Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment

Presenters:

Subject Matter Experts

- **Robby Knight, MBA, MS, MSW** – Co-Founder and Chief Executive Officer, Soda Health

- **Clay Johnston, MD, PhD, MPH** – Co-Founder and Chief Medical Officer, Harbor Health

- **Paul Berggreen, MD** – Chief Strategy Officer, GI Alliance, and Founder and President, Arizona Digestive Health

- **Kaitlyn Pauly, MS, RDN, DipACLM** – Chief Integration Officer, American College of Lifestyle Medicine

Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment

Robby Knight, MBA, MS, MSW

Co-Founder and Chief Executive Officer,
Soda Health

Robby Knight
CEO, Co-Founder

soda
health

Deliver benefits and rewards seamlessly on one customizable Smart Benefits card

Card Capabilities

Item-level, MID and MCC restrictions

Unlimited benefit purses

Distinct purses or super purse

Custom approved product lists

**Differentiated Payments Tech**

Real-time incentives and rewards

Patient-level reporting / insights

Dynamically unlock new benefits

Integrated engagement (SMS)

SDOH screening + intervention

Transportation

Co-pay assistance

In-home modifications

OTC

Utilities assistance

Grocery

debit

Rewards

&more™

Fitness

Vision

General spend

Hearing

Dental
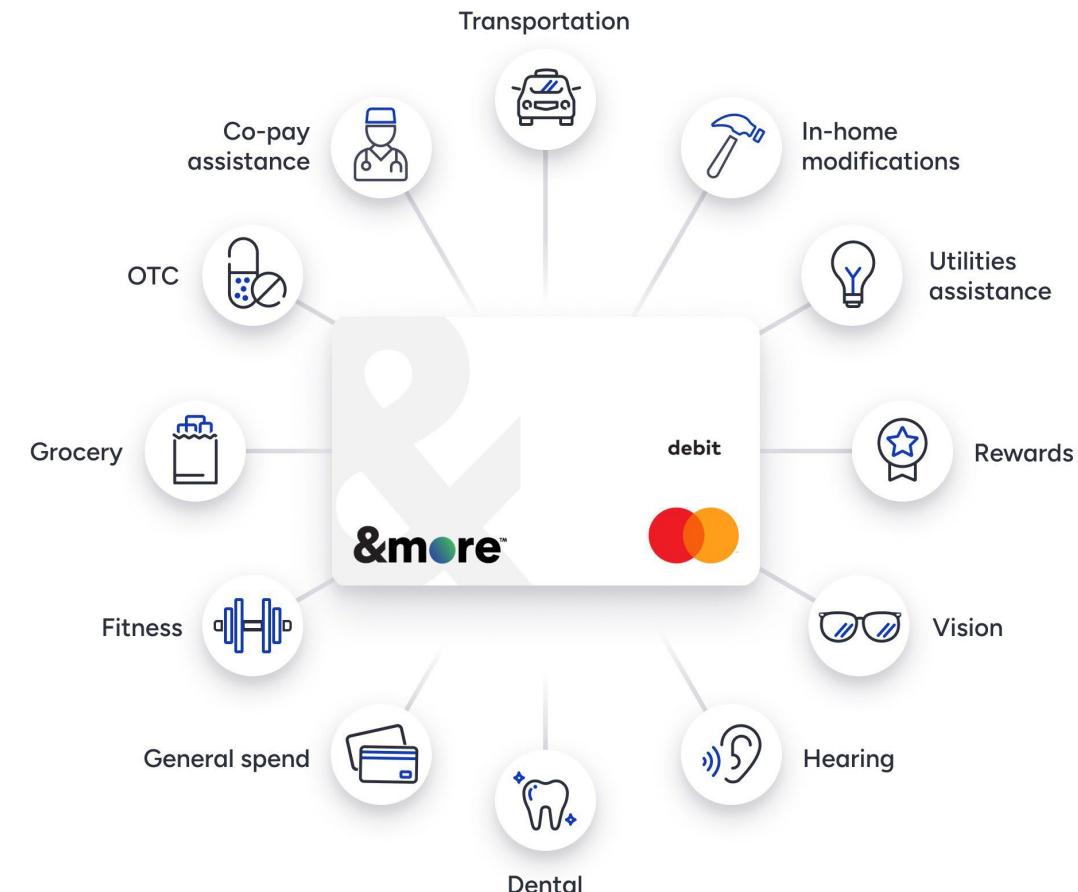
Drive behavior change and close care gaps with our dynamic engagement platform

Step 1:
Introduce participants to the reward experience

Step 2:
Engage participants through digital and in-person channels to close care gaps

Step 3:
Create a virtuous feedback loop

Smart Benefits Cards mailed, participants register for program

Personalized outreach to encourage activity

Convenient digital surveys unlock instant rewards

Activity completion tracked

Issue rewards instantly

Turn points of purchase into points of care
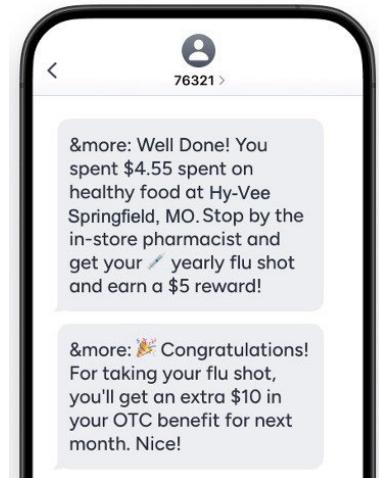
The Soda Health experience

Check your up-to-date benefit balance

See which items you've purchased in the past

Find the most convenient stores to shop

Know whether your items are eligible before you get to the register
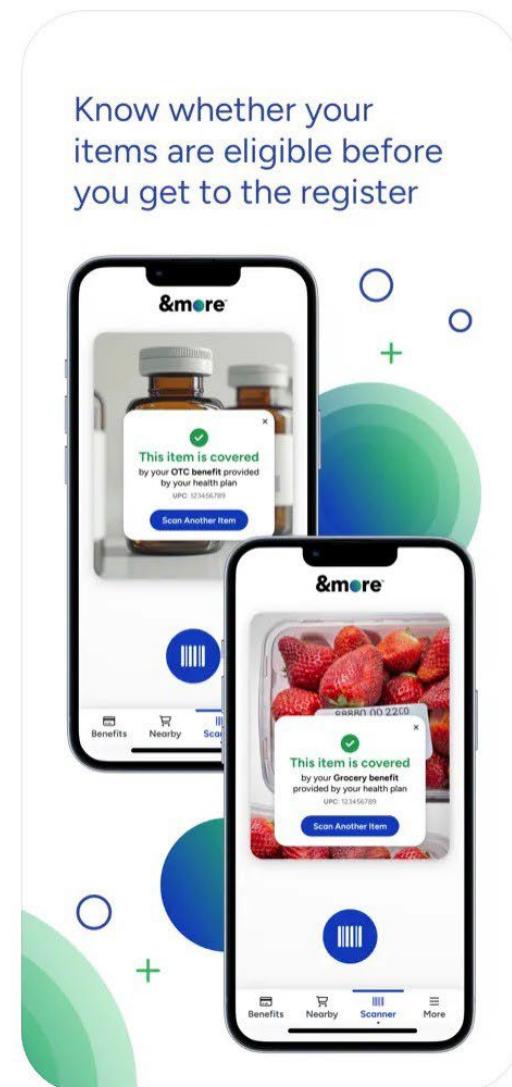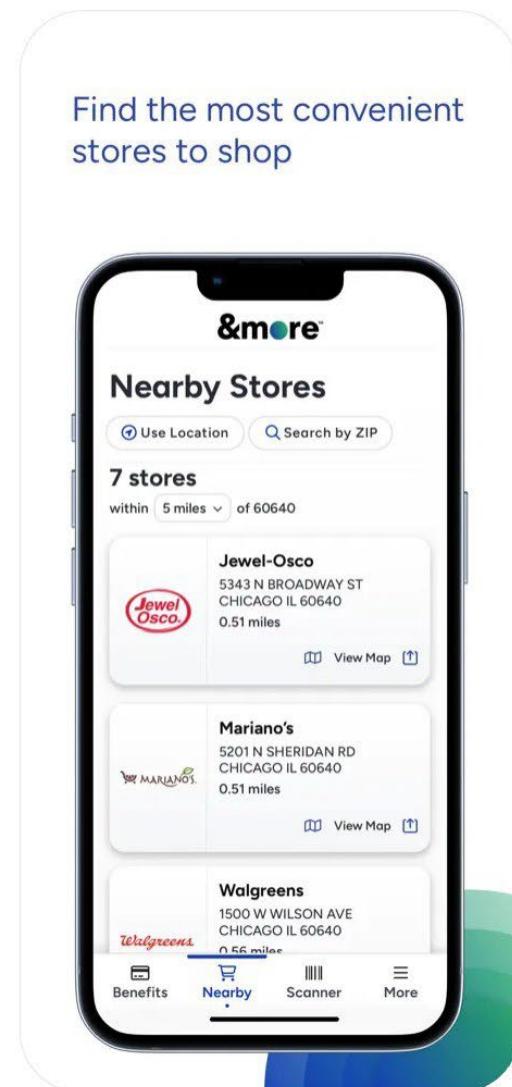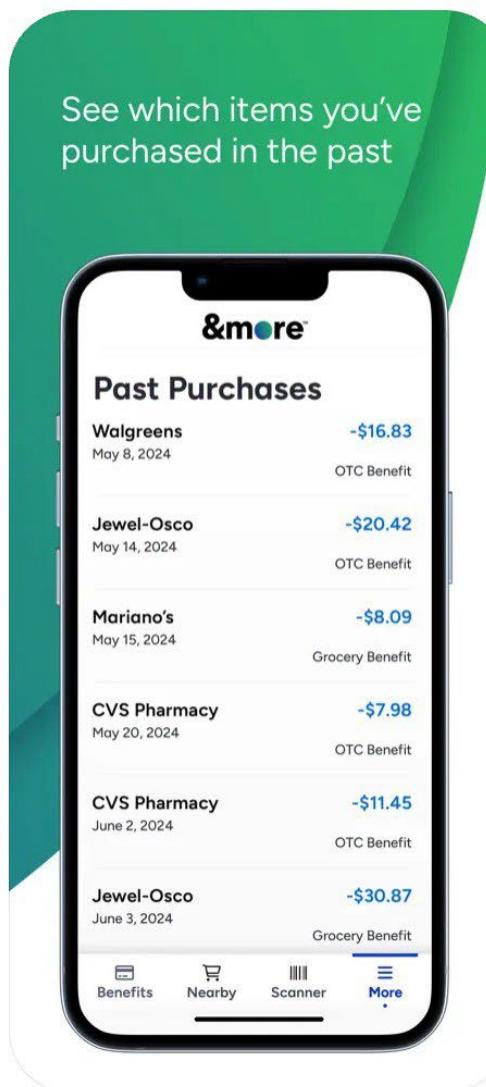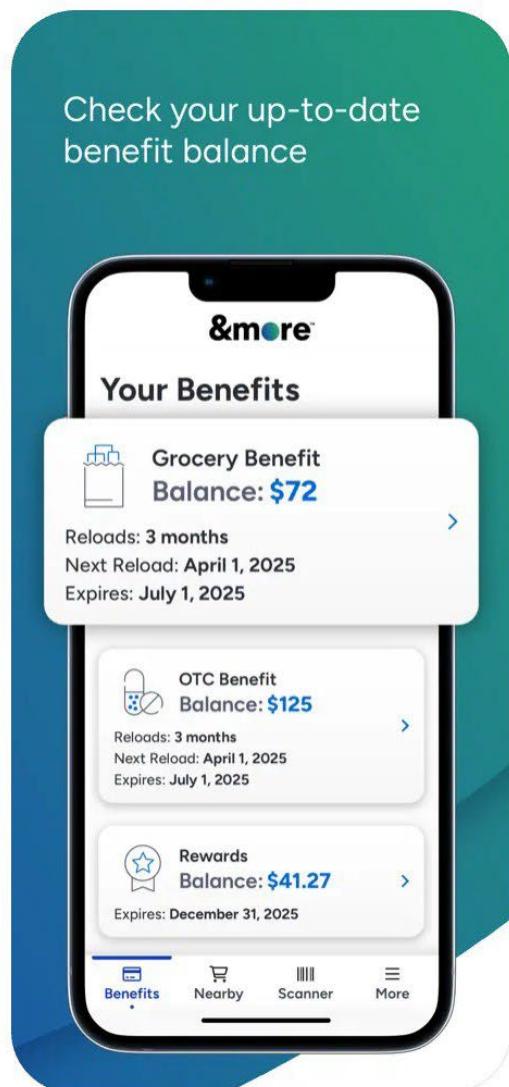
Gain real-time visibility into your program and track participant progress over time

