monogram health

2023 SNP Alliance Policy Roundtable:

Bringing Modernized Kidney Care Home

April 17, 2023

ACCREDITED NCQA POPULATION HEALTH PROGRAM 3 YEARS

r2 RISK-BASED 2-YEAR HITRUST® CERTIFIED

Agenda

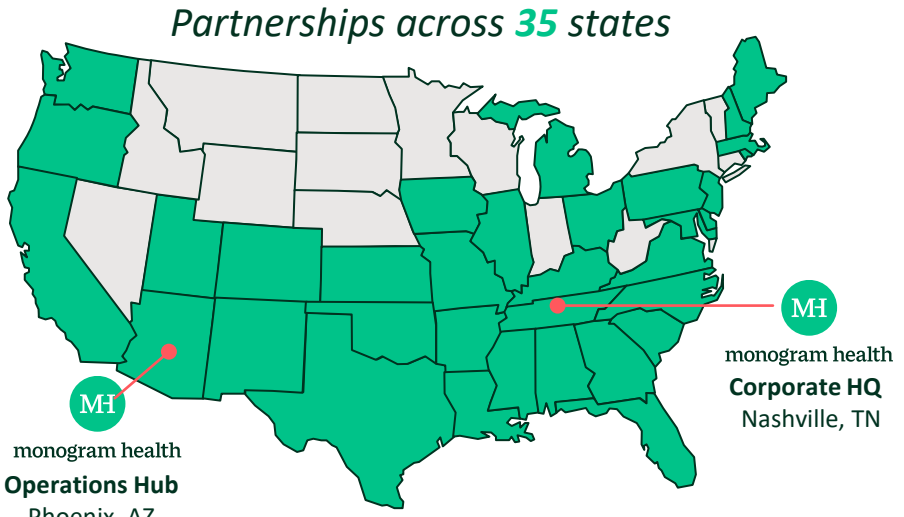
- Monogram Overview
- Clinical Outcomes
- Operational Challenges

Video

Monogram Overview

Monogram Health Overview

Footprint

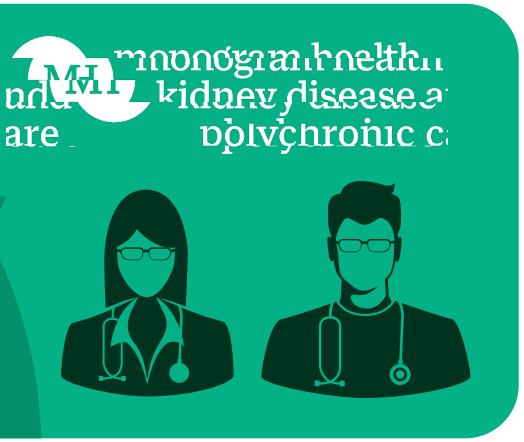


Selected Partners

agilon health · Cigna · Humana · Point32Health · Harvard Pilgrim Health Care · TUFTS Health Plan · scan health plan · DevotedHealth · Banner University Health Plans · Amerigroup An Anthem Company · AdventHealth · BlueCross BlueShield of Arizona · Louisiana · WellCare Health Plans · VA · U.S. Department of Veterans Affairs

Who We Are:

Leading value-based specialty provider of in-home evidence-based care and benefit management services for patients living with chronic conditions, including chronic kidney and end stage renal disease



Key Program Attributes

The following key attributes enable Monogram to measurably improve outcomes for patients living with polychronic conditions, including chronic kidney and end stage renal disease.

Home-First, Patient-Centric Engagement

Nationally Scaled Value-Based **Primary & Specialty Provider** Platform

Technology & **Analytics** driven by robust data infrastructure

Managed Service Organization Leveraging Proprietary **Evidence-Based** Criteria (formal CMS delegation)

Clinical Excellence: Managing Complex Comorbidities

Monogram **actively manages members' wide range of acute and chronic comorbidities** using our existing proprietary evidence-based protocols and order sets tailored to meet the needs of polychronic patients

