panels from FFS to TCOC, and payment for TCOC happens in arrears.

04

Change Management

Physician-led organizations typically do not have the expertise in change management, business acumen or a professional management team to transform their model.

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Chase Hammon, MBA

Chief Financial Officer, Duly Health and Care

Duly Health and Care

Chase Hammon
Chief Financial Officer

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HEALTH AND CARE

Other Experience –

CFO Springfield Clinic
CFO Bon Secours Mercy Health Richmond Physicians
Finance Executive – UT Southwestern

Independent Physician Groups provide a total cost of care between 20%-30% lower than large hospital systems. Yet, the economics of the current US Healthcare system continue to drive independent physician practices out of business. Removing the barriers for independent physicians to join and succeed in PB-TCOC models will reduce costs to employers, patients, and taxpayers, drive efficiency, and help reduce the physician shortage we are experiencing.

Barriers to participation in PB-TCOC

1. Economics associated with starting a VBC initiative, including the data analytics, reporting requirements, and care management, are so burdensome that many small practices simply don't do it.

2. Without scale and size, the time between performance and payment must be reduced. Many physician groups simply can not float the costs.

Chase Hammon
Chief Financial Officer

Chase Hammon serves as Chief Financial Officer at Duly Health and Care. In this role, Chase serves as a key member of the senior management team, further positioning our organization for profitable long-term growth and scalability.

Chase brings more than 16 years of multi-site health care services experience to the Duly organization. Chase has proven success in long-term capital planning, provider compensation, revenue cycle optimization, business development, mergers and acquisitions, integrated delivery models, strategic planning, and financial leadership of independent, multispecialty physician-directed medical groups.

Chase most recently served as CFO of Springfield Clinic, where he successfully negotiated significant increases from commercial payors, developed a value-based care platform, generated new revenue streams, and improved financial performance by implementing industry standard benchmarks and driving team-focused collaboration. Prior to that role, Chase served as a CFO of Bön Secours Mercy Health for seven hospitals, 400 providers, and more than 100 locations in Richmond, Virginia.

Chase earned his bachelor's degree in finance at George Mason University – School of Management in Fairfax, Virginia, and his MBA in Health/Health Care Administration/Management from The University of Texas at Dallas.

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Jessica Walradt, MS

Vice President, Finance, VBC Contracting & Performance,
Northwestern Medicine

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Vice President of Finance, VBC Contracting and Performance

Northwestern Medicine

About: Northwestern Medicine (NM)

- **11 hospitals**
- **40,000+ employees** (3,500+ physicians)
- Cares for **1.4M+ patients**
- Educating the next generation of physicians (**1,200+**), nurses (**2,000+ rotations**), & advanced practice providers (**300+**)
- **~7,000 active clinical trials**

NM's VBC Portfolio

Total VBC Portfolio

430,000+ patients

Current Medicare APM

Medicare Shared Savings Program (MSSP)

- **~80,000 patients**
- **37 practices**

Past Medicare APMs

Bundled Payments for Care Improvement (BPCI)	• COPD • LEJR • CHF • Stroke • Sepsis
BPCI Advanced	
Oncology Care Model (OCM)	**All cancers**

VBC Model Participation Considerations

Is the model aligned with the realities of clinical practice?

- Clear “problem” or “opportunity”
- Patient inclusion criteria
- Participant criteria

How does the model impact NM’s goals for innovation and discovery?