View all details about your program, including benefit dollars available, dollars spent by retailer and by item, and more
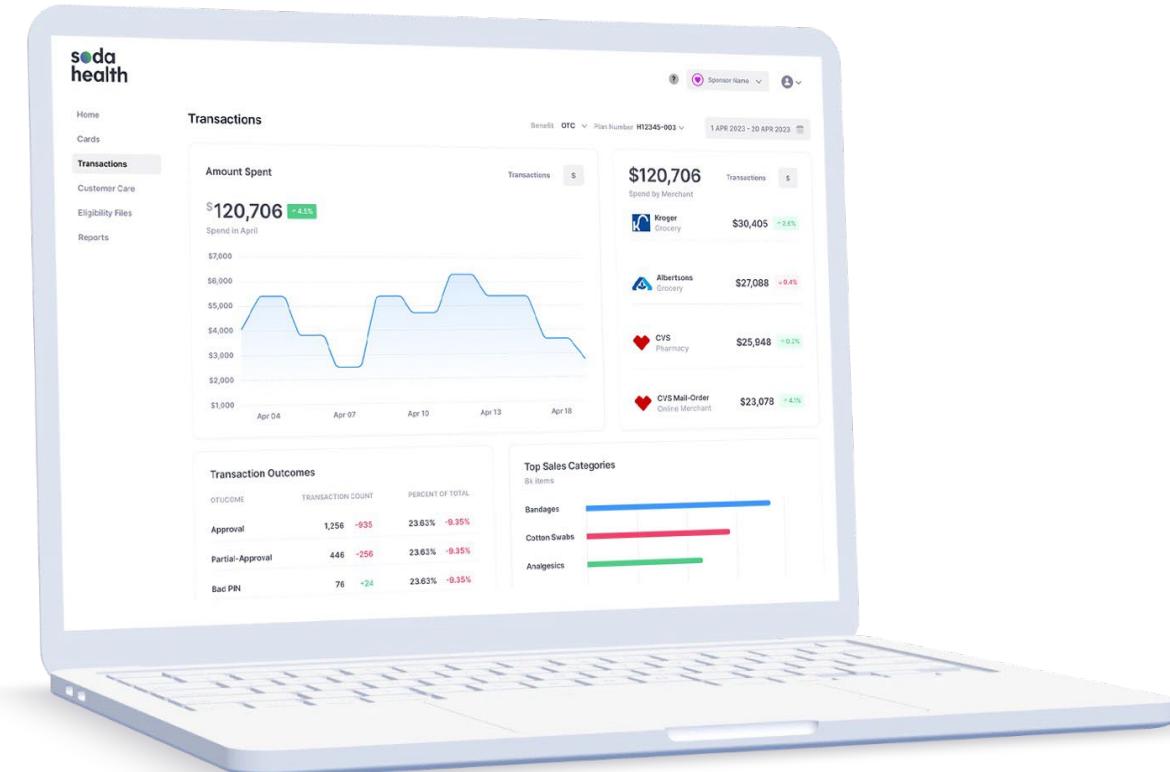
Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment

Clay Johnston, MD, PhD, MPH

Co-Founder and Chief Medical Officer,
Harbor Health

Aligning Member Incentives

S. Claiborne Johnston
CMO Harbor Health

Harbor is a vertically integrated payvider focused on Texas

Designed for people not patients

Organized around **health journeys and conditions** (not doctors, hospitals or drugs)
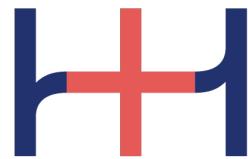
Built on risk transfer payments to the only agents who can really change the risk - **people teaming up with their clinicians and coaches**

Powered by modern **clinical intelligence informing smart subsidization** so that health journeys become faster, cheaper and way better

