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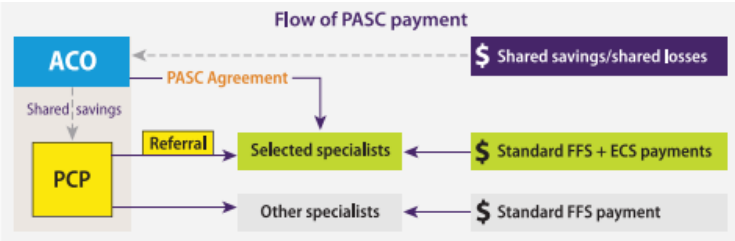
ACCOUNTABLE CARE NEWS

AMA Designs Payments for Accountable Specialty Care (PASC) Approach for Value Based Care

The AMA is of the opinion that "existing APMs, including Medicare accountable care organizations (ACOs), generally lack the ability to change the way specialists are paid and focus on meeting total-cost-of-care spending targets rather than improving quality and outcomes for patients with conditions that require referrals to a specialist."

So, "as a remedy to these issues, the AMA has designed the payments for accountable specialty care (PASC) approach, under which primary care and specialty physicians can work together to improve care for ACO patients with acute or chronic conditions or symptoms that require specialty care." How would a PASC arrangement work? The AMA tells is it involves agreeing up front on goals:

- Specialists who enter into a voluntary PASC agreement with an ACO would be accountable for delivering specific services in ways that improve quality while reducing costs or avoiding unnecessary spending.
- The specialist would receive enhanced condition services (ECS) payments in addition to standard Medicare fee-for-service payments, while being accountable for meeting performance standards that would be specified in the PASC agreement.
- The ECS payments would be counted toward the ACO's spending total used to calculate shared savings or losses. The ACO primary care physicians would be encouraged to give preference to specialists with whom the ACO has a PASC agreement when considering referrals as these specialists would be committed to delivering enhanced services to the ACO's patients and to coordinating patients' care with the ACO primary care physicians.



The AMA provides the example if a "specialist's services being supported by ECS payments are intended to cut emergency department visits or hospital admissions for a specific health condition such as heart failure. In such a case, the ACO and specialist could agree on the rate of ED visits or hospitalizations for that condition that is feasible to achieve for the patients covered by the PASC agreement."

The ANA states that "PASC builds upon previous APM proposals and pilot programs developed by physicians to address payment barriers in the current system and opportunities for savings for several conditions, including:

- Asthma and chronic obstructive pulmonary disease treated by allergists and pulmonologists.
- Heart failure treated by cardiologists.
- Inflammatory bowel disease managed by gastroenterologists.
- Unscheduled acute care treated by emergency medicine physicians."

The AMA tells us that “current payment barriers prevent or discourage specialists from spending adequate time to determine an accurate diagnosis without ordering unnecessary tests”; as wells from “educating and assisting patients to take actions, such as exercise or wound care, before and after surgery or other treatment that can improve outcomes and reduce complications.”

The AMA summarizes the PASC model addresses those shortcomings by providing these primary benefits:

A. by supporting better specialist-primary care coordination, PASC offers the potential for delivery of services not supported by current payment systems, reduced use of higher-cost services, and improved patient outcomes.
B. Implementation of PASC also could improve health equity by providing higher payments for care of patients who have complex conditions or who have been put at higher risk for poor outcomes due to social determinants of health or other factors.

Clover Health to Dial Way Back on ACO REACH Participation

The Clover Health, during its Third Quarter 2022 Earning Call, elaborated on plans to reduce ACO REACh participation for 2023. Clover Health operates two distinct lines of business: through their Insurance line of business, they provide PPO and HMO plans to Medicare Advantage members in selected markets; while their non-insurance line of business manages Medicare ACO participation. Both lines utilize their proprietary software platform, Clover Assistant, which is designed to aggregate patient data from across the health ecosystem.

