Spending Growth and Value-Based Care Reforms: Past, Present, and Future

FLPA Meeting

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June 16, 2026

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Agenda

- Welcome / Introduction
- Rising Health Care Costs: Value-Based Care Perspective
- Value-Based Payment Reforms and Cost Growth
- Value-Based Care Reform in the AI Era
- Implications for Major US Insurance Programs

Major Recent Drivers of Health Care Cost Growth

- **Hospital spending growth**
- **Specialty drug spending**
- **Rising labor costs and workforce shortages**: Accounts for most health care costs, with employment continuing to grow even as job growth in other industries is contracting
- **Administrative waste, fraud, complexity, and poor coordination**: Prior authorization burdens, duplicative claims processes, inefficient eligibility/recertification, complex licensure rules, and fragmented data systems as major cost drivers – despite large ongoing investments in electronic data inftrastructure
- **Rising prices**: Historically major component of US spending growth, with evidence that continuing horizontal and vertical integration continues to contribute
- **High burden of chronic disease and avoidable disease complications** contributing to significant care management and specialty care and drug costs

https://jamanetwork.com/journals/jama/article-abstract/2752664

Hospital Spending as a Key Cost Driver

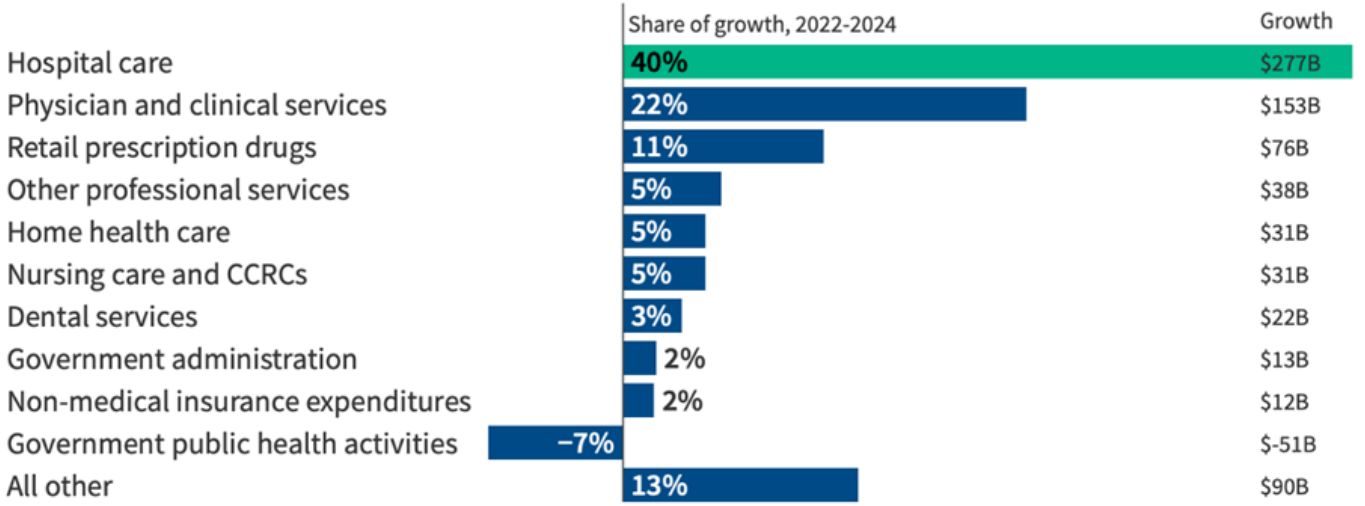
Recent trends and current projections show rising hospital spend is as a primary driver of state and national health care spending.

- In 2024, hospital care accounted for roughly **one-third** of the NHE.
- From 2000-2023, inpatient hospital utilization has decreased by 18%, but **outpatient utilization has increased by 31%**
- From 2022–2024, hospital spending contributed **$277 billion—about 40%—of total NHE growth**
- Recent spending growth is driven by **increased service use and intensity**
- Hospital prices have **grown more slowly in Medicaid and Medicare** than in the commercial market.

Figure 1

Hospital Spending Accounted for 40% of the Growth in National Health Spending Between 2022 and 2024, A Far Larger Share Than Any Other Health Spending Category

Distribution of the growth in national health spending by type of good or service, 2022-2024. Total national health spending grew from $4.6 trillion in 2022 to $5.3 trillion in 2024.



https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/
https://www.kff.org/health-costs/key-facts-about-hospitals/?entry=use-of-hospital-care-outpatient-utilization

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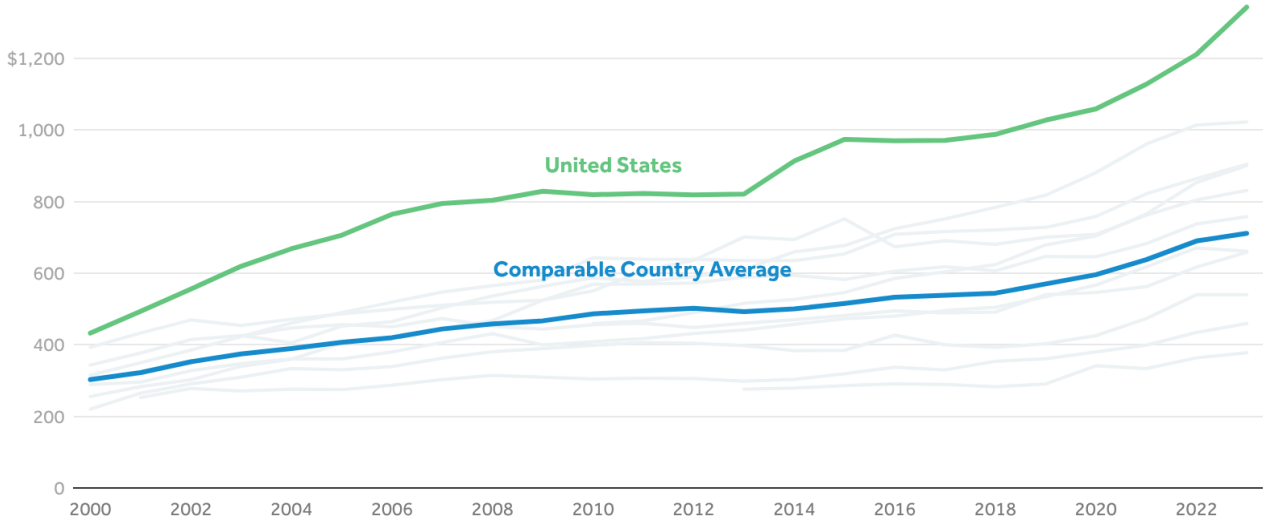
Specialty Drug Spending as a Key Cost Driver

- **Prescription drug costs contribute to health care spending growth, but their impact increasingly occurs through hospital-based care, particularly in outpatient settings.**
- From 2022—2024, retail prescription drugs accounted for **$76 billion or 11% of the growth** in national health spending, while hospital costs were the primary driver.
- Although the **US per capita drug spending is double that of peer countries**, a growing share of **high-cost drugs is administered in hospital outpatient departments**, where facility fees and administrative costs raise spending.
- The rapid expansion of the **340B program reflects incentives that favor drug administration in hospitals**, amplifying hospital spending growth.

Per capita prescription drug spending, USD, 2000-2023



Notes: Data for Sweden are missing before 2001, Belgium before 2003, Austria before 2004, Switzerland before 2010, and the U.K. before 2013. There is a difference in methodology for Canada in 2020, 2021, and 2022. Most recent year data for Canada and Japan are provisional. 2023 data for Australia are from 2022. Data are current prices an PPP adjusted.

Source: KFF analysis of OECD data

Peterson-KFF Health System Tracker

https://www.healthsystemtracker.org/chart-collection/eight-trends-shaping-2026-healthcare-costs/#Per%20capita%20prescription%20drug%20spending,%20USD,%202000-2023m
https://www.kff.org/health-costs/hospital-spending-accounted-for-40-of-the-growth-in-national-health-spending-between-2022-and-2024/
https://www.kff.org/health-costs/3-charts-about-drug-prices-in-the-united-states/