Delivered to the **communities** people live in. We started in Austin

Our Care Model

- Team-based and multispecialty organized by conditions

- Multi-layered consumer touchpoints across asynchronous, virtual, physical and referral encounters automated with clinical intelligence to create seamless health experiences
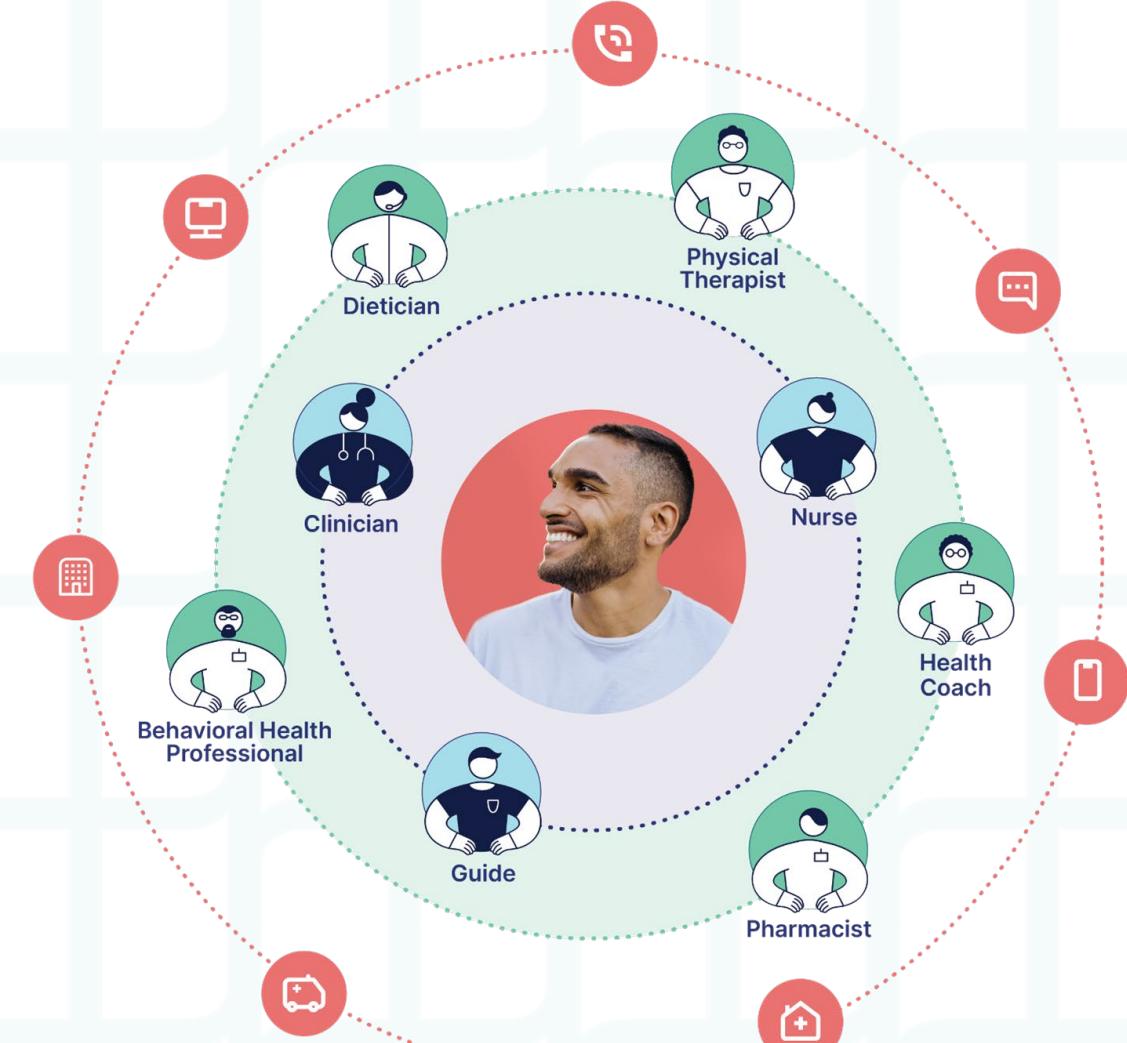
We are flipping the US healthcare system on its side
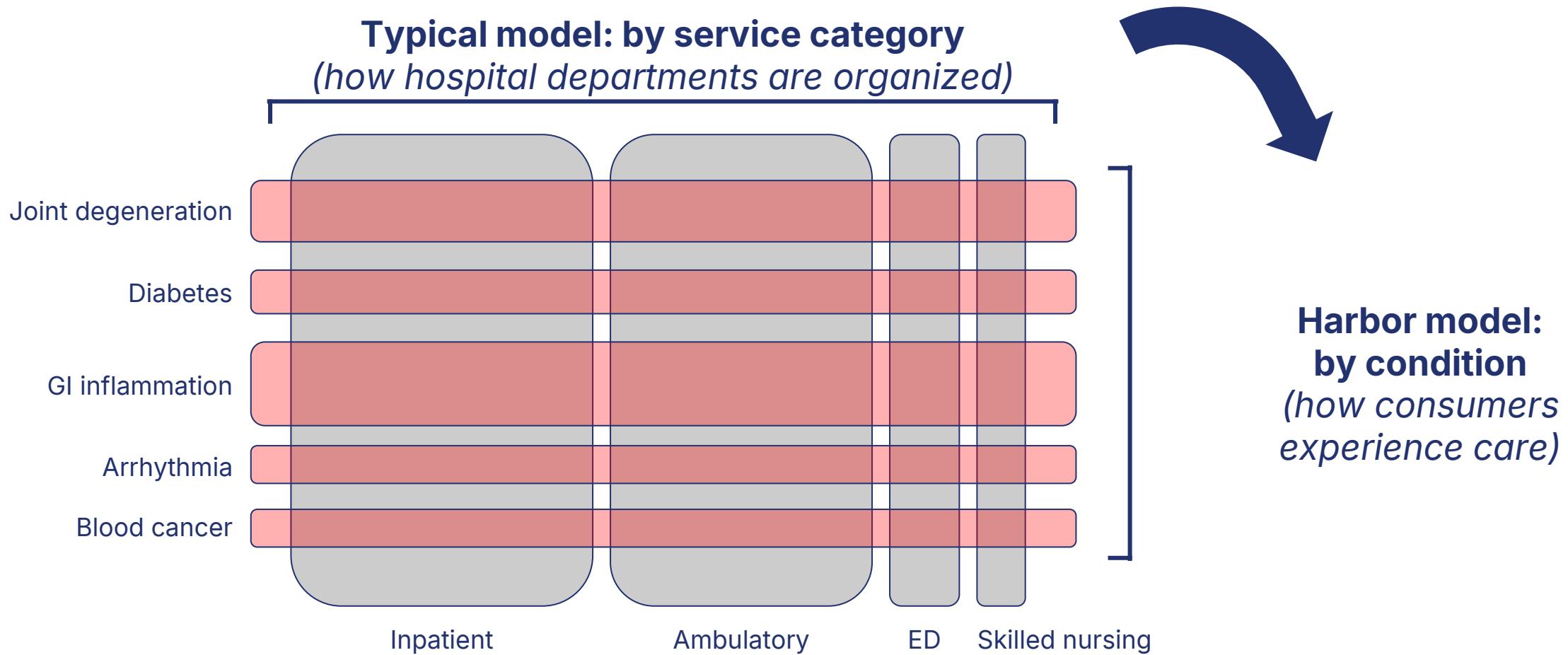
Typical model: by service category
(how hospital departments are organized)

Joint degeneration

Diabetes

GI inflammation

Arrhythmia

Blood cancer

Inpatient

Ambulatory

ED Skilled nursing

**Harbor model:
by condition**
*(how consumers
experience care)*

It's hard to know the best specialists

Where should we send a member for an ablation?

Specialist	Group	Health Grades
Specialist A	St. David's	4.9
Specialist B	St. David's	4.9

It's hard to know the best specialists

Where should we send a member for an ablation?

Specialist	Group	Health Grades	Quality score *(out of 10)*	Average cost
Specialist A	St. David's	4.9	8.01	$105,357
Specialist B	St. David's	4.9	8.32	$44,358

* Quality score includes measures such as surgical complication rates and adherence to guidelines.

There are always big spreads in quality & cost (...and they aren't related!)

Austin cardiologists (ablations)
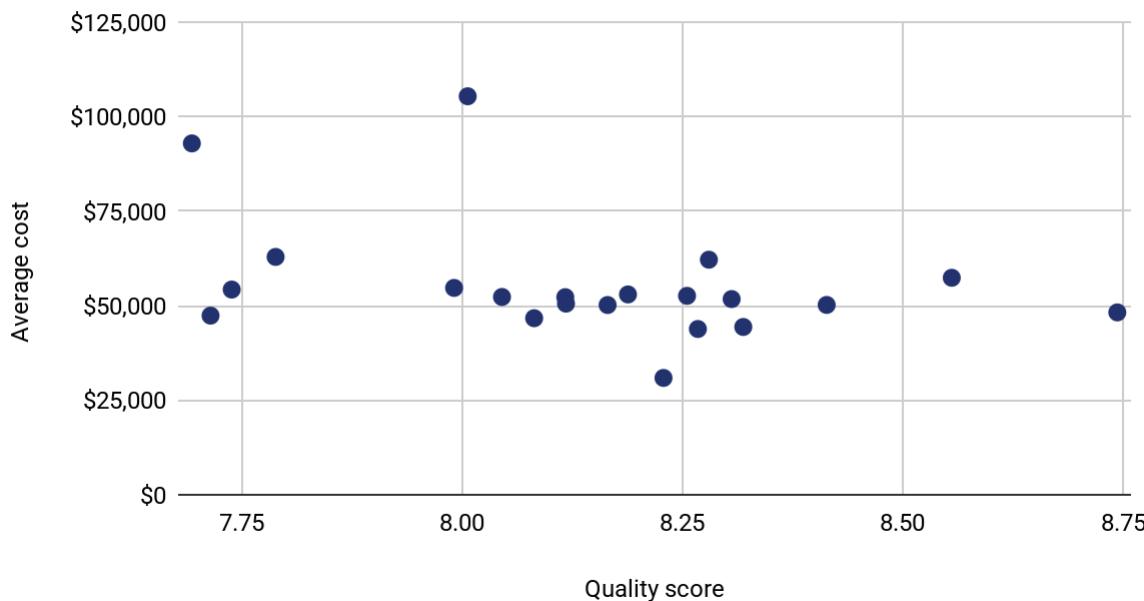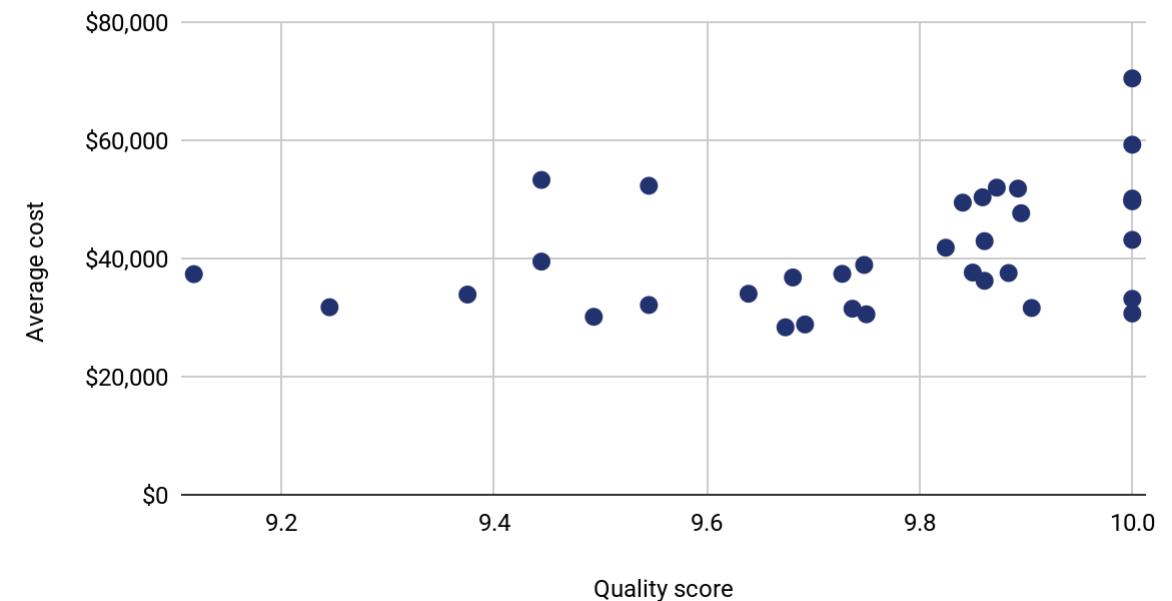
Austin orthopedists (knee replacement)

* **Quality score** includes measures such as surgical complication rates and adherence to guidelines.

