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NJ HMR
HEALTHCARE MARKET REVIEW

Opportunities for Value-Based Arrangements: What Does it Take to Succeed?

Lani M. Dornfeld, Esq.
Brach Eichler LLC
973-403-3136
ldornfeld@bracheichler.com
www.bracheichler.com

Brian Kern, Esq.
Acadia Professional
862-325-5900
bkern@acadia.pro
https://acadia.pro/

Steven Weiss
The Bloom Organization, LLC
305-341-9454
sweiss@bloomllc.com
www.bloomllc.com

PRESENTERS

Lani M. Dornfeld, Esq., CHPC
Member, Brach Eichler LLC

Lani represents a broad range of health care providers– both institutional and individual– in regulatory matters, including fraud and abuse, corporate compliance, HIPAA, OSHA, Medicare and licensure issues. She also represents clients in various corporate and contract matters and manages purchase and sale transactions, including private equity transactions, from letter of intent through due diligence, contract drafting and negotiation, closing and post-closing matters.

Lani is certified in healthcare privacy compliance (CHPC) by the Compliance Certification Board. Named among The Best Lawyers in America© in 2020 and 2021, Lani has also been peer-review rated as AV Preeminent, the highest rating for professional excellence by Martindale-Hubbell. She has also been selected as one of New Jersey's Women Leaders in the Bar by Martindale-Hubbell and ALM, publishers of the *New Jersey Law Journal*. In addition, Lani was recognized as a Top Legal Leader for New York and New Jersey by ALM in 2015 and was named a "2013 Top Rated Lawyer in Health Care" by American Lawyer Media and Martindale-Hubbell.

Brian Kern, Esq.
Partner, Acadia Professional

Brian is the CEO of Deep Risk Management, LLC, a value-based financial risk brokerage and consulting firm. He is also a partner with Acadia Professional, LLC, a medical professional liability (MPL) insurance firm, and NJ licensed attorney.

Mr. Kern focuses much of his time on helping medical practices understand and succeed in value-based risk programs by educating them on where new revenue sources exist and how to protect themselves from downside risk. He advises extensively on government, private payor, and employer models. Mr. Kern is also an expert in many facets of professional liability risk, including risk purchasing and retention groups, captives, and loss portfolio transfers.

Mr. Kern currently serves on the Advisory Board of The Health Alliance for Violence Intervention (HAVI) and is the Affiliate Chair on the Board of New Jersey Medical Group Management Association (NJMGMA). He is a member of the Union County Medical Society Judiciary Committee, has testified before the NJ Legislature, worked directly on several bills impacting healthcare, and was honored as one of "Forty Under 40" by NJBiz.

Steven Weiss, MBA, CPA
SVP, The Bloom Organization LLC

Steven is a Senior Vice President at the Bloom Organization where he is responsible for all aspects of M&A transactions including origination, transaction structuring, financing, and execution. He is currently leading the firm's value-based care and home health care initiatives.

Prior to joining, Steven worked at Ardent Investors and HIG Capital focused on acquiring middle market businesses and supporting portfolio companies by executing strategic operational initiatives. Prior to business school, Steven worked at Prince Capital Partners, a family investment office focused on private equity and multi-strategy fund investments. He began his career in corporate accounting and is a licensed CPA.

Steven earned his M.B.A. from The Wharton School at the University of Pennsylvania and his B.S. from Florida State University. He is a Trustee of the JAFCO Children's Foundation Board and is a member of the organization's Investment Committee.

