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Educational Webinar Series

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Cardiovascular Diagnostics & Value-Based Care

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Audience Poll (Choose one)

What is your biggest concern or pain point related to value-based care?

Data integration
and
interoperability

Lack of
resources to
sufficiently
implement

Revenue

Evolving
policies and
quality
measures

Provider
resistance to
VBC programs

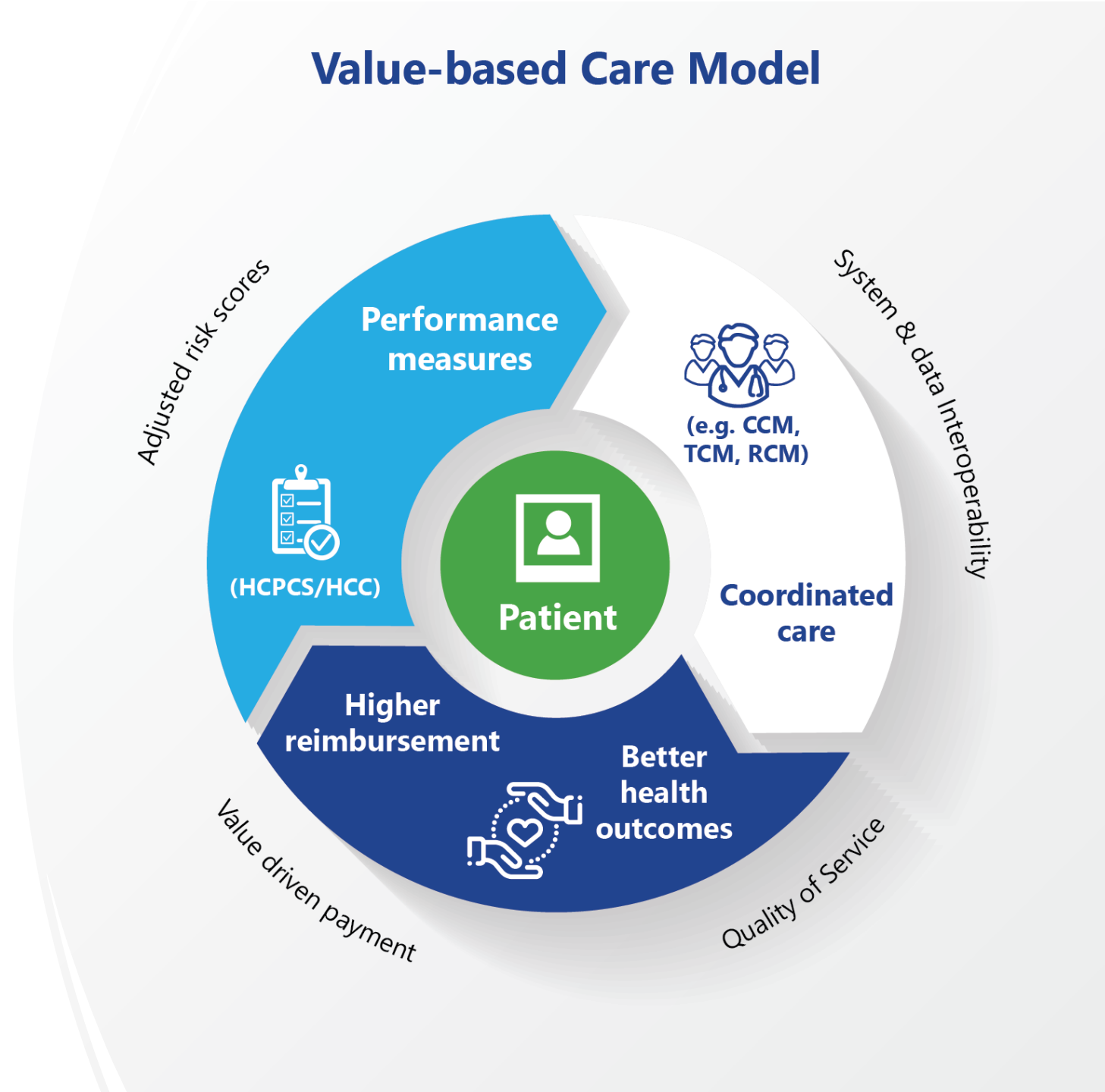
Fee For Service vs. Fee For Value

A Tale of Two Boats

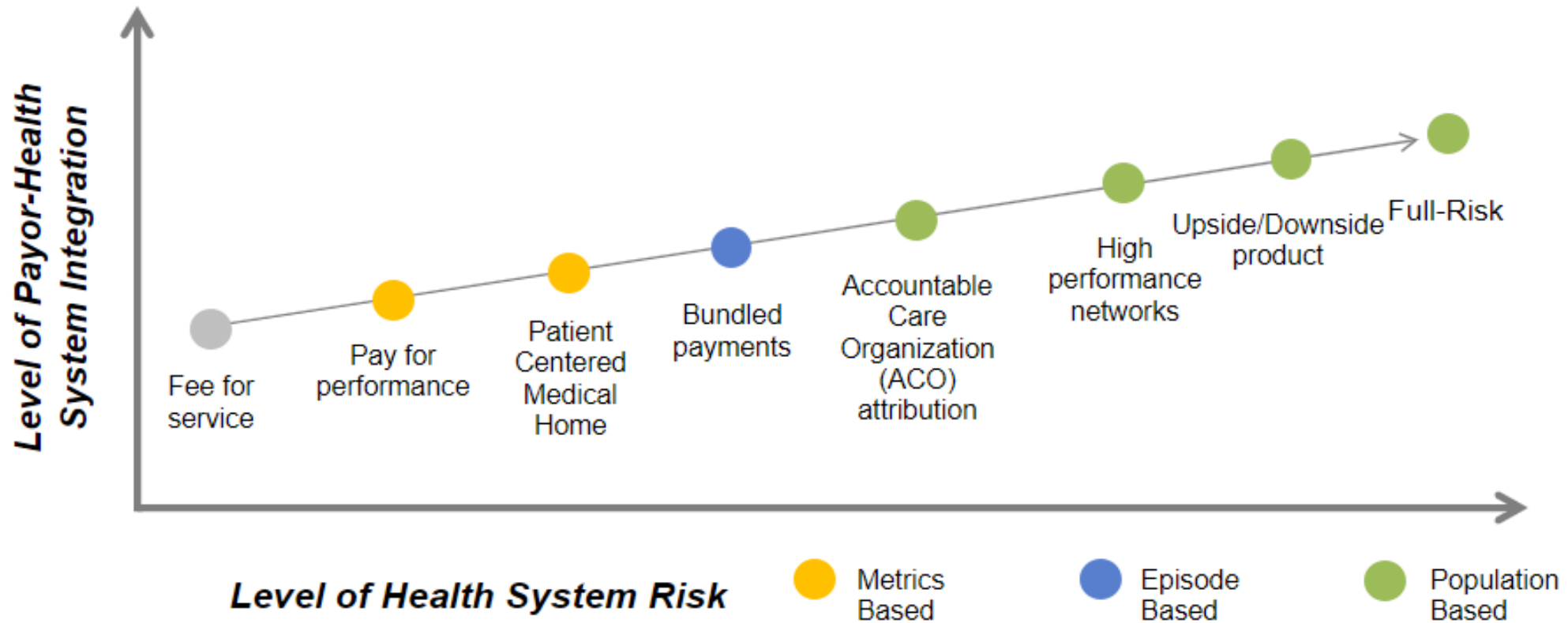


Healthcare providers have to have one foot in each boat, straddling for survival between Fee-for-Service and Fee-for-Value


Simplifying the VBC Construct



Payment Models Have Changed the Dynamics of Health System (Provider) and Payor Interactions



With increased risk and accountability for spending, provider network decision makers are increasing their focus on medical and pharmacy spend to understand how they impact one another and affect the total cost of care.