We can reduce copay for good choices

Austin cardiologists (ablations)
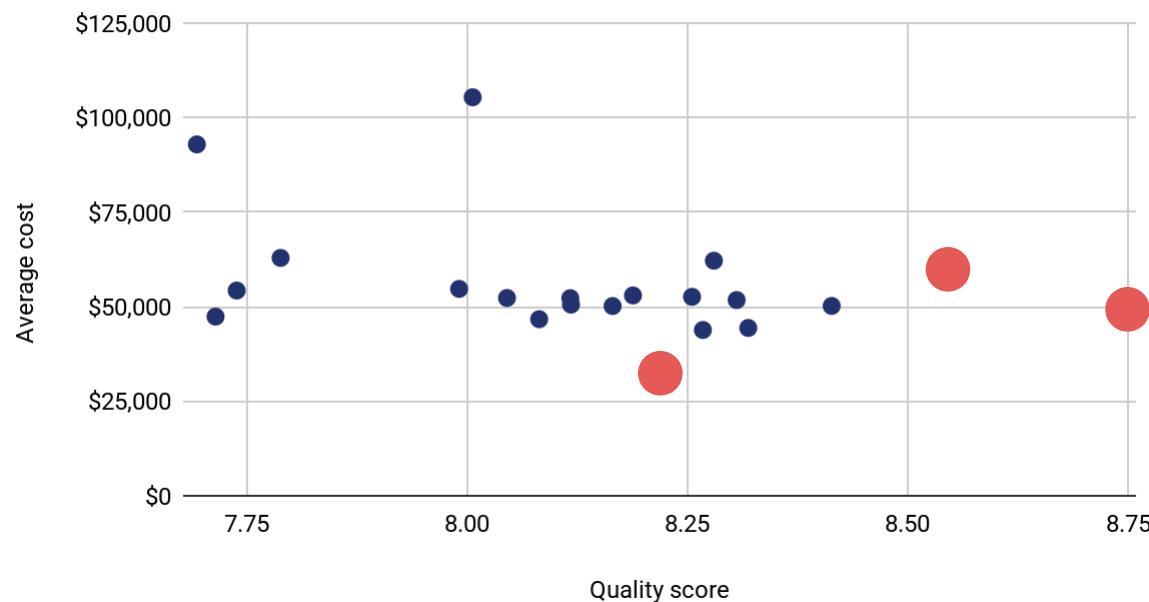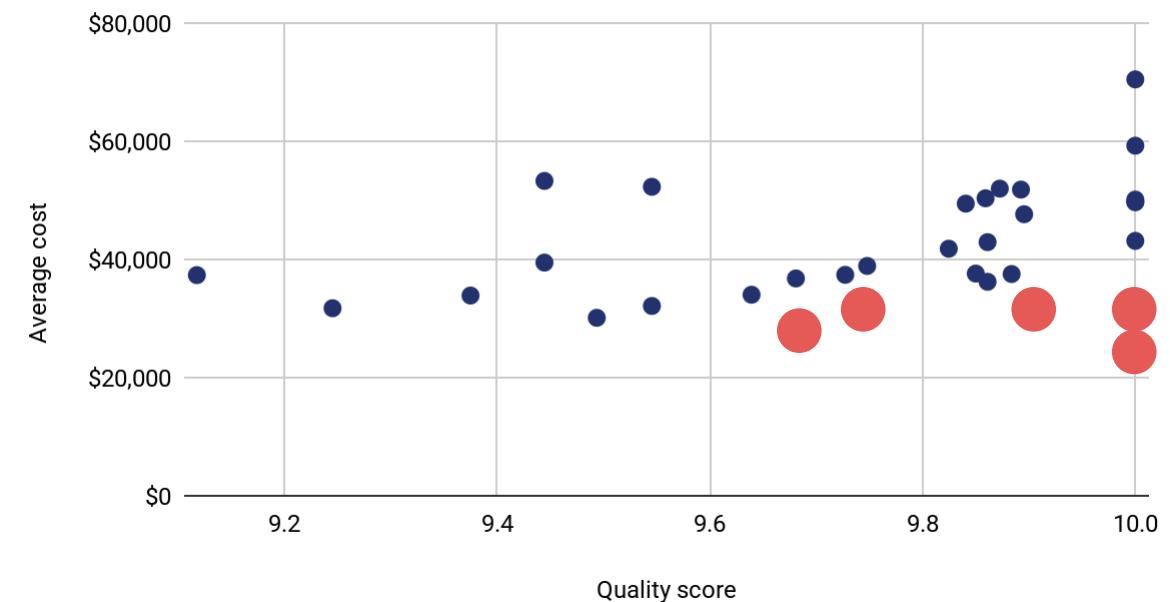

Austin orthopedists (knee replacement)

* **Quality score** includes measures such as surgical complication rates and adherence to guidelines.

$0 Copay

Financial Incentives for Members to Follow the Best Path

Knee MRI
Copay: **$$$$**

Off Health Pathway

Knee MRI
Copay: **$0**

On Health Pathway

Knee pain!

Injection
Copay: **$50**

Physical Therapy:
Copay: **$0**

Treatment Path

Specialized Rehab:
Copay: **$0**
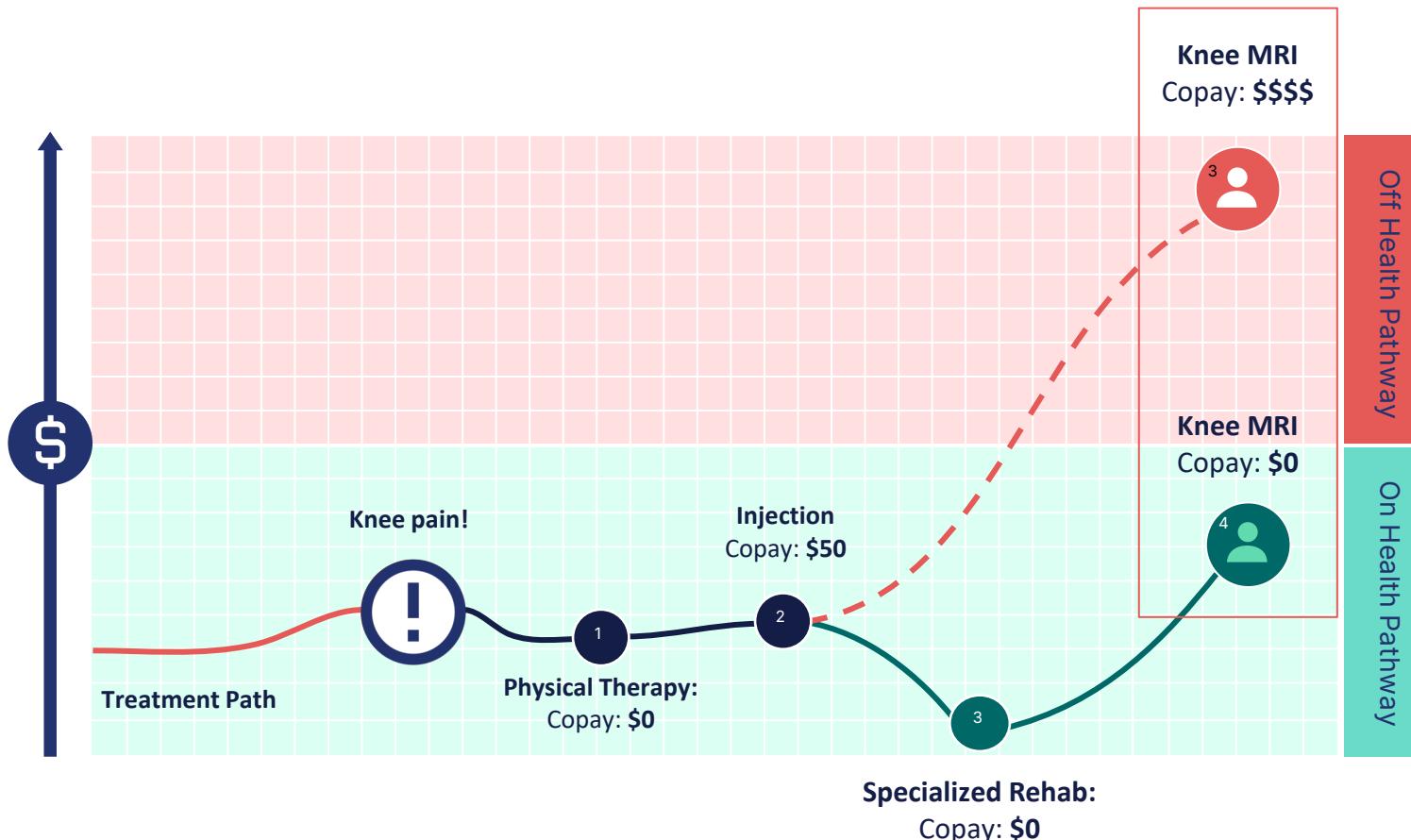
Designing benefit coverage from scratch:

- Personalized care journeys with Harbor Health pathways
- Know exact costs in advance
- Try conservative treatments first
- Use high value, effective treatments and providers (NPI driven)
- Coverage that costs you nothing but your premium when you follow our guidance.
- Care team you trust guiding you through the process

Harbor is Not Alone in Incentivizing Good Choices

Other New Insurers in Texas

- **Curative**
  - Initial onboarding visit required to reduce deductible to $0.

