THE PATH FORWARD

FOR VALUE-BASED CARE IN GI

Interviews with provider, payer, employer, and patient experts in GI conditions

SonarMD

INTRODUCTION

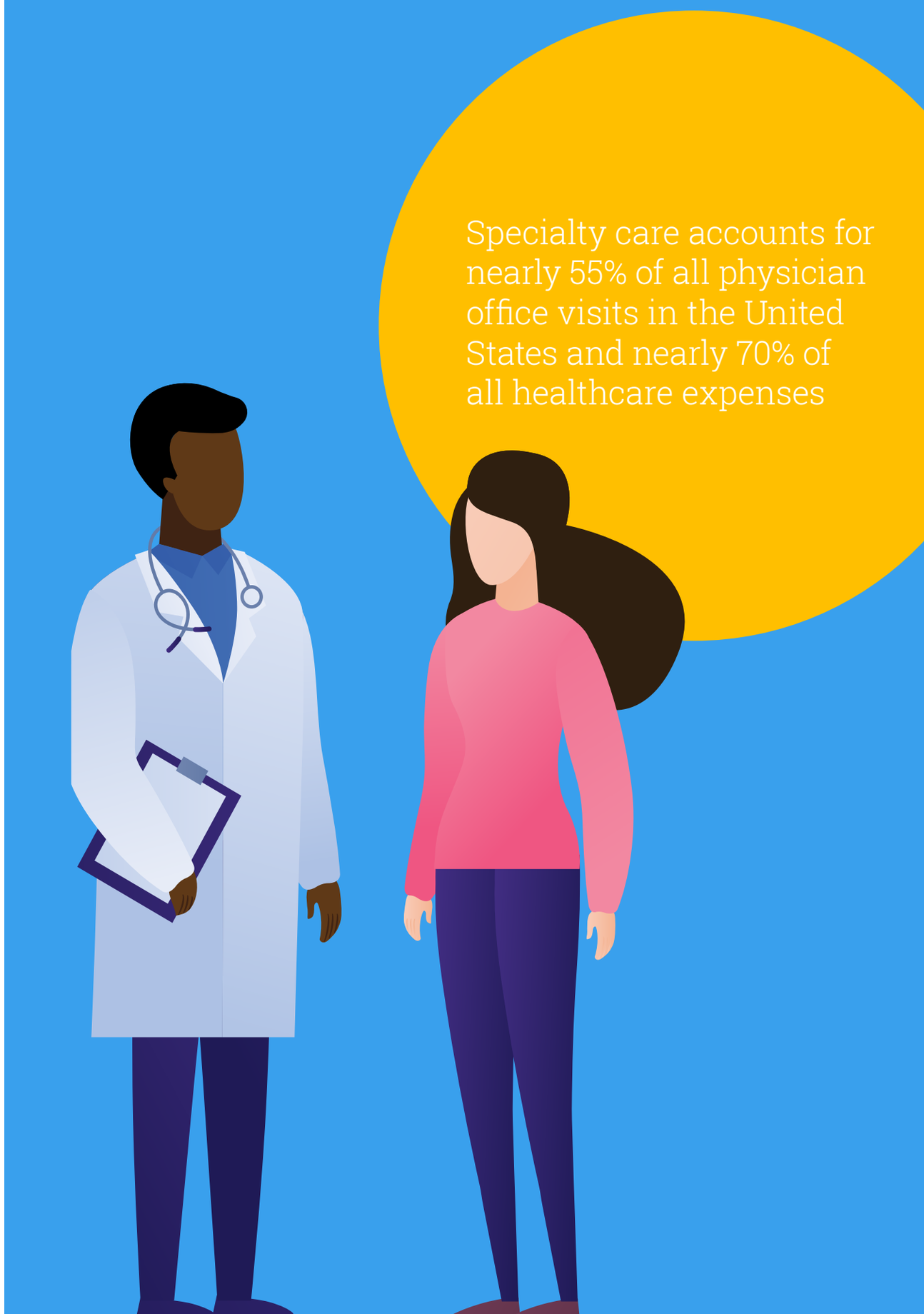
According to the Agency for Healthcare Research and Quality, specialty care accounts for nearly 55% of all physician office visits in the United States and nearly 70% of all healthcare expenses. What's more, roughly 96% of Medicare spending goes toward the treatment of chronic conditions, notes a paper in the International Journal of Environmental Research and Public Health.