- Attribution methodology
- Exclusion criteria & “carve outs”
- Risk adjustment

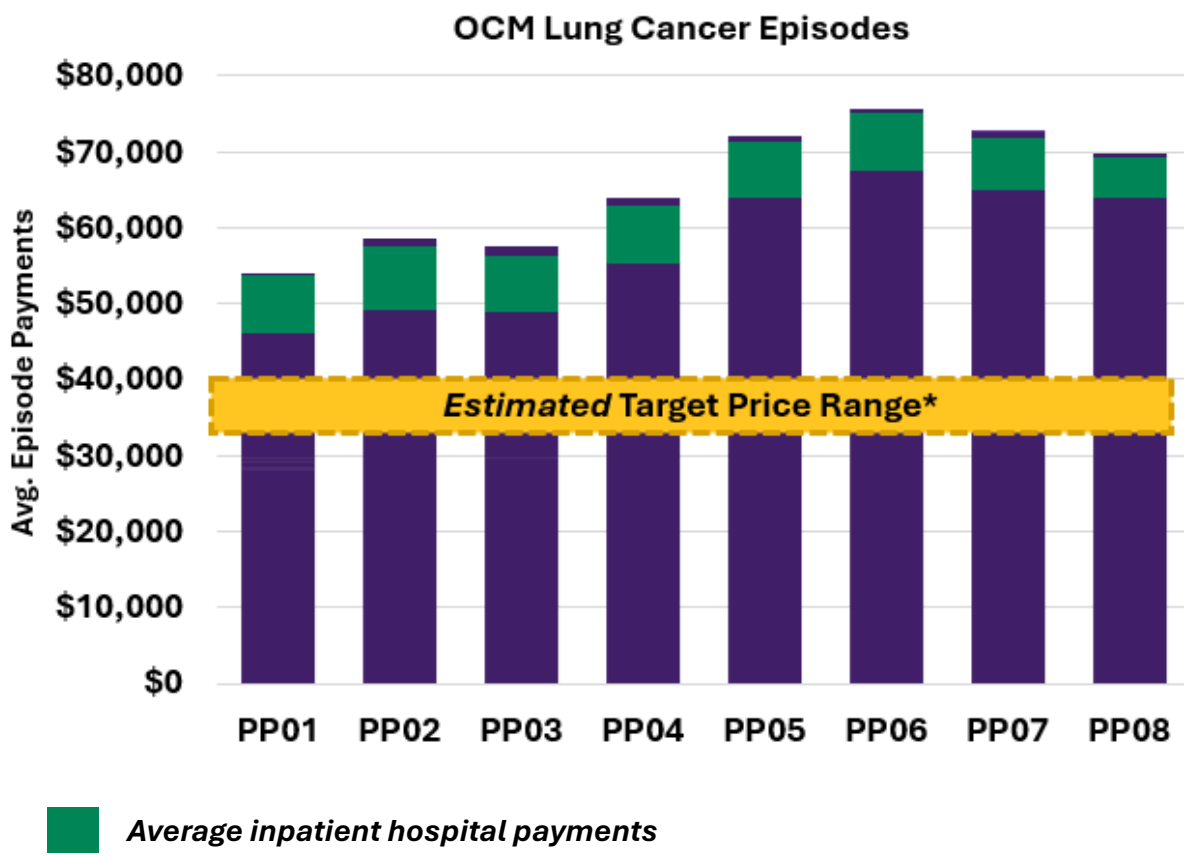
Is there a clinically appropriate path to generating savings?

- Benchmark/target price methodology
- Quality of available data

What is the administrative and operational lift?

- Data reporting
- Roster management
- Beneficiary notifications

Example: Insufficient Risk Adjustment and/or Carve Outs



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Brock Slabach, MPH, FACHE

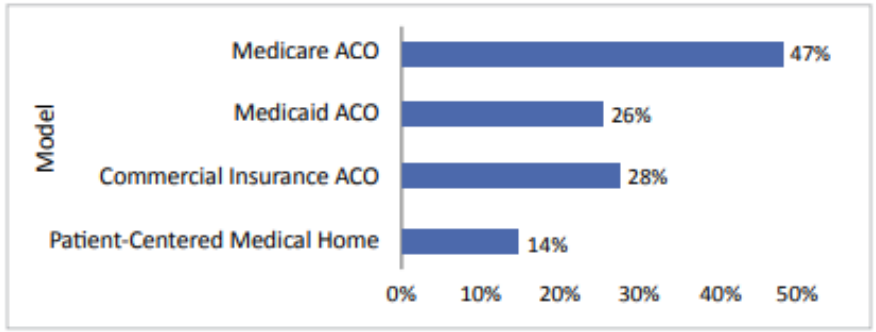
Chief Operating Officer,
National Rural Health Association (NRHA)