The Landscape is Changing: Key Trends in Value-Based Care

- **Global capitation arrangements:** In many markets, providers are being asked to adopt global capitation arrangements with their Medicare Advantage Organization (MAO) payer partners. This type of arrangement allows payors to divest much of their risk by paying providers a flat fee per member, up front (PMPY), leaving healthcare systems responsible for managing their annual budgets and member-driven costs of care. A group of IDNs are now stopping these contracts as they have been unable to manage cost in a slit model of F4S and VBC. (Beckers Report, September 2023)
- **Performance expectations are increasing:** MAOs will start to expect higher performance from their provider partners in the future, which will translate to increased expectations for providers to take greater risks within their Medicare Advantage populations. These expectations could emerge through greater downward pressure on the Division of Financial Responsibility (DOFR) percentage, fewer claim type carve-outs from the DOFR, increased expectations for the provider quality contribution, or several other areas within the contracting process.
- **Payors are building their own provider networks:** United Healthcare & Optum Care; Humana & CenterWell; CVS/Anthem buys OakStreet; Walmart/Optum Care (2022) and Walmart to buy ChenMed; BCBS of Arizona launches Prosano Health 2024.

Global Capitation

- **Total Cost of Care** is a measure of all direct and indirect costs incurred treating a population in a given time period expressed as a risk adjusted per member per month (PMPM).
- The measure includes all services associated with treating a patient including inpatient, outpatient, professional, pharmacy, and ancillary services.
- Utilization of the Total Cost of Care Model allows for fair comparisons between providers, insurers, and regions over time.

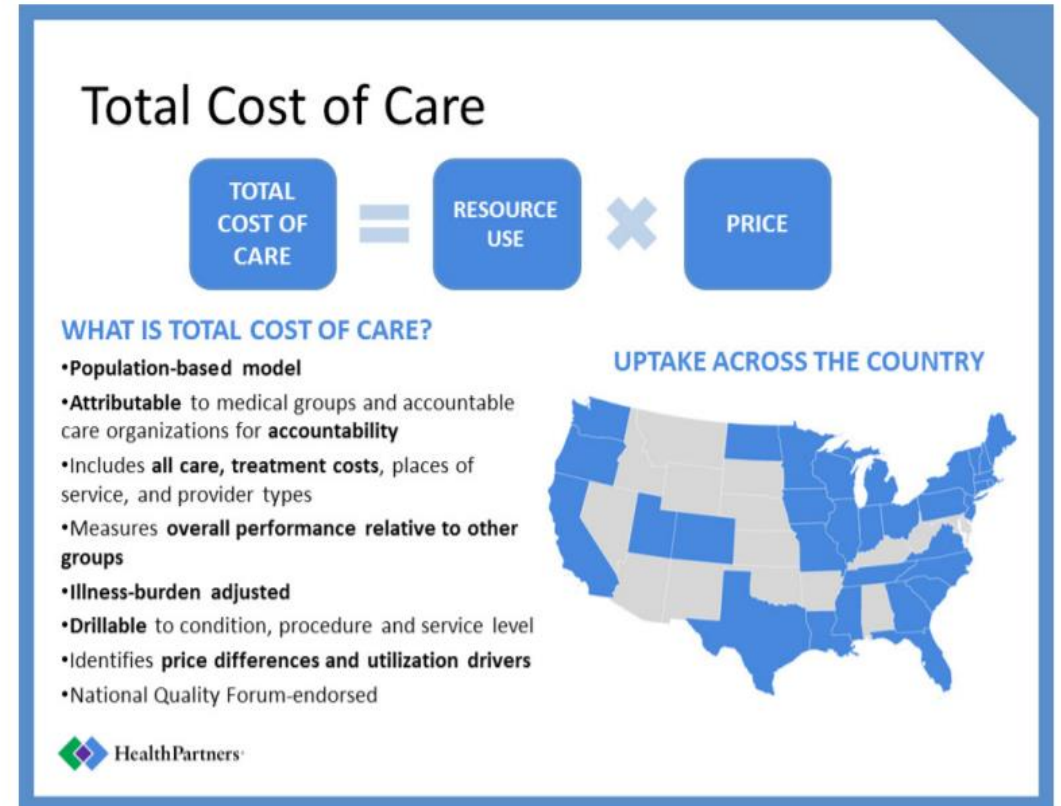
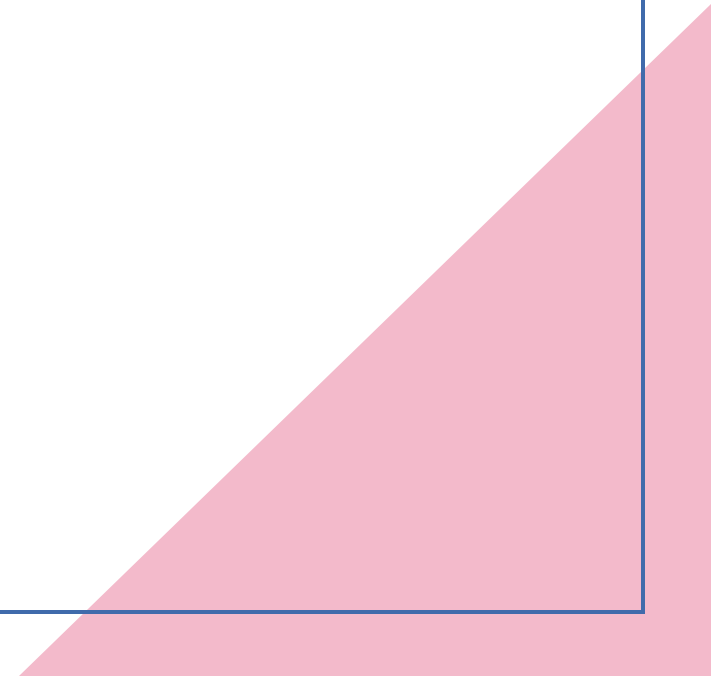


Figure 1: Total Cost of Care
Source: HealthPartners

**Value-Based Care
Engagement
Differs Across
Specialties**



Areas of Adoption of the VBC Construct

Value-based care adoption is highest in primary care but other specialties see meaningful and growing traction.