When it comes to value-based care models, though, specialists are rarely included. Value-based care tends to focus on primary care and has a stated goal of preventing the onset of disease. Under this type of model, physicians may be motivated to discourage the use of specialists in an effort to keep care costs down within their individual practice. As an American Journal of Accountable Care paper points out, this only leads to further division between primary care and specialty care — and it actually removes the incentive for specialists to participate in value-based care initiatives.

This is a missed opportunity for specialty care to slow chronic disease progression and reduce costly complications. For example, analysis of cost data has shown that there is little cost variability in many gastrointestinal (GI) conditions. These conditions — which include but are not limited to gastritis, colon polyps, Celiac disease, and diverticulitis — are well-positioned for bundled payment programs as a way to provide high-quality, low-cost care. On the other hand, conditions with high cost variability — such as Crohn's disease and ulcerative colitis — benefit from a model focused on care coordination and disease management.

This eBook features interviews with 12 provider, payer, employer, and patient experts in GI conditions. We spoke to these experts from January 2020 to March 2021 to get their perspective on trends, regulations, technologies, and other factors that will come together to reimagine GI care in the United States.

Our experts recognize that there are many obstacles to providing value-based care to treat GI conditions, ranging from the need for partnership and data transparency to the challenges that independent practices face in obtaining operational, technological, and financial support. However, our experts agreed on one key point: It is imperative for *all* stakeholders to support value-based models of GI care and do what's right for the patients they serve.



MEET OUR EXPERTS

Lawrence Kosinski, M.D., Founder and Chief Medical Officer of SonarMD, interviewed the following 12 experts for The Scope with Dr. K, a podcast series on the HealthcareNOW Radio Podcast Network. Download or listen to past episodes of the podcast here**.**

John Allen, M.D., is Chief Clinical Officer of the University of Michigan Medical Group, which employs more than 2,000 physicians in 20 clinical specialties across the state of Michigan. In 2019, the American Gastroenterological Association (AGA) recognized Allen for his lifelong contributions to the field.

Joel Brill, M.D. is Chief Medical Officer of Predictive Health, a provider of integrated medical management for employers. Brill is also the lead physician for the AGA Bundled Payment Project and co-founder of the AGA Center for GI Innovation and Technology.

Lili Brillstein is Chief Executive Officer of the consultancy BCollaborative and a strategic advisor to several payers and startups. In previous roles, she served as the Director, Episodes of Care for Horizon Blue Cross Blue Shield of New Jersey and Senior Director, Medicare for UnitedHealth Group.

Lee McGrath is Senior Vice President of Provider Strategy & Solutions at Premera Blue Cross. McGrath previously served as President of Illinois Health Partners, a Chicago-based clinically integrated network and joint venture between DuPage Medical Group and Edward Health Ventures with 250,000 patients.

Leanne Metcalfe, Ph.D, is Vice President of Enterprise Data and Analytics at Pathway Vet Alliance. Metcalfe previously worked as the Executive Director of Health Economics Research & Outcomes for Health Care Services Corp. and led a range of range of value-based care research.

Harold Miller is President and Chief Executive Officer of the Center for Healthcare Quality and Payment Reform, a national policy center focused on improvements to healthcare payment and delivery systems. Miller has worked with officials in more than 40 states to implement reform initiatives.

Elizabeth Mitchell President and Chief Executive Officer of the Purchaser Business Group on Health, working with purchasers, providers, policymakers and payers to improve care quality and cost. She also served as Co-Chair of the Physician-Focused Payment Model Technical Advisory Committee (PTAC).

Christina Ritter is Director of Patient Care Models Group at the Center for Medicare and Medicaid Innovation (CMMI). The Innovation Center develops and tests new payment and service delivery models, including the Quality Payment Program's Advanced Alternative Payment Models.

Lilly Stairs is Founder and Principal of Patient Authentic, working with healthcare companies and patient advocacy nonprofits to build patient empowerment programs. Diagnosed with Crohn's disease at age 19, Stairs also serves on the board of the American Autoimmune Related Diseases Association (AARDA).

Barry Tanner is Chairman of PE GI Solutions, which helps physicians and health systems develop GI practices and GI-specific ambulatory surgery centers (ASCs). Tanner founded the company in 1999 and currently focuses on partnership development, strategic direction, and services development.