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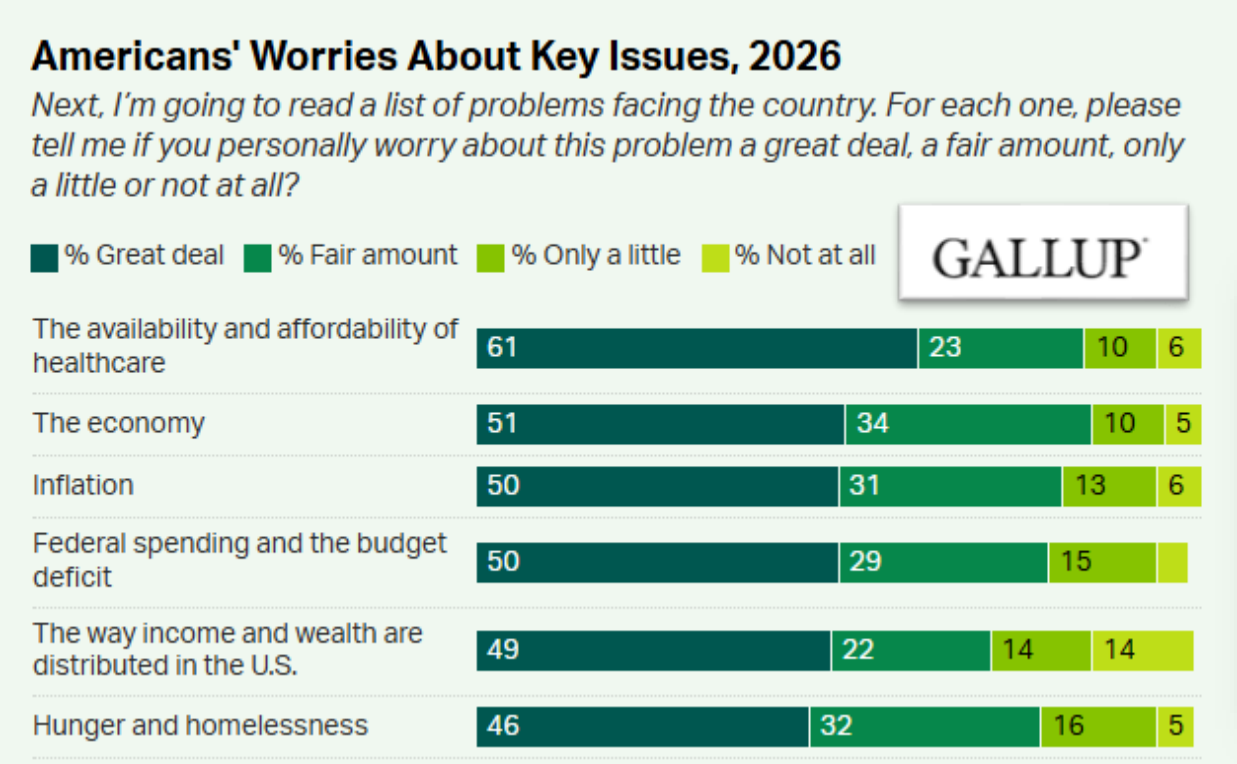
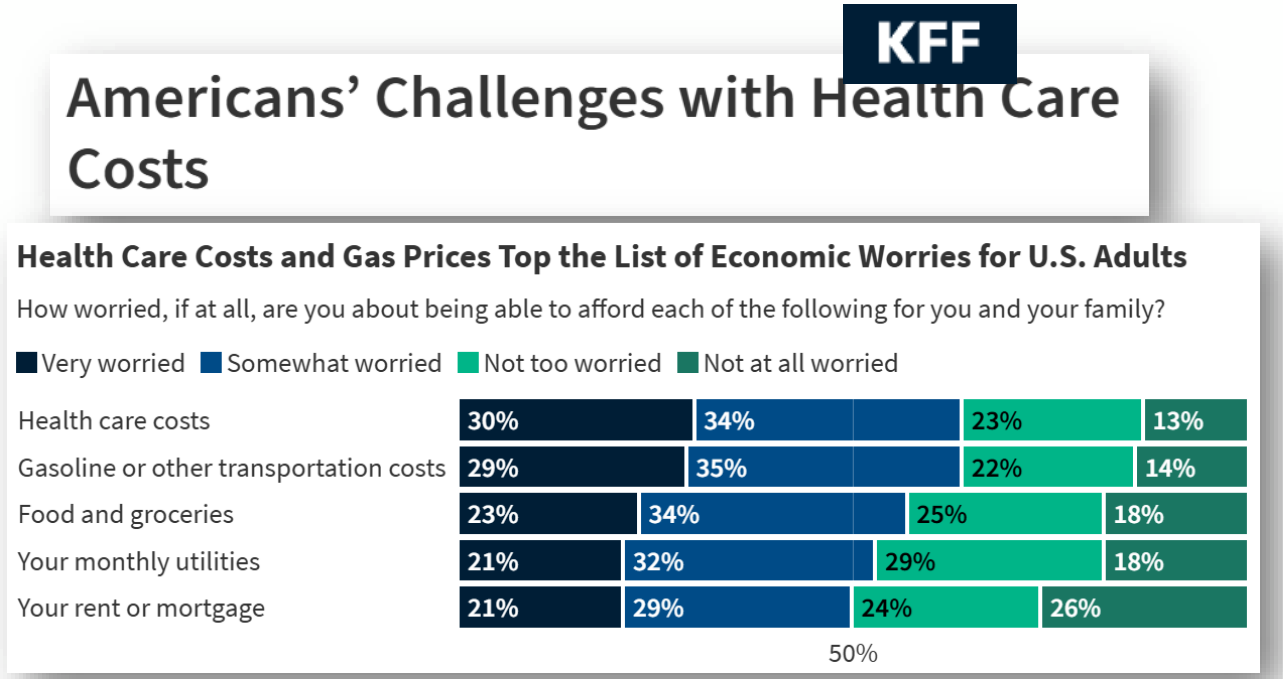
Healthcare Affordability and Access are Top Public Concerns





https://news.gallup.com/poll/707732/healthcare-reclaims-top-spot-among-domestic-worries.aspx
https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/
https://chir.georgetown.edu/do-you-want-to-tackle-health-care-affordability-heres-where-state-policymakers-can-start/
https://unitedstatesofcare.org/pr-rsc-2026/

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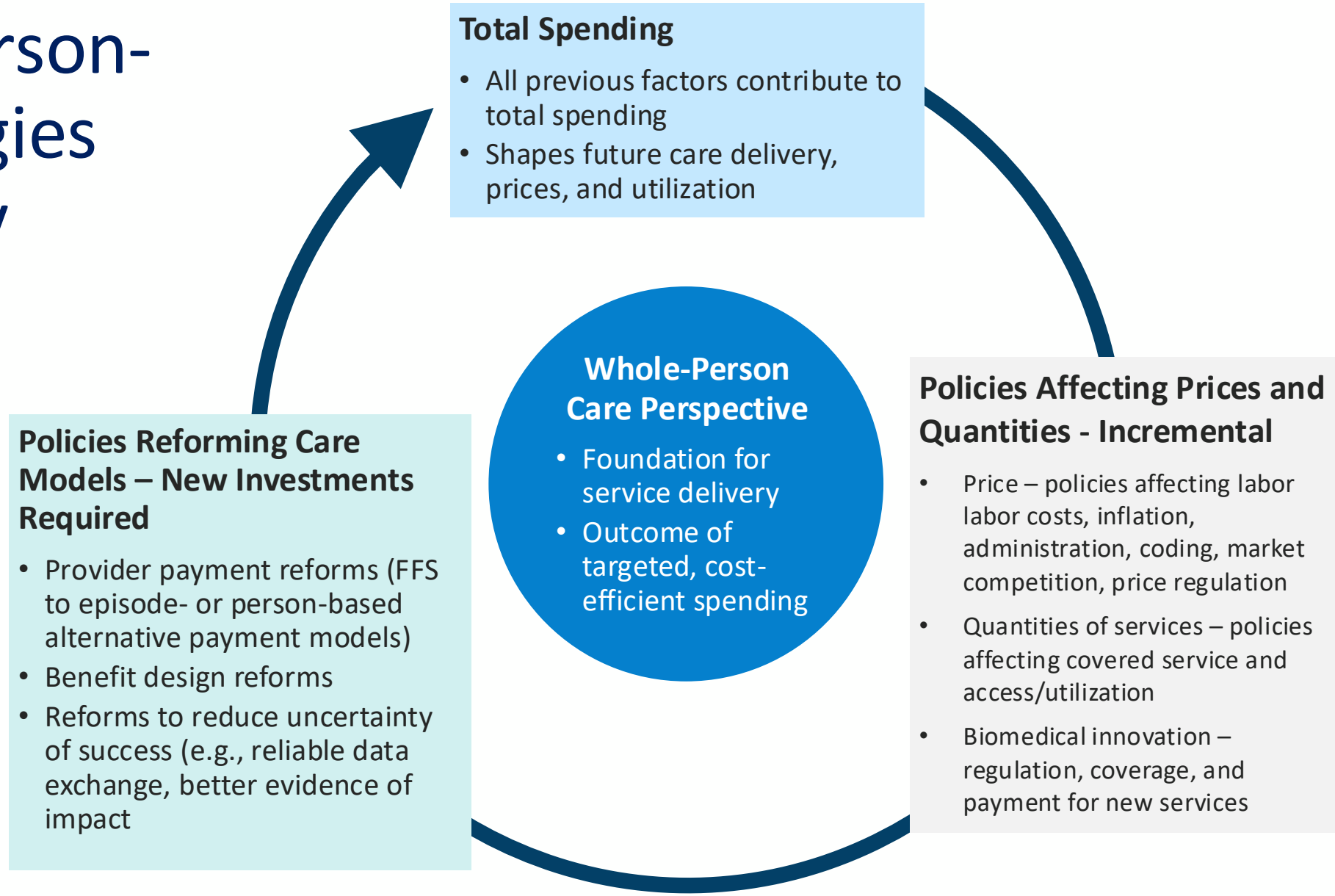
Service- and Person-Focused Strategies for Affordability

- Recent spending growth mainly driven by utilization
- Affordability challenges affecting all payers - Medicaid, Medicare, and commercial
- Different constraints and levers across payers