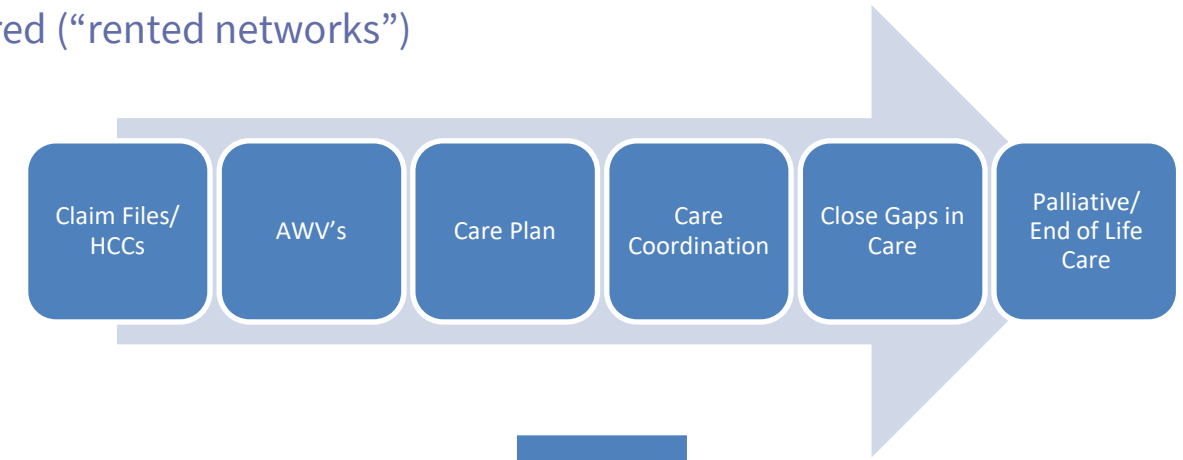
AGENDA

- Value-Based Models
- Overview of Stark Law Exceptions and Anti-Kickback Statute Safe Harbors for Value-Based Care
- ODS Legal Issues
- Value-Based M&A Landscape
- Moving to Risk: Key Elements
- Q&A

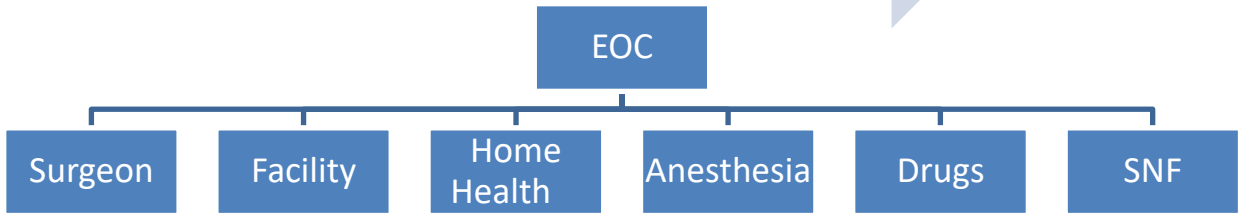
The Value-Based Model Overview

Government:	BPCI-A/OCM/ESRD ACOs
Commercial:	Shared Savings (/"risk") Programs
Hybrid:	Medicare Advantage/ Managed Medicaid
Employer:	Self-Insured ("rented networks")

Population Health



Episode of Care/ Bundled Payment



Stark & Anti-Kickback Statute Value-Based Reforms

- DHHS published final rules through a coordinated effort between CMS and OIG to overhaul regulations under the Stark Law, the Anti-Kickback Statute and the Civil Monetary Penalty Law
  - Published in the Federal Register 12/2/2020
  - Part of the "Regulatory Sprint to Coordinated Care"
  - To reduce regulatory barriers to care coordination and accelerate the transformation of the health care system into one that better pays for value and promotes care coordination

Value-Based Regulatory Framework

Law	Limited or No Risk Sharing	Meaningful or Substantial Downside Risk	Full Financial Risk
Stark Exception (CMS)	Value-Based Arrangements 42 CFR 411.357(aa)(3)	Value-Based Arrangements with Meaningful Downside Financial Risk 42 CFR 411.357(aa)(2)	Value-Based Arrangements with Full Financial Risk 42 CFR 411.357(aa)(1)
AKS Safe Harbor (OIG)	Care Coordination Arrangements to Improve Quality, Health Outcomes, and Efficiency 42 CFR 1001.952(ee)	Value-Based Arrangements with Substantial Downside Financial Risk 42 CFR 1001.952(ff)	Value-Based Arrangements with Full Financial Risk 42 CFR 1001.952(gg)

Risk Overview

- Limited or No Risk Sharing Arrangements
  - Stark: Exception protects physician compensation arrangements that qualify as VB arrangements, regardless of the level of risk undertaken through the arrangement.
  - AKS: Safe harbor protects in-kind (nonmonetary) remuneration within VB arrangements that further patient care coordination purposes, with no requirement to assume downside risk. CMS Example: SNF provides a hospital with staff to assist in coordinating patient care through the inpatient discharge process.
- Meaningful or Substantial Downside Risk Arrangements
  - Stark: Exception protects remuneration paid under a VB arrangement where both the physician and the VBE take on downside financial risk under a payor arrangement.
  - AKS: Safe harbor protects monetary and in-kind remuneration, with an intermediate level of downside risk in a payor arrangement and a requirement that the VBE take on a defined percentage of downside risk.
- Full Financial Risk Sharing Arrangements
  - Stark: Exception protects only arrangements where the VBE takes on full downside risk in the VB arrangement with a payor. However, participating physician does not need to also assume financial risk.
  - AKS: Protects arrangements (including in-kind and monetary remuneration) involving VBEs that have assumed “full financial risk” for the target population.