Jim Weber, M.D., is President and Chief Executive Officer of the GI Alliance, the largest physician-led GI network in the United States. Weber is also President/Board Chair of the Digestive Health Physicians Association (DHPA), which represents 97 practices and more than 2,300 physicians in 38 states.

Michael Weinstein, M.D., is the President and Chief Executive Officer of Capital Digestive Care. He also serves as Vice President of DHPA and maintains an academic appointment as an Assistant Clinical Professor of Medicine at the George Washington University School of Medicine and Health Sciences.

7 FACTORS INFLUENCING THE FUTURE OF VALUE-BASED GI CARE

Our conversations covered a lot of ground, but our experts' key takeaways broadly fell into six themes. The graphic below offers a quick summary of each theme, and the pages that follow cover each theme in more depth.

The Impact of Payment Reform

Value-based care models outlined by payment reform efforts such as the Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA) have been slow to make their way into GI care. Is momentum beginning to build to influence change, and is there a role for large employers?

The Future of the GI Practice

The reality of payment reform, coupled with ongoing M&A activity in healthcare, has made it tough for independent providers to hold on. What does this mean for GI practices?

The Value of Provider-Payer Partnership

One of the keys to successful value-based care is collaboration among payers and providers. What is the ideal model for this partnership, and what level of compromise does it require for both stakeholders?

The Importance of Data Transparency

High-quality care for any medical specialty depends on access to a longitudinal patient record. What information should payers and employers be sharing with GI providers to enhance clinical decision support?

The Long-Term Impact of COVID-19

Elective procedures halted immediately in the spring of 2020. What lessons did GI practices learn when from this sudden loss of a critical revenue source, and how can these learnings be applied to long-term business plans?

The Role of Employer-Sponsored Health Insurance

Half of Americans are covered by employer-sponsored health plans, and the majority of those plans are self-funded. How can payers and providers better work with employers to create and extend value-based care models?

The Importance of Patient Empowerment

Patient with chronic GI conditions can and should be valued members of their care team. How can GI practices engage patients in the care process and empower them to make informed treatment decisions?

THE IMPACT OF PAYMENT REFORM

Inflammatory Bowel Disease (IBD) is part of the Bundled Payments for Care Improvements Initiative, and CMS is exploring how bundled payment models can account for cost variability. For the most part, though, value-based care models have focused largely on primary care and not gastroenterology or other medical specialties. This has left specialists to remain in a fee-for-service mindset, even though gastroenterology is well represented among the most expensive ICD-10 codes in terms of per-capita member spending.

Our experts discuss whether momentum has been building to influence a shift to value-based models in GI care. They also address the challenges of applying to GI care the bundled payment models that serve other types of specialty care as well as the new, temporary expansion of telemedicine reimbursement in response to COVID-19.

"In academic medicine, we have extraordinarily high fixed costs. When you start losing marginal income, you lose the ability to pay those fixed costs. Think about it this way: In private practice, you do about 15 colonoscopies a day. By 11 a.m., you've covered your overhead for the day, and everything after that is pure profit. We don't have that kind of efficiency or throughput. We usually make that up with better payer contracts, but we're not making up the kind of revenue per doctor that you make up in community practice."

John Allen, M.D., *Chief Clinical Officer, University of Michigan Medical Group*

"Telemedicine is clearly here to stay. Does that mean CMS will now treat telemedicine as a preventive service and waive the co-pay and deductible? I'm not as sanguine. Commercial insurance is doing that, but as soon as the emergency is declared over, it will be very challenging unless Congress gives CMS the authority to really change the concept of what is a preventive service and what is a benefit design in original Medicare."

Joel Brill, M.D., *Chief Medical Officer, Predictive Health*

"There's a lot of head-scratching about how bundles can be applied to chronic condition episodes. If you think about a procedural episode, you have some criteria you use to craft the model. What event, procedure, or diagnosis triggers the episode? What is day one of the episode? As I build chronic condition episodes, I use the exact same design criteria. What triggers the episode? Is it the date of diagnosis? Date of first treatment? Date of hospital admission? And how long will you keep that episode open? They're isn't really a right or wrong; it depends on what the parties are trying to look at."

