# A Conversation Featuring:
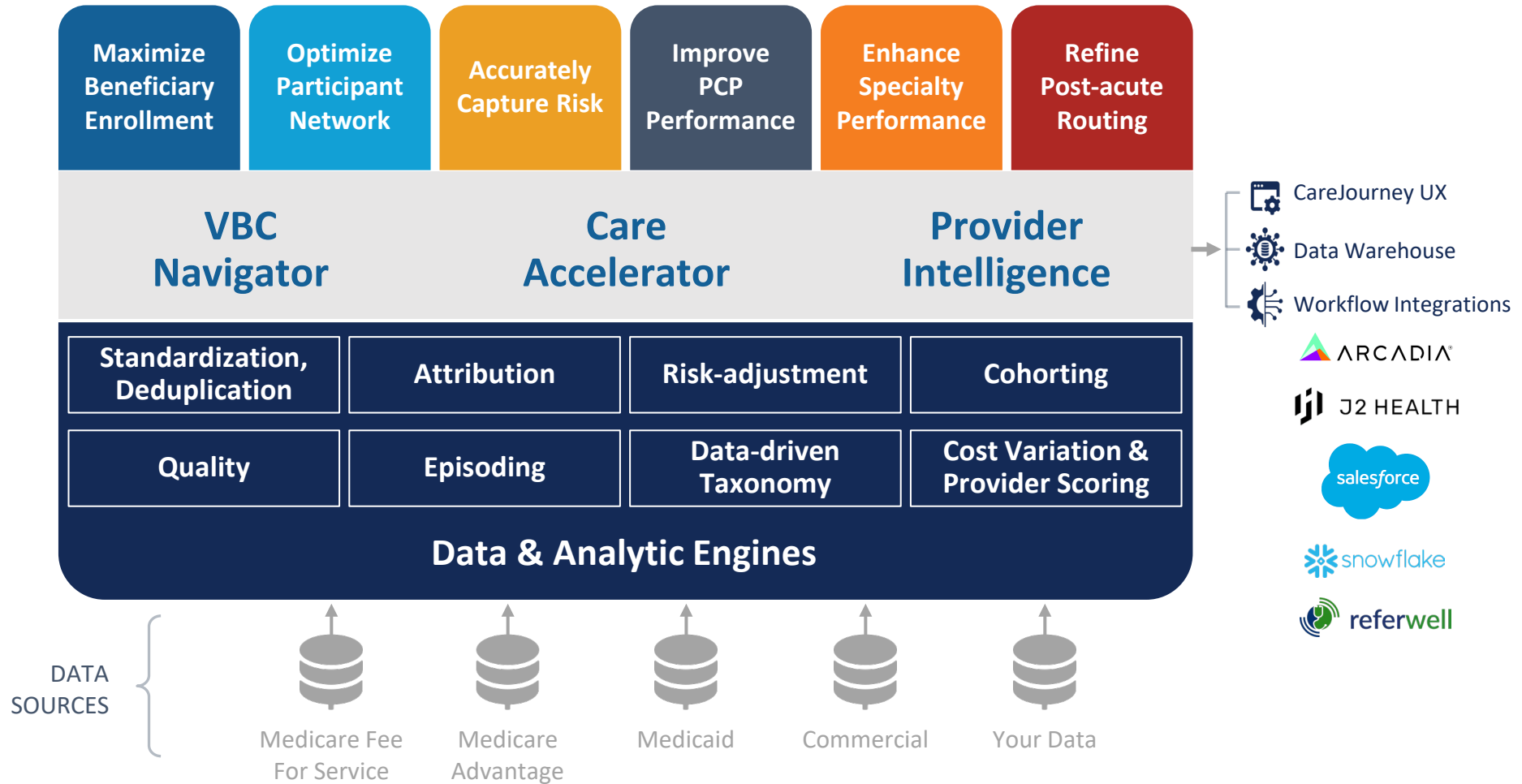
**Aneesh Chopra**
*Chief Strategy Officer*

**Keely Mulcahy**
*Sr. Director of Provider Intelligence*

**Erica Everhart**
*Head of Thought Leadership*

# Introducing CareJourney by Arcadia

| Maximize Beneficiary Enrollment | Optimize Participant Network | Accurately Capture Risk | Improve PCP Performance | Enhance Specialty Performance | Refine Post-acute Routing |
|---|---|---|---|---|---|