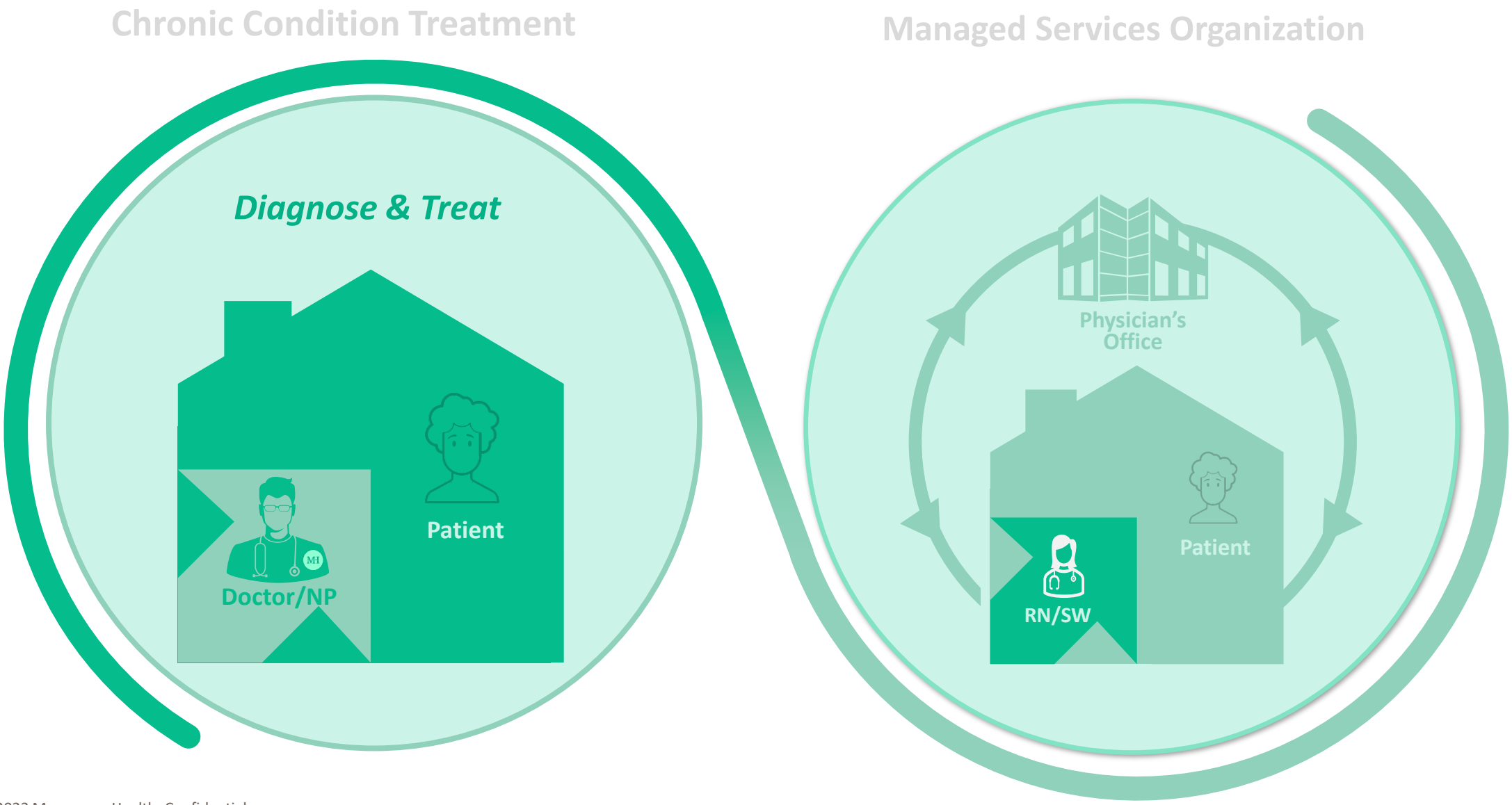
Patient-centered, home-first longitudinal evidence-based medicine…

….Delivered through Monogram's full-risk chronic condition practice and benefit management services:

- monogram health kidney disease and polychronic care
- monogram health managed services

- CKD
- ESRD
- Hypertension
- Ischemic Heart Disease
- Heart Failure
- COPD
- Diabetes
- Depression
- A Fib
- Cancer

Transforming the Patient Experience

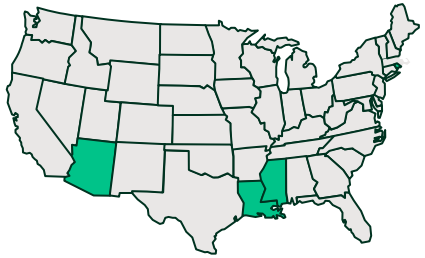


Evolution of Monogram Health

In early 2019, Monogram launched as a complex case and disease management solution for patients with CKD & ESRD…

monogram health
kidney managed services

Full stack array of Managed Services that are clinically rooted in metabolic disorders and nephrology



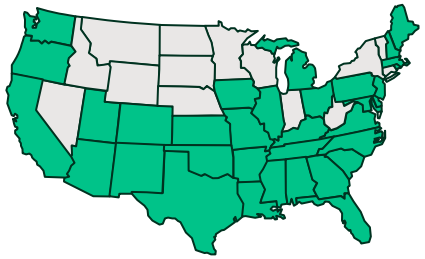
Local

…evolved to include a multi-specialty, national practice in 2020, a key differentiator that today enables Monogram to treat members longitudinally.

monogram health
kidney care

Multispecialty care delivery (Nephrology, Primary Care, and Chronic Condition treatment services)

National*



*Based on 2023 market presence

Nationally Scaled Multispecialty Provider, Pod Structure

Monogram Care Team and MSO deploys evidence-based clinical pathways across all polychronic conditions

Employed Multispecialty Practice & Supporting MSO

monogram health
kidney disease and polychronic care

- **Internal Medicine / PCP**
- **Nephrology**
- **Endocrinology**
- **Cardiology**
- **Pulmonology**
- **Palliative Care**
- **Behavioral Health**

monogram health
managed services

Full stack array of managed services supports the delivery evidence-based care for patients with chronic disease. Monogram's MSO takes formal delegation from our health plan partners (as a CMS First Tier Downstream, and Related Entity)