Graphic adapted from https://www.health.state.mn.us/data/affordability/docs/20251216slides.pdf

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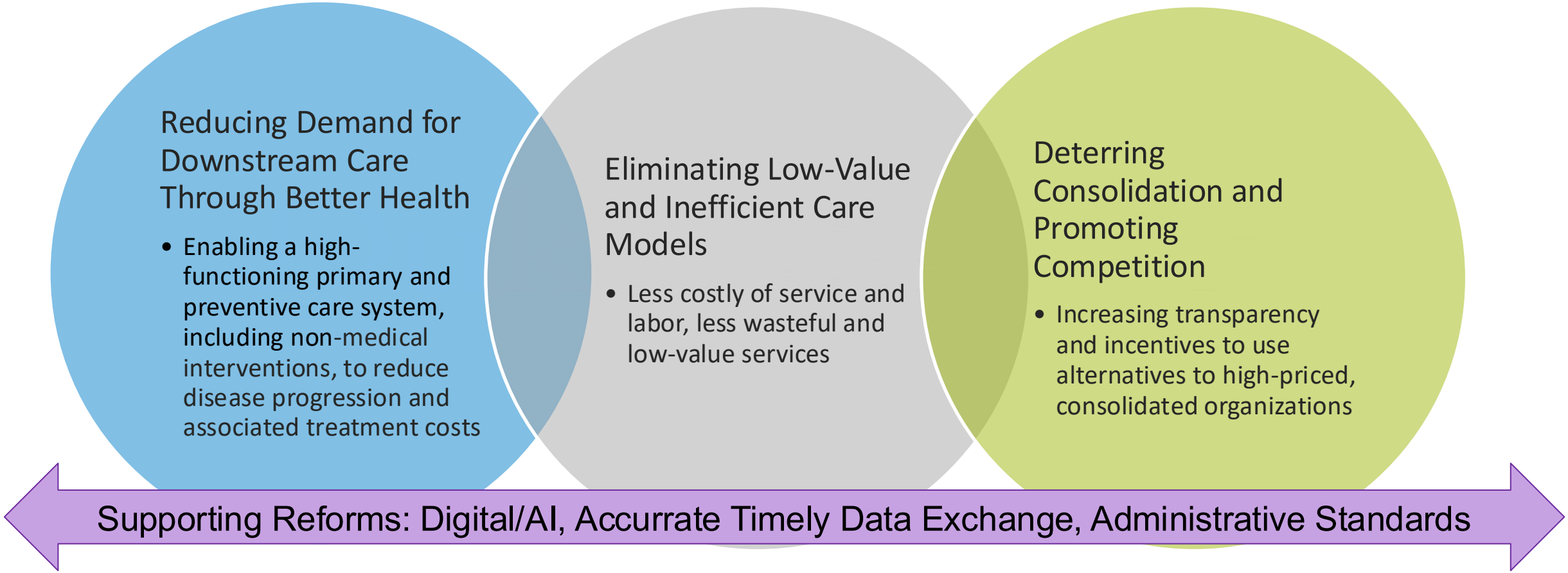
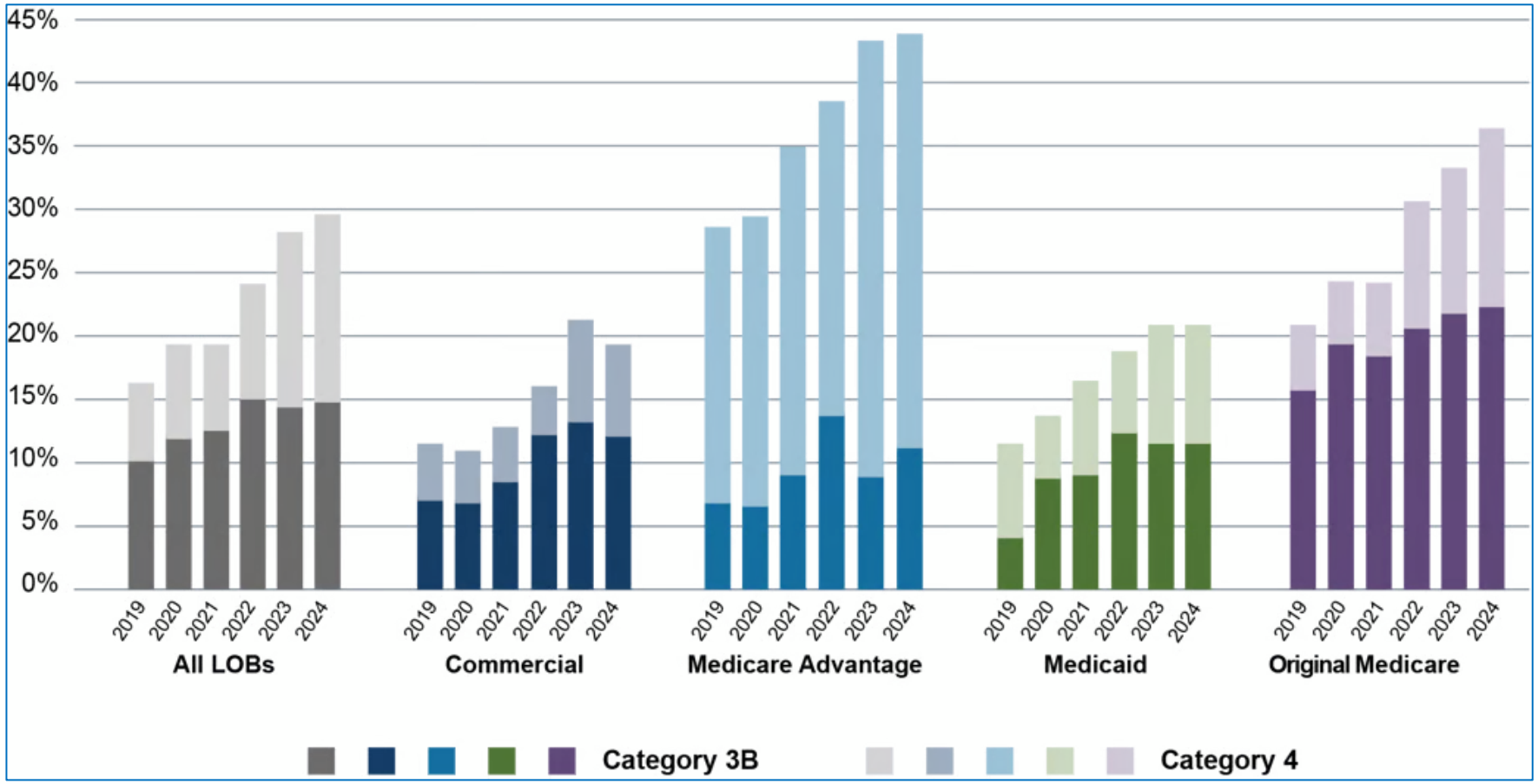
Person-Focused ("Value-Based") Strategies for Affordability



Value-Based Payment Reforms and Cost Growth

Tracking Progress in Value-Based Payment Reform

Many Value-Based Payment and care reforms underway, but most US payments are still based in Fee-for-Service



Shaded: adoption of alternative (value-based) payment models by payer
Darker shade: adoption of "advanced" alternative payment models (downside risk)

HCP LAN
Health Care Payment Learning & Action Network

https://www.ahip.org/resources/2025-apm-measurement

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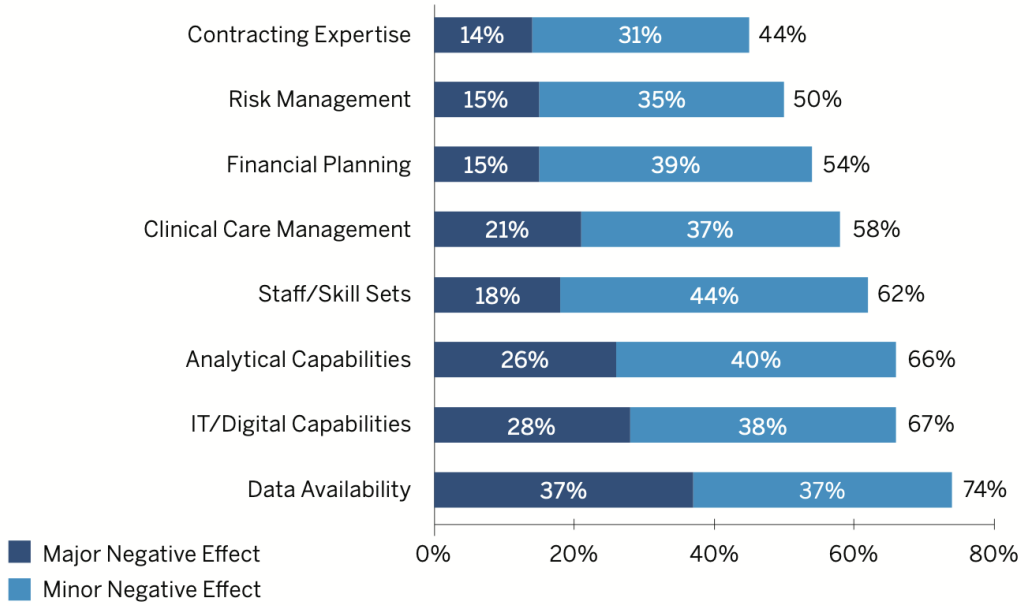
Obstacles Remain for Physician Groups and Payers To Shift to Person-Centered Care and Payment