| VBC Navigator | Care Accelerator | Provider Intelligence |
|---|---|---|

- CareJourney UX
- Data Warehouse
- Workflow Integrations

ARCADIA

J2 HEALTH

salesforce

snowflake

referwell

| Standardization, Deduplication | Attribution | Risk-adjustment | Cohorting |
|---|---|---|---|
| Quality | Episoding | Data-driven Taxonomy | Cost Variation & Provider Scoring |

**Data & Analytic Engines**

DATA SOURCES

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- Commercial
- Your Data

Adding cost, quality, and benchmark insights to next-generation data platform, analytics, and workflow tools  Learn more
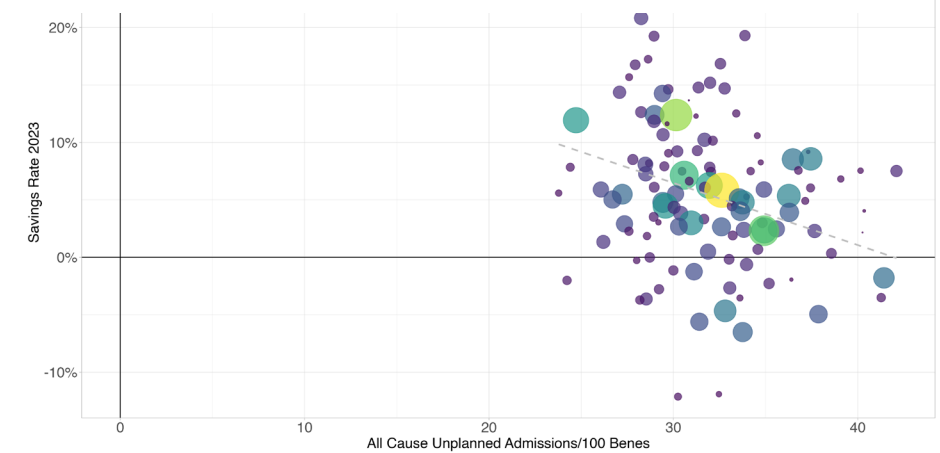
# The Unanswered "Why" on Drivers of Success