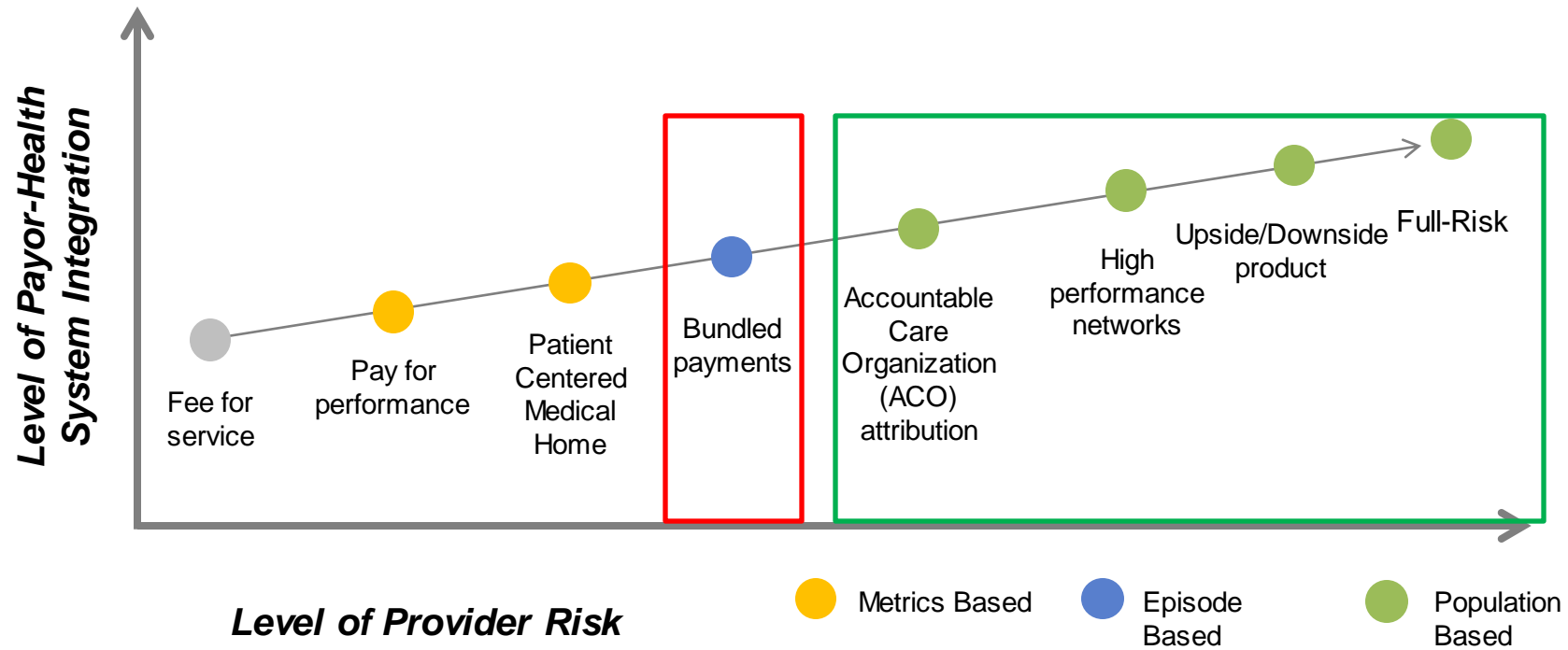
Value-based care (VBC) adoption by medical specialty,¹ nonexhaustive

	HIGH ADOPTION ← → LOW ADOPTION						
Specialty	Primary care	Nephrology	Oncology	Orthopedics	Women's health	Cardio-vascular	Behavioral health
Description	Enables primary care to act as the "quarterback" and take full responsibility for patient health	Enables nephrologists to succeed in CMS ⁴ and MA VBC ⁵ focused on reducing CKD/ESRD ⁶ costs	Enables oncologists to prescribe an appropriate drug for the patient while maximizing practice margin from prescription	Large spend area with significant employer focus and increase in penetration of episodes	Pregnancy episodes particularly in Medicaid and increasingly commercial	Large spend area, particularly in MA, driving high inpatient and emergency department utilization; site-of-care shift for procedures	Episode-based models for facilities with more innovative approaches involving PCPs on integration of BH ⁸ /physical health
Applicable CMMI model	Primary care first, MSSP, ² ACO REACH ³	Kidney care choices, ESRD treatment choices	Oncology care model, enhancing oncology model	Comprehensive care for joint replacement, BPCI ⁷	n/a	BPCI	n/a

¹Proportion of money in specialty at risk. ²Medicare Shared Savings Program. ³Accountable care organization Realizing Equity, Access, and Community Health (REACH) model. ⁴Centers for Medicare & Medicaid Services. ⁵Medicare Advantage value-based care. ⁶Chronic kidney disease/end-stage renal disease. ⁷Bundled Payments for Care Improvement initiative. ⁸Behavioral health.

Source: Centers for Medicare & Medicaid Services Alternative Payment Models program data; expert interviews and discussions with payer and provider senior executives

Major Differences in Specialty vs. Primary Care in Taking on Risk



With increased risk and accountability for spending, health system decision makers are increasing their focus on medical and pharmacy spend to understand how they impact one another and affect the total cost of care.

Major Differences in Specialty vs. Primary Care in Taking on Risk

Successful value-based care providers will increasingly need to look into more innovative levers to maintain value.

Sources of value for successful value-based care providers, and total cost-of-care savings, Medicare Advantage example, %

Low-hanging fruit 3–8	The harder stuff 3–6	Future innovations 3–5
<ul style="list-style-type: none">• Improve risk-coding accuracy to capture health status• Reduce out-migration of in-network care to out-of-network providers• Improve adherence of referrals to high-quality providers	<ul style="list-style-type: none">• Predict health risk status• Manage use and mix of diagnostic testing, drugs for pharmacy, and procedures (surgical vs noninvasive)• Reduce variable costs within specialties, and collaborate on scheduling and comanagement to increase patient access• Shift to lower cost, efficient sites of care: select discharges from senior nursing facility to home, outpatient surgery to ambulatory surgery center, low-acuity medical admits to observation, emergency department visits to primary care physician• Improve performance on Healthcare Effectiveness Data and Information Set, Centers for Medicare & Medicaid Services Star ratings measures, and in commercial-quality programs	<ul style="list-style-type: none">• Leverage digital twin capabilities to identify required interventions to tackle future health issues• Reduce preventable injuries, falls, etc, at home using remote patient-monitoring• Reduce preventable exacerbations• Reduce potentially avoidable hospital readmissions• Reduce medically unnecessary inpatient admissions from emergency department



**Improving the
Patient Journey for
Cardiovascular
& Palpitations**

Palpitations in Primary Care

Palpitations are common. Approximately 6 to 11% of people report experiencing palpitations over the course of a year.

In a survey of patients visiting their primary care providers, 16% of patients have complained of a fluttering sensation.