Lives under Clover Management

	September 30, 2022	September 30, 2021
Insurance members	88,136	67,281
Non-Insurance beneficiaries	166,432	61,818
Total Lives under Clover Management	254,568	129,099

Third Quarter 2022 Financial Highlights:

Dollars in Millions	Q3'22	Q3'21
Total revenue	$ 856.8	$ 427.2
Insurance MCR	86.3%	102.5%
Non-Insurance MCR	104.2	102.4
Salaries and benefits plus General and administrative expenses ("SG&A")[1]	$ 118.0	$ 119.2
Adjusted Salaries and benefits plus General and administrative expenses ("Adjusted SG&A") (non-GAAP)[1][2][3]	75.3	70.5
Net loss	(75.3)	(34.5)
Adjusted EBITDA (non-GAAP)[3]	(58.3)	(79.7)

During their thrid quarter earning call, Clover President Andrew Toy commented with regard to their non-insurance segment that: “our Q3 non-insurance MCR (Medical Cost Ratio) was 104.2%, which is a result that we intend to improve. ACO Reach is an innovative program and its rules and benchmark rates continue to be adjusted by CMMI, resulting in some amount of unpredictability. Given the program environment and the learnings with our participants, we have modified our ACO to target an MCR lower than 100% next year and have made adjustments to the number of physicians participating in the ACO Reach program.”

Toy announced that “despite having many new participation for 2023 that would have allowed for a substantial program growth, we have decided to significantly decrease the total number of participating physicians. We believe this will reduce total attributed live and revenue managed by our ACO by up to two-thirds. We still expect this business line to have a scale of approximately $1 billion of annual revenue. And importantly, we very much believe these adjustments will result in a sustainable business line with an MCR below 100%.” Toy added that “to be clear, we continue to strongly believe in Clover Assistant being used for the entirety of a physician's Medicare panel, including fee-for-service. For the physicians who we will not be admitting to our ACO in 2023, we are exploring alternate opportunities to support them in shifting their fee-for-service population on to value-based care. For example, we are looking at potentially partnering with them on existing statutory program such as the Medicare shared savings program. We believe these other programs could be a very good fit for a number of these physicians, and we will provide more updates here as they come about.”

What will this mean to Clover with respect to numbers? Clover CFO Scott Leffler stated that “the decision to reduce the scale of participation in the ACO program will result in a reduction of our non-insurance revenue by up to two-thirds. As Andrew mentioned, we still expect non-insurance to be a $1 billion revenue line of business. Both of these changes are reflective of our increasing emphasis on profitability and will drive continued improvement in MCR and adjusted EBITDA performance, ultimately driving us towards profitability.” What about the future? Toy shared that “you'll see us move away from having everyone is fee-for-service just an ACO REACH, and then we'll discuss more about motion into MSSP and having a blended portfolio for fee-for-service, and we'll talk more about that in the future.”

VALUE BASED PAYMENT NEWS

Value-Based Care: New Dialysis Studies Inform Delivery of Care, Ways to Improve Patient Outcomes

A national Return-to-Screening effort initiated and led by the American College of Surgeons (ACS) helped restore cancer screenings to pre-pandemic levels and contributed to a significant number of additional screening tests, according to new research published in *JAMA Network Open*. By catching cancer earlier, overall treatment costs can be reduced.

In response to growing concerns about missed cancer screenings related to COVID-19 restrictions and lockdowns, the ACS Cancer Programs, together with the American Cancer Society, launched a Return-to-Screening national Quality Improvement (QI) Project in early 2021 to help accredited programs estimate and reduce local cancer screening deficits. The article in JAMA Network Open reveals, for the first time, final data from the QI project, which included 786 Commission on Cancer (CoC) and National Accreditation Program of Breast Centers (NAPBC) accredited programs. These programs include hospitals, treatment centers, and other cancer facilities. It is estimated that the CoC programs treat nearly 70 percent of recently diagnosed cancer patients in the U.S. annually.*

The collaboration marked the first time when the accredited programs came together under one unified quality improvement goal, noted corresponding author Heidi Nelson, MD, FACS, Medical Director of ACS Cancer Programs.

“When we first started enrolling accredited programs in this quality improvement project, we discovered that more than half of the participating sites still had not returned to pre-pandemic levels of monthly screening by early 2021,” she said. “We learned that by applying a unified quality improvement framework with toolkits, collaborative learning opportunities, and other resources, we could positively increase screening rates and reverse the trends we were seeing related to missed screenings. The same principles we used here can potentially be used as a model to address other gaps in cancer care.”

Accredited cancer programs are squarely focused on providing quality care for patients, Dr. Nelson added, and the environment of these programs optimally allowed centers to quickly resume screening patients across the country.