Brock Slabach, MPH, FACHE
Chief Operating Officer, NRHA

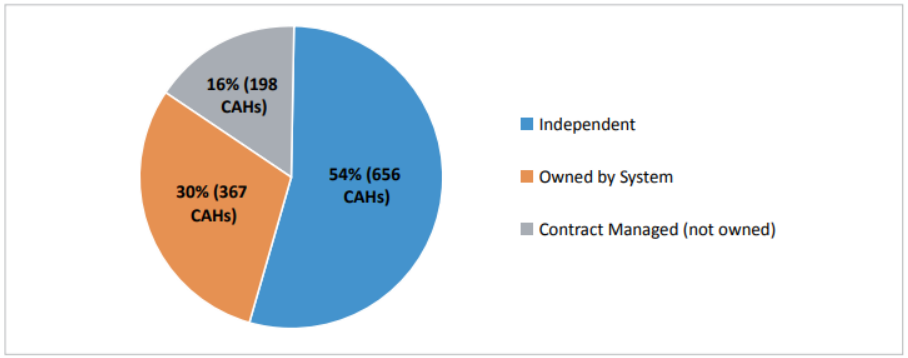
National Rural Health Association

National CAH Quality Inventory & Assessment National Report

- Quality Payment Model Participation



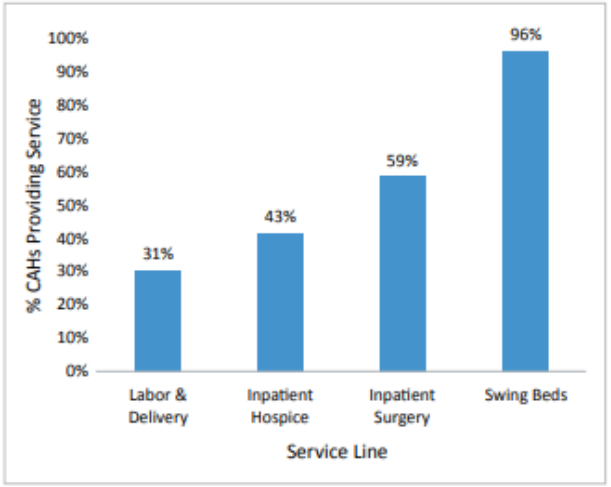
- CAH System Affiliation



- CAH Volume Measures

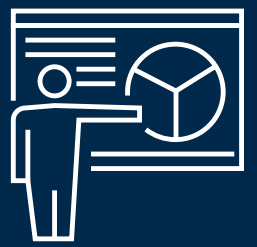
Description	CAH Respondents (n=1,221)
Median Average Daily Census (2022)	4.0
Median Emergency Department Volume (2022)	5,200

- CAH Inpatient Services



Flex Monitoring Team (FMT) National Report on CAH Quality Inventory, Released April 8, 2024

Rural Realities



1. The percentage of America's rural hospitals **operating in the red is 43%.**

2. Medicare Advantage now accounts for **39% of all Medicare-eligible patients in rural communities**. In 7 states, penetration exceeds 50%.

3. Access to inpatient care continues to deteriorate with **182 rural hospitals** either closing or converting to a model excluding IP care. We were at 162 last year.

4. **Nearly 432 rural hospitals** are 'vulnerable to closure' according to a new, expanded statistical analysis.

5. Between 2011 and 2022, **293 rural hospitals dropped OB services**. This represents over **25%** of America's rural OB units.

Rural Considerations in PB-TCOC Models

- Bench strength of leadership to implement transformational programming
- Lack of clarity around risk/reward analysis
- Little/no appetite for double-sided risk models
- Operations are running on thin margins with little/no capital to invest in alternative programming
- Historic “churn” of VBC programming that is either changed or terminated
- Lack of alignment across multiple payers on payment incentives and quality metrics
- Increasing diversion of patients from Traditional Medicare to Medicare Advantage

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Michael Barbati, MHA

Vice President of Government Programs,
Enterprise Population Health,
Advocate Health

Mike Barbati

VP, Government Programs | Advocate Health

President | Advocate Physician Partners Accountable Care Inc. | Accountable Care Organization of Advocate Aurora Health

13K+
Participating Physicians

15
ACOs | CINs | Networks

2.4M
Managed Lives

110+
Value-Based Contracts

$761.5M
Total CMS/CMMI Taxpayer Savings

$1.4B
Total Value Savings Paid Out

73
Participating Hospitals

- **Participation in disparate value contracts across Medicare, Medicaid and Commercial**
- **Size, Scale and Multidisciplinary Clinical Integration across continuum**
- **Sophisticated Population Health Platform (infrastructure)**
- **Specialty and Nested Care models**

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Total Cost of Care Participation Barriers

Regulatory and Administrative Burdens – Large integrated delivery networks typically have more resources to address complex regulatory and administrative requirements. Lack of lead time for applications, limited financial methodology details and complex program statutes severely limit applications and participation.