Figure 5

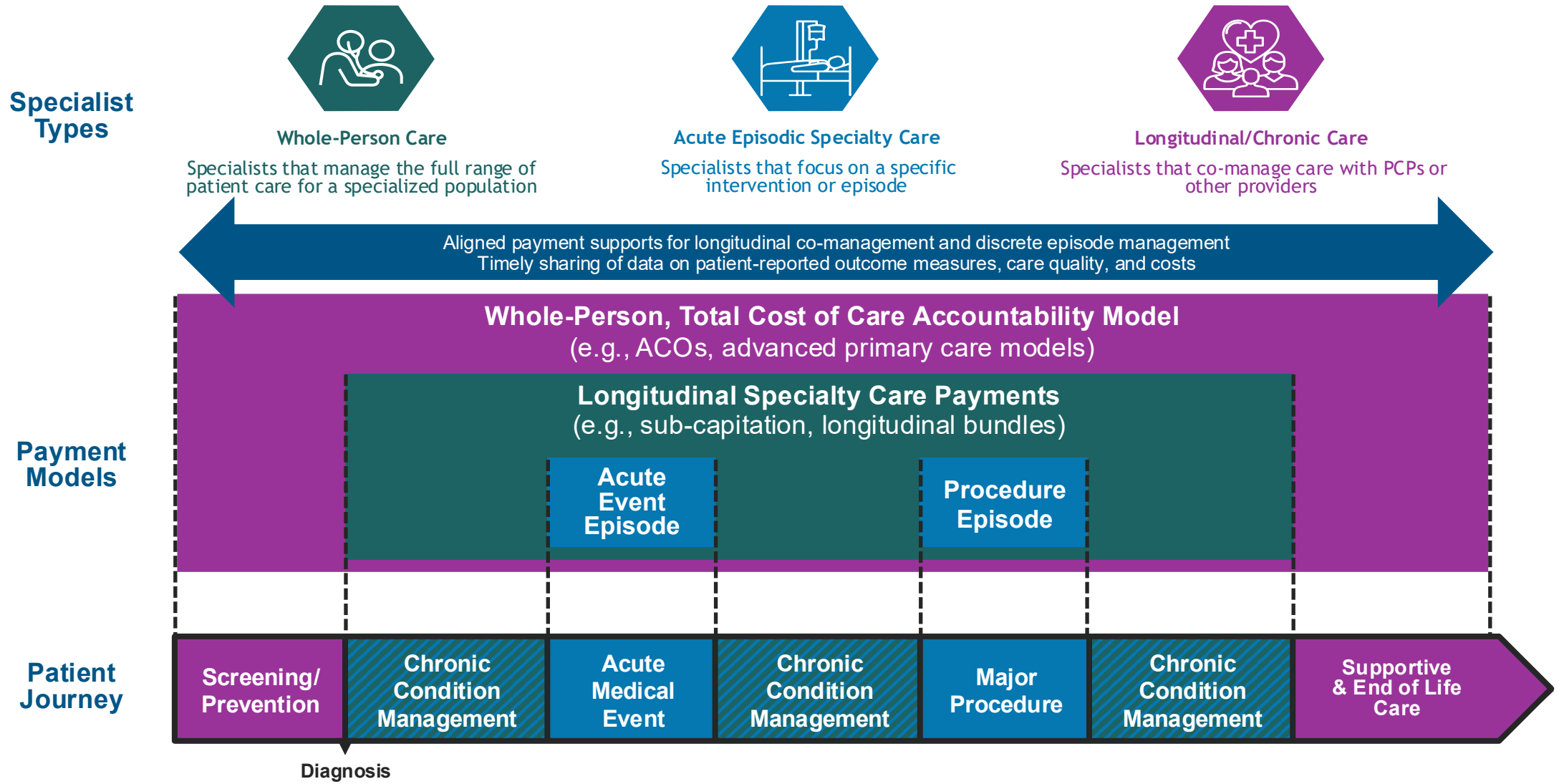
Share of Respondents Saying That Capability Gaps Have Had a Negative Effect on the Performance of Their VBC Programs



Promising Directions for Value-Based Payment Reforms

- *Reforms with total cost of care accountability, especially for primary care practices* – Medicare SSP and AIM, BCMA AQC
- *Mandatory* reforms not voluntary "pilots" -- TEAM, ASM, CJR-X
- *More aligned payment reforms across payers* focused on total cost of care accountability – MD AHEAD
- *Aligned value-based benefit reforms* with price and quality transparency – Pubished employer models
- *Well-defined and targeted interventions to address nonmedical drivers* – Medicaid NC HOP, FoodSmart published reform evaluations
- *Clear and reliable long-term path* to support increased investment over time – Medicare SSP + LEAD to improve payment reliability contracting, MA reform goals
- *Specialty care integration* into TCOC models

Framework for Integrating Value-Based, Longitudinal Specialty Care



Adapted from Strengthening Specialist Participation in Comprehensive Care through Condition-Based Payment Reforms and Engaging Specialists in Accountable Care: Tailoring Payment Models Based On Specialties And Practice Contexts

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Value-Based Care Reforms in the AI Era

Technology (Digital/AI)-Enabled Care Transformation

Transformation Opportunities for Care Models in Every Stage of Patient Journey

Area of Opportunity	Goal	Technology Advancement
Operational Efficiency	Reduce administrative burdens and improve care coordination and followup	• Ambient scribing • Priority gap closure opportunities • Automate and refine reliable data use (payment documentation, prior auth, contract simplification, etc.)
Patient Engagement	Leverage patient facing technology to improve care planning and treatment	• Wearables/Remote Patient Monitoring • Conversation AI tools for education/check-ins/triage
Targeted Risk Reduction	Personalized risk identification and risk-reducing interventions	• Surveillance/prediction tools for geographic or demographic disease pattern changes • Population risk prediction tools to assign available resources appropriately
Clinical Decision Support	Implement care plan and care management approach	• Risk prediction algorithms & triage • Personalized care recommendations • Tools to surface relevant patient history information
Care Model Reform	Support lower-cost, more reliable care models	• Triage • Automated Software as a Medical Device (SaMD) to move early specialty care to primary space (e.g., diabetic retinopathy) • AI tools for personalized care planning

Impact of Payment Mechanisms on AI Adoption

FFS Payment:
More efficient services – but also more billing and spending

- Ambient listening, task shifting enables more and less costly procedures and visits
- More tools for optimizing prior authorization and documentation on both sides – unclear effects on value, but providers have more data to leverage
- More access and billing for services that AI could augment, or provide: diagnostic tests, telehealth, remote monitoring
- Continuation of fragmented care, optimized to FFS payment structure

Person-Level Payment:
Potentially more access, efficiency and value if well targeted – but requires new supports

- Per-member per month (PMPM) payments for sets of digital/AI-enabled services, linked to patient experience and quality/outcomes
- Aligns with accountable care payments to providers, to integrate services for more efficient, prevention-oriented whole-person care
- Challenges in implementing reliable measures of patient experience and outcomes

Technology (Digital/AI)-Enabled Care Transformation

Foundational Data Sharing Infrastructure

- Need for actionable, real-time data supported by FHIR standards
- Ability to access key data from multiple sources reliably (payers, other providers, patients)
- Apply AI tools to make less structured data more actionable

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The Future of Digital Health and AI