For this study, researchers established project-specific targets based on differences in mean monthly screening test volumes between pre-pandemic (September 2019, January 2020) and pandemic (September 2020, January 2021) time periods. Between June to November 2021, accredited cancer programs enrolled in the QI project completed a total of 859 QI projects, which included implementing evidence-based screening interventions at each local program aimed at reducing cancer screening deficits exacerbated by the pandemic. Each accredited program was encouraged to select one or more target screening areas of greatest importance to their local community: breast, colorectal, lung, or cervical cancer.

The researchers found that most cancer programs (79%) enrolled in the QI project successfully restored screening rates to pre-pandemic volumes and achieved a minimum of 10% growth in screening. They did not find any major differences between hospital characteristics, though there were some variabilities based on the type of cancer screening. The success of the QI project, the researchers added, can be attributed to the motivation of healthcare professionals to reverse pandemic-related screening deficits, the presence of existing cancer accreditation resources, and the rapid formation of the national-level QI project when it was needed the most.

“Any quality improvement project, even at a local level, is difficult to accomplish and takes a concerted effort,” said lead author Rachel Hae-Soo Joung, MD, MS, a PGY-6 general surgery resident at the Northwestern University Feinberg School of Medicine. “I think this study speaks to the larger implications of how a quality improvement project can be implemented in a swift manner to address urgent needs. With cancer screening, we didn’t want to wait for two years to realize that there had been dips in volumes. We wanted data readily available to help us understand and address missed screenings.”

Study co-authors are Timothy W. Mullett, MD, MBA, FACS, Scott H. Kurtzman, MD, FACS, Sarah Shafir, MPH, James B. Harris, MD, FACS, Katharine A. Yao, MD, FACS, Karl Y. Bilimoria, MD MS, FACS, and William G. Cance, MD.

Value Based Care Industry News

CVS Health's Aetna Collaborates with Crossover Health to Offer New Value Based Heath Plan

Crossover Health and Aetna, a CVS Health company announced a collaboration to offer a new health benefit design to Seattle-area employers and their employees, entitled Aetna Advanced Primary Health, which will be available January 1st. The new hybrid care model is integrated into a health plan and pairs a trusted interdisciplinary care team with a fixed-fee, value-based payment model.

Aetna Advanced Primary Health provides an interdisciplinary care team which includes primary care, mental health, physical therapy, health coaching, and care navigators who refer into high-value secondary care services. Crossover's hybrid care model includes nearsite health centers and a virtual care network which enables members to have choice in how they receive care – in person, virtually or via asynchronous messaging.

Catherine Gaffigan, MD, President of Aetna's Northwest-Mountain Market explained that "Aetna Advanced Primary Health is a key part of our commitment to deliver high value health benefits to our plan sponsor partners. Our members will have exclusive virtual and in-person access to Crossover Health's primary care, behavioral health, physical therapy, chiropractic care, and more as part of a comprehensive medical home. This offering will also provide access to the entire broad Aetna network and represents the type of innovation the market is demanding in the commercial insurance industry."

Cristine Vogel Named Director of Value-Based Health Care Delivery for State of Delaware

Delaware Insurance Commissioner Trinidad Navarro announced Cristine Vogel will serve the Delaware Department of Insurance as its Director of Value-Based Health Care Delivery As the inaugural Director, Vogel will lead efforts that relate to value-based care, primary care, pharmaceuticals and pharmacy benefit managers, affordability, and other health-policy initiatives including grant programs.

Director Vogel has been involved with healthcare management for over 25 years, with experience in hospitals and medical practices, state government, insurance, and consulting. Leading the Office of Value-Based Health Care Delivery, Vogel will establish, implement, and monitor Affordability Standards such as those to increase primary care investment, and manage the reporting of carrier investments in health care. This will include assessing commercial reimbursement rates for primary and chronic care services, the role of price and utilization in healthcare spending, and prescription drug spending as a driver of total cost of care.

Vogel most recently served as the Director of Population Health Initiatives for Nuvance Health System in Connecticut, where she developed solutions to improve clinical outcomes, increase quality of care, and control healthcare costs through implementing a nurse care management program, a clinical pharmacy program, and through integrating behavioral health within primary care practices. Her experience in healthcare reform also includes leading the State of Connecticut's Office of Healthcare Access and evaluating Certificates of Need. The position, funded by the department, was made necessary by several legislative mandates related to healthcare affordability and pharmacy benefits.