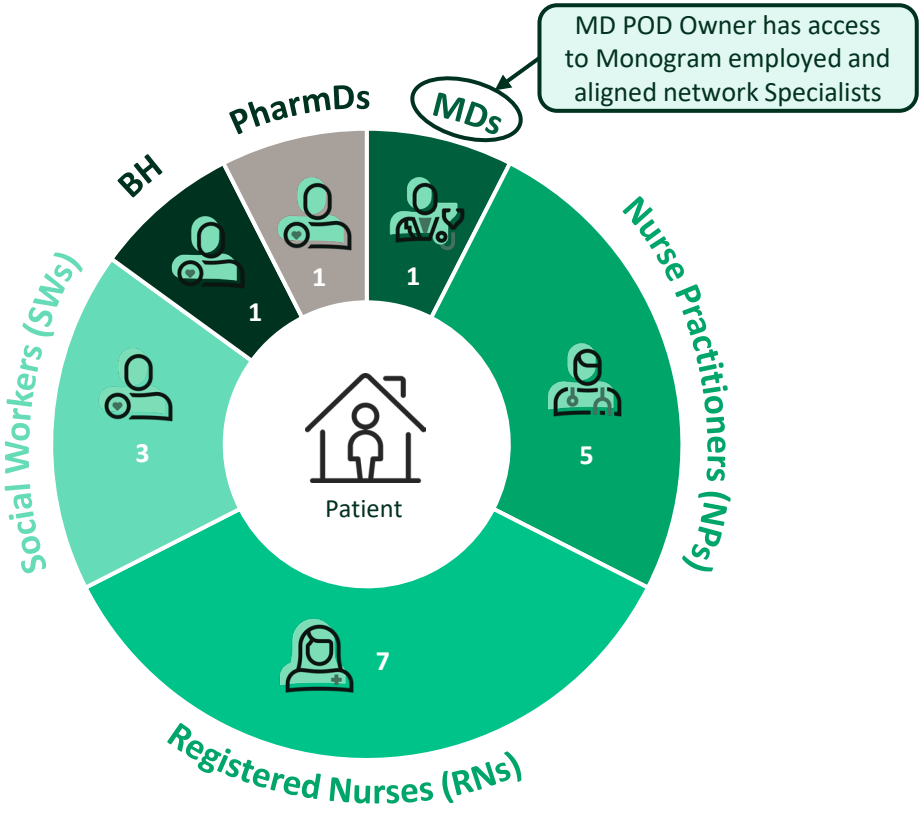
Clinical Pod Staffing Structure

Attributed Member Staffing Approach

A standard pod will cover approximately 5k **attributed members.** Each resource's panel will be based upon attributed member thresholds to drive recommended staffing levels:

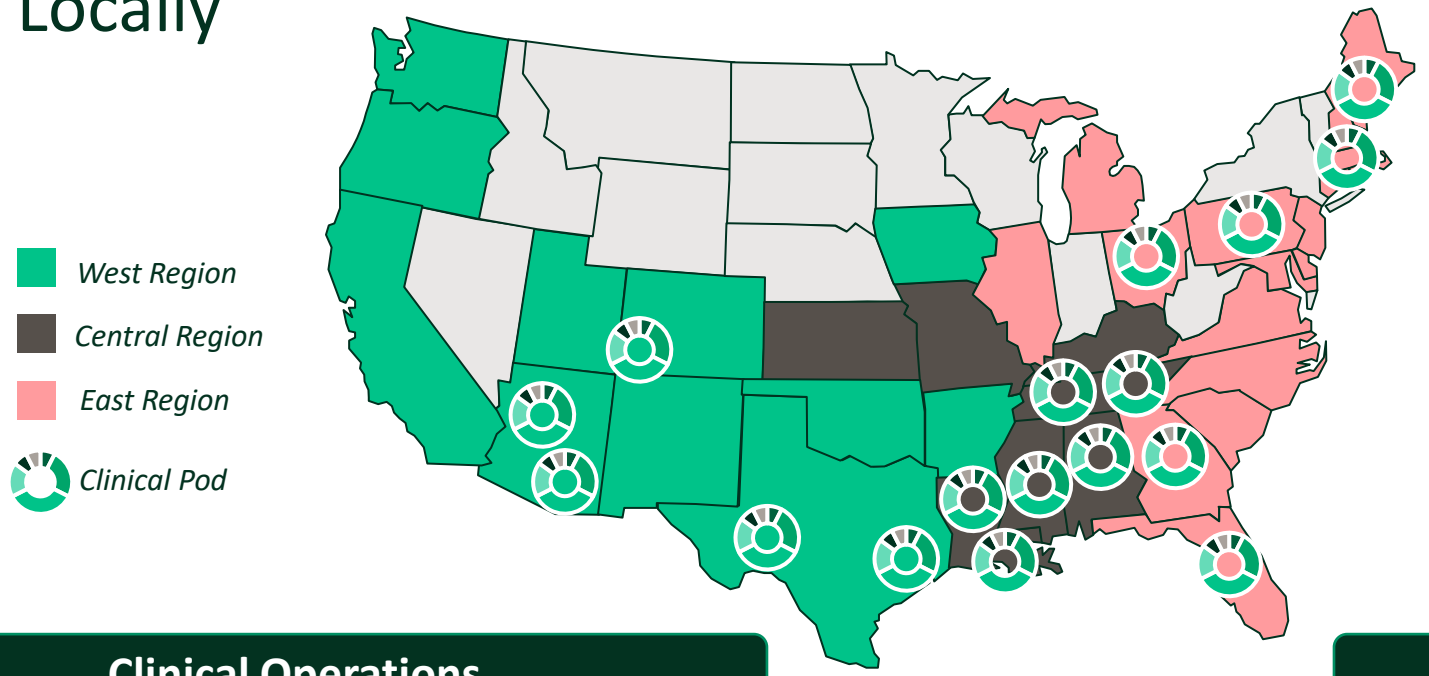
~5000 members per MD
~5000 members per BH
~5000 members per PharmD
~1000 members per NP
~700 members per RN
~1600 members per SW

Monogram Engagement Rate
= 35% of Total Attributed



Makeup of Pod structure is dynamic and staffed based on market dynamics and patient needs

Regional Accountability Structure Addresses Market Dynamics & Drives Healthcare Locally



Clinical Operations

POD MD

MPM

Clinical Team:
PharmD
5 NPs
7 RNs
3 SWs

Market Administrative Coordinator

Market Pod Teams have direct support within Pod via Market Administrative Coordinator

Dedicated Support
Clear Communication
Partnership to Deliver Results

Call Center Operations

5 Team Members
Dialer Outreach
Inbound Calls
Recurring Maintenance Outreach
Territory Visit Reassignment
Post Hospital Discharge & Urgent