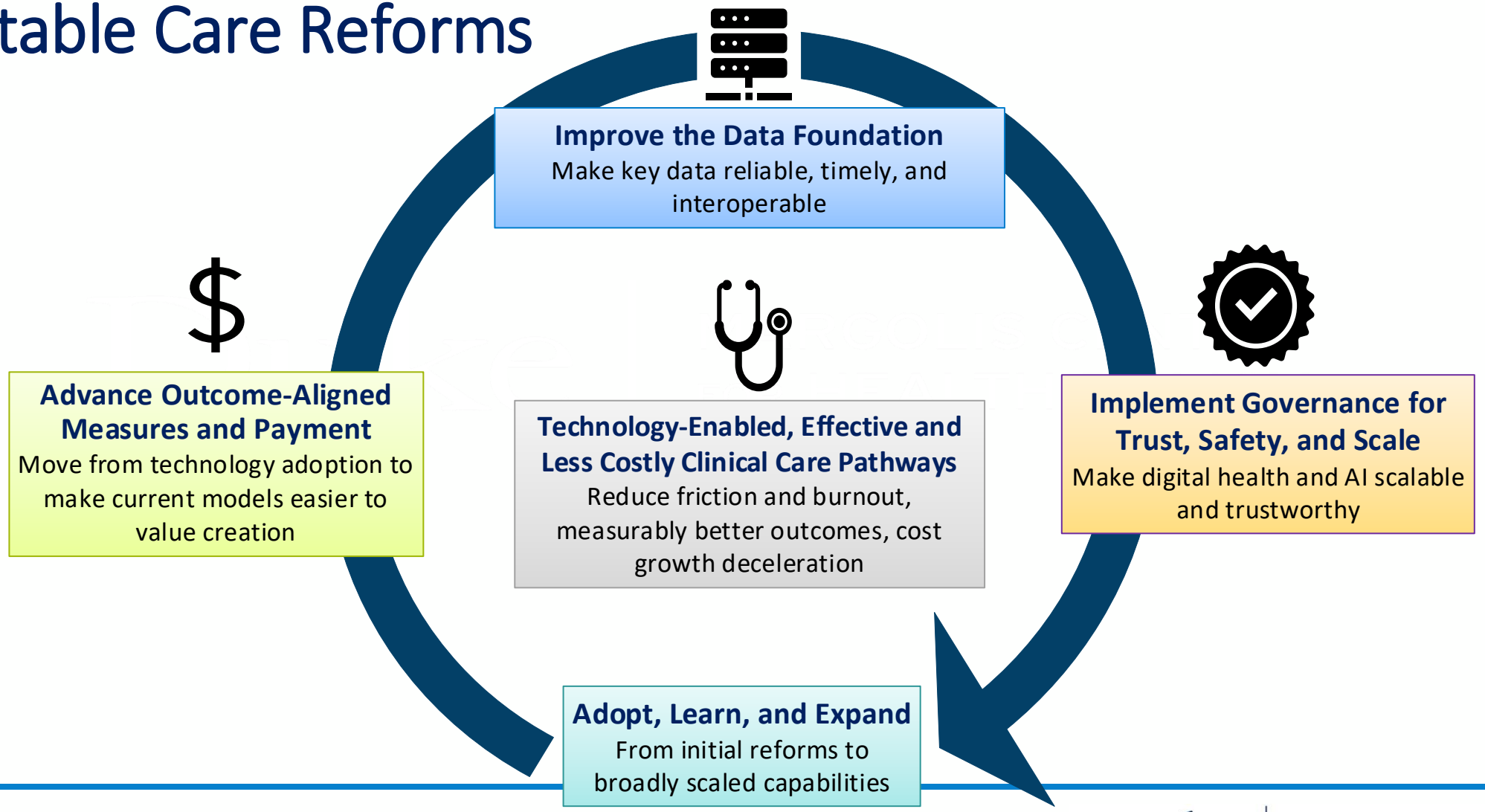
Great Potential

- ***Administrative*** applications enable improved patient experience, reduced clinician burnout, and significant reductions in labor costs
- ***Clinical*** applications – starting with decision support tools and extending to clinical care delivery – to improve care access and quality, and patient outcomes
- ***Supports for smaller and less-resourced care providers*** and increasing direct-to-patient (and direct to consumer) tools improve access and affordability
- ***Transparency*** on performance, safety and value of AI solutions across locations and patient populations enables informed and confident adoption

Achieving the Potential

- ***Unbiased and accurate data*** are available for AI training and in using AI applications
- ***Financial supports*** reward adoption and diffusion of AI that improves patient experience and outcomes, reduces costs – including by less-resourced providers
- ***"Assurance" collaborations*** *support sharing and refinement of best practices* for governance: AI transparency, appropriate uses, privacy/security, and ongoing assessment in use
- ***Shared assessment platforms*** enable secure data analysis of safety, effectiveness, and value using and appropriate evaluation methods evaluation methods

Achieving Tech-Enabled, Affordable Care: Key Role for Accountable Care Reforms



ACCELERATING PROGRESS

Technology-enabled, accountable care that drives efficiency and delivers high quality care for all Americans.

FOUNDATIONS FOR CARE DELIVERY

Reliable Source Data with Timely Availability

Payment Aligned with Value to Person Not Services

Governance

REINFORCING PAYER REORMS

Original Medicare

Medicare Advantage

Medicaid

Commercial

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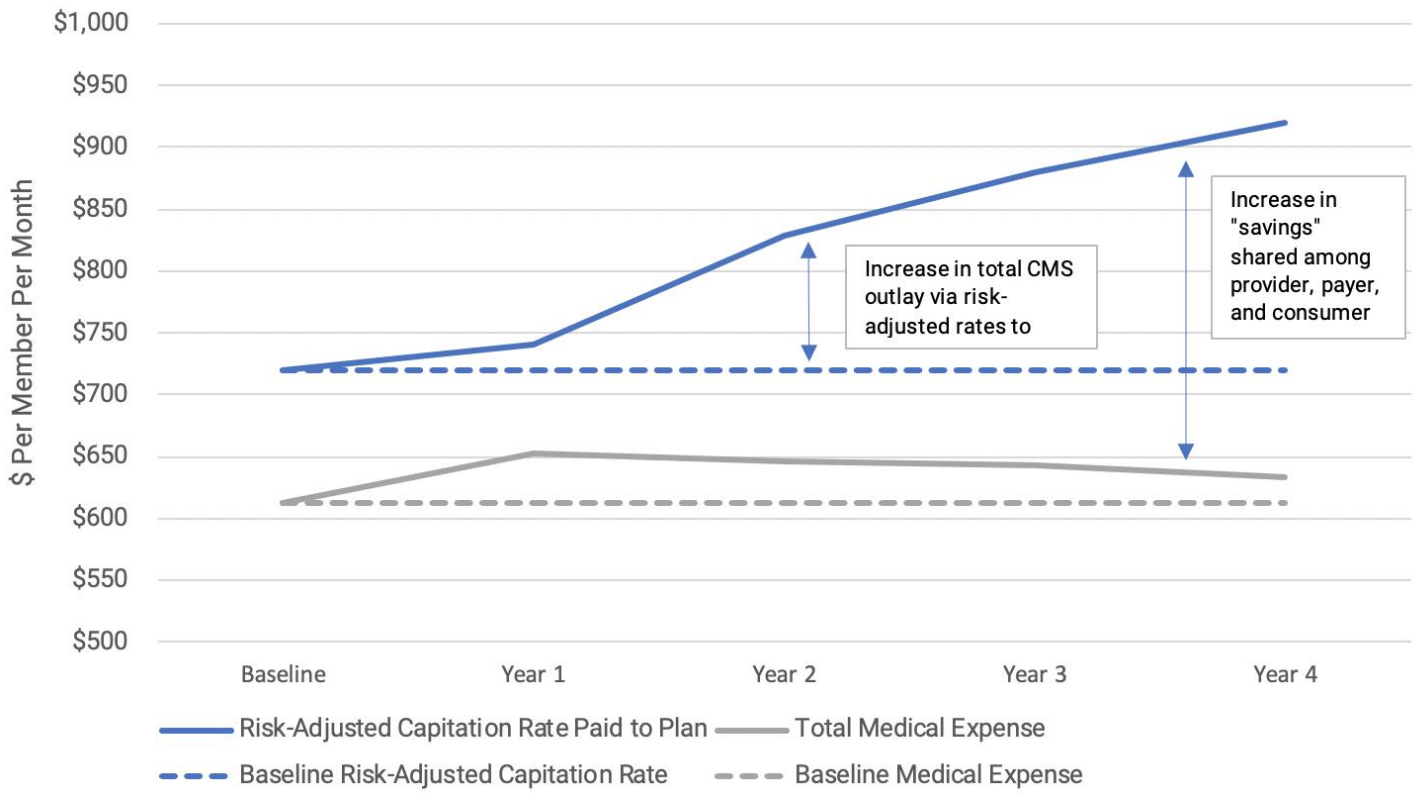
Implications for Major US Insurance Programs

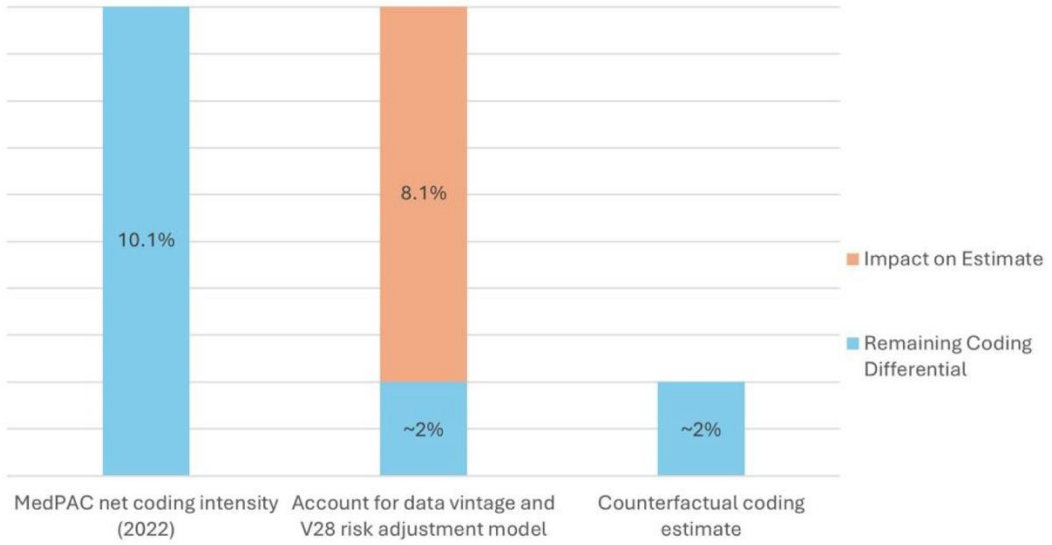
Medicare Advantage Risk Adjustment Policies Can Achieve Less Costly Care, Shared Savings with Providers, *and* Net Spending Growth