Humana's CenterWell 2023 Expansion Plan Includes New Markets of Indiana, Mississippi and Virginia

CenterWell Senior Primary Care will continue expanding in 2023, announcing plans to open in new markets including Indiana, Mississippi and Virginia, as well as opening new centers in seven other states where CenterWell already is active.

CenterWell intends to open 30 to 35 new senior-focused primary centers in 2023 through a joint ventureopens new window with private equity firm Welsh, Carson, Anderson and Stowe, and while locations and timing are always subject to change, initial plans call for:

- Centers in the new markets of Tidewater and Richmond, Virginia;
- Centers in the new markets of Biloxi, Gulfport and Jackson, Mississippi;
- Centers in new markets in Indiana (specific communities to be determined later)

Other communities where CenterWell Senior Primary Care plans to open new care centers in 2023 include: Lake Charles and Lafayette, Louisiana; Dallas, Texas; Las Vegas, Nevada; Raleigh and Durham, North Carolina; Myrtle Beach and Columbia, South Carolina; Lexington, Kentucky; and Nashville, Tennessee.

Exact locations and opening dates will be determined later, but CenterWell's goal is to open all of the centers named above by the end of 2023.

POPULATION HEALTH NEWS

Rising Housing Cost to Income Ratio Strongly Linked to Poor Health, Death, Suicide

The widening gap between personal disposable income and the cost of housing is strongly linked to poor health, preventable deaths, and suicide, finds an international study of developed countries in the *Journal of Epidemiology & Community Health*. But state spend on unemployment and pensions benefits can lower these risks, as can policies such as the provision of public housing stock and rent controls, the findings indicate.

Wealthy countries have promoted home ownership through policy measures, but have paid relatively little attention to affordable housing, note the researchers. While it's known that unaffordable housing is associated with poor health at the personal level, it's not clear what impact this might have at the population level, or whether social policies might alter these risks. In a bid to find out, the researchers drew on Organization for Economic Co-operation and Development (OECD) national stats for 27 member countries for the period 2000 to 2019, which included the global financial crisis of 2008. (The 27 countries were: Australia; Austria; Belgium; Canada; Czech Republic; Estonia; France; Finland; Germany; Greece; Hungary; Japan; Latvia; Luxembourg; Lithuania; the Netherlands; Norway; New Zealand; Poland; Portugal; Slovak Republic; Slovenia; Spain; Sweden; Switzerland; the UK; and the US.)

The figures on mortality focused on avoidable deaths, classified as treatable—prevented through timely healthcare provision—and preventable—avoided through public health policy; and suicides as a proxy for 'deaths of despair' associated with economic hardship.

To obtain country-level data on unaffordable housing, the researchers drew on housing cost to income ratio data, to include rents; assumed rental value for owner-occupiers; and maintenance and other associated costs, as a percentage of household disposable income. They then looked at social spend per head of the population for each country, to include pension and unemployment benefits, healthcare, and housing. They specifically assessed the effect of two housing policy measures on death: the size of a country's social housing stock; and the presence of rent controls.

Higher social housing stock was defined as more than 10% of total housing provision (5 out of the 27 countries). Rent control includes controls on initial rent charged and/or regulated and/or negotiated rents applied across rental sectors (13 out of the 27 countries).

Their analysis of all the OECD data showed that housing cost to income ratio was strongly associated with preventable and treatable deaths as well as suicide during the period following the global financial crisis (2009-17), but not in the period before (2000-08). The analysis also revealed that social spending on pension and unemployment benefits was protective, lowering the death rate associated with unaffordable housing. In countries with higher social housing stock, the link between unaffordable housing and preventable/treatable deaths and suicide was weakened.

Similar patterns were observed for countries with rent controls: in countries without this measure unaffordable housing was strongly linked to preventable/treatable deaths and suicide.

Unaffordable housing may affect health in various ways: by squeezing spend on good nutrition, heating, and healthcare; through psychological stress; and through unhealthy lifestyle behaviors, all of which an economic downturn, such as that experienced after the global financial crisis, is likely to worsen, suggest the researchers.

"We also demonstrated that social spending on old-age and unemployment benefits was significantly associated with lower mortality rates. This finding aligns with existing studies that social spending buffers households against economic hardship," they point out.

Housing policy measures are also key, they add. "First, social housing for broad segments of the population appears to be associated with lower mortality risks…Second, rent controls intend to keep living costs affordable, particularly for lower income residents by limiting the amount that landlords can demand for leasing a home.