Pod Call Center Operations accountable for optimized schedules for all Clinical pod members

Monogram's Dynamic Approach to Specialty Care Delivery Enables Better Access to Care

Employed specialty functions are centralized to deliver value to local markets, limiting referrals to downstream network specialists and reducing fractured care…

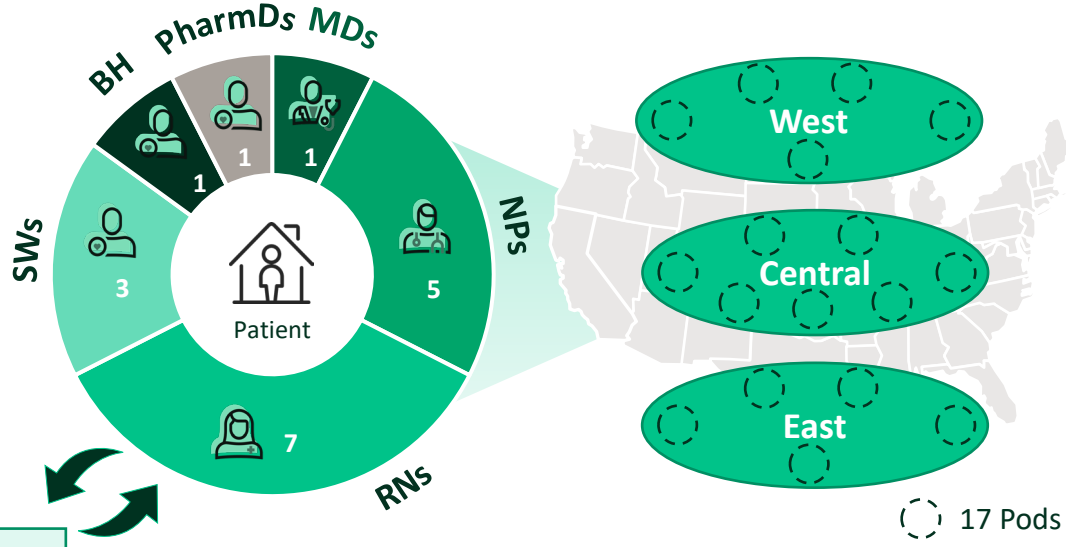
…while local integrated PODs include highly versatile, trained internists that practice at the top of their license and on-the-ground specialist NPs in select markets.

Centralized Multispecialty Platform

- Chief Nephrologist
- Chief Pulmonologist
- Chief Endocrinologist
- Chief Palliative Care Specialist
- Chief Cardiologist
- Credentialed Dialysis Providers

Specialists use order sets and evidence-based care to serve NPs on the ground with patients, while also addressing escalated patient needs through direct virtual consults.

Clinical Pod Structure



Payer Network & Strategic Alliances

- Primary Care Network
- Dialysis Network
- Specialty Network
- Acute / Ancillary Network

Monogram leverages payer network of specialists and strategic network alliances for additional care delivery

Polychronic Treatment & Management

Situation

At the first monogram treatment visit, patient complained of dyspnea on exertion and bilateral 3+ pitting LE edema. The Monogram team identified the patient was taking 30 mg of pioglitazone for diabetes control, which can contribute to fluid retention, and worsen CHF symptoms. This caused the patient to need frequent admissions to the hospital for CHF/Edema. Diabetes was under control and acceptable home blood sugars.

Action

The field clinician consulted with Monogram's Endocrinologist to discuss options with pioglitazone, the medication in question. The recommendation was to decrease the pioglitazone by 50%.

Results

With this one simple change, the patient lost 9 pounds and her dyspnea and edema were completely resolved. We avoided a hospitalization and expensive cardiac workup. Blood sugars have remained under good control on the lower dose of pioglitazone as well.

Details

67-year-old female

Co-Morbidities: CKD stage IV (GFR 17), CHF, Diabetes Type II, Hyperlipidemia, Hypertension, Secondary Hyperparathyroidism

Specialty Care Delivered Nationally

Seamless integration with in-home and specialty care will allow Monogram to achieve optimal outcomes for patients

Centralized Multispecialty Platform

- Chief Nephrologist
- Chief Pulmonologist
- Chief Endocrinologist
- Chief Palliative Care Specialist
- Chief Cardiologist
- Credentialed Dialysis Providers

Key Enablers

- Scaled Technology Stack
- Specialized Training & Expertise
- Clinical Pathways & Order Sets
- POD Operating Model

Multi-Specialty Clinic

Inter-Professional Consults

- Patient specific consultation
- Clinical management outside guidelines
- Pre-discharge recommendations

Telemedicine Clinical Visits

- Bridging care for members without access to specialty care - i.e. Nephrology, cardiovascular disease, diabetes, etc.