Value-Based Definitions

- Every VB arrangement must have one or more "Value-Based Purposes"
  - Coordinating and managing the care of a target population
  - Improving the quality of care for a target population
  - Appropriately reducing the costs to or growth in expenditures of payors without reducing the quality of care for a target population
  - Transitioning from health care delivery and payment mechanisms based on the volume of items and services to mechanisms based on the quality of care and control of costs of care for a target patient population

- Value-Based Activity
  - One or more activities reasonably designed to achieve at least one value-based purpose, which may include the provision of an item or service, the taking of an action, or the refraining from taking an action

- Value-Based Enterprise (VBE)
  - Two or more VBE participants collaborating to achieve at least one value-based purpose, where each participant is a party to a VB arrangement with the other or at least one other participant in the VBE, and the VBE has an accountable financial and operational oversight body and a governing document describing the VBE and how the participants will achieve the value-based purpose.

Organized Delivery Systems: Legal Issues

- ODS Definition
  - A legal entity that contracts with a carrier for the purpose of providing or arranging for the provision of health care services to those persons covered under a carrier's health benefits plan, but which is not a licensed health care facility or other health care provider.
    - Examples: preferred provider organizations (PPOs), physician hospital organizations (PHOs) and independent practice associations (IPAs).

- Certification or Licensure by NJDOB
  - Whether an ODS must become certified or licensed depends upon whether the ODS assumes financial risk from the carrier. An ODS that assumes financial risk must become licensed, unless the DOB determines the financial risk is "de minimus." An ODS that does not assume financial risk or that is determined to assume only a de minimus financial risk must become certified.

- NJ providers entering into VB arrangements may need to become certified or licensed as an ODS.

M&A Market

Business | Prognosis

Medicine's Worst-Paying Specialty Is Luring Billions From Wall Street

Private equity, pharmacy chains and health insurers are vying for the doctors at the gates of the health-care system

- Private equity investors, retailers, and health insurers are deploying capital into primary care at record-breaking levels
- 8 of the largest primary care players have gone public in the last two years, including VillageMD, One Medical, Oak Street Health, Agilon Health, Privia Health, and Cano Health
- Health insurers are adding to the rapidly growing competition in VBC with the biggest sellers of private MA plans such as UnitedHealth, Humana and CVS's Aetna expanding their primary-care capacities

Value-Based Care Industry Highlights

Large Market with Significant Whitespace	• Value-based care has the potential to reduce healthcare costs by $1 trillion, with the current VBC sector of $250bn estimated to grow to nearly $900bn by 2030 • Shift to VBC reimbursement to grow from 2% of total medical spend in 2020 to 12% by 2030
Favorable Demographic Tailwinds	• Aging population and significant increases in healthcare expenditures favor value-based care models • Costly treatment for chronic conditions can be reduced/prevented through higher primary care utilization, creating opportunities for experienced VBC providers to take cost out of the system and share in savings upside
Unique Strategic Partnerships Drive Growth	• Care management and patient engagement technology enable care to be provided in lower cost settings and better coordination/integration of care • Data and analytics, in addition to high touch service, to add value for providers
Organic and Inorganic Growth Opportunities	• Favorable primary growth trends from Medicare Advantage enrollment, Medicare direct contracting, and penetration growth in Employer and Medicaid • Highly fragmented competitive landscape creates M&A opportunities
Commitment to Clinical Quality and Compliance	• Investment in technology, preventative care, and automation is critical to drive clinical care capabilities and ultimately profitability • In a space that has considerable regulatory scrutiny, compliance best practices are critically important