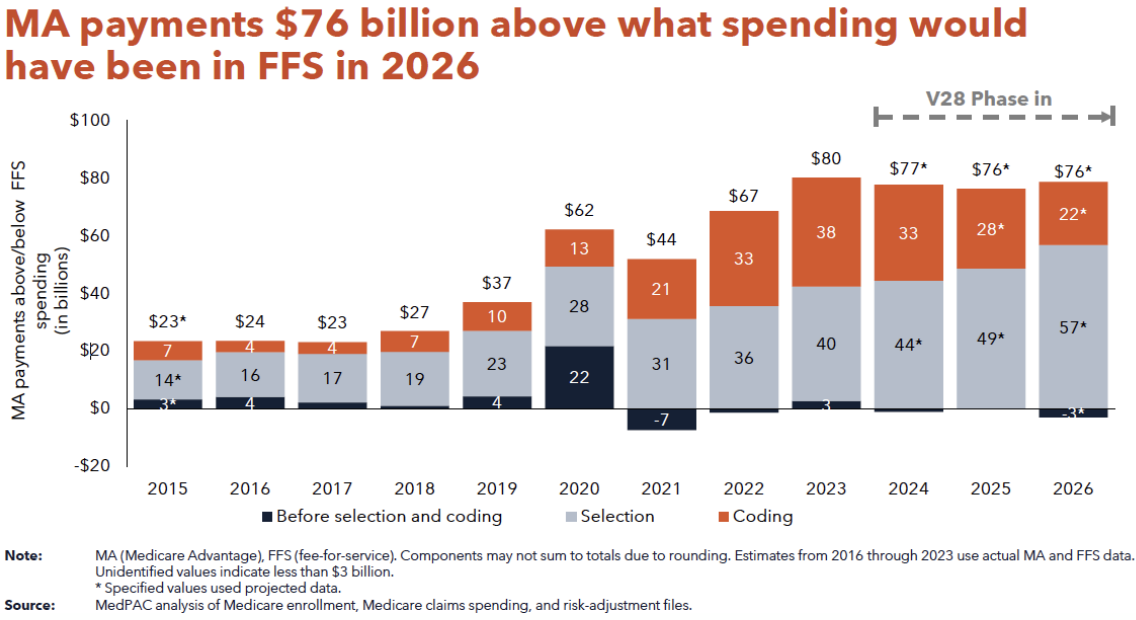
- "Percentage of premium" health plan contract sets a medical expense target for the accountable provider group as a percentage of the total risk-adjusted capitated payment (e.g., provider benchmark is 84% of the plan's risk-adjusted capitated payment)
- Aligns purchaser, insurer, and accountable provider on reducing total medical spending while improving performance
- *But* also aligns insurer and provider on maximizing effort to report diagnoses that increase risk-adjusted capitated payment



Sharp et al. Realizing the Vision of Advanced Primary Care: Confronting Financial Barriers to Expanding the Model Nationwide. Health Affairs Blog March 2020. DOI: 10.1377/hblog20200325.524312

Medicare Advantage / Original Medicare Net Savings





- Costs of delivering Medicare benefits appears significantly lower in MA HMO plans vs OM, but estimated Medicare spending is higher
- Recent CMS analysis reflecting phased in V28 and more recent utilization patterns substantially reduces estimated MA vs OM per-beneficiary payment differential due to risk coding
- Unlinked chart review elimination will also reduce coding intensity
- However, MedPAC analyses suggest substantial favorable risk selection into MA
- Significant risk data improvements needed to improve reliability of assessments

Health Affairs Scholar, 2026, 4(1)
https://www.medpac.gov/wp-content/uploads/2026/01/Tab-N-MA_Status-Jan-2026.pdf
https://academic.oup.com/healthaffairsscholar/advance-article/doi/10.1093/haschl/qxag010/8430651?searchresult=1

Post-V28 MA Payment Reforms

Recent

- **Reform MA performance measures and payments** to move to more meaningful and less burdensome measures, including shift to use of standard electronic health data, that are less additive to spending vs OM
- **Reform risk adjustment** to reduce opportunities to manipulate data

Still to Go

- **Risk adjustment reform with more accurate, objective data on diagnoses and severity**

Original Medicare

ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model

The ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model introduces **Outcome-Aligned Payments (OAPs)** — an approach that rewards results, not activities, and enables flexible, technology-supported care that improves patients' health

CMS Goals:

- Reward outcomes improvement – reliably measured risk reduction – not documentation of diagnoses or processes
- Encourage :deflationary" competition to scale lower-cost, digital/AI intensive solutions

	OAP Tracks
1	**Early Cardio-Kidney-Metabolic (eCKM)**: Hypertension, dyslipidemia, obesity or overweight with marker of central obesity, and prediabetes
2	**Cardio-Kidney-Metabolic (CKM)**: Diabetes, chronic kidney disease, or atherosclerotic cardiovascular disease
3	**Musculoskeletal (MSK)**: Chronic musculoskeletal pain
4	**Behavioral Health (BH)**: Depression or anxiety

	Information for Clinicians and ACOs
1	**ACCESS Co-Management Payment**: clinicians who co-manage ACCESS beneficiaries with an ACCESS participant may bill a new ACCESS Model Co-Management service
2	**Benchmarking Effects**: For 2026 and 2027, CMS anticipates that there will be no impact from ACCESS OAPs on ACO benchmark and PY calculations for MSSP and ACO REACH

Original Medicare | Medicaid

CMS Health Technology Ecosystem Framework

In July 2025, CMS announced a **Health Technology Ecosystem Framework** comprised of **CMS-recognized *beneficiary* apps** and tools, **CMS Aligned Networks** to enable needed data sharing with providers and plans, and **Early Adopters** for implementation in 2026

Framework Criteria	Stakeholder Types (Early Adopters)
• Patient Access & Empowerment	• Data Networks
• Provider Access & Delegation	• Payers
• Data Availability & Standards Compliance	• Electronic Health Records (EHRs)
• Network Connectivity & Transparency	• Health Systems and Providers
• Identity, Security & Trust	• Patient Facing Applications (below)

CMS is implementing a national healthcare directory, starting with provider information

CMS is implementing digital patient identity verification, expected to be free for Medicare beneficiaries

CMS is working on an app store interface on Medicare.gov to highlight specific applications

Patient-Facing Application Use Cases

Kill the Clipboard

Chronic Disease Prevention and Management

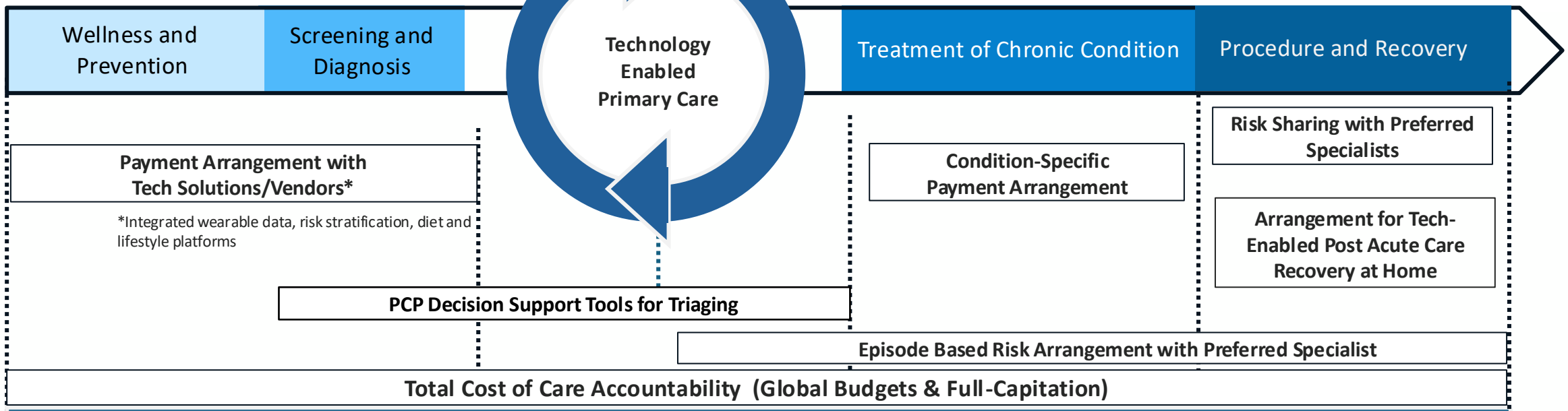
Conversational AI Assistants

Sources: https://www.cms.gov/health-technology-ecosystem/interoperability-framework
https://www.cms.gov/health-tech-ecosystem/early-adopters

Electronic Health Data Policies: Interoperability and Transparency to Support Value-Based Care