## Small correlation re: unplanned admissions, benchmark, and results



Components of Spend (PMPY) by REACH Savings Group 2023
With Average Benchmark

All Cause Unplanned Admissions vs ACO REACH Gross Savings Rates

Final Benchmark (PMPY) vs ACO REACH Gross Savings Rates

*Source: ACO REACH PUF.*

# A Look at CCM Patterns

*Top 12 CCM Billing Providers*

| Top Billing NPI | Sum of CCM Claims in 2023 | ACO Affiliation in 2023 |
|---|---|---|
| Provider 1 | 894,763 | No |
| Provider 2 | 94,416 | No |
| Provider 3 | 31,740 | Yes |
| Provider 4 | 29,024 | No |
| Provider 5 | 27,022 | No |
| Provider 6 | 26,361 | Yes |
| Provider 7 | 25,699 | Yes |
| Provider 8 | 20,140 | No |
| Provider 9 | 16,242 | Yes |
| Provider 10 | 13,771 | No |
| Provider 11 | 13,750 | No |
| Provider 12 | 13,403 | No |
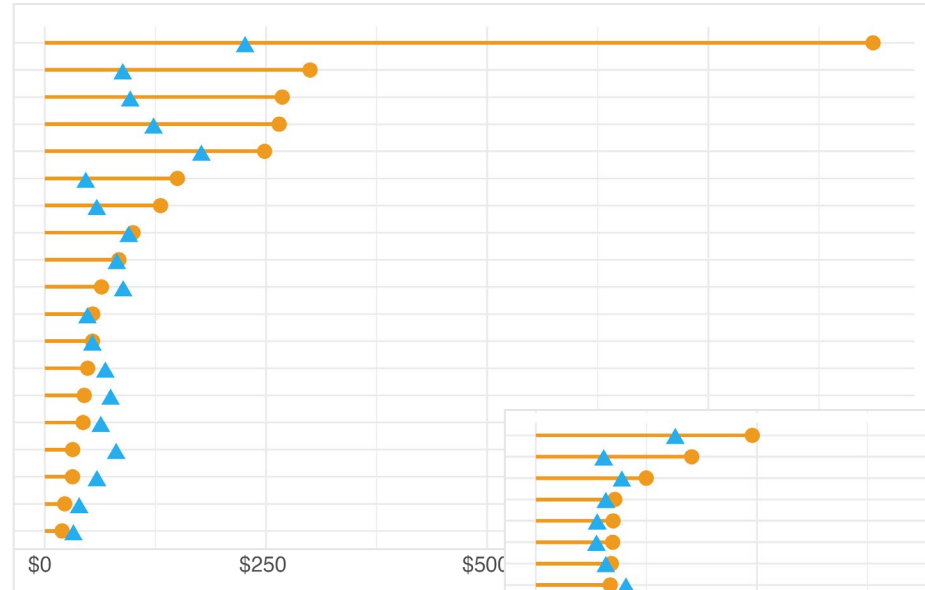
*Negative Savers Care Coordination per Frail Elder Observed v. Expected*
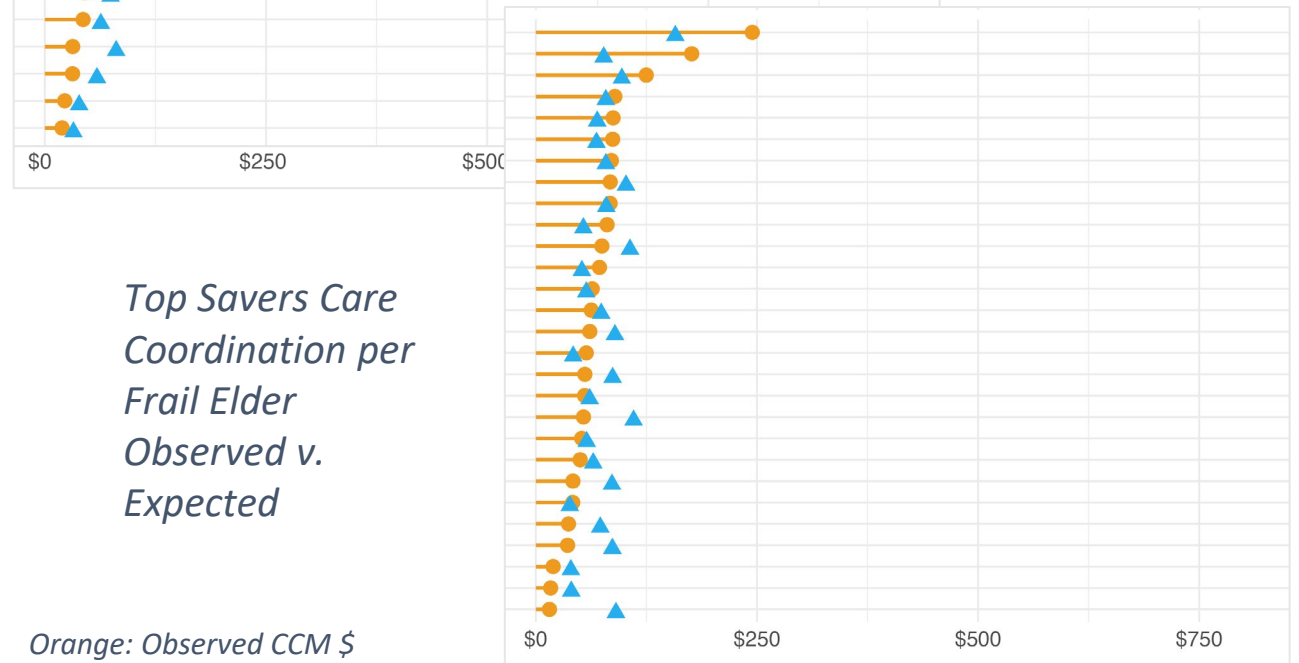
*Top Savers Care Coordination per Frail Elder Observed v. Expected*