Lili Brillstein, *Chief Executive Officer, BCollaborative*

"We have to engage everyone, specialists included, to make sure incentives are aligned. I don't think there's a one-size-fits-all kind of a model. Global risk in the Medicare Advantage space can be quite successful to make sure all of the incentives are aligned, but it shouldn't be the only model, and it might not be attractive to many employer groups. We have to develop products, incentives, and networks that meet everybody's needs."

Lee McGrath, *Senior Vice President of Provider Strategy & Solutions, Premera Blue Cross*

"We have been looking at how the up-front payment in the Oncology Care Model has been playing out in the course of the savings, and we have determined that we need that bidirectional, two-sided risk. If we don't have that back end risk, it's not enough to accept a payment and see if you can get a performance. There's less incentive to move quickly."

Christina Ritter, *Director of Patient Care Models Group, Center for Medicare and Medicaid Innovation*

"More than eight years ago, we created a Centers of Excellence network for specialty care. We used very robust quality metrics to select participating specialists — and then we contracted with them directly because we couldn't get the health plans to participate. We did prospective bundles with warranties, we used patient experience metrics to select and evaluate care. We got dramatically better outcomes and experience. We saw a 50% reduction in surgeries that were deemed unnecessary, and we reduced readmissions and infections."

Elizabeth Mitchell, *President and Chief Executive Officer, Purchaser Business Group on Health*

THE FUTURE OF THE GI PRACTICE

Gastroenterologists are trained to treat the full spectrum of GI conditions. However, the vast majority of revenue for a GI practice is derived from elective colonoscopies, with more complex chronic conditions which are responsible for most of the total cost of care resulting in only a minority of their income. This disparity creates a difficult situation to build value-based care solutions.

Superimposed into this environment, private equity has accelerated the trend of merger and acquisition environment in the GI market. For independent practitioners, there's increased pressure to join a larger entity, whether it's a network of GI practices or a hospital network. Our experts explore what these trends mean for today's gastroenterologists, how to bring much-needed GI care to underserved communities, and how to expand service offerings beyond elective screenings.

"We need to take more a team-based multidisciplinary approach to the management of weight-related disorders. Why shouldn't gastroenterologists be at the hub and focus of those issues? Should we be looking at diagnostics, tele-coaching, behavioral health, and nutrition? Should we be looking at the pipeline for endoscopic therapies for diabetes or caloric restriction? You can't just do a procedure; you need to have an infrastructure that supports a patient's behavioral and nutritional needs."

Joel Brill, M.D., *Chief Medical Officer, Predictive Health*

"One of the biggest care gaps in rural communities is access to specialists. If you're paying a gastroenterologist based on how many colonoscopies they do, there's not going to be enough colonoscopies to be able to pay them. Let's support specialists to locate in those communities. The gastroenterologists, instead of spending all their time just doing colonoscopies, can support the community by treating other gastrointestinal illnesses, which would be difficult for a busy, overworked primary care physician to do."

Harold Miller, *President and Chief Executive Officer, Center for Healthcare Quality and Payment Reform*

"The ideal setup is to make you feel like you are an independent practitioner, not a salaried employee. You get to decide how many staff members you want in your care division, and the compensation levels. Ninety percent of what you do is run an independent practice, just like you did before, but you're part of a federation of practices that come together for the purpose of accessing capital, recruitment, and data collection and dissemination. We bring the benefits of scale but protecting their independent voice."

Barry Tanner, *Chairman, PE GI Solutions*

"We interviewed more than 70 private equity companies. Rather than say, 'We're going to conform to what a private equity firm thinks we should look like,' we wanted a private equity backer and business partner who believes that what we're doing is the right thing — who will help us on the clinical side but keep their hands off the clinical side. Private equity doesn't help a doctor be a better doctor."

Jim Weber, M.D., *President and Chief Executive Officer, GI Alliance*

"There is a need for capital, but the strategy is not to see how fast you can increase the value. We're thinking not in terms of 1-3 years, like private equity, but 10-20 years. We're trying to build a sustainable, relevant, and independent medical practice so that physicians can be bosses of themselves in their own environment — but also take advantage of superior back-office management services, increase purchasing power, be more relevant to payers, and build more ancillary services."