"Overall, these protective measures protect households against suffering from housing cost induced stressors."

This is an observational study, and as such, can't establish cause. And the researchers acknowledge various limitations to their findings. These include the inability to distinguish between different socioeconomic groups or include national housing policy changes over time. Nevertheless, they conclude: "Our findings suggest that housing cost burden can be related to population health…. Unfortunately, since there was a growing pressure to cut back on social spending after the economic crisis, an increasing number of households are faced with [it]."

Death, Hospital Readmission More Likely for Black Patients After Coronary Stenting

Black patients who undergo minimally invasive procedures for clogged arteries are more likely to die or be readmitted to the hospital months after the procedure, a Michigan Medicine study finds.

The research team analyzed more than 29,000 older patients with Medicare insurance who underwent percutaneous coronary intervention, which includes stenting and balloon angioplasty, between 2013 and early 2018 using data from the Blue Cross Blue Shield of Michigan Cardiovascular Consortium. They found that Black patients were 1.62 times more likely to be readmitted to the hospital within 90 days of discharge after the procedure and were 1.45 times more likely to die in long-term follow-up when adjusting for age and gender. Coronary stents are now used in nearly all angioplasty procedures. A stent is a tiny, expandable metal mesh coil. It is put into the newly opened area of the artery to help keep the artery from narrowing or closing again.

Once the stent has been placed, tissue will start to coat the stent like a layer of skin. The stent will be fully lined with tissue within 3 to 12 months, depending on if the stent has a medicine coating or not. You may be prescribed medicines called antiplatelets to decrease the "stickiness" of platelets. Platelets are special blood cells that clump together to stop bleeding. The medicine can also prevent blood clots from forming inside the stent. Your healthcare team will give specific instructions on which medicines need to be taken and for how long.

“We’ve known that there are broad racial disparities that exist in cardiovascular disease, with Black patients less likely to undergo coronary intervention or invasive angiography, but there is a lack of data on the long-term outcomes for these patients after coronary stenting procedure,” said Stephanie Spehar, M.D., first author of the study and chief medical resident in the University of Michigan Health Department of Internal Medicine.

“We have seen efforts nationwide to improve the care quality of coronary stenting, particularly during the procedure, and current studies including ours show generally similar in-hospital outcomes for Black and white patients,” Spehar said. “However, our findings show a concerning disparity in outcomes after patients leave the hospital.”

The results, published in the American Heart Journal, reveal that social determinants of health – including community economic well-being, personal income and wealth, and preexisting health conditions – played a significant role in the outcomes.

“Our findings demonstrate that these disparities may be, at least in part, explained by multiple complex factors including social determinants of health,” said senior author Devraj Sukul, M.D., M.S., interventional cardiologist at the U-M Health Frankel Cardiovascular Center and a clinical assistant professor of cardiology at U-M Medical School.

“Moreover, focusing on understanding and potentially addressing these disparities in both the peri-procedural and post-procedural settings is critically important,” Sukul said. “All of these factors, such as wealth, community economic stress and comorbidities, are interconnected and accumulate over time. Lower socioeconomic status can potentially lead to worse health status, just as illness may undermine financial security and economic opportunity. Preventative action must be taken to address the complex social, environmental and behavioral factors that contribute to these outcomes.”

Percutaneous coronary intervention is performed both for patients coming in with emergent situations, such as a heart attack, as well as those experiencing chest pressure with exertion or chest discomfort. It is one of the most common cardiovascular procedures performed in the United States, with more than 635,000 procedures completed in 2017.

In addition to the long-term disparities uncovered in the study, 75% of white patients were referred for cardiac rehabilitation, compared with 58.5% of Black patients. Researchers say the findings highlight a need to reduce such disparities at the time of discharge after PCI, which will take a multi-faceted effort.

“We need policies to reinforce and expand programs that have been developed to reduce the burden of cardiovascular conditions, like hypertension and diabetes, in minority groups,” Spehar said. “Clinicians can also partner with social services to address issues such as transportation and copays, trying to eliminate financial barriers to care. And cardiovascular providers must prioritize ongoing cultural competence and implicit bias training.”

CARE ANALYTICS NEWS

Novel AI Blood Test Detects Liver Cancer

A novel artificial intelligence blood testing technology developed and used by Johns Hopkins Kimmel Cancer Center researchers to successfully detect lung cancer in a 2021 study has now detected more than 80% of liver cancers in a new study of 724 people.