*Orange: Observed CCM $*
*Blue: Expected CCM $*

# A Need For Transparent Episode Approach

## Patient Episoding and Segmentation

*Capturing 250+ acute, chronic, procedure and patient segment episodes*

**HARVARD**
SCHOOL OF PUBLIC HEALTH

**High-Need, High-Cost Segmentation Framework**

Developed by Jose F. Figueroa, MD, MPH at the Harvard T.H
Work Funded by the Commonwealth Fund

| Patient Segment | Attributable Patients |
|---|---|
| Moderate Morbidity | 24% |
| Frail Elderly | 23% |
| Complex Multimorbidity | 16% |
| Relatively Healthy | 10% |
| Major Disability | 9% |
| Minor Morbidity | 6% |
| Serious Mental Illness | 8% |

| Episode Name | Number of Episodes | Cost Score | Average Observed Cost | Average Expected Cost | Adjusted O/E Ratio | Opportunity | Average Observed vs Expected Cost |
|---|---|---|---|---|---|---|---|
| Spinal Fusion | 62 | 2 / 5 | $32,524 | $32,125 | 1.01 | $208,563 | |
| Back And Neck Pain Treatment Without Fusion | 37 | 1 / 5 | $12,354 | $11,108 | 1.11 | $77,300 | |
| Fracture/dislocation Treatment Pelvis/hip/femur | 27 | 5 / 5 | $28,309 | $38,629 | 0.73 | N/A | |

## Establishing an O:E Ratio



**Example Expected Episode Cost Calculation**

Observed Episode Cost — HCCs — Risk Factors (age, disabled status, ESRD, etc.) → Expected Episode Cost
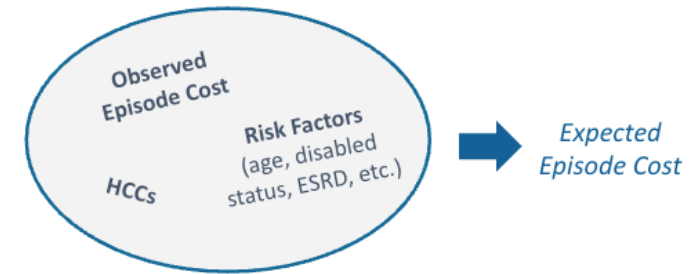
*The regression model differs slightly for each episode type – more information is available on the next slide.*

The "score" for each episode is then calculated as the observed vs. expected cost ratio within a CBSA.

**Attributed Provider for Cardiac Valve Episode**
Dr. Smith

Total Allowed: $3,204
Expected:* $3,500

**O/E = 0.915** for this particular population

# Top ACOs Best Manage Risky Patients

## Top Savers reduced treatment for most expensive patients by 17%.

| Frailty Cohort | Average Total Cost of Care: Observed to Expected, by Patient Segment *ACO REACH PY2023* | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| | **Negative Savers** | | | | **Top Savers** | | | |
| | % Pop | Obs. | Exp. | O:E | % Pop | Obs. | Exp. | O:E |
| **All** | 100% | $16,075 | $16,283 | 0.99 | 100% | $14,265 | $17,109 | 0.83 |
| **Frail Elders** | 23% | $28,902 | $28,887 | 1.00 | 27% | $24,099 | $28,958 | 0.83 |
| **People with complex multimorbidity** | 16% | $15,101 | $15,560 | 0.97 | 18% | $13,086 | $15,940 | 0.82 |
| **People with moderate morbidity** | 27% | $9,304 | $9,731 | 0.96 | 25% | $8,600 | $10,056 | 0.86 |
| **People with minor morbidity** | 7% | $6,929 | $7,391 | 0.94 | 5% | $6,039 | $7,082 | 0.85 |
| **Relatively healthy** | 8% | $6,450 | $7,089 | 0.91 | 4% | $5,989 | $6,663 | 0.90 |
| **People with serious mental illness** | 9% | $13,499 | $13,821 | 0.98 | 11% | $10,723 | $13,446 | 0.80 |
| **People with Major Disability** | 10% | $24,923 | $24,524 | 1.00 | 10% | $20,047 | $23,367 | 0.92 |