- **Everly**
  - Rewards card loaded when activity documented
    - $100 for health survey
    - $50 to enroll in wellness program
    - $50 to enroll in exercise program
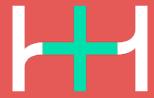
Thank you!

Physician-Focused Payment Model Technical Advisory Committee

Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment

Paul Berggreen, MD

Chief Strategy Officer,
GI Alliance,
and Founder and President,
Arizona Digestive Health

Paul Berggreen, MD

Chief Strategy Officer The Specialty Alliance

Improving Delivery of Clinical Value
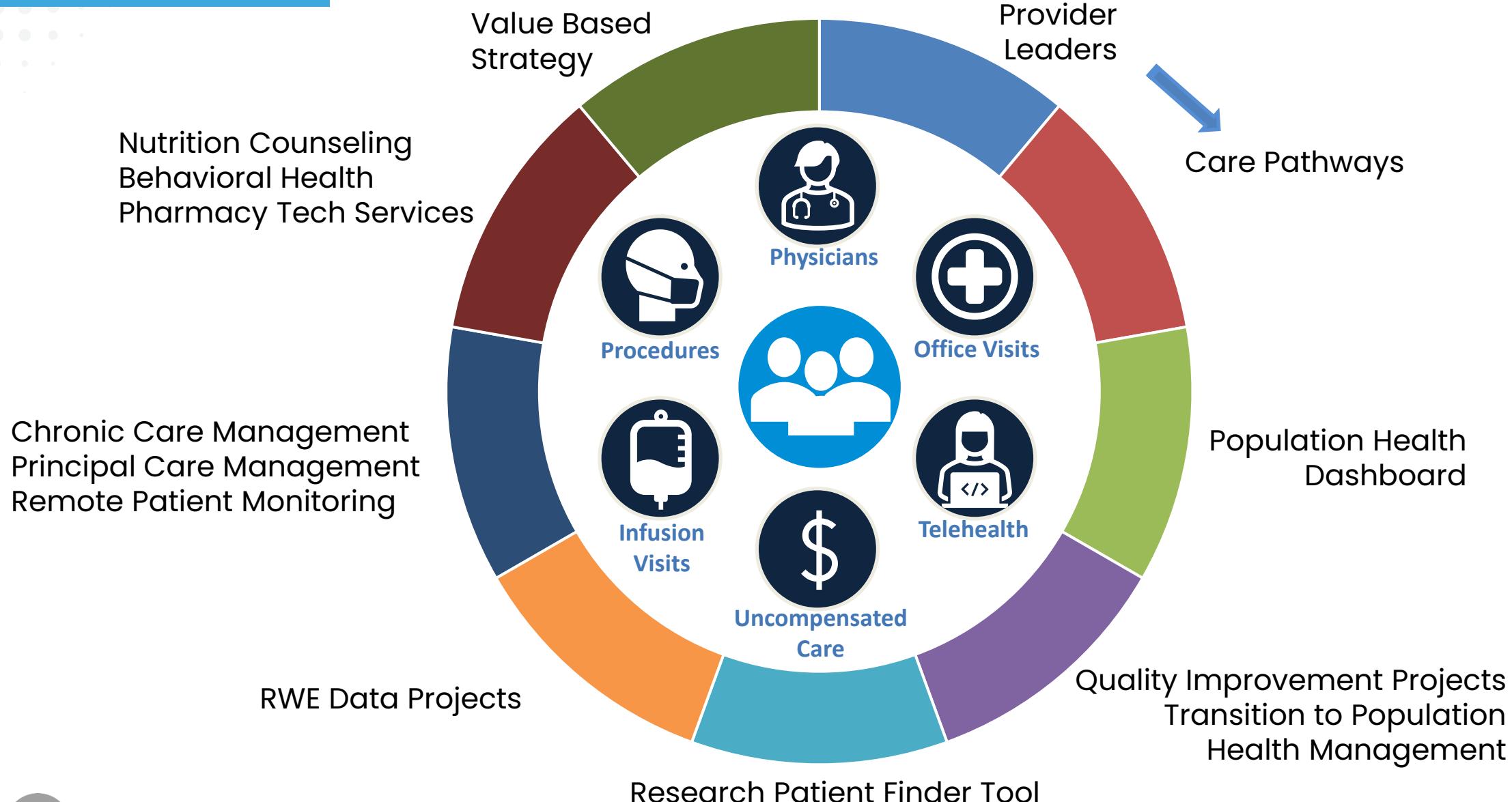
PPS Analytics for GI

Total Patients 2,078,800

Appointments and Recalls

On Recall list
(All) ▾

Appointment Scheduled
(All) ▾

Office Visit Within Last Year
(All) ▾

Demographics

Gender

Female	1,233,540
Male	864,650
Unknown	1,150

Age 4 — 123

0 - 20	40,644
21 - 30	136,963
31 - 40	198,798
41 - 50	289,202
51 - 60	370,312
61 - 70	478,494
71 - 80	432,578
81+	168,277

Plan Name
(All) ▾

Follow-Up Scheduled
- Yes
- No
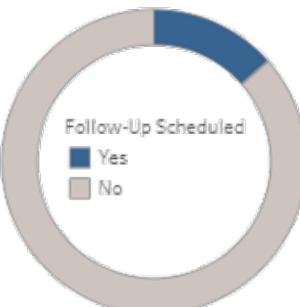
IBD

114,230 Patients

Ulcerative Colitis	51,464
Crohn's	46,760
Lymphocytic Colitis	14,076
Collagenous Colitis	9,402
Indeterminate IBD	2,523
Other Microsocopic Coli..	1,474

Time Since Last Encounter

Within 12 months	75,177
Over 12 months	39,108

Years Since Last Colonoscopy

<1	31,988
1 - <2	26,061
2 - <4	23,994
4 - <6	4,237
>6	1,110
No Data	26,949

CCM Patients

No	1,498
Yes	112,737

Colon Pathology

706,474 Patients

Benign Neoplasm	971,204
Polyp of Colon	334,852
Family History	55,545
Personal History	25,704
Colon Cancer	10,872

Time Since Last Encounter

Within 12 months	323,614
Over 12 months	385,917

Years Since Last Colonoscopy

<1	227,351
1 - <2	213,988
2 - <4	212,742
4 - <6	30,685
>6	7,069
No Data	19,301

CCM Patients

No	3,897
Yes	702,698

Functional GI

236,278 Patients

IBS	194,577
Functional dyspepsia	45,059
Anxiety	30,956
Depression	9,014
Functional diarrhea	6,008
Functional Intestinal Disorders	1,692

Time Since Last Encounter

Within 12..	131,271
Over 12 m..	105,285

Years Since Last Colonoscopy

<1	41,787
1 - <2	
2 - <4	47,684
4 - <6	
No Data	93,224
>6	

Months Since Last EGD

<6	17,488
>6	101,117
No Data	117,977

CCM Patients

No	3,457
Yes	232,837

Chronic Liver DZ

332,390 Patients

Obesity	305,838
NAFLD	140,034
Chronic Liver	45,187
NASH	19,903
Alcoholic liver disease	17,843
Chronic viral hepatitis C	12,280
Chronic viral hepatitis B without delta-agent	7,707
Autoimmune hepatitis	3,798
Primary sclerosing cholangitis	1,234

Time Since Last Encounter

Over 12 months	152,981
Within 12 months	180,189

Months Since Last Scan

<6	3,284
>6	19,743
No Data	309,699

CCM Patients

No	5,573
Yes	326,885

Esophageal DZ

870,272 Patients

Gastro-Esophageal	796,442
Esophageal obstruction	129,298
Barrett's	100,828
Eosinophilic esophagitis	38,865
Other specified diseases of esophagus	22,995
Ulcer of esophagus without bleeding	28,118
Esophageal disease	20,197
Disease of esophagus,	15,346

Time Since Last Encounter

Over 12 months	424,632
Within 12 months	449,863

Months Since Last EGD

<6	92,682
>6	491,662
No Data	290,407

CCM Patients

No	6,628
Yes	863,805

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IBD Dashboard

Total Patients: 108,413

Active Patient: Active

Source System: (Multiple values)
Provider Group Name: (All)
Provider Name: (All)

