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CARDIOVASCULAR SOLUTIONS

# Partner One-Pager

A quick-reference leave-behind for presenting Evolent's cardiovascular condition management program to employer, broker, and health plan audiences.

| 20+ | ~$1.2B | 78% | 88% |
|---|---|---|---|
| Years of CV experience | Managed under risk | Providers satisfied | Cardiologists shift after P2P |

## What it is

An end-to-end cardiovascular condition management solution that goes beyond traditional utilization management. Evolent focuses on high-value authorizations across the full cardiovascular spectrum — diagnostic, interventional, and vascular — reducing medical costs while preserving the provider relationships health plans depend on.

## How it works

- **Comprehensive Condition Management** — full cardiology scope covering coronary artery disease, heart failure, arrhythmias, peripheral artery disease, venous disease, and structural heart disease
- **Subspecialty-Matched Clinical Review** — 65+ general cardiologists, interventionalists, electrophysiologists, and vascular surgeons drive peer-to-peer decisions, not generalist reviewers
- **GDMT Integration** — Guideline-Directed Medical Therapy built into clinical pathways; adherence improved from 28% to 65% post-Evolent in a multi-state Medicaid payer
- **Provider Alignment** — monthly scorecards, gold-carding for high performers, and value-based contract options reduce abrasion and drive long-term behavior change
- **Flexible Financial Model** — PMPM fee or full capitation; Evolent takes clinical and financial risk

## Why it's credible

- 20+ years of cardiovascular management experience; approximately $1.2B managed under risk
- 8-member independent Cardiovascular Scientific Advisory Board spanning Mass General Brigham, Yale New Haven Health, NorthShore University HealthSystem, and others
- 78% of providers report being satisfied or extremely satisfied with Evolent (2023 Provider Satisfaction Survey)
- 88% of cardiologists change their approach after a subspecialty-matched peer-to-peer conversation
- GDMT adherence improved from 28% → 65% across a multi-state Medicaid payer — 29% reduction in mortality with appropriate GDMT
- Example health plan result: total Medicare cardiology spend fell from $45.8M to $39.2M (-$6.6M) for ~31K members

## The close

**"Let's find a time to walk through your numbers."** Always end with a concrete next step — a follow-up meeting, a data request, or a one-page collaboration document.

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# Train-the-Trainer Guide

The full talk track, supporting data, objection-handling appendix, and language guide for partners presenting Evolent's cardiovascular condition management program externally.

## 1. THE TALK TRACK

### Open: Establish the problem

Cardiovascular disease is the highest-volume specialty cost category in health plans — and the fastest-growing. Lead with the market pressure before introducing Evolent. Let the audience feel the urgency before you offer the solution.

- **Cost trajectory** — direct medical costs of CVD are projected to more than double, reaching $749B by 2035 (AHA, Circulation 2017)
- **Fragmented utilization** — cardiovascular isn't a single condition; it's a multi-condition "wild west" with highly variable overuse across procedures and diagnoses
- **Procedure overuse** — ProPublica/CareSet analysis found approximately 30,000 patients underwent atherectomies despite questionable clinical need; coronary stent overuse is well-documented in the Lown Institute data
- **Aging population** — demographic pressure is compounding utilization growth, pushing health plans to act now rather than wait for the trend to stabilize

**Suggested pivot question:** "Does this match what you're seeing in your own cardiology spend and provider feedback?"

### Establish credibility: Evolent at a glance

- 20+ years of cardiovascular management experience
- Approximately $1.2B managed under cardiovascular risk
- 65+ physicians across general cardiology, interventional cardiology, electrophysiology, and vascular surgery
- 8-member independent Cardiovascular Scientific Advisory Board (Mass General Brigham, Yale New Haven Health, NorthShore University HealthSystem, Wayne State University, Advocate Christ Medical Center, Boston Medical Center)

### Show the scope: what Evolent manages

The clinical scope slide is a deliberate credibility pause — walk through the conditions column by column to show breadth, then flag that current and proposed expanded scope includes everything from non-invasive diagnostics through surgical procedures. The key message: Evolent is not a point solution for one procedure type.