Higher financial exposure can limit financial stability – Health systems often have larger financial obligations and higher operating costs compared to physician groups. Leading to a higher level of certainty required on contract terms before taking downside risk.

Data Silos and Interoperability issues – lack of clear and uniform standards from CMS, payers, and vendors creates data silos and interoperability issues that puts the burden on participants in TCOC models to solve for. These data silos require larger infrastructure investments to create workarounds to solve for the lack of interoperability.

Specialty Care Transformation must be embedded in TCOC models – Disjointed and unconnected care models offered within the same market create conflict and result in fragmentation of care. Nested specialty care models within a total cost of care model can create more opportunity for partnership and improve total cost of care reductions.

Fragmented plan designs – Because plan designs vary across payers, significant investments must be made to tailor to unique contract and program design for each individual payer and model. This results in additional investments that could otherwise have been streamlined, freeing up more funds to support communities and patients.

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Appendix

Considerations on Participation in TCOC Models

Financial Risk & Revenue

- **Strong Financial Case:** Value Based Care requires stronger margin opportunity than FFS.
- **Downside Risk:** Is downside risk tolerable?
- **Actuarial considerations:** Risk-adjustment methodologies, trend factors, ability to audit payer calculations, play a significant role in participation decisions.
- **Variability:** Capitation vs. Partial Risk vs. shared savings.
- **Additional trends impacting risk success:** E.g. – impact of Part D, increase Part B cell & gene therapy expenses.

Data Integrity & Performance

- **Payer Data confidence:** Transparency in data, performance audits, and risk-adjustment/ attribution methodologies is key to success.
- **Operational capabilities:** Success requires administrative, analytical, and care management infrastructure and confidence in ability to perform.
- **Critical Mass:** Attributed lives >5,000 is necessary to mitigate adverse selection and balance risk.

Strategic Fit and Competitive Factors

- **Competing Models:** The presence of competing models, such as Medicare Advantage (MA) and employer-driven VBC contracts, influences strategic decisions.
- **Business Model Fit:** Alignment between financial incentives and care delivery strategies to avoid unintended revenue loss.
- **Clinical Model Fit:** Certain service lines may be kept outside TCOC models to retain higher-margin revenue streams.

These factors may vary by participating entity and their maturity within Population-Based Total Cost of Care Models

Key Tenets to Success in TCOC Models

	Provider Differences	Geographic Differences	Incentivizng Participation	Physician Compensation	Incentiivize Beneficiaries	Payor Lessons
Resource limits and lack of infrastructure	✓					
Funding upfront costs	✓					
Opportunity differenced due to baseline spend	✓					
Risk of financial losses	✓					
Level competition and more fragemented care		✓				
Access to technology		✓				
Level of socio-economic deprivation		✓				
Level of social determinants of health		✓				
Degree of model flexibility			✓			✓
Approach to risk-adjustment			✓			
Integration of SDOH incentives			✓			
Continuum alignment (hospital, PCP, SPC)			✓			✓
Embedded bundles				✓		
Balance of mandate and resources availability				✓		
Physician compensation alignment				✓		
Enhanced Benefits					✓	
Patient awareness					✓	
Tailored care programs					✓	
Coordination across payors and continuum						✓

Multiple programs in a single market causes conflict between programs resulting further fragmentation of the market

TCOC Success Factors

Adaptability to Policy Changes

Early adoption and leadership in transformation initiatives, including participation in CMMI models, 1115 Medicaid waiver/ transformation and commercial ACO risk

Size & Scale of Clinical Integration

CINs Across States: 3 Clinically Integrated Networks (CINs) managing 2.4 million value-based lives across five states

Multidisciplinary Engagement: Inclusion of primary care, specialists, hospitals, and post-acute networks

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Population Health Platform

Advanced Analytics & Risk Modeling

Evidence-Based Protocols

Focus on Preventive Care

Avoidable Cost Reduction & Quality Improvement

Value Innovation/Learning Health System

Advocate Health ACO's

259,998
2024 Total Lives

94.2%
Average Quality Score

$761.5M
Total Generated Savings

$384.3M
Total Savings to the Networks

$128.2M
2022 Generated Savings

$69.9M
2022 Savings to the Network

$25.2M
2022 Total Savings Retained by AH

$46.5M
2023 Forecast

$79.8M
2023 Projected

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