Reset

Appointments and Recalls

Recall Scheduled: (All)
Appointment Scheduled: (All)
Office Visit In Last Year: (All)
Overdue Recall: (All)

Demographics

Gender: (All)
Age: 0 — 125
Plan Name: (All)

Filters

Diagnosis
Primary: (All) **Secondary:** (All)

Test & Results Filters
Fecal - Months Since: (All) **Fecal Cal - Trend:** (All)
CRP - Months Since: (All) **CRP - Trend:** (All)
Albumin - Months Sin...: (All) **Albumin - Trend:** (All)
HGB - Months Since: (All) **HGB - Trend:** (All)
On Oral Steroids: (All) **Months on Oral Steroid:** (All)
Years Since Colonosc...: (All) **Months Since Hep B:** (All)
TB Test Results: (All) **Months Since TB:** (All)
Vitamin D Labs: (All) **Months Since Vitamin D:** (All)

Medication (All)

Drug Class: (All) **Description:** (All)

Earliest Medication Date: January 2005 — March 2025
Latest Medication Date: April 2005 — December 2024

Medication	Count
ORAL MESALAMINE	43,166
BUDESONIDE	38,619
PREDNISONE	31,978
NO MEDICATION	18,130
HUMIRA	14,334
REMICADE	11,337
ENTYVIO	10,837
CANASA	10,021
AZATHIOPRINE	9,877
STELARA	8,079
SULFASALAZINE	6,506
ROWASA	5,444
BALSALAZIDE	4,671
METHOTREXATE	3,610
SKYRIZI	3,598
RINVOQ	3,428
MERCAPTOPURINE	3,303
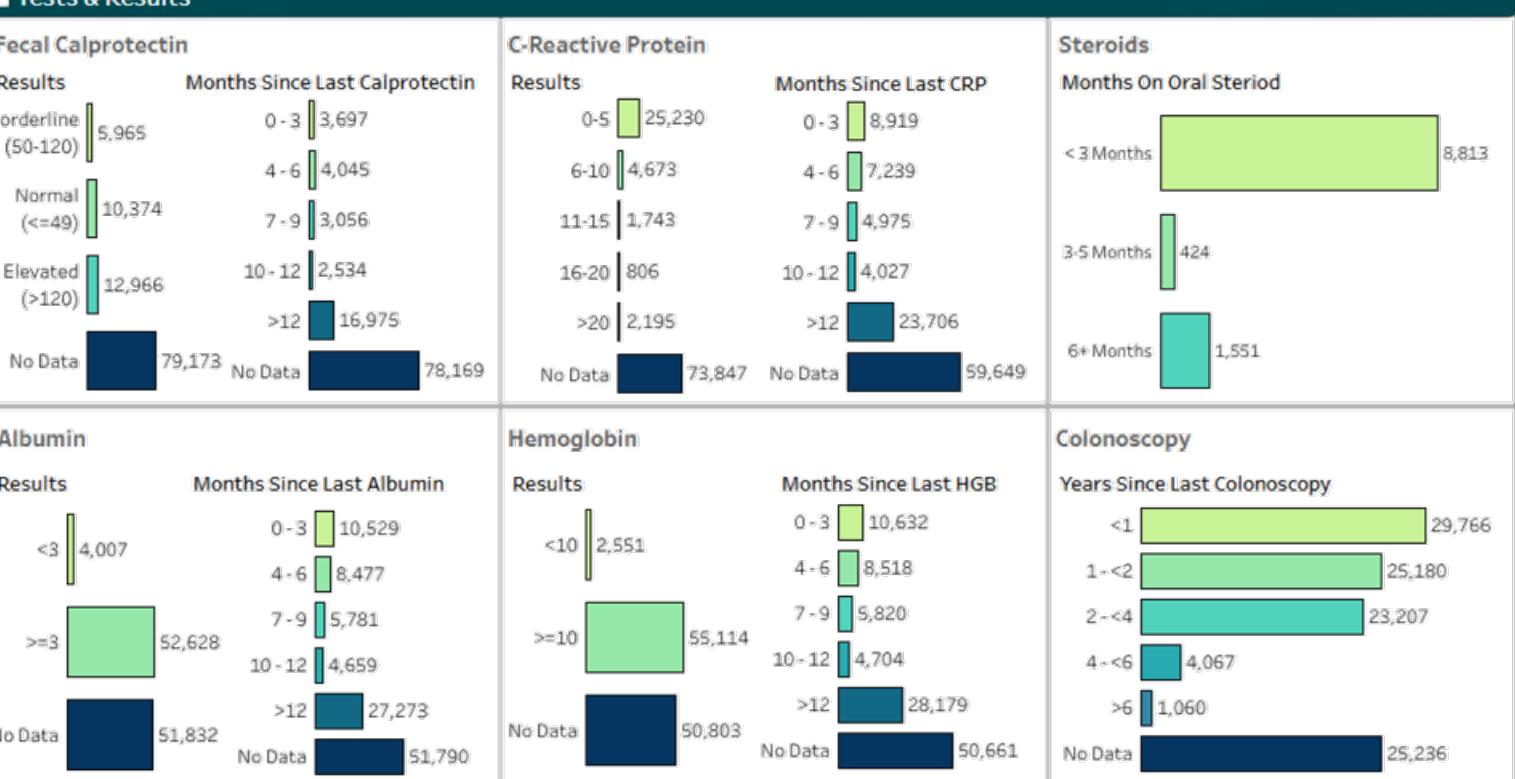
Chronic Care Management (CCM)

CCM Status:
Status	Count
CCM Candidate	39,296
CCM Inactive	1,872
CCM Patient	1,469
Ineligible	65,853

Months Since Last:
Months	Count
0 - 2	788
3 - 6	681
7 - 9	181
10 - 12	118
>12	1,573

Tests & Results

Fecal Calprotectin

Results:
Result	Count
Borderline (50-120)	5,965
Normal (<=49)	10,374
Elevated (>120)	12,966
No Data	79,173

Months Since Last Calprotectin:
Months	Count
0 - 3	3,697
4 - 6	4,045
7 - 9	3,056
10 - 12	2,534
>12	16,975
No Data	78,169

C-Reactive Protein

Results:
Result	Count
0-5	25,230
6-10	4,673
11-15	1,743
16-20	806
>20	2,195
No Data	73,847

Months Since Last CRP:
Months	Count
0 - 3	8,919
4 - 6	7,239
7 - 9	4,975
10 - 12	4,027
>12	23,706
No Data	59,649

Steroids

Months On Oral Steroid:
Duration	Count
< 3 Months	8,813
3-5 Months	424
6+ Months	1,551

Albumin

Results:
Result	Count
<3	4,007
>=3	52,628
No Data	51,832

Months Since Last Albumin:
Months	Count
0 - 3	10,529
4 - 6	8,477
7 - 9	5,781
10 - 12	4,659
>12	27,273
No Data	51,790

Hemoglobin

Results:
Result	Count
<10	2,551
>=10	55,114
No Data	50,803

Months Since Last HGB:
Months	Count
0 - 3	10,632
4 - 6	8,518
7 - 9	5,820
10 - 12	4,704
>12	28,179
No Data	50,661

Colonoscopy

Years Since Last Colonoscopy:
| Years	Count
<1	29,766
1 - <2	25,180
2 - <4	23,207
4 - <6	4,067
>6	1,060
No Data	25,236

Patient List

Download... | Name: | MRN:

MRN	Patient Name	Date Of Birth	Provider Name	Last Encounter Date	Appointment Date	Next Recall	Overdue Recall Date	CCM Last Date	Colonoscopy Last Date	Ca T
10BL			Kulkarni, Aparna	3/20/2024	3/10/2025	Null	Null	Null	6/12/2023	
14BL			Kang, Kalle	6/5/2024	Null	Null	Null	Null	10/17/2023	
16BL			Yap, Eric	6/3/2024	Null	6/23/2025	Null	Null	6/20/2023	
23BL			Selinger, Roanne	11/12/2024	4/25/2025	Null	9/2/2023	Null	11/7/2023	
38.0C			Robertson, Jeffrey	2/12/2025	Null	4/19/2026	Null	Null	4/24/2024	
45BL			Ferguson, Craig	1/9/2023	Null	6/22/2033	Null	Null	6/20/2024	
96.0			Lacey, Brent	7/12/2024	3/14/2025	7/25/2025	Null	Null	7/25/2024	
131			Tsai, John	2/26/2025	3/13/2025	Null	3/1/2024	Null	2/5/2024	5/
134.0			Ramos, Christopher	3/1/2023	Null	2/25/2027	Null	Null	2/25/2025	1