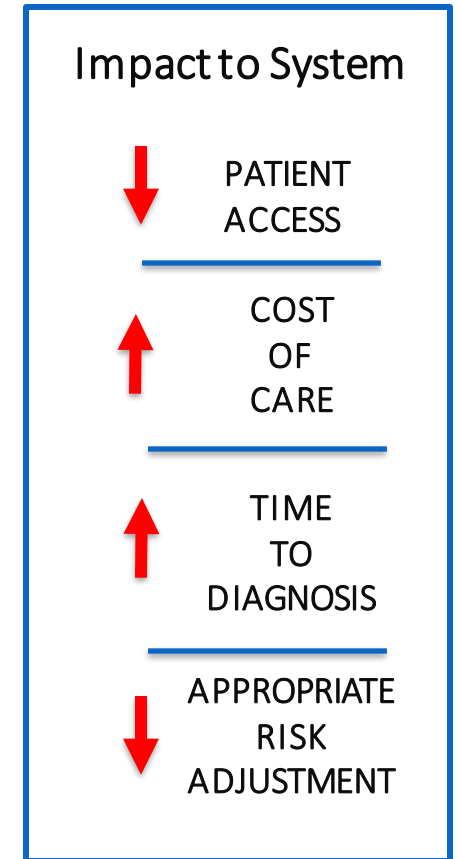
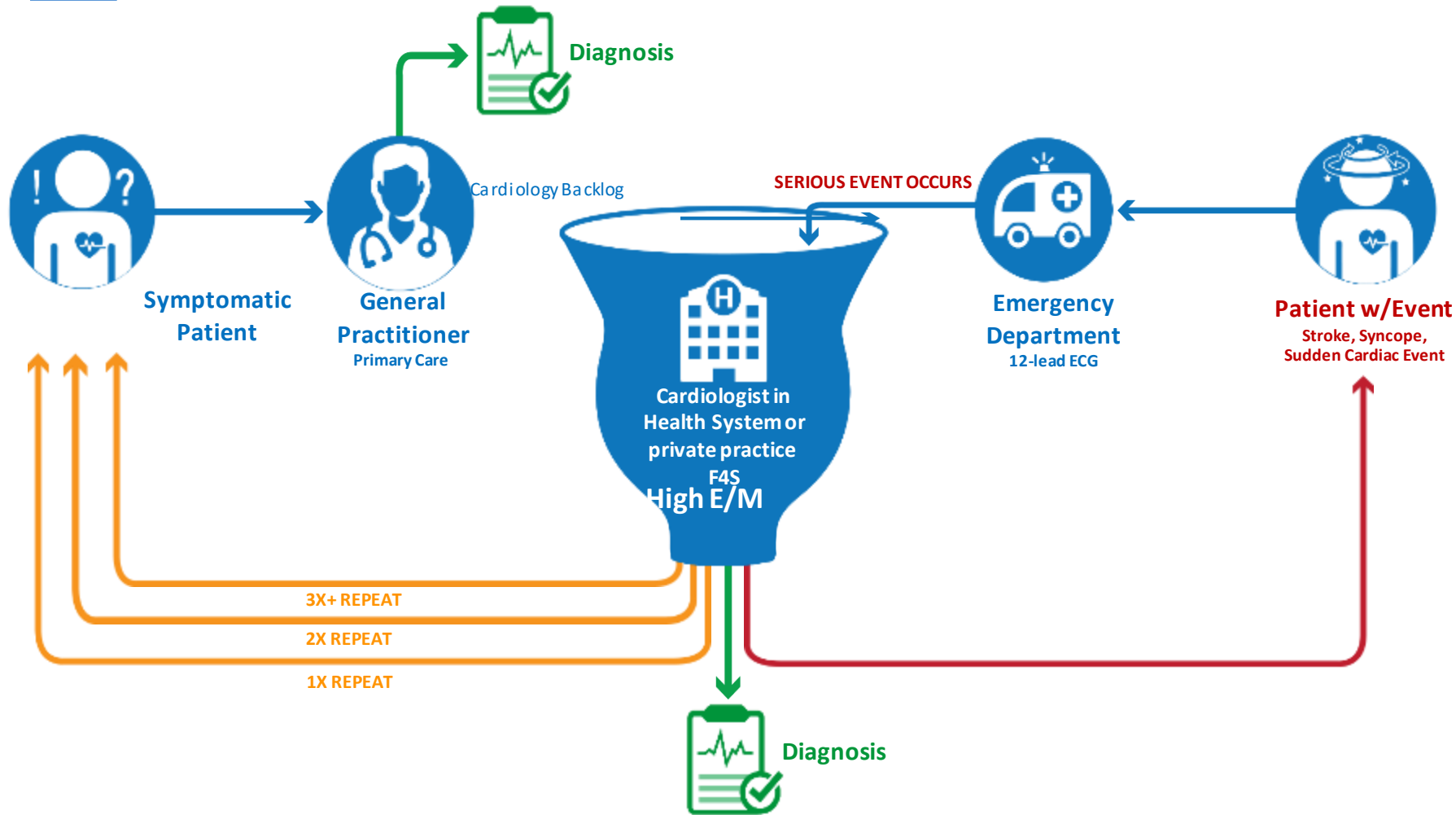
In fact, palpitations are the second most common reason patients are referred to a cardiologist.¹

Causes: 190 people with palpitations were followed for one year, and the sensation was attributed as follows:

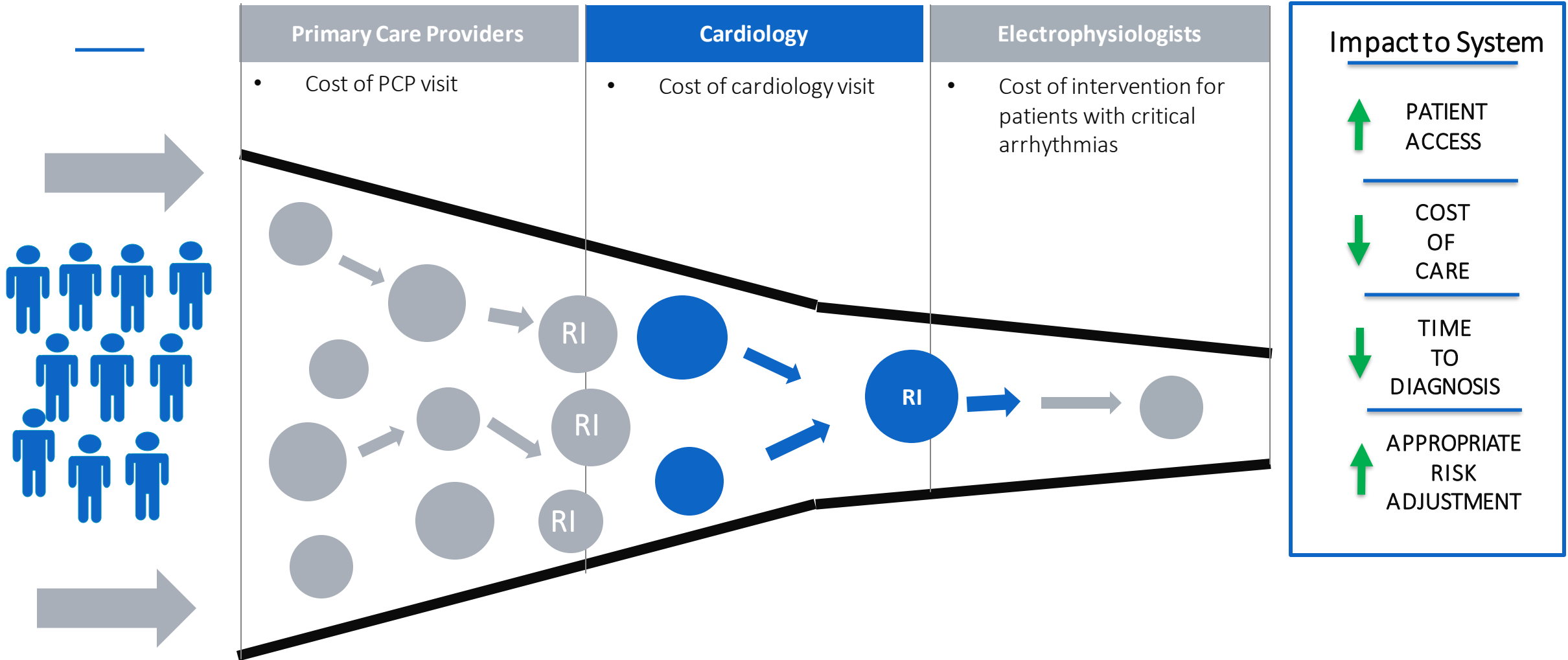
- 43% were caused by cardiac causes
- 31% were caused by anxiety or panic disorder
- 6% were caused by medications or supplements
- 4% were caused by other non-cardiac causes
- 16% of the time, no cause was found

1. Shirazi, Jonathan. "Heart Palpitations: The Importance of Rhythm and Context | Parkview Health." *Parkview*, Feb. 2022, www.parkview.com/blog/heart-palpitations-the-importance-of-rhythm-and-context#:~:text=Of%20190%20people%20with%20palpitations.