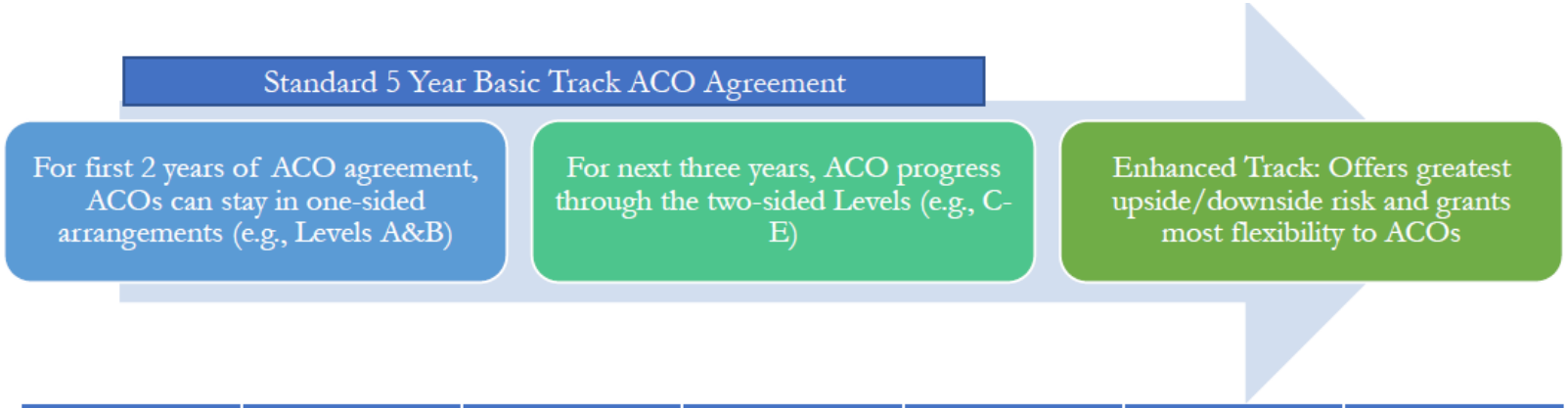
Practical Applications

The Models and the Multiples

Entities	Type of Entity	Population Focus	Est. # of Patients	Valuation	$/Person	Mechanism
Oak Street Medical	PCP Group	MA	90,000	$13 B	$196,000	IPO
Agilon Health	PCP MSO	MA	170,000	$11.4 B	$67,000	IPO
Clover Health	MA Insurer	MA	57,000	$3.5 B	$61,000	SPAC
Alighment Health	MA Insurer	MA	81,000	$4.2 B	$52,000	IPO
Iora Health	PCP Group	MA	38,000	$2.1 B	$55,000	Acquisition
Village MD	ACO PCP Company	ACO/ MA	500,000	$10 Billion - Target	$20,000	IPO Planned
Devoted Health	MA Insurer	MA	17,000	$3 B	$176,000	Private Equity
CANO Health	PCP Group & MSO	MA	103,000	$4.4 B	$43,000	SPAC
Bright Health	Insurer	MA, Exchange & Commerical	220,000	$11.3 B	$51,000	IPO

Source: Health Affairs: "Annual Medicare Part A and B spending per individual is roughly $12,000. PCP's typically receive only 5% of that amount."

ACO Track Summary



Characteristic	Level A&B (1-sided)	Level C	Level D	Level E	Enhanced Track	Direct Contracting Entity
Sharing Rate	40%	50%	50%	50%	75%	DCEs are new risk-bearing entities that build on the ACO model and enable provider organizations to take greater upside and downside risk: • 50% for Professional DCEs • 100% for Global DCEs Currently in first performance year, limited to 53 DCEs currently.
Max Gain	10%	10%	10%	10%	20%	
Shared Losses	N/A	30%	30%	30%	40% to 75%	
Max Losses	N/A	2% of Revenue capped at 1% of Benchmark	4% of Revenue capped at 2% of Benchmark	8% of Revenue capped at 4% of Benchmark	15% of Benchmark	
Annual Election to Enter Higher Risk	Yes	Yes	Automatically transition to Level E next year	No; Max level of risk/reward under Basic	No; Highest level risk/reward under MSSP	
% of ACOs in 2021	59% in 1-sided model (upside only)	41% in two-sided model (upside and downside risk)				
SNF 3-Day Rule Waiver and Expanded Telehealth	No	Yes	Yes	Yes	Yes	