4

IBD KPIs

Flowood:
Starting Rank: 2nd
Current Rank: 1st

DHAT Plano Preston Rd:
Starting Rank: 30th
Current Rank: 7th

San Antonio Camden:
Starting Rank: 74th
Current Rank: 37th

TDDC Plano:
Starting Rank: 23rd
Current Rank: 2nd

All WAGI:
Starting Rank: 43rd
Current Rank: 20th

ADH Coronado:
Starting Rank: 38th
Current Rank: 3rd

Patient Attrition: Patient Tracking

501 Patients Found to be Inactive

Patient Declined Appointment 21, 4%

Transferred Care 175, 35%

Moved Away 115, 23%

Unreachable 190, 38%

407 Patients Scheduled

297 E&M Visits

196 CBC Labs

195 CMP Labs

181 CRP Labs

97 Calprotectin Labs

65 Colonoscopy

57 Biologic

32 Small Molecule

45 Steroids

45 5-ASA
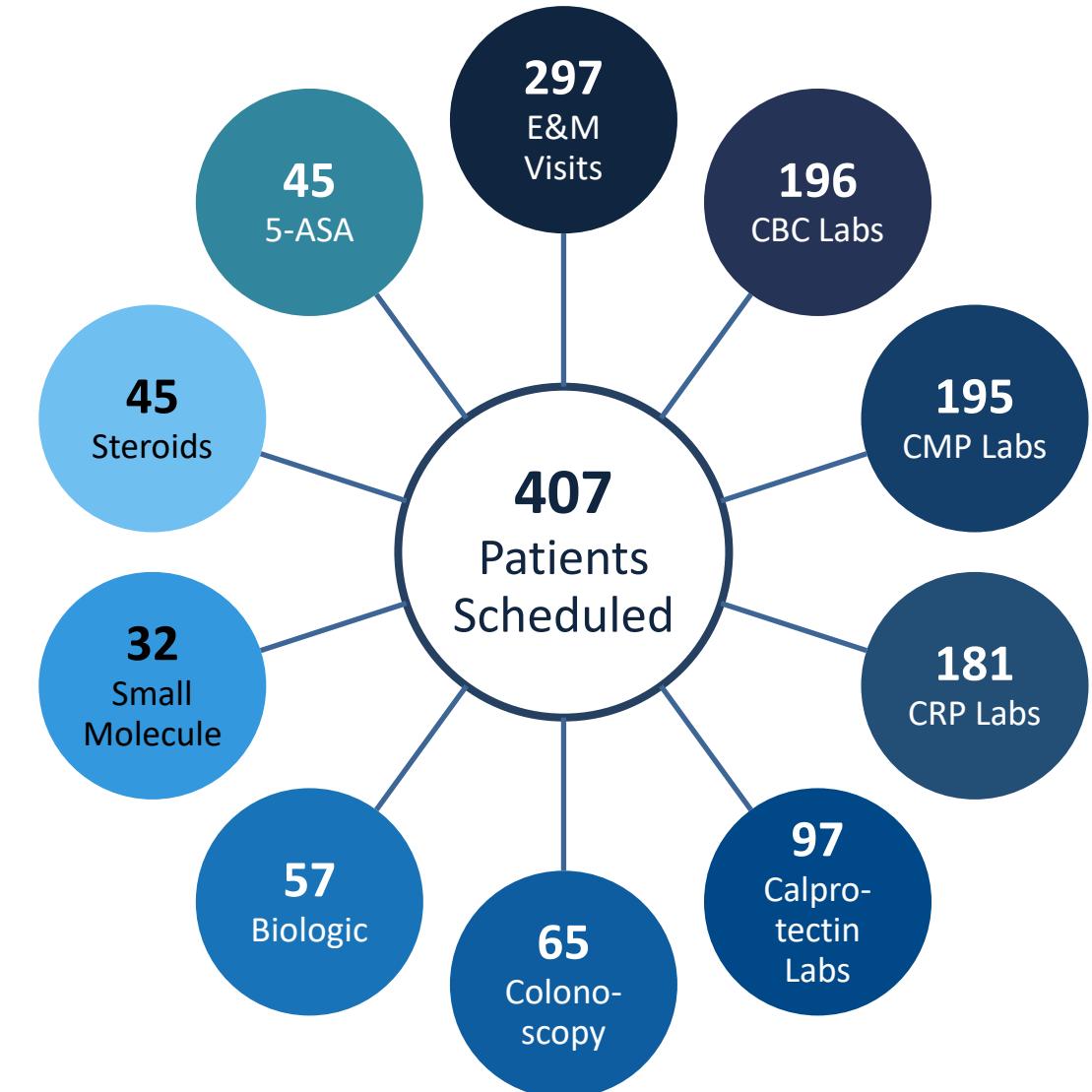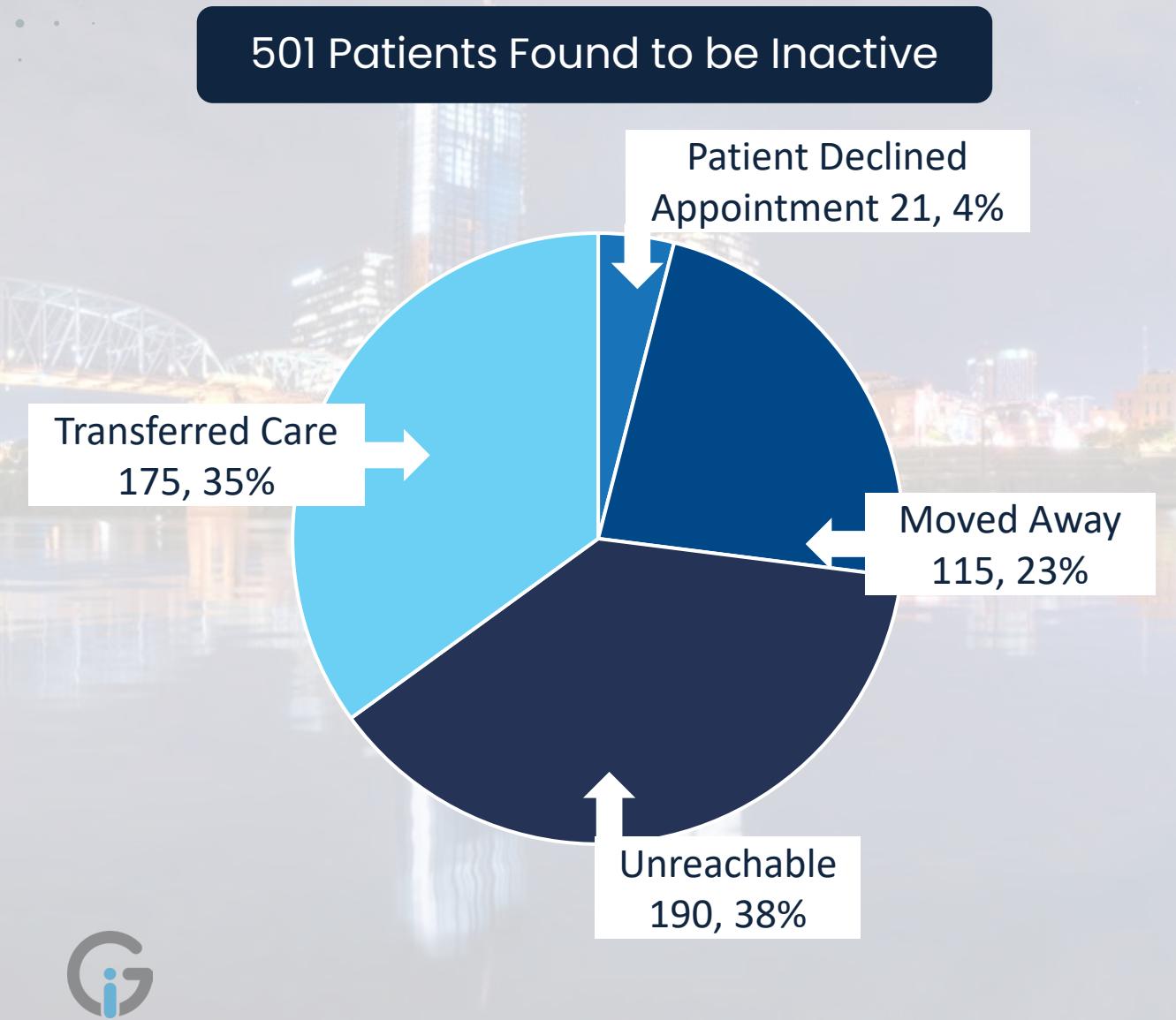
Everyone Wins With Better Information

PATIENT

- Longitudinal care for patients with chronic conditions

- Access to previously uncovered services

- Better clinical trial enrollment

- Improved compliance and outcomes

PHYSICIAN

- Better patient compliance

- Chronic Care Management revenue can help offset significant up-front program costs

- Dependable, automated office processes increase efficiency, may decrease costs

- Satisfied patients

PAYERS
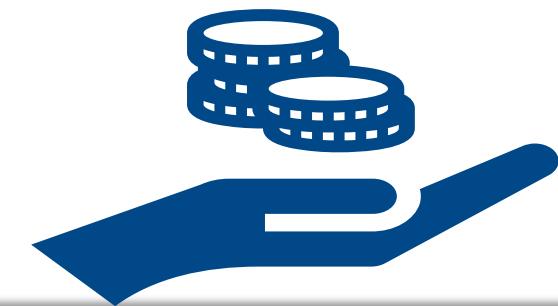
- Lower per patient cost due to population management

- Options for value based direct-to-employer carve outs

- Most specialties still live in a Fee For Service world

- Limited interest from payers in specialty specific VBC initiatives

Thank You

Physician-Focused Payment Model Technical Advisory Committee

Session 5: Payment Models and Benefit Design Improvements to Enhance Patient Empowerment

Kaitlyn Pauly, MS, RDN, DipACLM

Chief Integration Officer,
American College of Lifestyle Medicine

CURRENT REALITY

➢ Lifestyle-related chronic conditions are not properly addressed within medical and health professional education, **nor are there proper payment and reward systems** that incent treating their root causes.

➢ **Misalignments quality measures and risk scoring <u>penalize</u> health restoration, disease remission, and medication de-escalation**.