Michael Weinstein, M.D., *President and Chief Executive Officer, Capital Digestive Care*

THE VALUE OF PROVIDER-PAYER PARTNERSHIP

One of the keys to successful value-based care is collaboration among payers and providers. Each stakeholder has insight that the other does not: Payers have the longitudinal view of what has been happening to a member outside the physician's office, while physicians have the established trusting relationship with a patient.

For value-based care models to succeed, payers and providers need to leverage each other's expertise. That hasn't always been easy, given that these stakeholders can view each other as adversaries instead of partners. This adversarial relationship also has a negative impact on care coordination — with the impact directly felt by patients who are forced to become full-time managers of their chronic conditions.

Our experts discussed the ideal model for payer-provider partnership, along with the level of compromise that's required from both stakeholders in order to make partnership work.

"It can be easier to deal with regional plans, as creating a national model with a national plan requires so much more coordination. But with all the health plans in this country, their systems sit on a fee-for-service chassis, and they're set up to think about and pay for care in terms of units of care, not the suite of services related to a particular diagnosis."

Lili Brillstein, *Chief Executive Officer, BCollaborative*

"It's important to walk in the shoes of both sides in order to be able to solve complex problems, have empathy, and know what the issues look like from the other side. It doesn't matter who has it harder. The objectives and the goals are all the same — to make communities happier and healthier — and the only way we're going to do that is to align incentives. We can't have a situation where the payer wins and the provider loses, or where the provider wins and the payer loses."

Lee McGrath, *Senior Vice President of Provider Strategy & Solutions, Premera Blue Cross*

"When payers and providers partner together, providers can get that holistic view of the patient: Where else are they going? What other specialists are they seeing? What else is going on in that patient's life? On the payer end, we're seeing patients that have better outcomes and better physical and financial health."

Leanne Metcalfe, Ph.D., *Former Executive Director of Health Economics Research & Outcomes, Health Care Services Corp.*

"Our healthcare system is a complete and utter mess. It's really hard to navigate. I feel like I'm micromanaging everyone. When I call for a referral, the hospital or the physician's office is supposed to send it to the insurance company, but somebody drops the ball and it doesn't happen, and I'm left to coordinate between the two. I'm lucky that I know how to do that and have the time to do that — but a lot of people don't."

Lilly Stairs, *Founder and Principal, Patient Authentic*

THE IMPORTANCE OF DATA TRANSPARENCY

Data is critical to all healthcare decision-making. You can't manage what you don't measure. It's especially important for supporting value-based care, as all stakeholders need insight into cost, quality, and outcomes for key tasks such as determining program structure or evaluating treatment options.

However, data can also be a roadblock for value-based care, especially in specialty care. The investment in effort and infrastructure necessary to analyze a wide range of clinical, claims, and patient data sources may be an insurmountable hurdle for even the largest organizations.

Here, our experts talk about the role of data transparency, both inside and outside organizations. We also learn about the negative consequences of a lack of data transparency at both a systemic and individual level.

"We've tried to negotiate with payers for any type of value-based care, and it has gotten nowhere. They get terabytes of data every day. For them to parse out something as small as gastroenterology, and then to identify provider, site of care, and benefit package – they simply can't do it due to their archaic computer systems. I even went to another provider, and the response was, 'We have 22 different payers, and the IBD population for every payer is pretty small, so we can't put that together.' There's no way to aggregate that data well enough to be able to sell it to a payer."

John Allen, M.D., *Chief Clinical Officer, University of Michigan Medical Group*

"We provide information about how the providers are doing, and how quality is being met. The relationship that we set up puts those expectations in place. I use data and transparency and carrots and sticks to make sure the customer has the right experience and has the best possible quality at an efficient price. I have an opportunity to partner differently and make it work."

Lee McGrath, *Senior Vice President of Provider Strategy & Solutions, Premera Blue Cross*

"My bloodwork is the least invasive way to make sure that my autoimmune diseases are still in remission. I have avoided getting bloodwork, sometimes for over a year at a time, even though I'm supposed to get it every three months, because it gets coded incorrectly and I end up having to pay thousands of dollars out of pocket."

Lilly Stairs, *Founder and Principal, Patient Authentic*

"As a management entity, our job is to arm the physicians with more data so they can make more informed care delivery decisions. It's important to protect the individuality of how any physician chooses to practice. However, if there's intense collaboration among physicians, and you see the outcomes they're achieving, that may influence the way you deliver care. If you had real-time access to that information, it may change your behavior in such a way that you improve patient outcomes."