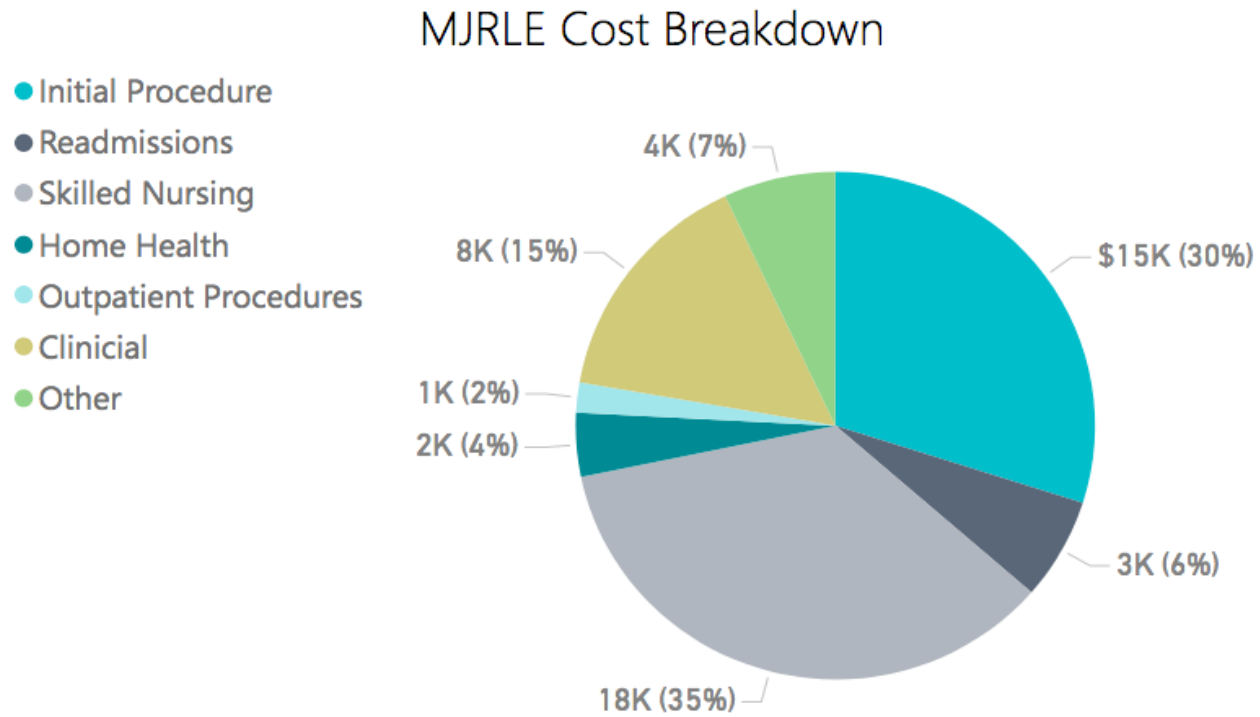
Moving to Value-Based Care, and Succeeding

- Data
- Data Analytics
- Care Coordination
- Understanding Risk (Benchmarks)

Two Ways to Succeed in VBC:

1. Reduce Cost of Care
2. Increase Benchmark

Assess Opportunities: Benchmark (Target Price), Areas to Reduce Spend



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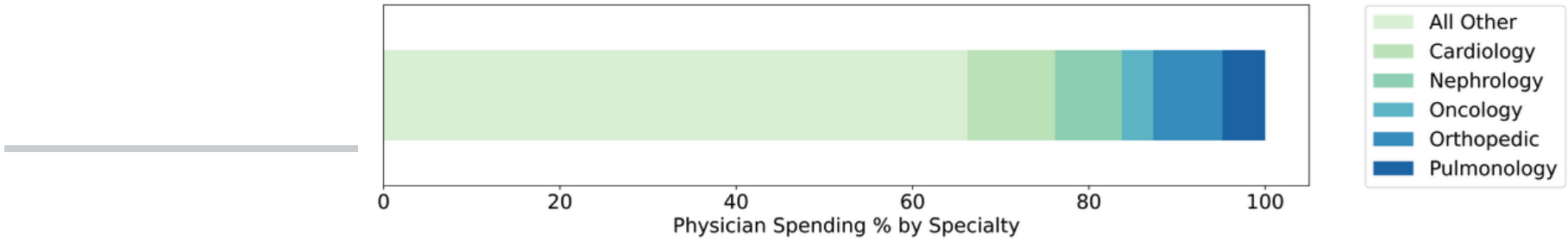
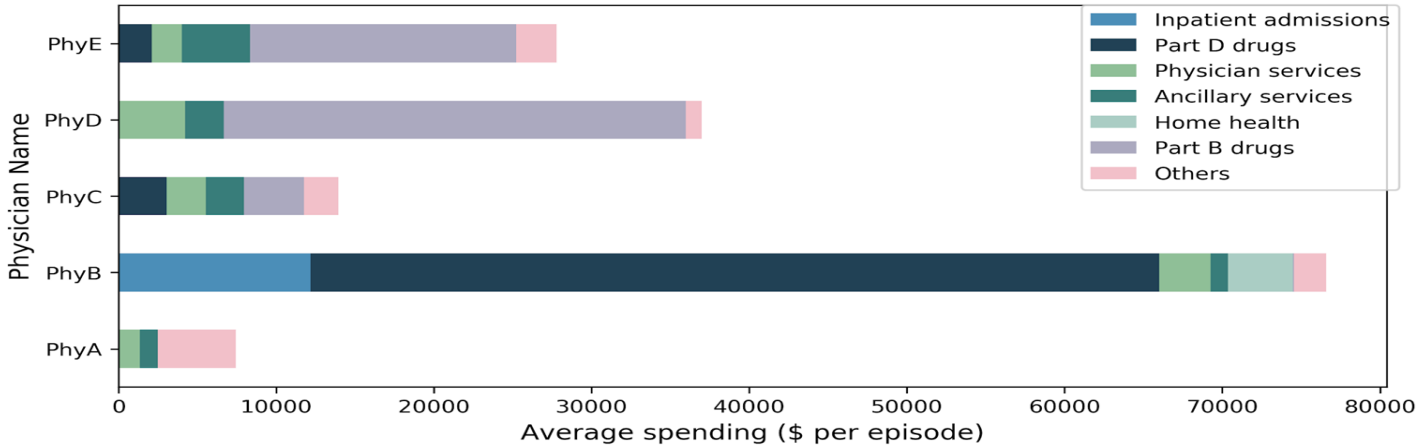
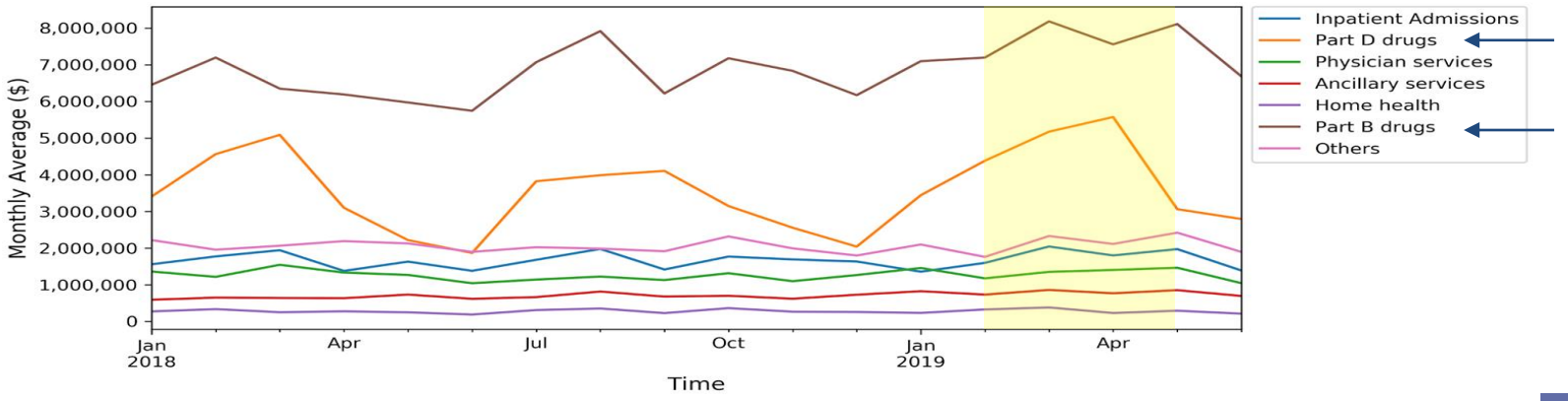
Drill Down into Expenditures