Patient Journey for Palpitations from Primary Care



Improve Patient Journey of Palpitations from Primary Care



Aligning with Value-Based and Risk-Based Incentives

Stars Ratings/Quality

CMS HARP

REDUCING 30-DAY
READMISSIONS AND LOS etc.

- Thresholds applied to sharing rates, quality bonus rates or as a minimum requirement for payment

Risk Score/Coding

APPROPRIATE DIAGNOSIS

- Risk score is nearly a direct multiplier on revenue from CMS for Medicare Advantage contracts. Contracts typically include risk-adjusted health care expense targets.

Total Cost-of-Care & UM

REDUCING HCRU AND TOTAL
MEDICAL COSTS

- Per capita expenditures are compared against a target, which is often prescribed by payers.

Catastrophic Cases

EARLIER DETECTION AND
TREATMENT OF UNDERLYING
DISEASE

- Truncated at the patient level at a pre-set dollar amount, gradual/tiered truncation for patient-level costs above \$x

How iRhythm is Aligning to Value-Based Care

Where does Ambulatory Cardiac
Monitoring (ACM) fit in?

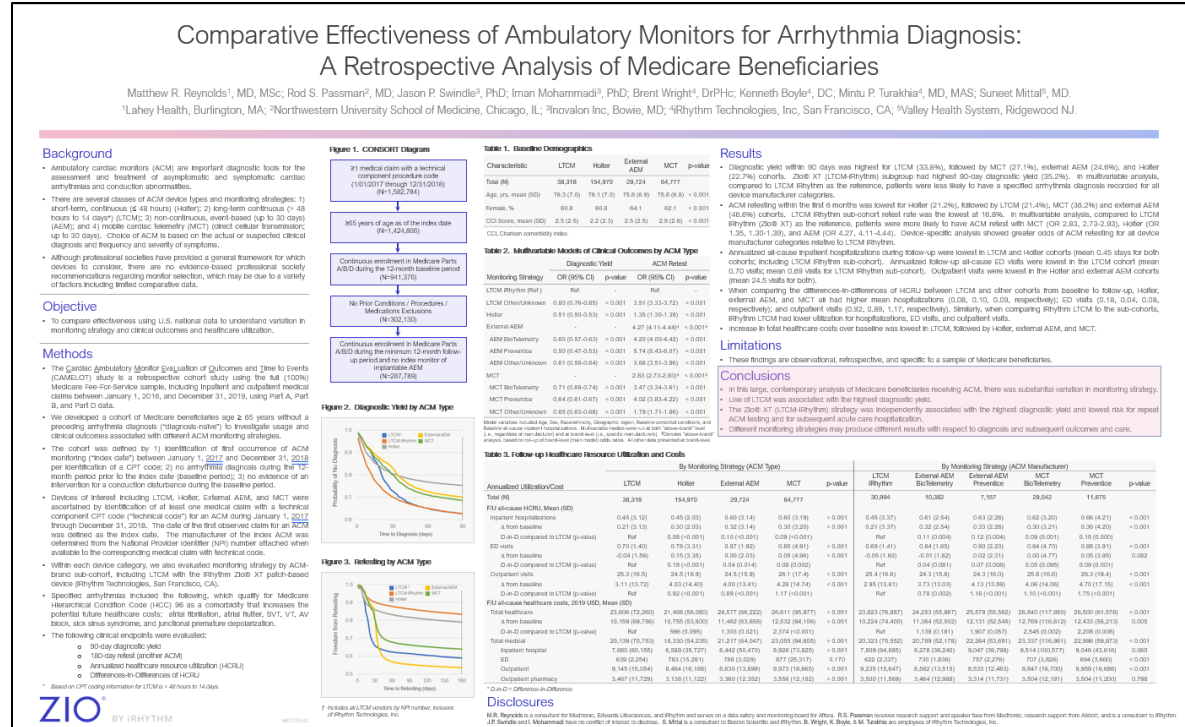


CAMELOT

The Cardiac Ambulatory Monitor EvaLuation of
Outcomes and Times to events

Objectives

- To compare effectiveness of monitoring strategy on clinical outcomes and healthcare resource utilization (HCRU).¹
- Clinical and Economic Endpoints :¹
 - Diagnostic Yield of Specified Arrhythmias Defined by Hierarchical Condition Categories 96 (HCC 96)
 - Retest Likelihood
 - Healthcare Resource Utilization and Medical Costs
 - Emergency Department Visits
 - Inpatient Hospitalizations
 - Outpatient Visits