Barry Tanner, *Chairman, PE GI Solutions*

THE LONG-TERM IMPACT OF COVID-19

In order to keep clinical staff safe and respond to the first wave of COVID-19 in the spring of 2020, elective procedures halted immediately. The American Medical Association estimates that elective GI procedures dropped as much as 90%. This had an immediate and dramatic effect on revenue for GI practices — but less so for some hospitals.

Our experts explore the immediate and long-term impact of COVID-19 on GI care. Key considerations include how to account for the potential of lost revenue from those elective procedures, as well as how payment models may need to evolve in order to provide practitioners with greater financial stability in the event of a future pandemic.

"COVID-19 allowed us to borrow and go out on a credit line. That buffered faculty salaries. In private practice, once you lose monthly cash flow, you lose your income."

John Allen, M.D., *Chief Clinical Officer, University of Michigan Medical Group*

"It wasn't just that endoscopy reimbursement went away. It was all the ancillaries as well — the ASC facility fee, pathology, and anesthesia. You also need to think about colorectal screening. A lot of that is on our commercial population. If people lost their insurance due to COVID-19, those patients aren't just going to walk into the gastroenterologist's office and say, 'I've got $2,000. I'd like to get my colonoscopy screening.'"

Joel Brill, M.D., *Chief Medical Officer, Predictive Health*

"One of the challenges we will face in post-pandemic rebuilding is whether people will simply try to get back as quickly as possible to the old way of doing things, or whether it becomes an opportunity to do things differently. It starts with recognizing that part of the reason we had a problem is because of the way we pay for care. There was no stable funding to sustain the core capacity, and so much of hospital and physician funding was dependent on elective procedures, which then disappeared in the middle of the pandemic."

Harold Miller, *President and Chief Executive Officer, Center for Healthcare Quality and Payment Reform*

"One of the things we are diving into is the role of digital health, and the pandemic has shown us that it's bigger than we thought. How can we expand access and best practices with digital technology solutions? We have been so stuck in brick and mortar. There's a huge opportunity for care in the home, care in the community. The pandemic has really accelerated models that include these alternative sites of care. And are enabled with technology."

Elizabeth Mitchell, *President and Chief Executive Officer, Purchaser Business Group on Health*

"COVID-19 was probably the most distressful and hardest thing that has ever hit me personally, my practice, and this country. But as horrible as it was, it built us stronger, together. We supported the practices and our staff, while protecting or patients along the way, and we never lost a dollar in our business even in the worst month that we had. We also took advantage of the downtime to make some process improvements, to do some IT integration, and to put an ERP system in place."

Jim Weber, M.D., *President and Chief Executive Officer, GI Alliance*

THE ROLE OF EMPLOYER-SPONSORED HEALTH INSURANCE

According to the Kaiser Family Foundation, about of half of Americans are covered by employer-sponsored health insurance. About 60% of all plans are self-funded, meaning that employers pay for healthcare services directly — and bear the burden of the high cost of care, unnecessary care, and poor health outcomes.

Clearly, employers should have a seat at any table where value-based care is being discussed. In traditional care models, though, providers and employers rarely directly communicate. Our experts dive into how employers can contribute to the conversation; they also offer suggestions to help payers and providers better partner with employers and employer groups to develop value-based care programs, build networks, and help individuals with out-of-pocket care costs.

"Employers look at their own healthcare spending, but also want to make sure their employees are happy and healthy. We'll talk about mental health programs and how to manage stress at work. We'll also talk about how people connect with their systems. If employees in large manufacturing plants work a certain shift, and the doctor's office isn't open when they need to go, how do those workers get access to healthcare?"

Leanne Metcalfe, Ph.D., *Former Executive Director of Health Economics Research & Outcomes, Health Care Services Corp.*

"Instead of having people just buy insurance, let's have people start pre-paying for their healthcare. That's more of a savings plan than an insurance plan. A colonoscopy screening isn't insurance. You know you're going to need a screening after age 50; you simply need to have saved money to pay for the healthcare you need. We can rethink what insurance is in a way that will provide more stability for individuals, regardless of whether they're employed or not, and more stability for providers of healthcare, who aren't dependent on whether or not their patients happen to be employed that day."