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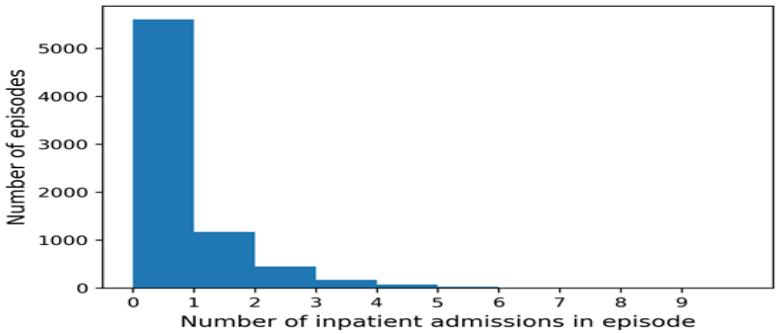
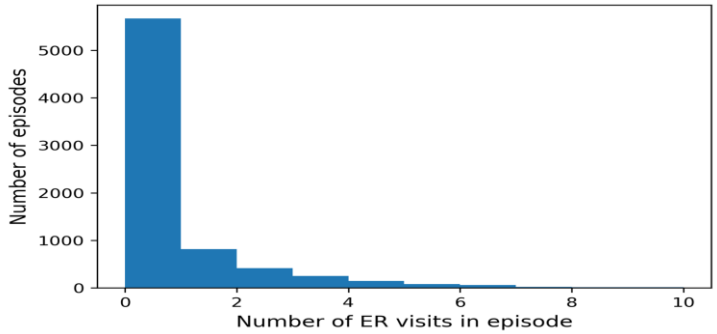
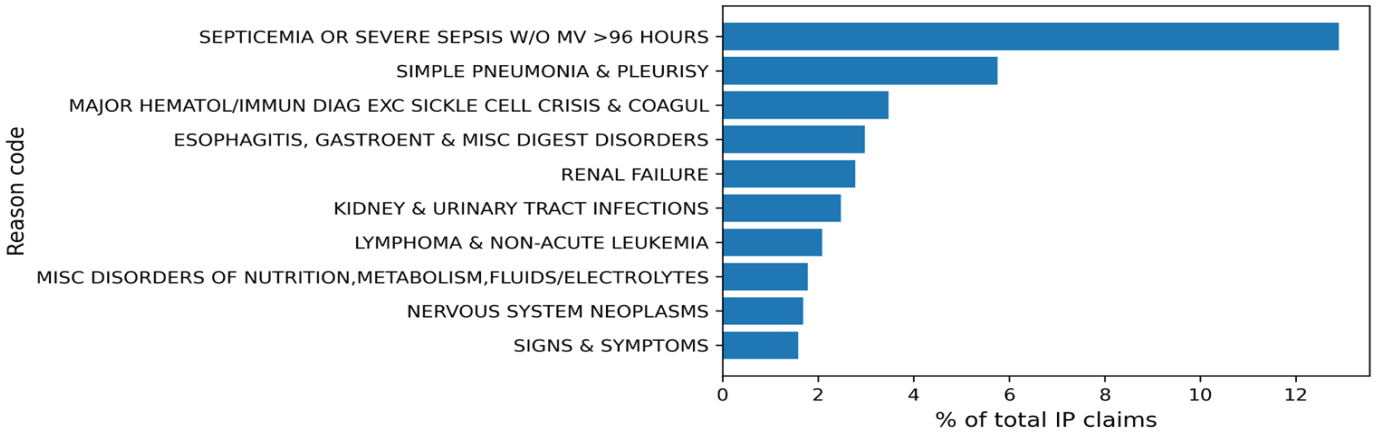
Hospitalizations, Site of Service Opportunities

Practice with high rates of IP admissions and ER visits may have opportunities for increased care coordination.







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Quality Metrics and HCC Coding (Risk Adjustment)

Quality Performance, by Measure

OCM Quality Measure	Measure Source	Scoring Basis	Performance1	Maximum Points1	Earned Points1
OCM-2: Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode	Claims	Performance	22.9%	10	7.5
OCM-3: Proportion of patients who died who were admitted to hospice for 3 days or more	Claims	Performance	49.9%	10	5
OCM-4: Pain Assessment and Management Composite	Registry	Performance	99.3%	10	10
OCM-5: Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS 2v6.3, NQF 0418)	Registry	Performance	78.5%	10	8
OCM-6: Patient-Reported Experience of Care	Survey	Performance	8.47	10	8

HCC Code	HCC Description	HCC Weight	ICD Codes			
			2017	2018	2019	2020
18	Diabetes with Chronic Complications	0.302	E11610	X	E1165	X
19	Diabetes without Complication	0.105		E119	E119	O
85	Congestive Heart Failure	0.331	I509	X	I5031	I509
86	Acute Myocardial Infarction	0.195		I213	X	X
88	Angina Pectoris	0.135		I209	O	O
108	Vascular Disease	0.288		I70213	X	I779
111	Chronic Obstructive Pulmonary Disease	0.335		J449	X	J449
170	Hip Fracture/Dislocation	0.350			S7290XA	N/A
	HCC Total Weight for Year		0.633	0.923	0.983	0.954