➢ The current healthcare ecosystem emphasizes and incentivizes disease and **symptom management** through increasing quantities of pills and procedures instead of acknowledging and rewarding achievement of health restoration, disease remission, medication de-escalation and chronic disease prevention through **root-cause treatment approaches**.

➢ **Time** needed to apply comprehensive behavior change interventions in current healthcare ecosystem is limited.

➢ **Scalability** is often precluded in current 1:1 model of care.

OUR MISSION

Advancing evidence-based lifestyle medicine to treat, reverse, and prevent non-communicable, chronic disease

OUR VISION

A world wherein lifestyle medicine is the foundation of health and all healthcare

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WHAT IS LIFESTYLE MEDICINE?

Lifestyle medicine is a medical specialty that uses therapeutic lifestyle interventions as a primary modality to treat chronic conditions including, but not limited to, cardiovascular diseases, type 2 diabetes, and obesity.

Lifestyle medicine certified clinicians are trained to apply evidence-based, whole-person, prescriptive lifestyle change to treat and, when used intensively, often reverse such conditions. Applying the six pillars of lifestyle medicine also provides effective prevention for these conditions.

SIX PILLARS OF LIFESTYLE MEDICINE

- Optimal Nutrition

- Physical Activity

- Stress Management

- Avoidance of Risky Substances

- Restorative Sleep

- Connectedness
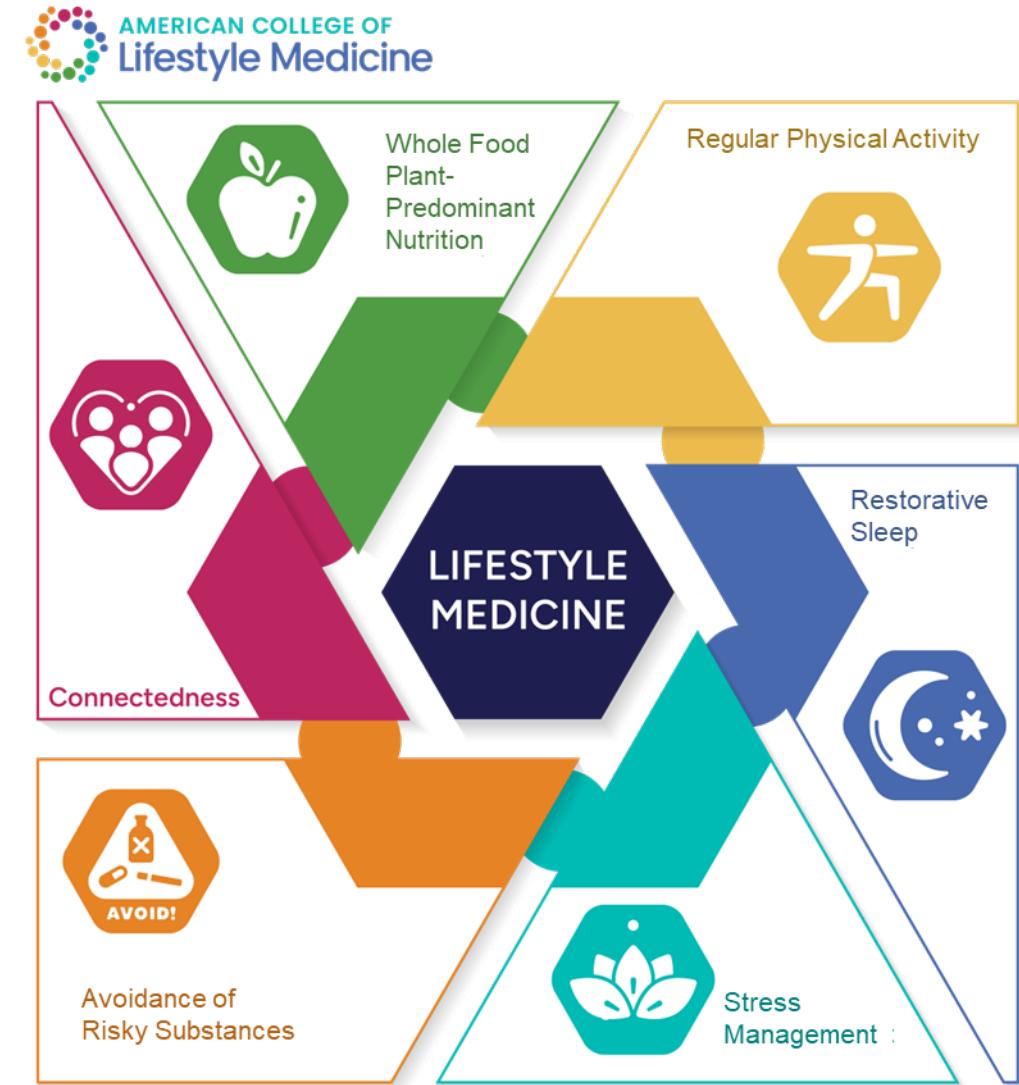
EVIDENCE-BASED CARE

- Clinical practice guidelines (CPGs) for:

  ✓ hypertension

  ✓ type 2 diabetes

  ✓ cardiovascular disease

  ✓ obstructive sleep apnea

  ✓ obesity

  ✓ cancer

  ✓ cognitive decline

  ✓ polycystic ovarian syndrome

List lifestyle interventions as **preventative, adjunct** and often the **first treatment** approach.

LIFESTYLE MEDICINE CAN ACHIEVE REMISSION

Richard M Rosenfeld [1,✉], Meagan L Grega [2], Mahima Gulati [3]

▸ Author information   ▸ Article notes   ▸ Copyright and License information

Abstract

This review is based on a presentation at the 2024 Annual Meeting of the American College of Lifestyle Medicine (ACLM), which showcased ACLM's first clinical practice guideline on *Lifestyle Interventions for Treatment and Remission of Type 2 Diabetes and Prediabetes in Adults*. Our goal is to offer pragmatic implications of the guideline for everyday patient care, including case presentations showing how the guideline recommendations (key action statements) can be implemented. The target audience is any clinician or healthcare professional in a community or outpatient healthcare setting involved in managing non-pregnant adults with T2D, prediabetes or a history of gestational diabetes mellitus (GDM). Unique features of the ACLM guideline include placing lifestyle interventions as the foundation of T2D management and prevention, offering strategies for sustained behavior change, and emphasizing all six pillars of lifestyle medicine: plant-predominant nutrition, regular physical activity, restorative sleep, stress reduction, social connectedness, and avoiding risky substances. This review is not intended to substitute for the full guideline, which should be read before doing the recommended actions.

*In lifestyle medicine, the clinical goal is **health with no evidence of disease.***

***Remission** is the return to a state of non-disease as determined by the failure to meet the recognized criteria for diagnosing the disease.*

***Reversal** is the process of disease treatment with the clinical goal of health with no evidence of the disease.*

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VISION: EMPOWERING PATIENTS

- **Patient activation/engagement:** benefit design enables patient control of lifestyle change

- **Therapeutic Alliance:** clinical care teams and patients are allies in health behavior change

- **Shared Decision-Making:** patient education, awareness and empowerment

SICK CARE

HEALTH CARE

BENEFIT DESIGN

- Expand coverage of **therapeutic and intensive therapeutic lifestyle interventions** delivered by trained clinicians

- Eliminate or limit **cost-sharing** for **high-value lifestyle services** that address root-cause prevention, treatment, or remission of chronic conditions

- Cover lifestyle intervention **beyond clinic walls** where people live and work

- Cover engagement with **all qualified team members** who deliver evidence-based lifestyle intervention

- Cover tools that allow for **asynchronous follow-up** to support behavior change and health engagement beyond the clinic walls

- Cover services that **address barriers** to applying lifestyle change: i.e., nutritious food access, supervised exercise

- **Remove one-time beneficiary rules** for lifestyle interventions

PAYMENT MODELS

- We need **aligned payment, incentives and quality measures** that reward evidence-based **root-cause approaches** to achieving better health outcomes across the spectrum of chronic disease (prevention → treatment →remission), along with a removal of penalties and barriers that providers who deliver better health outcomes using these approaches currently experience.

- Payment models **should support and reward evidence-based interventions** that address root causes of disease (lifestyle) to engage and empower patients to take control of their own health destinies

PAYMENT INNOVATION

- Reimburse sustainably for evidence-based **therapeutic and intensive therapeutic lifestyle interventions** delivered by trained clinicians

- Create hybrid payment models to cover **multi-modal interprofessional care** team delivery of lifestyle behavior interventions/support

- Support sustainable payment and clarity on for delivering **group visits/shared medical appointments to scale treatments**

- Support the use of expansive **digital/asynchronous tools**

- Expand the options to address **social drivers of health**

- Incent and reward **remission, health restoration and patient engagement**

- Use metrics **like lifestyle improvement, patient activation, quality of life**, health improvement/outcomes, disease remission, and medication reduction to measure progress and incent/reward clinicians

CALLS TO ACTION

Pilot and Scale:

- Support pilot programs that test hybrid payment models that align with lifestyle behavior change guidelines (intensity/dosing/proper payment/incentives/rewards and removal of barriers)

Policy Recommendations:

- Propose specific regulatory or legislative changes to remove structural/systemic barriers to address payment and quality measure misalignments

Partnerships:

- Invite collaboration with CMS, payers, clinicians, employers and beneficiaries to co-design sustainable benefit structures that empower patients and reward clinicians

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