Curbside Consults

- General management recommendations
- Standards of care
- Diagnostic tools and recommended referrals
- Non-specific CV questions

In Market Specialists

- Dialysis therapy prescribing and oversight
- Palliative care

Scalable Clinical Pathways & Longitudinal Capabilities Founded on an Evidence Base

Led by a world class clinical team…

Clinical Management Team

Shaminder Gupta, M.D., Nephrology
Chief Medical Officer

Raymond Hakim, M.D., Ph.D
Chief Medical Officer Emeritus

Amal Agarwal, D.O.
Chief Clinical Officer

Gorav Bohil, M.D.
National Medical Director – Managed Services

Venkat Srinivasan, M.D.
National Medical Director – Polychronic Care

Lydia Nesemann, Pharm.D
SVP, Medication Management & Performance

…Guided by clinical evidence and standardized protocols

Evidence based protocols for chronic conditions, including CKD, ESRD, CHF, Diabetes and COPD

Condition-Specific Pathways			
CKD	CKDelay	Advanced CKD Transitions	
ESRD	Dialysis	Post Transplant	Palliative
Heart Failure	Asymptomatic	Symptomatic	End Stage
Diabetes	Symptomatic	With Complications	End Stage Complications
COPD	GOLD: A&B	GOLD: C&D	End Stage

Longitudinal Polychronic Capabilities

- Medication Therapy Mgmt.
- SDOH
- Behavioral Health
- Palliative Care

Solutions that Address Social Determinants and Health Inequities

Focusing on Underserved Communities

Monogram Membership Overview

22% Enrolled in Dual Eligible SNPs and Managed Medicaid

55% Minority

85% Geographic footprint below U.S. Median Household Income level (1)

79% Members live in top 50th %tile of Underserved Communities (2)

ACO REACH Preparedness

- Extensive experience managing patients in underserved communities
- Existing care model supports new Health Equity requirements of ACO REACH

1) 85% of counties that Monogram serves have household income levels below national median.
2) Analysis of Monogram counties vs. CMS ACO REACH benchmark study: "Neighborhood Atlas: from the Center for Health Disparities Research, University of Wisconsin School of Medicine and Public Health.

Monogram's **Robust Clinical Model and focus on SDoH** has enabled us to assume **SNP and MCD Model of Care Delegation** on Behalf of our Partners

Addressing Social Determinants of Health

- Financial assistance
- Housing benefits applications
- Unemployment and vocational rehab services
- Removal of transportation barriers
- Nutritious food programs
- Language Translation Services

Addressing Racial Bias through eGFR Calculation

Addressing Access to Care Challenges

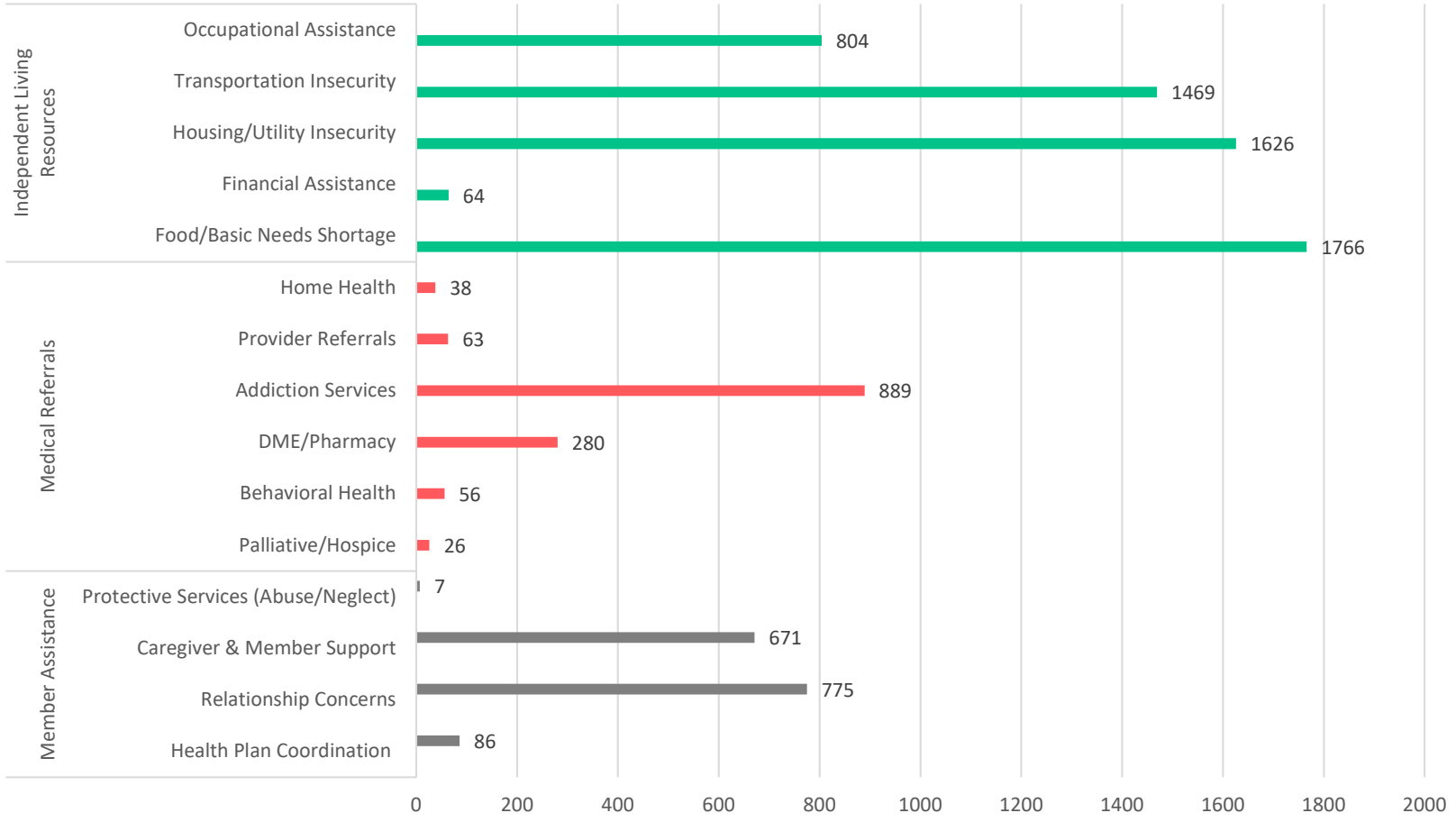
Social Determinants of Health Reporting

8,620 Assessed Social Determinants of Health

Independent Living Resources:
5,729
(67%)