What is a specified arrhythmia?^{1,2}

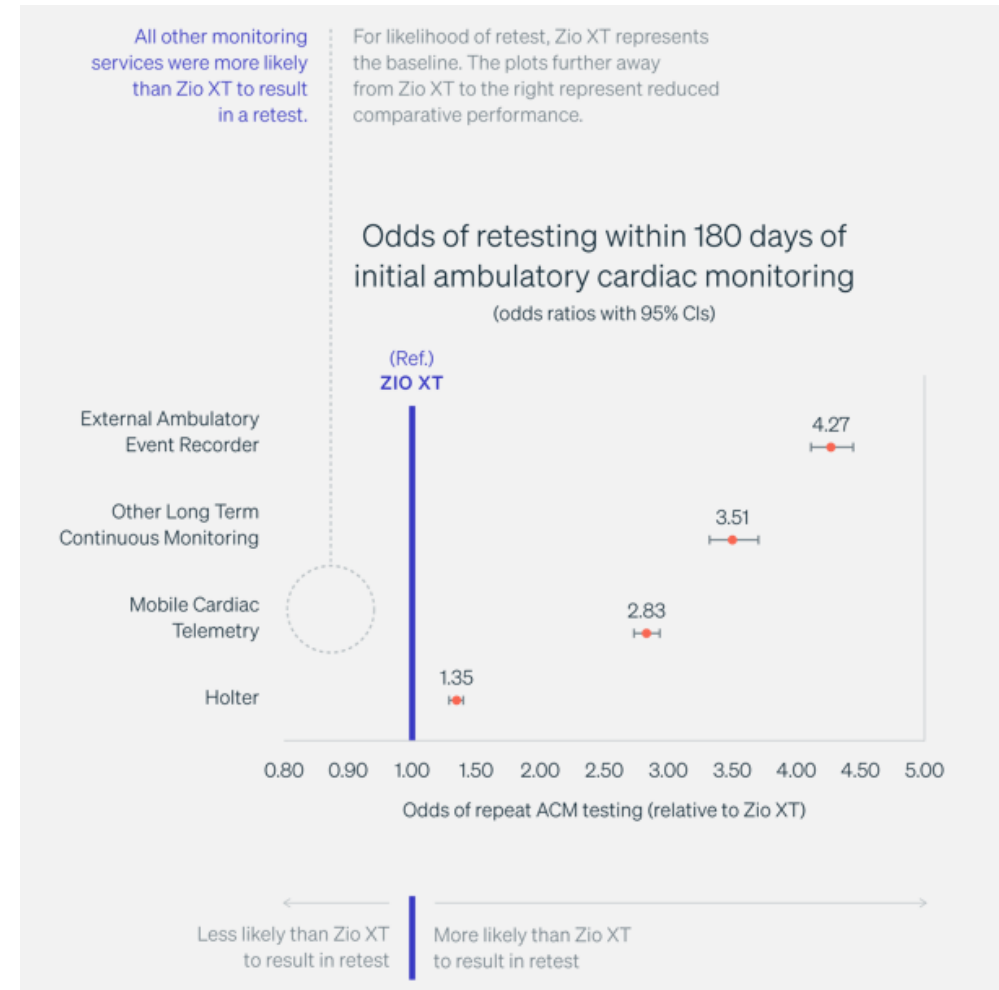
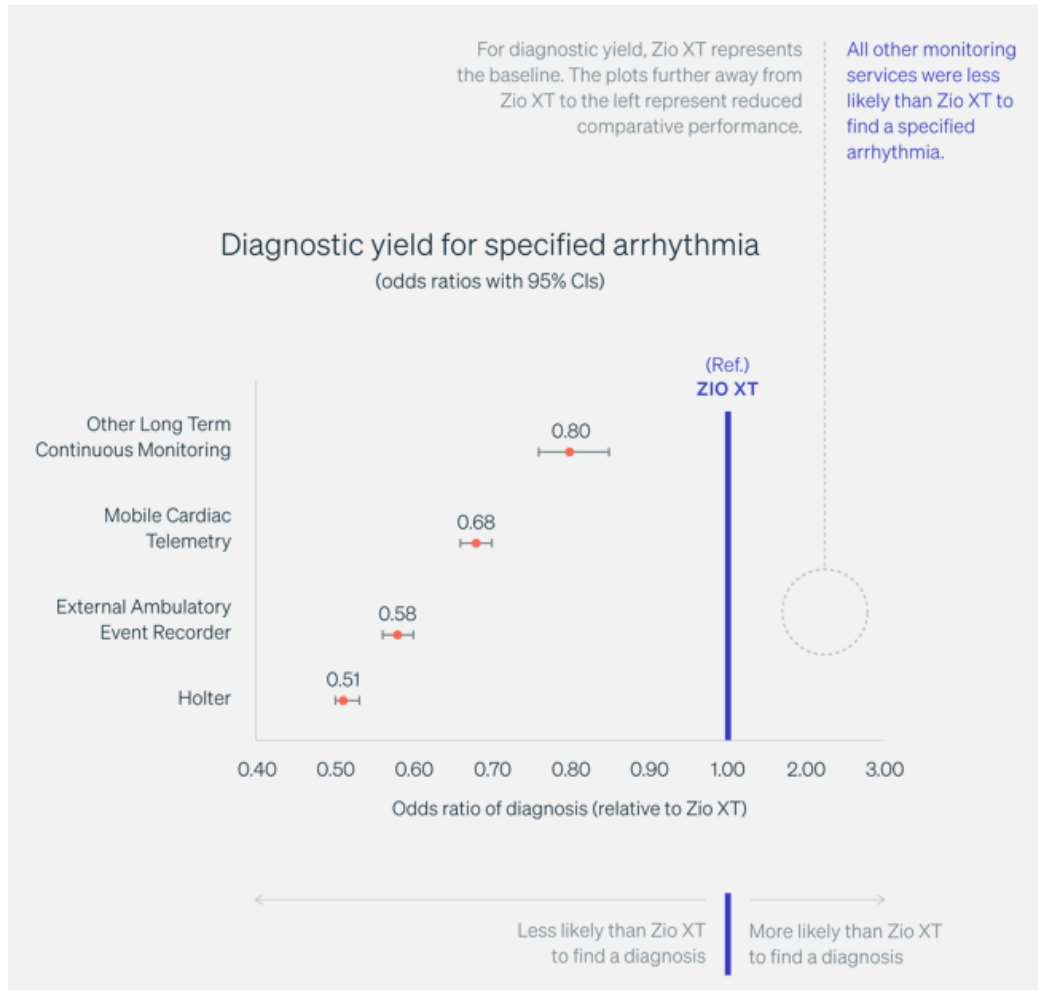
A specified arrhythmia is one that qualifies for CMS hierarchical condition code (HCC) 96 as a comorbidity that increases the potential future healthcare cost of caring for the patient and include the following:

- 142.2 – Atrioventricular block, complete
- 147.0 – Re-entry ventricular arrhythmia
- 147.1 – Supraventricular tachycardia
- 147.2 – Ventricular tachycardia
- 147.9 – Paroxysmal tachycardia, unspecified
- 148.0 – Paroxysmal atrial fibrillation
- 148.11 – Longstanding persistent atrial fibrillation
- 149.19 – Other persistent atrial fibrillation
- 148.20 – Chronic atrial fibrillation, unspecified
- 148.21 – Permanent atrial fibrillation
- 148.3 – Typical atrial flutter
- 148.4 – Atypical atrial flutter
- 148.91 – Unspecified atrial fibrillation
- 148.92 – Unspecified atrial flutter
- 149.2 – Junctional premature depolarization
- 149.5 – Sick sinus syndrome

1. Reynolds et al. Comparative effectiveness of ambulatory monitors for arrhythmia diagnosis: A retrospective analysis of Medicare beneficiaries managed with ambulatory cardiac monitors between 2017 and 2019. Accepted for ACC.23 presentation, presented at New Orleans, LA.

2. Specified arrhythmias defined by Hierarchical Condition Categories (HCC) 96.

Which monitoring service is associated with the highest diagnostic yield and lowest likelihood of retesting?