Harold Miller, *President and Chief Executive Officer, Center for Healthcare Quality and Payment Reform*

"The people paying the bills are actually the employers. It's really critical that people connect the dots that healthcare prices are coming out of a core business of a manufacturer or tech company or retailer. Employers want to make sure they have access to the highest-quality specialty and hospital care. They do know that quality varies and outcomes vary — and it is very hard to get that information. There's so little meaningful transparency in the U.S. healthcare system."

Elizabeth Mitchell, *President and Chief Executive Officer, Purchaser Business Group on Health*

"People don't necessarily want their employer to have a lot of identifiable data. We really need the information to be going to the clinicians, where care should be managed. What employers can do is direct their plans to share data — but right now there are contract provisions in place that prohibit this. Where we are headed — and this is long overdue — is requiring the collection and use of patient-reported outcomes measures, because we believe that is a key indicator of actual care quality.

Elizabeth Mitchell, *President and Chief Executive Officer, Purchaser Business Group on Health*

THE IMPORTANCE OF PATIENT EMPOWERMENT

Patient with chronic GI conditions can — and should — be valued members of their care team. After all, these long-lasting conditions affect patients' everyday lives in many ways, from employment opportunities to living situations to interpersonal relationships.

Here, our experts provide their thoughts on how GI practices can proactively engage patients in the care process and empower them to make informed treatment decisions. Our experts also discuss why patients also need to be proactive in managing their own care, especially when it comes to finding alternative treatment options.

"The old style game of waiting for someone to show up in your office is clearly being eclipsed by the new opportunity to be proactive. Why shouldn't we want to figure out if they're doing OK, or if they have issues they'd like to discuss with us, and figure out if we discuss it right then and now or at a scheduled time? That's better than waiting for them to come into the ER."

Joel Brill, M.D., *Chief Medical Officer, Predictive Health*

"In my work with payers, as contracts were being written and discussed every day, I was quite struck that there was never a discussion about the patient."

Lili Brillstein, *Chief Executive Officer, BCollaborative*

"We always talk about care management, but our research showed that some conditions had a huge variability in terms of outcomes and cost. Now we understand which conditions respond better to management while being under control, and which conditions are expensive no matter what you do. That helps us direct services toward conditions with high cost variability. That way, you don't have so many care management programs that don't show results. Instead, you have a small number of programs directed at improving someone's quality of life, reducing their financial burden, reducing the number of time they're in the ER or an ambulatory setting, and just living a better life."

Leanne Metcalfe, Ph.D., *Former Executive Director of Health Economics Research & Outcomes, Health Care Services Corp.*

"You know yourself best, so it's so important that you advocate for yourself, that you do your own research and bring it to your physicians and ask questions. We should always be challenging the status quo. Don't just accept a treatment plan if it's not fully working for you. Keep pushing for more. Don't settle. There is so much happening in the world of biotech and pharma. There is a lot of hope."

Lilly Stairs, *Founder and Principal, Patient Authentic*

CONCLUSION

Healthcare clearly has much work to do to achieve value-based care's Quadruple Aim of better outcomes, higher quality, lower costs, and a better work experience for clinical staff. Progress and momentum thus far has been largely limited to primary care, leaving specialties such as GI care on their own to devise value-based care models.

As our interviews with Lawrence Kosinski, M.D., have shown, there are forward-thinking leaders at provider organizations, insurance companies, employer groups, and patient advocacy organizations looking at new and novel ways to provide high-quality, low-cost GI care for patients regardless of condition complexity. While there are several obstacles to overcome in the pursuit of value-based care — from the longstanding challenges of payer-provider partnership to the new uncertainty of care delivery in a post-pandemic world — the innovative approaches and perseverance of our GI care experts suggest that there is a path forward and reason for optimism.

ABOUT SONARMD

SonarMD contracts with payers and works directly with sub-specialists in their network to create value-based arrangements and support patients with inflammatory bowel disease (IBD). Our clinical staff uses technology to virtually connect with patients, calculate potential risk, and coordinate care to prevent problems and reduce complications. We're starting in (IBD), which includes Crohn's disease and ulcerative colitis, because it is responsible for more than half of the variable cost of care for the entire GI space. We've proven we can keep people healthier — and reduce costs by 15% per member per year.

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Connect. Calculate. Coordinate.

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