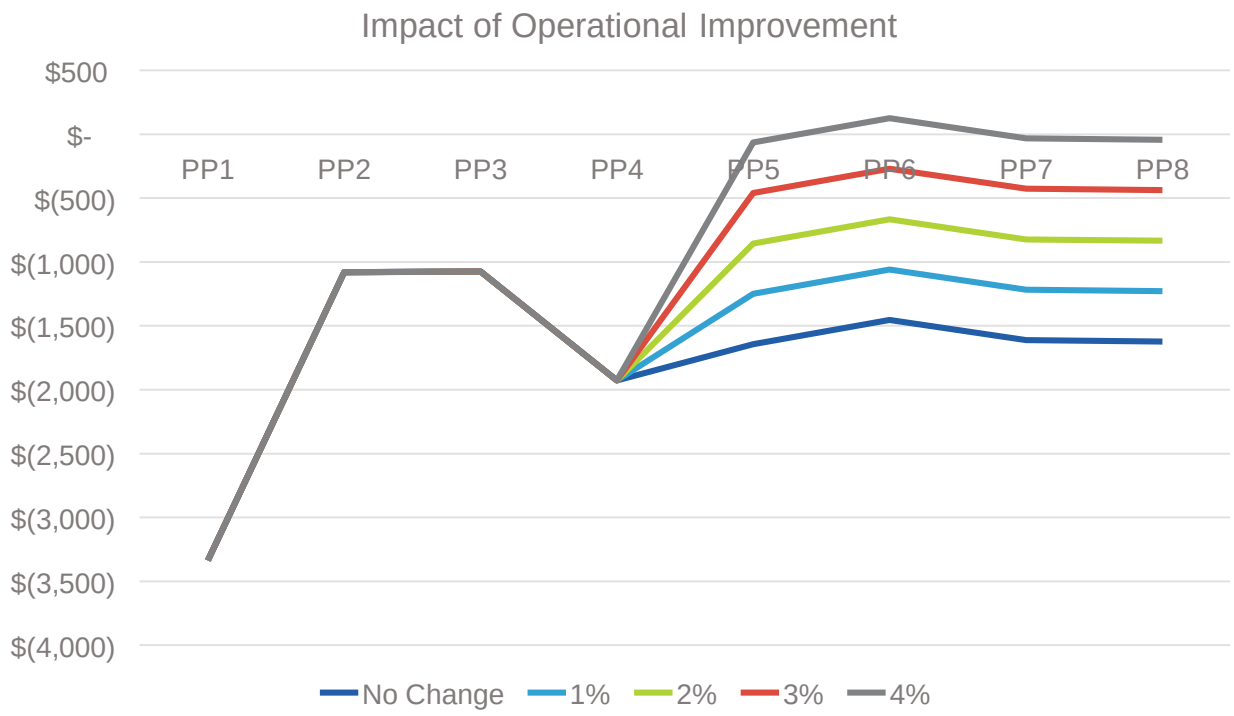
"Raising the Benchmark"

Achieving Quality Measures

Comorbidities

Social Determinants of Health (Health Equity)

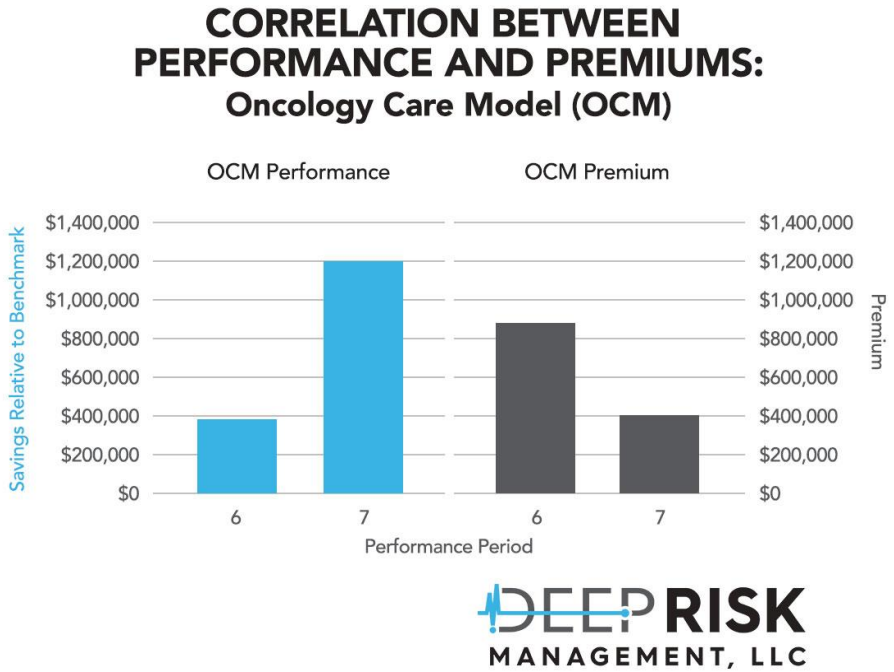
Predictive Modeling, The Impact of Interventions



- Sensitivity analysis showing impact of operational improvement as a % of total episode cost.
- Internally modeled 3 interventions:
  - Care management
  - End of life management
  - Drug swaps (ex: biosimilars).
- Evidence shows that each intervention can result in about 2% operation improvement.

Cede Risk, Not Control Over Risk

Understanding risk is a key to success in healthcare:
Stop buying reinsurance from the payors



Q & A

THANK YOU!

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