Comparison of inpatient hospitalizations by type of monitoring service

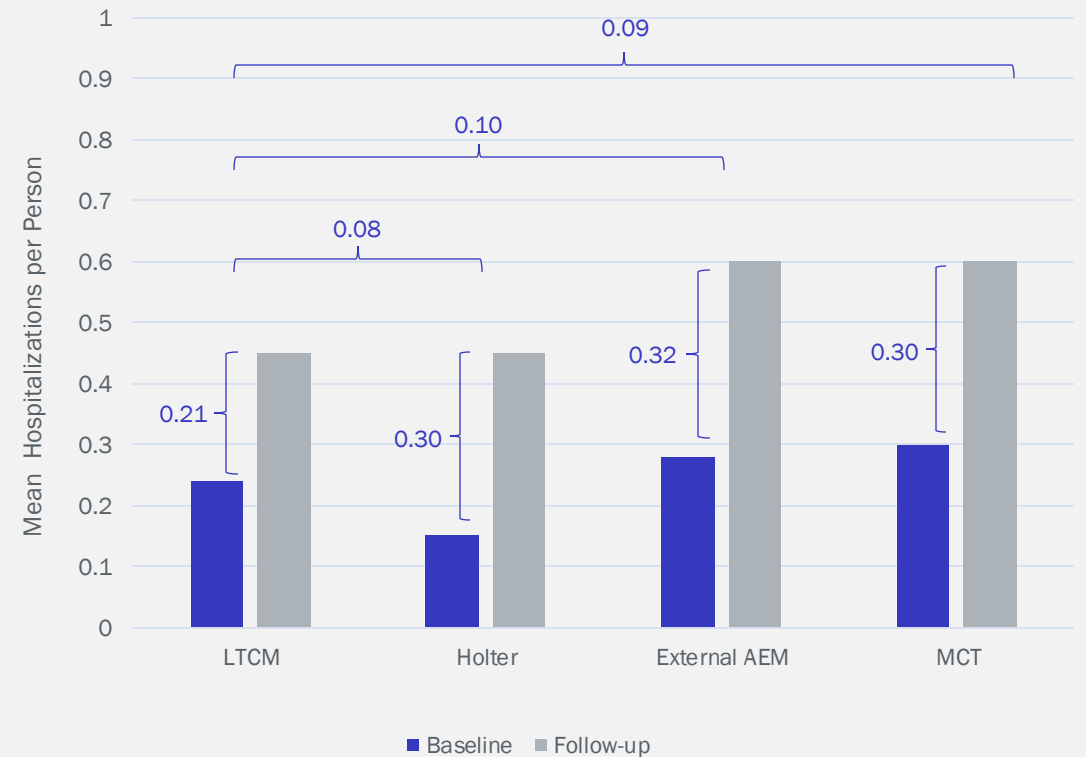
On average, compared to LTCM services:

- Holter monitoring services are associated with 80 more inpatient hospitalizations for every 1,000 patients.^{1,2}
- Event monitoring services are associated with 100 more inpatient hospitalizations per 1,000 patients.^{1,2}
- MCT monitoring services are associated with 90 more inpatient hospitalizations per 1,000 patients.^{1,2}

1. Reynolds et al. Comparative effectiveness of ambulatory monitors for arrhythmia diagnosis: A retrospective analysis of Medicare beneficiaries managed with ambulatory cardiac monitors between 2017 and 2019. Accepted for ACC.23 presentation, presented at New Orleans, LA.

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Differences in the change of inpatient hospitalizations from baseline to follow-up



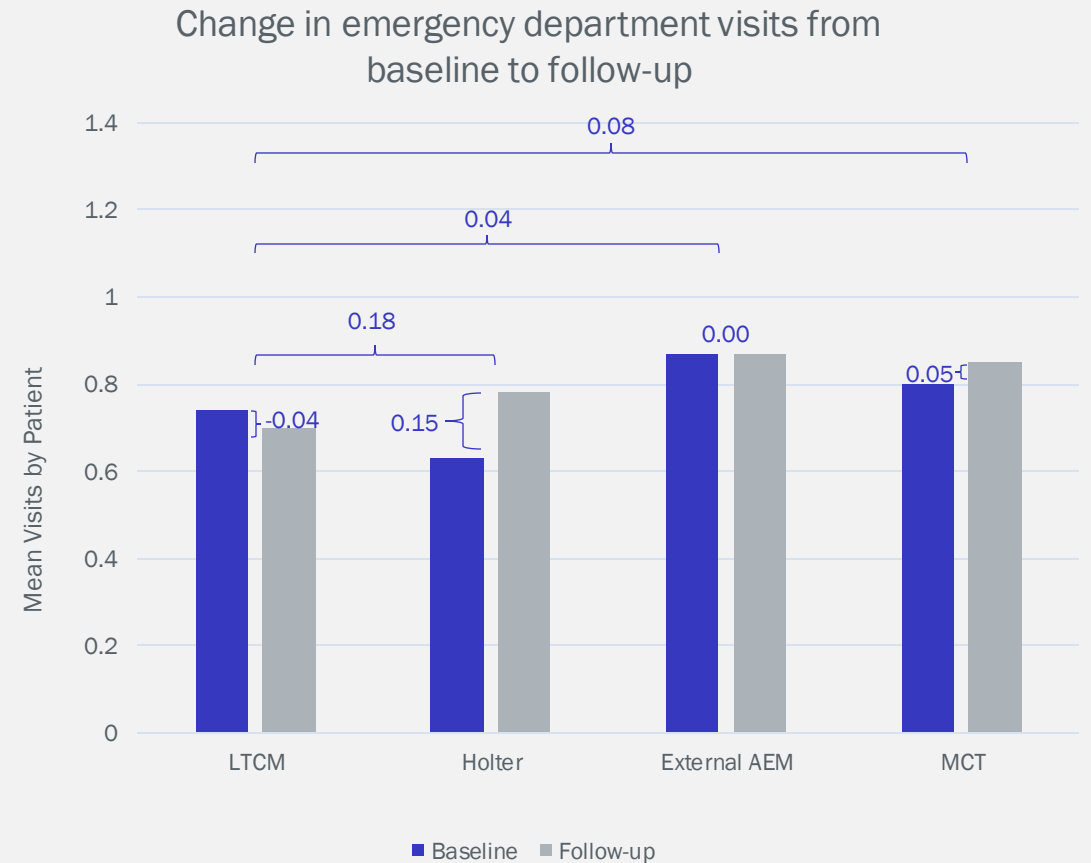
Comparison of emergency department visits by type of monitoring service

On average, compared to LTCM services:

- Holter monitoring services are associated with 180 more emergency department visits per 1,000 patients.^{1,2}
- Event monitoring services are associated with 40 more emergency department visits per 1,000 patients.^{1,2}
- MCT monitoring services are associated with 80 more emergency department visits per 1,000 patients.^{1,2}

1. Reynolds et al. Comparative effectiveness of ambulatory monitors for arrhythmia diagnosis: A retrospective analysis of Medicare beneficiaries managed with ambulatory cardiac monitors between 2017 and 2019. Accepted for ACC.23 presentation, presented at New Orleans, LA.