Medical Referrals:
1,352
(15%)

Member Assistance:
1,539
(18%)



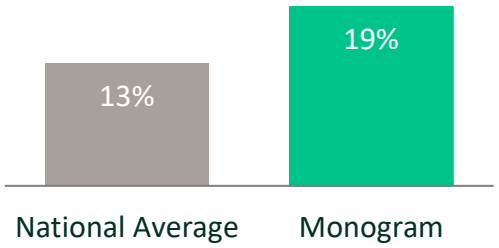
SDOH Status Tracking

- Monogram identifies SDOH barriers through in-home assessments with robust tracking to ensure referrals are made and findings are addressed
- **70%** of all active SDOHs are confirmed to be referred or receiving services
- **30%** of all active SDOHs are confirmed to be receiving services by the Member

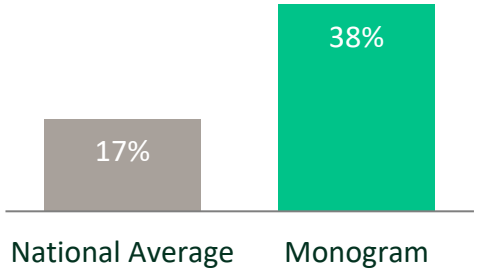
Clinical Outcomes

Robust Clinical Model Delivers Compelling Outcomes

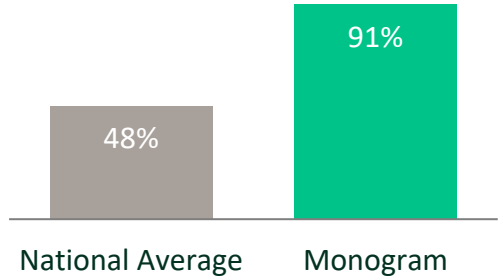
Increased Home Dialysis Utilization



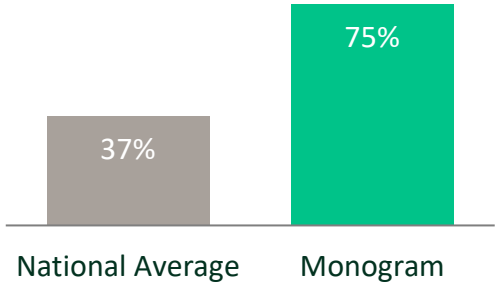
Dialysis Starts with Permanent Access



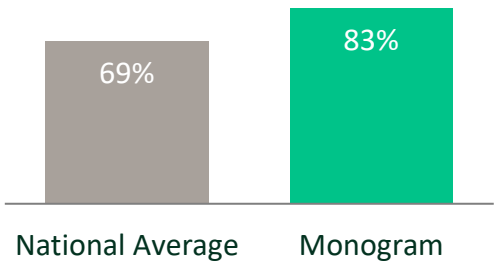
PCP / Nephrologist Engagement



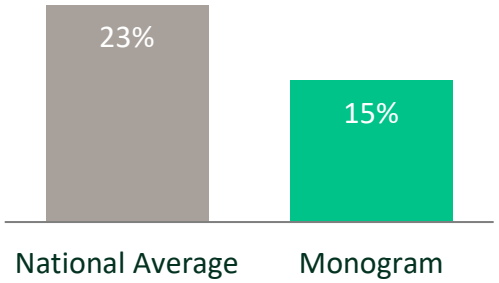
Controlled Hypertension



Controlled A1C



Reduced 30-Day Re-Admission Rate*

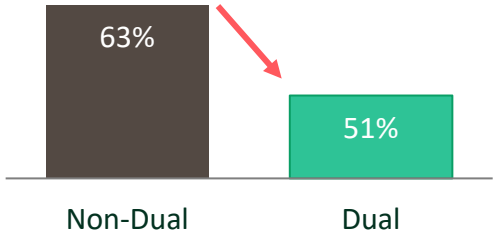


Note:
- National benchmarking data based on U.S. Renal Data System 2022 Annual Data Report
- Quality Outcomes as of April 2023
- *As of August '22; the new data warehouse remodel has complicated my ability to update this measurement

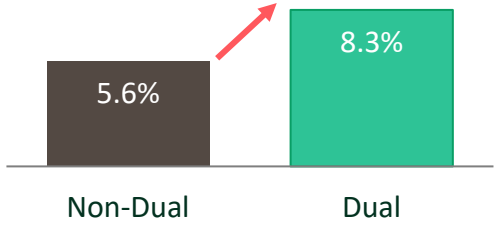
Social Complexity: Social Determinants of Health

Dual-eligible patients also suffer from higher levels of social challenges that negatively impact overall member health.