- **EHR data standards: FHIR-based data exchange using USCDI, USCDI+ standards**
  - CMS certified EHR requirements now enable timely, accurate, secure bulk data sharing
    - "Bulk FHIR" exchange methods using APIs can support bulk data exchange among providers and with health plans
    - TEFCA, QHINs provide secure data sharing mechanisms
    - CMS infrastructure supports coming online: identity authentication, provider directory, security monitoring, …. +
  - But not yet widely used for sharing such data for improving care or reducing administrative burden of coverage determinations and payment – still based on nonstandard forms, faxes, and claims ("encounters")
- **Lead policy reform "use cases" to create ROI for adoption**
  - ***Automated prior authorization*** through CMS standards for clinical data exchange needed to resolve most common types of prior authorization – Health plan commitments, new CMS Health Tech Ecosystem Payer-Provider Group
  - **Automated risk adjustment determinations** using standard bulk data access from electronic health records and utilization data
  - ***Performance measurement and automated reporting*** through Medicare/multipayer adoption of measures that support low-cost bulk access from HER, patient-generated, and utilization data

Medicare Strategies for Tech & AI-Enabled Care Reforms



Patient Engagement: wearables/Remote Patient Monitoring, conversational AI tools for education/check-ins, lifestyle and diet platforms

Care Delivery

- Ambient scribes
- Automated Software as a Medical Device (SaMD) to move early specialty care to primary space
- Remote Patient Monitoring
- AI tools for personalized care planning
- Referral to technology first specialty care for chronic conditions
- Agentic AI care coordination
- Agentic AI to address gap closures
- AI-supported imaging
- Remote Patient Monitoring

Operations

- Surveillance/prediction tools for geographic or demographic disease pattern changes
- Population risk prediction tools to assign available resources
- Algorithms and decision support to drive population health management & high-quality referrals
- Automate data interoperability (claims decisions, quality measures, etc.)
- Data sharing between specialists and primary care

A strong data infrastructure with reliable, multi-source, reliable and secure data availability

Modernizing Medicaid with Value-Based Care Reforms

- Advance health technology and data sharing, including for implementation of community engagement requirements
- Refine and accelerate payment reforms, especially total cost of care models
- Address upstream prevention through whole-person care, including care management and coordination
- Establish clear guidance on empirical evidence for budget neutrality
- Catalyze innovative coverage features and benefits within the bounds of budget neutrality
- Leverage rapid evaluation to target services and scale successful programs to get to a more sustainable Medicaid
- Facilitate opportunities for cross-state and state-federal collaboration to scale and standardize where appropriate

Medicaid

Rising Risk Identification for Targeted Care Management

Utilization of intensive, costly services such as emergency department visits or inpatient care can drive higher spending, necessitating the use of standardized, evidence-based, and data-driven approaches to better target needs and improve the effectiveness of services and spending.

- **Cross-Sector Data Integration to Identify Risks Earlier**: Integrate data across sectors (e.g., clinical, social, educational, and justice data) to enable earlier and more effective identification of at-risk individuals. This approach can support timely interventions, improve coordination across systems, reduce service duplication, and lower administrative costs.
- **Target Services to Those With the Greatest Need**: Target specific interventions to individuals most likely to benefit, such as people with the highest health care costs or individuals at elevated clinical risk (e.g., pre-diabetes or diabetes, individuals with high-risk pregnancies. Cross-sector data integration can help more effectively identify and prioritize these populations.

Examples

- **NC Integrated Care for Kids**: Risk stratification algorithm uses data across health care, education, and social systems to holistically understand needs and identify children who may benefit from additional supports.
- **Waymark**: Uses machine learning models leveraging longitudinal claims and other data sources to identify rising-risk Medicaid patients. Machine learning-powered risk identification and care management intervention was associated with PMPM cost savings and decreases in all-cause acute events.

Medicaid

Framework for Innovative, Sustainable Medicaid Service Benefits

Care Management & Coordination Interventions & Implementation Pathways

Intervention Type	Services	Levers & State Examples/Potential Pathways & Authorities	Intervention Impact Examples	Implementation Mechanisms
Care Management and Coordination	• Targeted Case Management (TCM) • Health system navigation and resource coordination (Community Health Workers)	• **1115 waivers:** CA • **Section 1905(a) State Plan Authority:** UT, TN • **Section 1915(c) HCBS Waiver:** KY • **1915(i) State Plan HCBS**	**Waymark/Aetna VA MCO Authority** **ROI:** Early community-based interventions supported by rising-risk machine learning models were associated with PMPM cost savings. **Health impacts:** Those interventions were also associated with decreases in all-cause acute events.	• Health plans • Plan contracted entity • State-sponsored entity

Data Infrastructure for Improved Health Risk Identification and Service Use

Case Example: NC Integrated Care for Kids (NC InCK)

- Risk stratification algorithm uses data across health care, education, and social systems to holistically understand needs and identify children who may benefit from additional supports
- The Government Data Analytics Center safely stores and links shared data, safeguarding data privacy and security while helping health care organizations and plans be more effective in reducing risk

Efficient Evaluation Methods for Demonstrating Impact of Innovative Services and Care Management

Case Example: Waymark

- Uses machine learning models leveraging longitudinal claims and other data sources to identify rising-risk Medicaid patients and prioritize guidance to care teams on the specific interventions most likely to impact risk trajectory
- Includes a range of methodologic tests to validate model predictions

Medicaid

Innovative Medicaid Service Benefits Matrix

Service	State Policy Levers	Impact on Health Outcomes and Cost
Food Care • Nutritional counseling/medical nutrition therapy • Medically-tailored meals • Home-delivered meals • Pantry stocking	**1115 Waivers** **Section 1905(a) State Plan Authority** **1915(c) HCBS Waivers** **MCO Authorities**	**Foodsmart** • RCT found Medicaid patients with Type II diabetes who received free produce significantly improved blood sugar levels • Matched pair propensity study found MCO beneficiaries receiving food care services had combined PMPM spend $97 less than control group
Housing • Tenancy support • Wraparounds to housing benefits • Medical respite/recuperative care • Home safety and accessibility modifications	**1115 Waivers** **Section 1905(a) State Plan Authority** **1915(i) State Plan HCBS** **1915(c) Waivers** **MCO Authorities**	**California – Medi-Cal ILOS 1915(B)** • Accessing at least one of three housing community support services was associated with reduced inpatient and ED use • Housing deposit services were associated with reductions in costs across inpatient, outpatient, ED, long-term care, and outpatient mental health services
Non-Medical Transport • Transport to covered non-medical services	**1115 Waivers** **1915(c) Waivers** **1915(i) State Plan HCBS**	**Ohio**: Pregnant Medicaid beneficiaries who could access enhanced smart transportation had increased satisfaction compared to their usual transportation. **Iowa**: Medicaid beneficiaries used ride services to address health-related social needs, with some reporting that they could not otherwise meet their transportation needs.
NC Healthy Opportunities Pilots (NC HOP): • 29 covered services across **Food Care**, **Housing**, **Non-Medical Transportation**, **Interpersonal Violence/Stress**	**1115 Waiver**	**NC HOP Interim Evaluation** • HOP participation was associated with reductions in ED utilization overall, and reductions in inpatient admissions among non-pregnant adults • HOP enrollment was associated with a differentially lower trend in per member per month (PMPM) spending (-$85 PMPM)

Cross-Cutting Example Across Service Domains

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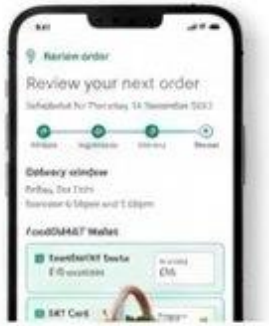
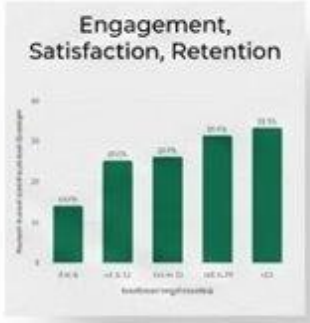
Foodsmart Telenutrition & Value-Based Foodcare: Clinically Validated Results & ROI

Foodscripts (Fx) referrals & outreach
+ Care Coordination

FoodSMART Telenutrition
w/ Foodcare Plans



FoodSMART & Food-as-Medicine
Benefits Mgmt (FBM)



Top-tier Evidence on
Sustained Savings & Growth

CLINICALLY VALIDATED RESULTS

42%
with food insecurity
become **food secure**
by 6 months

33%
with obesity
lose ≥ 5% weight
at 2 yr; 1yr for Medicaid

Sustained weight loss
3 yrs +; programs like DPP regain weight by 1.5-2 yr; ozempic users regain more weight than lost & 2/3 discontinue by 1 yr

36% with dyslipidemia
return to **normal lipid levels**
over average 18 months

39%
with diabetes
control HbA1c
(-0.07%) at 24 months

33% with hypertension
achieve BP control
(-5.6/4.0 mmHg) orng 9

RCT 0.5 drop in HbA1c- largest RCT in world with top national payvider & top nutrition university

ROI & SAVINGS

Claims Savings:
Foodsmart generates
$40 PMPM Savings
across a **National Commercial** population as validated by Optum

Foodsmart generates
$53 PMPM Savings
across
Medicaid populations

(National commercial payer, national health IT leader, community health plan consortium: $25-$58 PMPM savings)

Employer-Driven Value-Based Care Reforms to Reduce Costs and Improve Care Leveraging Technology-Enabled Care Models and Aligned Benefit Designs

Key Elements

Modernized Primary Care that incorporates direct-to-beneficiary wellness and prevention supports	**Personalized Care Support** using better and more timely data, analytics, and real-world evidence to identify employee risks and needs and align with efficient access to service providers, preventive and specialized, to improve outcomes and lower costs	**Redefined Networks of Specialized Care Providers** that reliably deliver high-quality, lower-cost care, linked to benefit designs, incentives/nudges, and actionable information on quality and cost for employees	**High-Value Specialty Care Models** incorporating high-cost drugs and curative therapies, including direct biopharma-patient models	**Reliable Outcome and Value Measurement** to provide evidence for improving and scaling effective reforms

Supporting Policy Reforms

Near Term	Longer Term
More reliable and frictionless exchange of critical data to support care improvement; public-private initiatives to improve evidence; regulatory reforms (e.g., network requirements) and other steps to accelerate scale-up of successful models	More effective and affordable care models provide foundation for supporting public policy reforms – ICHRA expansion and ACA coverage reforms designed to integrate innovative care models into exchange coverage; employer tax subsidy reform to finance lon0-term, reliable access to high-value employer coverage

Health Value-ROI: DispatchHealth

Dispatch delivers on-demand health care to patients in the comfort of their own home, reducing unnecessary ER visits and hospital readmissions. Dispatch's system of care includes in-home ER-level medical care, advanced/hospital alternative care, and recovery/bridge care.