The blood test, called DELFI (DNA evaluation of fragments for early interception) detects fragmentation changes among DNA from cancer cells shed into the bloodstream, known as cell-free DNA (cfDNA). In the most recent study, investigators used the DELFI technology on blood plasma samples obtained from 724 individuals in the U.S., the European Union (E.U.) and Hong Kong to detect hepatocellular cancer (HCC), a type of liver cancer.

The researchers believe this is the first genome-wide fragmentation analysis independently validated in two high-risk populations and across different racial and ethnic groups with different causes associated with their liver cancers.

Their findings were reported Nov. 18 in Cancer Discovery and at the American Association for Cancer Research Special Conference: Precision Prevention, Early Detection, and Interception of Cancer.

It is estimated that 400 million people worldwide are at higher risk of developing HCC because of cirrhosis from chronic liver diseases including chronic viral hepatitis or non-alcoholic fatty liver disease, according to a worldwide analysis of the burden of liver disease (J. Hepatology, 2019).

“Increased early detection of liver cancer could save lives, but currently available screening tests are underutilized and miss many cancers,” says Victor Velculescu, M.D., Ph.D., professor of oncology and co-director of the Cancer Genetics and Epigenetics Program at the Johns Hopkins Kimmel Cancer Center, who co-led the study with Zachariah Foda, M.D., Ph.D., gastroenterology fellow, Akshaya Annapragada, M.D./Ph.D. student, and Amy Kim, M.D., assistant professor of medicine at the Johns Hopkins University School of Medicine.

Of the 724 plasma samples studied, 501 were collected in the U.S. and E.U. and included samples from 75 people with HCC to train and validate the machine learning model, a type of artificial intelligence that uses data and algorithms to improve accuracy, explains Foda. For validation, an additional 223 plasma samples were analyzed from individuals in Hong Kong and included samples from 90 people with HCC, 66 with hepatitis B virus (HBV), 35 with HBV-related liver cirrhosis and 32 people with no underlying risk factors.

The DELFI technology uses a blood test to measure the way DNA is packaged inside the nucleus of a cell by studying the size and amount of cell-free DNA present in the circulation from different regions across the genome. Healthy cells package DNA like a well-organized suitcase, in which different regions of the genome are placed carefully in various compartments. The nuclei of cancer cells, by contrast, are like more disorganized suitcases, with items from across the genome thrown in haphazardly. When cancer cells die, they release DNA fragments in a chaotic manner into the bloodstream.

DELFI identifies the presence of cancer by examining millions of cfDNA fragments for abnormal patterns, including the size and amount of DNA in different genomic regions. The DELFI approach only requires low-coverage sequencing, enabling this technology to be cost-effective in a screening setting, the researchers say.

In the latest study, researchers performed the test — which was previously shown to accurately classify lung cancer — on cfDNA fragments isolated from the plasma samples. They analyzed the patterns of fragmentation across each sample to develop a DELFI score.

Scores were low for cancer-free individuals with viral hepatitis or cirrhosis (median DELFI score was 0.078 and 0.080, respectively), but, on average, 5 to 10 times higher for the 75 HCC patients in the U.S./E.U. samples, with high scores observed across all cancer stages, including early-stage disease (DELFI scores for Stage 0 = 0.46, Stage A = 0.61, Stage B = 0.83, and Stage C = 0.92). In addition, the test detected fragmentation changes in the content and packaging of liver cancer genomes, including from genome regions associated with liver-specific activity.

The DELFI technology detected liver cancers at their earliest stages, with an overall sensitivity — or ability to accurately detect a cancer — of 88% and a specificity of 98%, which means it almost never incorrectly provided a false positive result, among people at average risk. In samples collected from those at high risk of HCC, the test had 85% sensitivity and 80% specificity.

“Currently, less than 20% of the high-risk population get screened for liver cancer due to accessibility and suboptimal test performance. This new blood test can double the number of liver cancer cases detected, compared to the standard blood test available, and increase early cancer detection,” says Kim, co-senior author on the study.