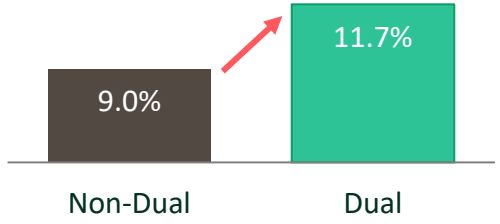
Level of Education: High School or Greater



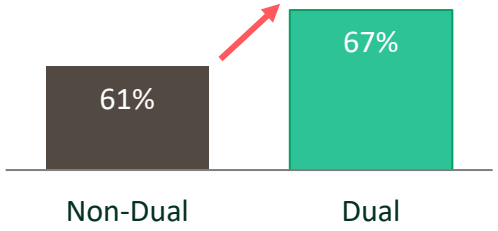
Concerned with Housing Status



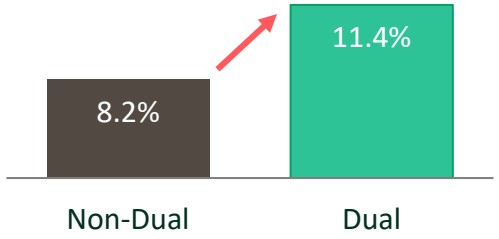
Not Enough $ to Pay for Basic Needs



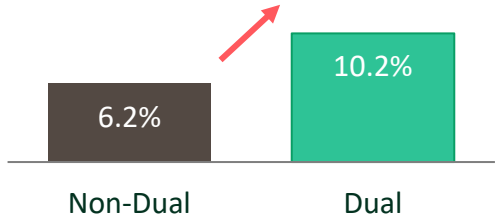
Some Degree of Vision Impairment



Past Year Transportation Issues



Past Year Utility Issues



Notes:
- Information sourced from Monogram Social Determinants of Health member assessment.

Clinical Research Update

Clinical Research Update: Leonard Davis Institute

Penn LDI
LEONARD DAVIS INSTITUTE *of* HEALTH ECONOMICS

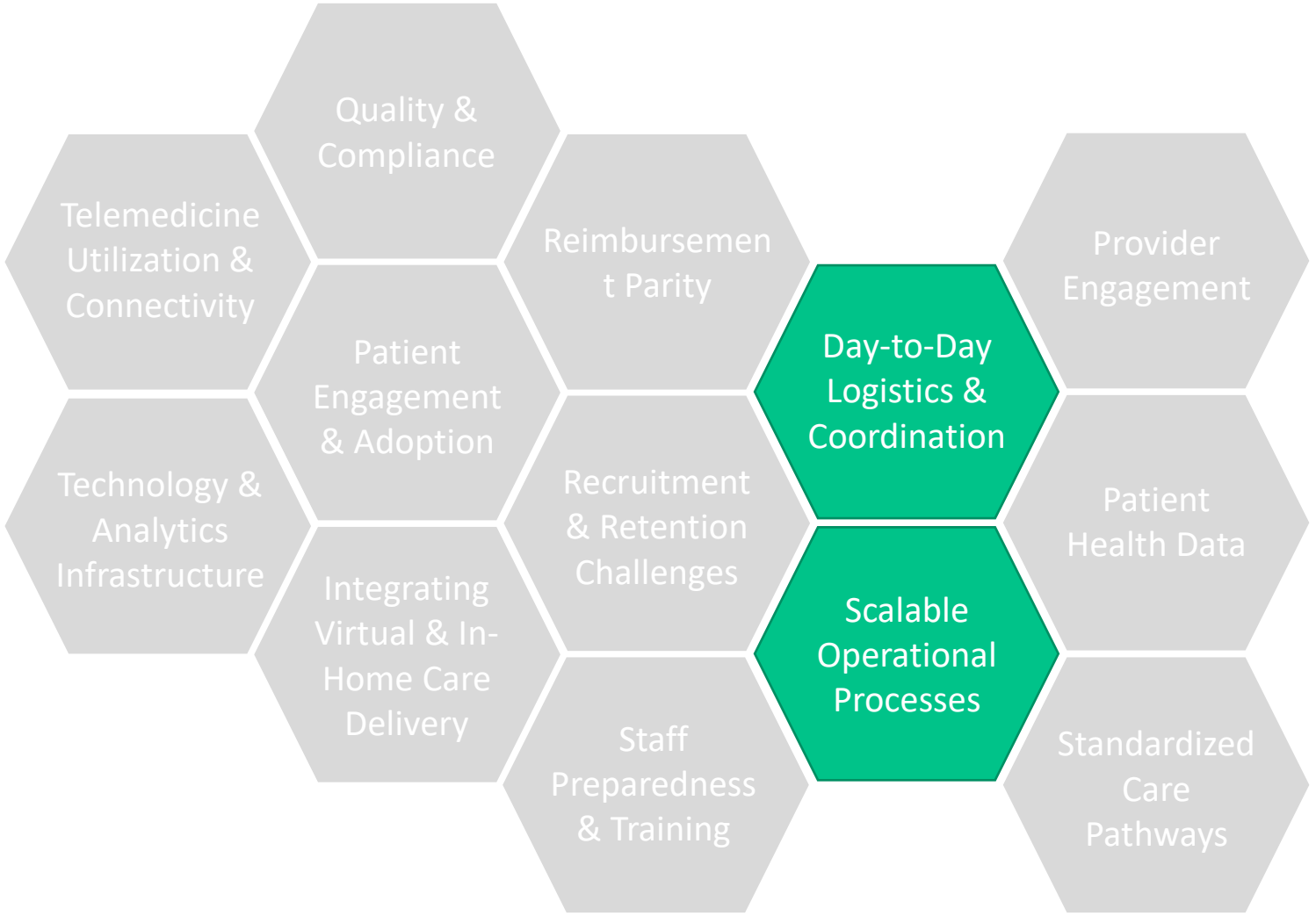
- Projects:
  - Promoting the equity and effectiveness of home-based palliative care for patients with dialysis-dependent chronic kidney disease
  - An interactive, conversational virtual healthcare agent to educate and engage patients with advanced chronic kidney disease about transplantation
  - Evaluating the Impact of A Novel Kidney Care Pathway on Optimal Transitions for Patients with End-Stage Kidney Disease *
- All projects working on IRB Approval
- Interim Report 1 due 9/8/2023