*Source: CareJourney research*

**Top Savers**: those ACOs attaining greater than 10% gross savings;
**Negative Savers**: those ACOs experiencing gross losses

# Top ACOs Keep Risky Patients Out of Hospital

## Top Savers prevented 20% of expected hospitalizations in a year

| Frailty Cohort | Unplanned Hospitalizations per 1000 Person-Years: Observed to Expected, by Patient Segment ACO REACH PY2023 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Negative Savers | | | | Top Savers | | | |
| | % Pop | Obs. | Exp. | O:E | % Pop | Obs. | Exp. | O:E |
| **All** | 100% | 237 | 232 | 1.02 | 100% | 203 | 259 | 0.78 |
| **Frail Elders** | 23% | 502 | 490 | 1.02 | 27% | 415 | 520 | 0.80 |
| **People with complex multimorbidity** | 16% | 172 | 173 | 0.99 | 18% | 143 | 190 | 0.76 |
| **People with moderate morbidity** | 27% | 287 | 299 | 0.96 | 25% | 226 | 292 | 0.78 |
| **People with minor morbidity** | 7% | 97 | 99 | 0.97 | 5% | 81 | 106 | 0.77 |
| **Relatively healthy** | 8% | 72 | 81 | 0.90 | 4% | 62 | 77 | 0.81 |
| **People with serious mental illness** | 9% | 197 | 204 | 0.97 | 11% | 132 | 204 | 0.65 |
| **People with Major Disability** | 10% | 414 | 396 | 0.98 | 10% | 327 | 407 | 0.88 |

*Source: CareJourney research*

# Top ACOs Effectively Manage Other Episodes

Top Savers significantly beat expected results across complications, ED visits, and admissions.

| | Average Episode Payment | | Complications | | Admissions/Readmissions | |
|---|---|---|---|---|---|---|
| | Negative Savers O:E | Top Savers O:E | Negative Savers O:E | Top Savers O:E | Negative Savers O:E | Top Savers O:E |
| **Coronary Artery Disease** | 0.99 | 0.96 | 0.96 | 0.88 | 1.00 | 0.94 |
| **Emphysema (COPD)** | 0.99 | 0.84 | 0.94 | 0.72 | 0.99 | 0.85 |
| **Heart Failure** | 0.96 | 0.81 | 0.91 | 0.70 | 0.99 | 0.83 |

*Source: CareJourney research*

# Success Amplified By Four Key Factors

## Peer Benchmarks

*A guidepost to frame your context and motivate performance*

## Open Approach

*Ability to unpack episodes, understand clinical nuance, and identify patients for impact*

## Parallel Analytics on Your Data

*Tracking real time during an episode to identify earliest intervention possibility*
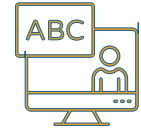
## Integration into Workflow