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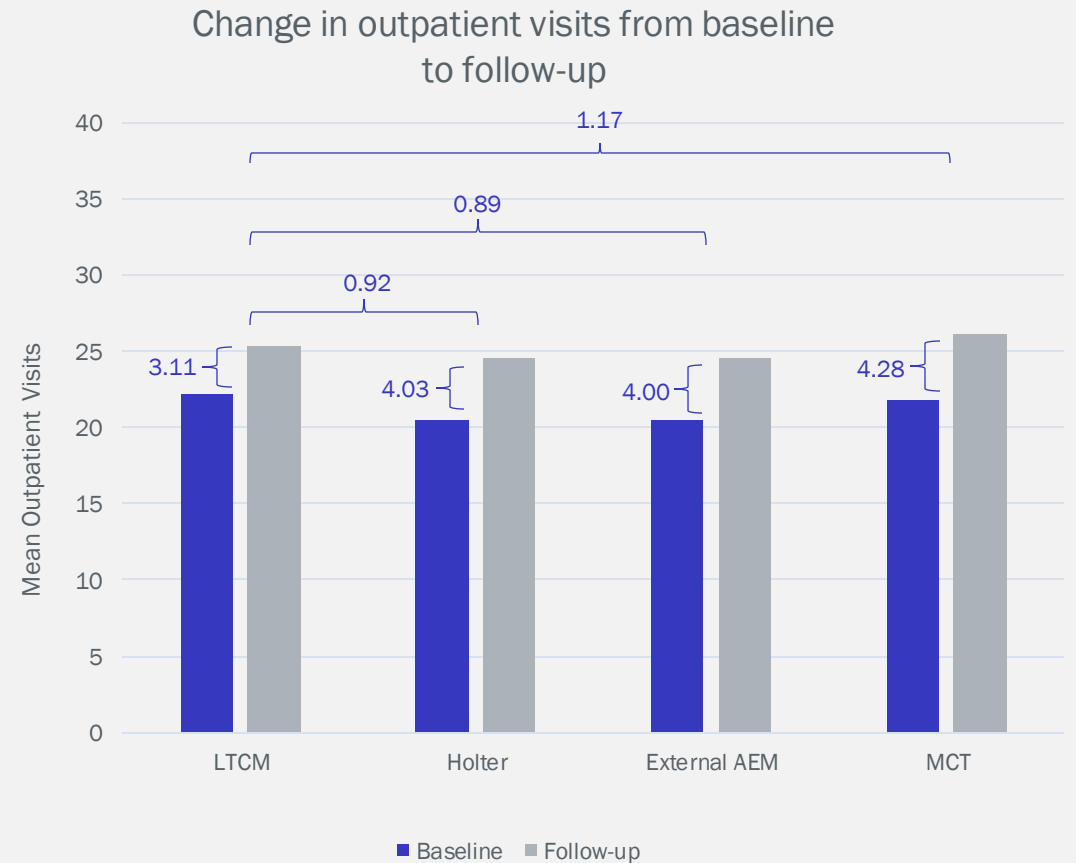
Comparison of outpatient visits by type of monitoring service

On average, compared to LTCM services:

- Holter monitoring services were associated with 920 more outpatient visits per 1,000 patients.^{1,2}
- Event monitoring services are associated with 890 more outpatient visits per 1,000 patients.^{1,2}
- MCT monitoring services are associated with 1,170 more outpatient visits per 1,000 patients.^{1,2}

1. Reynolds et al. Comparative effectiveness of ambulatory monitors for arrhythmia diagnosis: A retrospective analysis of Medicare beneficiaries managed with ambulatory cardiac monitors between 2017 and 2019. Accepted for ACC.23 presentation, presented at New Orleans, LA.

2. Specified arrhythmias defined by Hierarchical Condition Categories (HCC) 96.



Healthcare Economic Information (HCEI)¹

- HCEI is information from analysis that identifies, measures, or describes the economic consequences of the use of a drug/medical device, which may be based on the separate or aggregated clinical consequences of the represented health outcomes. Such analysis may be comparative to the use of another drug/medical device or to no intervention.
- HCEI pertains to the economic consequences (including, but not limited to, monetary costs or resource utilization) related to the clinical outcomes of treating a disease (or specific aspect of a disease) or of preventing or diagnosing a disease.
- HCEI may include comparative analyses of the economic consequences of a drug's clinical outcomes to alternative options (including the use of another drug) or to no intervention.
- HCEI should only be presented to entities with knowledge and expertise in the area of health care economic analysis,
- HCEI should clearly and prominently present the study design and methodology (e.g., type of analysis, modeling, patient population, perspective, comparator, time horizon, cost estimates, assumptions), generalizability, limitations, sensitivity analyses, and information relevant to providing a balanced and complete presentation.

1. Food and Drug Administration Modernization Act of 1997 (FDAMA) (Public Law 105-115) and the 21st Century Cures Act (Public Law 114-255). <https://www.fda.gov/media/133620/download>

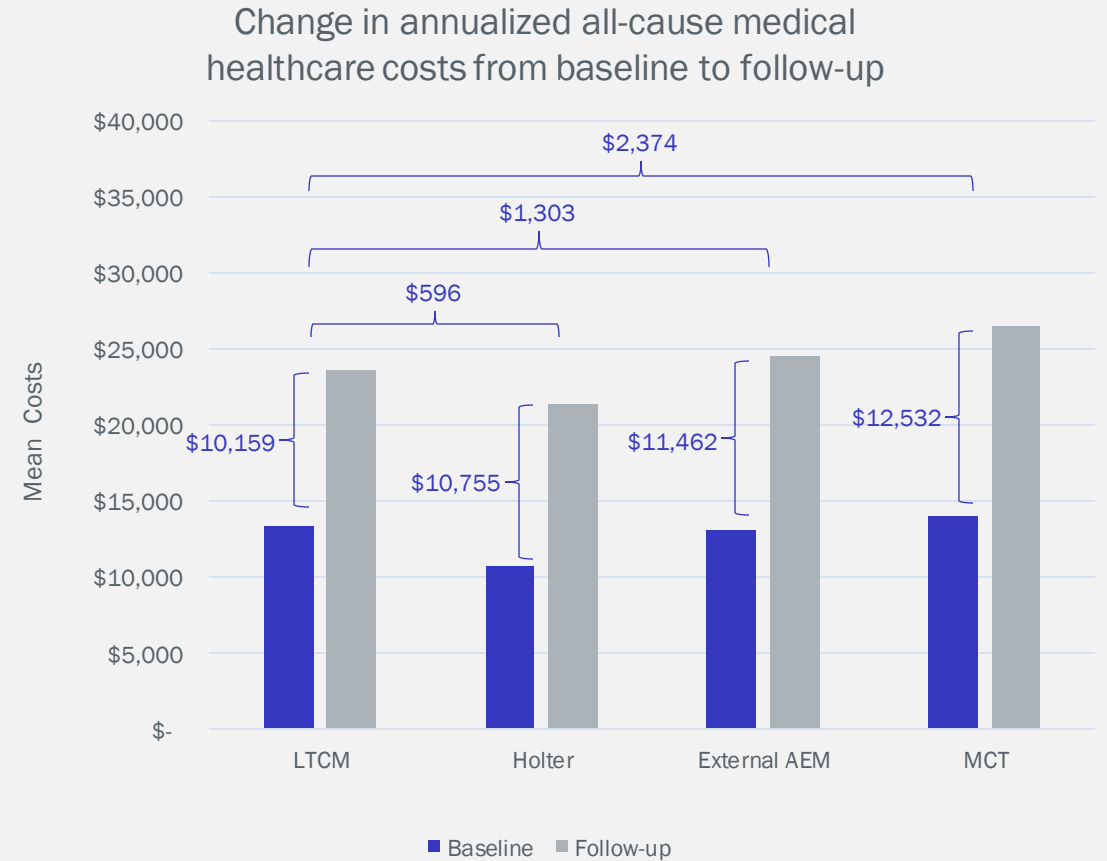
LTCM monitoring services is associated with the least change in annualized all-cause healthcare medical costs from baseline to follow-up compared to all other monitoring services^{1,2}

On average, compared to LTCM monitoring services:

- Holter monitoring services are associated with \$596,000 more healthcare costs per 1,000 patients.^{1,2}
- Event monitoring services are associated with \$1,303,000 more healthcare costs per 1,000 patients.^{1,2}
- MCT monitoring services are associated with \$2,374,000 more healthcare costs per 1,000 patients.^{1,2}

1. Reynolds et al. Comparative effectiveness of ambulatory monitors for arrhythmia diagnosis: A retrospective analysis of Medicare beneficiaries managed with ambulatory cardiac monitors between 2017 and 2019. Accepted for ACC.23 presentation, presented at New Orleans, LA.

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Q&A

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Questions for our speaker? Email bwright@irhythmtech.com