Operational Challenges

Complexities of a Home-Based Model of Care

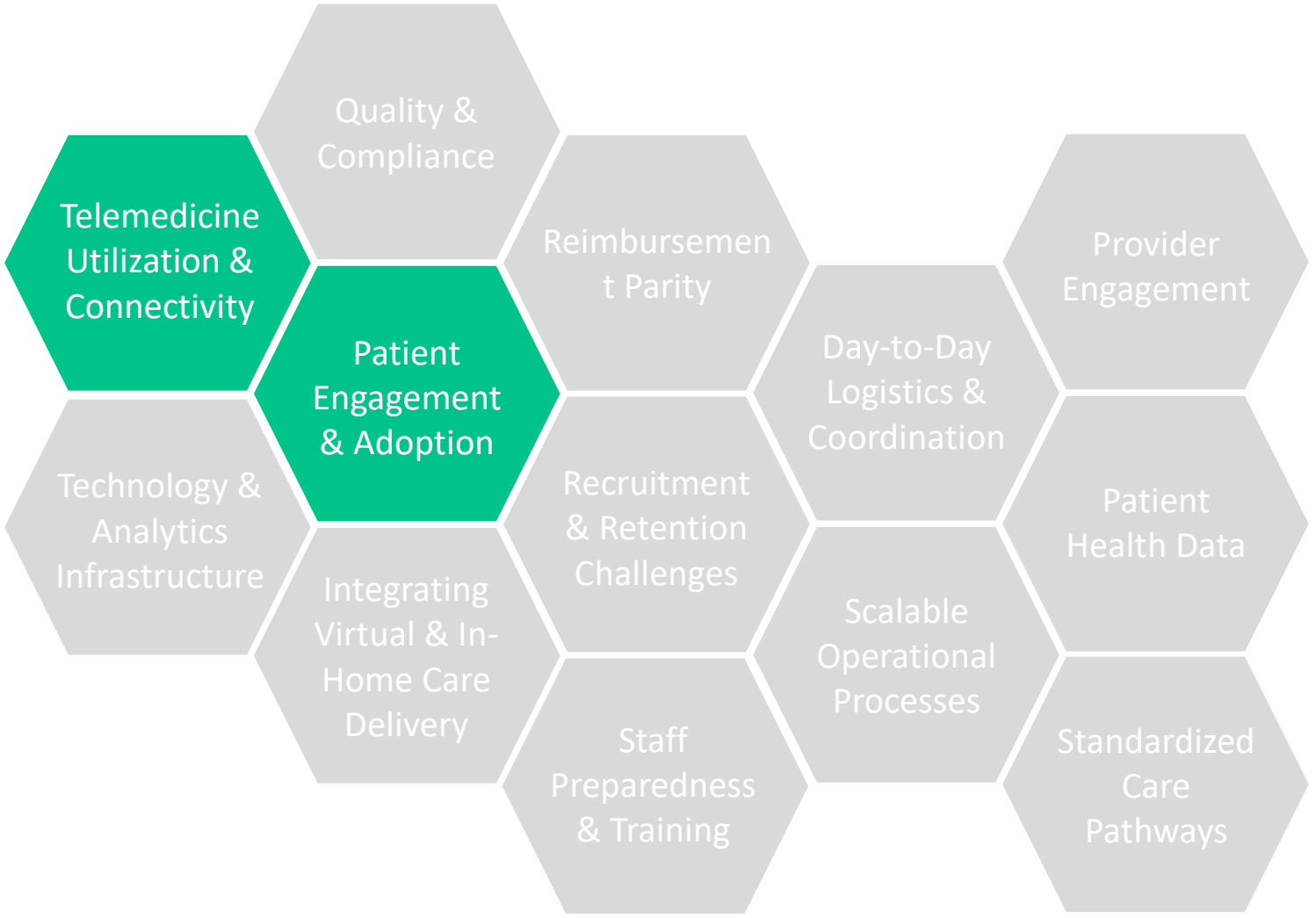
Home-based care is proven to **lower costs and improve outcomes, particularly in underserved communities**, however **regulatory changes are needed** to enable widespread efficacy and adoption.

Complexities of a Home-Based Model of Care



- Standardized processes are foundational to achieve national scale and operational efficiencies.
- Centralized call center services support PODs to optimize schedules by scheduling visits well in advance, while allowing field teams autonomy to fill in schedule gaps with acute visits.

Complexities of a Home-Based Model of Care



- Members do not know who we are, and often do not answer or cancel a scheduled telehealth visit.
- Members in rural areas can benefit from telehealth services the most, but location and poor connectivity continue to be obstacles.

Complexities of a Home-Based Model of Care

- Home-based care requires unique expertise and comfort level with going into a patient's home.
- The uniqueness of the home-based model of care requires a training curriculum that focuses on the patient, but also the environment around the patient

Complexities of a Home-Based Model of Care

- Collaborating with local providers is critical to delivering more effective care for our members
- Data is often limited and when available presents an incomplete profile of the patient; Local providers can often help close this gap

Types of Policy Changes Needed To Strengthen And Support The Delivery Of Home-based Care

Regulatory Needs*	Approach
Reimbursement Parity	Home-based care services are reimbursed in an economically viable way (i.e. reimbursement at parity with traditional reimbursement or value-based arrangements)
Home Dialysis	Bolster access to home dialysis by providing reimbursement for staff assistance for home dialysis treatments.
Quality Standards	Institute standardized methods and requirements for measuring and reporting the quality of home-based care services.
Workforce Investments	Grow the home-based care workforce by establishing grants to invest in the pipeline and career development and training of home-based care professionals
Benefit Design Flexibility	Redesign benefits to support direct delivery of Care at Home, as well as enabling services such as telemedicine, in-home labs and diagnostics, etc.

*Not exhaustive