*Opportunity to drive action without an added burden*

# Driving Action Through Insight

## Uncovering variation + prioritizing intervention

**Michael's CHF Episode Timeline**
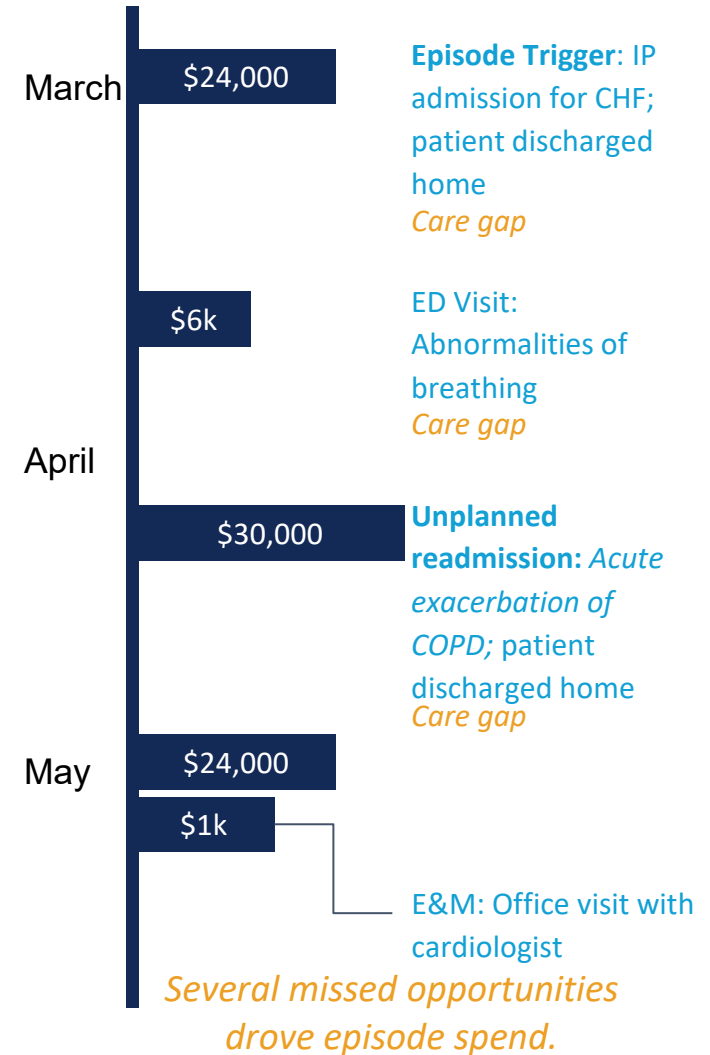


*For our cardiology group of interest: Understand high-cost patient CHF episode outliers to identify specific interventions*

**Michael**
*Male, 70 yo*

**HCC Score**

1.15

**Care Gaps**

*Risk assessment*
*Medication Reconciliation*
*Care Plan Adherence*
*Patient Education*

*Michael's episode spend is 3x higher than the practice average*

**March** — $24,000 — **Episode Trigger**: IP admission for CHF; patient discharged home *Care gap*

$6k — ED Visit: Abnormalities of breathing *Care gap*

**April**

$30,000 — **Unplanned readmission:** *Acute exacerbation of COPD;* patient discharged home *Care gap*

**May** — $24,000

$1k — E&M: Office visit with cardiologist

*Several missed opportunities drove episode spend.*

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FEBRUARY 25 + 26

**VBC Analytics Certificate**

By participating in this program, you will learn how to use data and analytics to:

- Increase your understanding of alternative payment models.
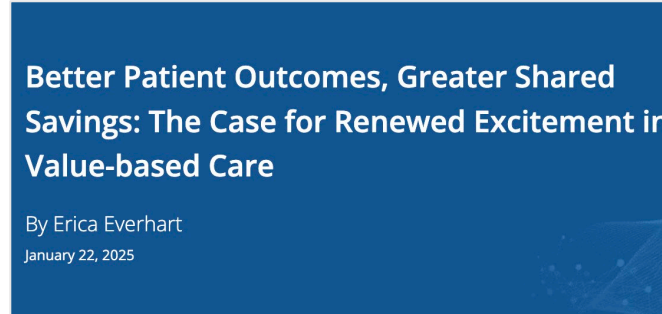- ICON-Bars Evaluate value-based care models that improve patient outcomes.
- Design and manage highly-functional networks of providers and facilities.

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## CATCH UP ON OUR RECENT CONTENT:

**Better Patient Outcomes, Greater Shared Savings: The Case for Renewed Excitement in Value-based Care**

By Erica Everhart

January 22, 2025

Controlling the rapidly increasing costs of healthcare is fraught with ethical conundrums, particularly around limiting access to care. After all, there are only so many ways to reduce healthcare costs – largely boiling down to (1) reducing utilization or (2) reducing the cost of services. Of the two options, reducing utilization was the focus of healthcare reform over the last decade.

In some cases, inadequate provider networks limit the number of "in-network" providers reducing the number of beneficiaries who can feasibly receive care covered by their insurance plan in a year. In other instances, a practice called prior authorization requires the insurance company's approval of care in advance. These utilization management practices engender strong emotions from people who feel their health, or

Read the details of how we partner for care gaps and beyond here.

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