The researchers say next steps include validating this approach in larger studies for clinical use. In addition to Velculescu, Foda, Annapragada and Kim, other researchers were Kavya Boyapati, Daniel Bruhm, Nicholas Vulpescu, Jamie Medina, Dimitrios Mathios, Stephen Cristiano, Noushin Niknafs, Harry Luu, Michael Goggins, Robert Anders, Jing Sun, Shruti Meta, David Thomas, Gregory Kirk, Vilmos Adleff, Jillian Phallen and Robert Scharpf.

HEALTH BUSINESS NEWS

HLTH Conference Features Major Partnership Announcements, Reporting on State of Digital Health Ventures, and VC Advice for Startups

November's HLTH Conference in Las Vegas included major partnership announcements, presentations on the current state of digital health, and venture capital panels providing advice for healthcare startups. Perhaps no announcement created as much buzz as the Highmark Health, Google Cloud and League unveiling of their collaboration on an interoperable digital health platform.

The navigation technology can be envisioned as a "digital front door" to a holistic customer experience and will initially be integrated into a new My Highmark health insurance member portal and mobile application. Via one username and password, My Highmark will provide seamless care navigation, shared care plans, virtual and digital health, simplified bill payment, and cost transparency to Highmark's 6.8 million members.

The platform will use data to guide consumers through their individualized health journeys, connecting them with the right care at the right time. By creating a pathway that suits each member's needs and interests, it's easier to engage in and take the right steps to manage care, which ultimately improves health outcomes and overall population health.

My Highmark will begin a phased roll out to select populations of Highmark members in January 2023. In addition to providing a single access point for members' health coverage and care, My Highmark will include third-party partner programs and other employer-sponsored benefit programs—accessible via one app.

Meanwhile, presenters from Galen Growth and FINN Global Digital Health Group presented report finding that included:

- Early-stage venture funding remains strong and promises a healthy innovation pipeline, while the IPO market has stagnated, with 6 IPOs and 4 SPACs globally. M&A activity has maintained strength, with a dip of only 7% YOY.
- With only 27% of ventures having raised venture capital in the last 18 months, the remainder of the ecosystem could be facing a bumpy ride, pushing their C-Suite and investors to cut costs, focus on profitability before growth or rethink business models.
- A global analysis of 12,000+ digital health ventures reveals that just 17% have significant clinical strength. Though some therapeutic areas saw funding shrink by more than 30%, oncology maintained the position of the most invested therapeutic areas in Q1 – Q3 2022, and mental health held the second position.
- Among the top 5 most invested therapeutic areas, gastroenterology was the only one that saw an increase in funding (2%) from 2021 to 2022.

As U.S. digital health funding slowed in 2022 from a record $30 billion the previous year, another HLTH session featured venture capitalists that sounded a note of caution for startups, predicting that the past year's lower valuations may continue in 2023. Krishna Yeshwant, a general partner at Alphabet venture arm GV, suggested that firms lean toward profitability. As a result, startups might not be able to get more funding if they need it and, given 2023 and 2024 will also likely be a challenging environment, may have to stretch cash until 2025.

"If companies are thinking about raising funds in 2023, "we're advising them to raise even sooner, because I think things will look worse in [2023] than they do now," Yeshwant said, noting many digital health startups don't even have a plan for eventual profitability. "We're kind of in a moment where the environment just won't tolerate that anymore."

Healthcare Dive, reporting on the session, interviewed Jacob Effron, a principal at RedPoint Ventures, who cautioned that "there's a shift in terms of where the focus is. I'd say the mood has changed a little bit from grow at all costs, even if you're burning a lot of money, to be careful — you have to run your business in a very cash-efficient way," said

Startups, experts say, need to get back to basics — taking a disciplined stance on operations, focusing on unit economics and keeping an eye toward profitability without making getting into the black their first priority, according to venture capitalists. Securing funding is expected to only become more challenging in the next few quarters, making business execution paramount for startups. As a result, some of the top VCs in digital health are advising their portfolios to be more conservative.

Healthcare Dive cited Oak HC/FT co-founder Andrew Adams, speaking in the session: "You're coming out of this market where there was essentially free money," and how much startups received didn't necessarily match their value. Now, startups need to revisit their core mission in order to remain solvent. "What you should do with your precious cash resources and time in the day is really refocus on those efforts and reprioritize" on foundational priorities like a product roadmap, Adams said.

Venture capital firms agreed that the explosion of funding during the COVID-19 pandemic was good, but the ongoing market correction is good, too. As a result of more due diligence on the part of warier investors, the market will have more certainty about surviving business models.