Health Value (HV) Model	HV-KPIs*
Population: Medically complex patients, frequent ER/hospital utilizers; often Medicare or MA eligible; over half are typically homebound. In 2019, >800k Medicare hospitalizations could have qualified for hospital-at-home. [1]	• **Member satisfaction/Net Promoter Score (NPS)** (scale of 100): Across markets, Dispatch achieves a typical NPS of 97-98.[4] Results from Dispatch's work with a regional Blue plan showed an NPS of 95 among members who received acute care and 97 among those who received Recovery Care.[4] • **Hospital readmission rate:** A regional Blue plan saw a 49% reduction in readmission rate and 53% improvement in 30-day hospital readmissions among members who received Dispatch's Recovery/Bridge Care solution.[5] • **ER, ambulance, and hospital diversion rate:** Across markets, Dispatch Acute Care visits divert patients from the ER 58% of time, from an ambulance 20% of time, and hospital admission 3% of time.[5] Advanced Care visits lead to an 30-day hospital readmit rate of 8.5% (the national average is 20%).[5] • **Savings per diverted ER visit and hospital readmissions:** Across markets, Dispatch sees medical cost savings of $1,625 per Acute Care visit and $5-7k per Advanced Care visit. Total Acute Care and Advanced Care savings amount to $1.5B across all markets.[4] Dispatch's work with a regional Blue plan saved $1,700 per diverted ER visit and $30,000 per avoided hospital readmission, or ~$3M in total savings.[5] *Echo Health Ventures uses a strategic engagement model to establish and improve partnerships between its health plan stakeholders and portfolio companies. Echo believes its involvement in expanding Dispatch's contract with the regional Blue plan mentioned above helped contribute to the KPI results and Dispatch's overall impact.
Patient Outcomes: In-home services lower mortality rates, fall risk, and the onset of delirium.[1,2] The Dispatch system of care allows members to remain in their homes, avoid hospitalizations that may come with complications, and maintain quality of life as defined by member goals.	
Payer Impact: Shifting site of service enables patients to remain in their homes, even for acute and inpatient interventions, which would traditionally be delivered in the ER or inpatient setting. This reduces health care spend for payers.[3]	

Sources: 1. Laurila, Jaakko V., Raimo O. Pitkala, Harriet Strandberg, and Timo E. Tilvis. 2009. "Delirium in Elderly Home-Treated Patients: A Prospective Study with 6-Month Follow-Up." *BMC Geriatrics.* https://pmc.ncbi.nlm.nih.gov/articles/PMC2693729/; 2. Stuck, Andreas E., Juerg C. Egger, Gerhard Hammer, Christa M. Minder, and John C. Beck. 2015. "Preventive Home Visits for Mortality, Morbidity, and Institutionalization in Older Adults: A Systematic Review." *BMC Public Health*. https://pmc.ncbi.nlm.nih.gov/articles/PMC3951196/.; 3. Smith, Adam C., and Jonathan P. Jones. 2017. "Innovative Home Visit Model Associated with Reduction in Costs, Hospitalizations, and ED Use." *Journal of the American Geriatrics Society.* https://pubmed.ncbi.nlm.nih.gov/28264943/; 4. Dispatch Analytics Department. 2024. *Internal Report on Home Healthcare Data;* 5. Regional Blue Health Plan. 2024. *Health Plan Data Report.*

Health-Value ROI: Strive Health

Strive is a leading provider of value-based kidney care. It aims to improve outcomes for patients with chronic kidney disease (CKD) and end-stage kidney disease (ESKD) by lowering the total cost of care through its high touch, technology-enabled care model that addresses comorbidities and delays disease progression.

Health Value (HV) Model	HV-KPIs*
Target Population: Kidney disease affects ~37M people in the U.S. and is more common in people >65 years and those with diabetes and high blood pressure, which cause 45% and 28%, respectively, of kidney disease cases.[1,6]	• **Member satisfaction/Net Promoter Score** (scale of 100): Strive's average patient satisfaction score is 94%.[7] • **Optimal Start rate:** 67% increase in rate of optimal starts (includes preemptive kidney transplant or initiation of dialysis), compared to unenrolled patients in Strive markets.[5] • **30-day Hospital readmission rate:** 36% reduction in Strive patient readmission rate, compared to historical benchmark.[5] • **Hospitalization rate:** 49% reduction in hospitalizations among high-risk Strive patients, compared to historical benchmark.[5] • **ER diversion rate:** 10% reduction in ED visits, compared to initial baseline.[7] • **Nephrology visits:** 31% increase in visits, compared to initial baseline.[7] • **Total Cost of Care:** Strive national results show a reduction in Total Cost of Care by 20%.[5] *Echo Health Ventures uses a strategic engagement model to establish and improve partnerships between its health plan stakeholders and portfolio companies. In addition to supporting Strive's partnerships with regional Blue plans in our Alliance, Echo was at the table to support the creation of Strive in 2018. We partnered with the founders to transform the company from a concept to a leading kidney care solutions company.
Patient Impact: About 90% of people with CKD do not realize they have the disease until the condition reaches late-stage or end-stage kidney disease (ESKD), and those with CKD or ESKD carry a disproportionate burden of cardiovascular morbidity/mortality, and health care utilization and costs.[1,2] Strive Health's care model engages and educates patients at the highest risk, brings care to preferred settings, and manages the care continuum. Strive treats the whole person and keeps patients on the ideal care journey, while slowing down overall kidney disease progression.	
Cost Impact: Over $100B in annual Medicare spend on kidney disease patients, with costs to U.S. health plans increasing exponentially as CKD progresses.[3,4,8] Strive saves money for payers by lowering the total cost of care (TCoC) via overall improved quality of care, a reduction in hospital admissions and an increase in optimal dialysis starts.	

Sources: 1. American Heart Association. 2020. "Cardiovascular Disease in Chronic Kidney Disease." *Circulation*. https://www.ahajournals.org/doi/10.1161/CIRCULATIONAHA.120.050686; 2. Jha, Vivekanand, and Geoffrey A. Block. 2023. "Global Economic Burden Associated with Chronic Kidney Disease." *International Journal of Nephrology and Renovascular Disease*. https://pmc.ncbi.nlm.nih.gov/articles/PMC10499937/; 3. American Journal of Managed Care. 2023. "Medical Costs for Managing Chronic Kidney Disease and Related Complications in Patients with Chronic Kidney Disease and Type 2 Diabetes." *AJMC*. https://www.ajmc.com/view/medical-costs-for-managing-chronic-kidney-disease-and-related-complications-in-patients-with-chronic-kidney-disease-and-type-2-diabetes; 4. National Kidney Foundation. 2023. "Federal Investment in Kidney Disease Research and Care." *National Kidney Foundation*. https://www.kidney.org/get-involved/advocate/legislative-priorities/federal-investment; 5. Strive Health. "Strive Metrics: Analysis Details." *Strive Health*. Accessed March 5, 2025. https://strivehealth.com/strive-metrics/. *6.* National Kidney Foundation. "Diabetes and Chronic Kidney Disease." National Institute of Diabetes and Digestive and Kidney Diseases. "Kidney Disease Statistics for the United States." *National Institute of Diabetes and Digestive and Kidney Diseases*. Accessed March 5, 2025. https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease. 7. Strive Health. "Strive Media Kit" *Strive Health*. Accessed March 11, 2025. https://strivehealth.com/wp-content/uploads/2024/10/MediaKit_Q42024_v2.pdf. 8. CDC. "Chronic Kidney Disease: Common, Serious, and Costly." CDC.gov. Accessed March 11, 2025. https://www.cdc.gov/kidney-disease/ckd-facts/index.html.

Looking Ahead

- Reliable, expanding, secure interoperable data – supported by and enabling value-based payment reforms
- Increased AI adoption for affordability, access, and coordination – incorporated in or disrupting existing health care models
- Policy choices and health plan leadership will influence how technology-enabled care progresses – with timely opportunities for progress in all major payment programs