- **Peripheral Artery Disease** — Arterial Duplex, Angiographies, Lower Extremity Revascularization
- **Coronary Artery Disease** — Stress Tests with Imaging, CCTA, Cardiac Caths, PCIs
- **Heart Failure** — TTE, Implantable Devices (GDMT program)
- **Arrhythmias** — EP Studies, EP Ablations
- **Venous Disease** — Venography, Sclerotherapy/Phlebectomy, Venous Ablations
- **Structural Heart Disease** — Valve Repair & Replacement, PCIs

**Frame it as a spectrum:** "We focus on procedures where there is the highest risk of patient harm, the highest documented rate of overuse or misuse, and the highest downstream cost waterfall if the wrong call is made."

## Go deeper if asked: value pool sizing

This is a dense, data-driven slide — don't walk every row. Use it reactively when a finance or medical director asks "where does the savings actually come from?" Lead with the two or three conditions most relevant to their membership.

- **EP Ablations** — $15k–$20k/case; Evolent manages to 5% intervention rate vs. <3% traditional UM
- **Heart Failure Implantable Devices** — $15k–$20k/device; 25% Evolent-managed vs. <5% traditional UM
- **Atherectomies** — $10k–$15k/case; Evolent manages to 40% vs. <10% traditional UM
- **PCIs** — $7k–$10k/case; 25% Evolent-managed intervention rate
- **Cardiac Caths** — $2k–$3k/case; 15% Evolent-managed vs. <5% traditional UM

## Explain the model: condition management vs. traditional UM

Walk through the three-way comparison deliberately — don't read every cell, but make sure the audience understands the key differentiators Evolent has versus both traditional UM and complex multi-specialty point solutions:

- **Cardiovascular Scope** — Evolent covers the full spectrum (diagnostic + interventional + vascular surgery); traditional UM is diagnostic imaging only; multi-specialty point solutions treat cardiology as one of many verticals with no dedicated program
- **Clinical Review** — subspecialty-matched MDs (general cardiology, interventional, EP, vascular surgery); traditional UM uses non-specialized reviewers with high abrasion
- **GDMT / Gaps in Care** — integrated into clinical pathways, adherence improved 28% → 65%; neither traditional UM nor multi-specialty point solutions have a GDMT program
- **Financial Risk Model** — PMPM fee or full capitation (Evolent takes clinical and financial risk); traditional UM is fee-based only; multi-specialty solutions retain most risk at the payer
- **Provider Alignment** — monthly P2P, APMs, gold-carding, VBC contracts, MSO scorecards; traditional UM is reactive relations only
- **Network & Footprint** — health plan network plus Evolent's owned FL network (800+ contracted MDs)

## GDMT deep dive: use when the audience is clinically sophisticated

Four medications titrated effectively are critical to managing heart failure and CAD. The problem: they are dramatically under-prescribed and under-utilized even when prescribed.

- **Beta blockers** — 25% of eligible patients not prescribed
- **RAAS Inhibitors (ACE/ARB/ANRI)** — 33% of eligible patients not prescribed
- **MRA** — 55% of eligible patients not prescribed
- **SGLT2 / anti-anginal medications** — only 1% of all eligible HFrEF patients simultaneously taking target dosages across all three RAAS/beta-blocker/MRA classes

Evolent's response: GDMT integrated as a clinical pathway requirement before authorizing certain imaging or interventional procedures. Result across a multi-state Medicaid payer: 28% adherence pre-Evolent → 65% at full penetration. Supporting evidence: 29% reduction in mortality with appropriate GDMT (McCullough et al., 2021).

## Prove it: results that matter

- 2023 cardiology authorization requests: 68% auto-approvals, 28% manual approval of initial requests, 3% modified or withdrawn, 1.3% denials
- Savings breakdown from interventional cardiology requests: 55% from modified requests, 24% from withdrawn requests, 21% from denials — savings are not denial-driven

- 78% of providers satisfied or extremely satisfied with Evolent
- 88% of cardiologists change their approach after a subspecialty-matched peer-to-peer engagement
- Example health plan result: $45.8M pre-Evolent cardiology spend → $39.2M with Evolent, -$6.6M for ~31K Medicare members
- GDMT case study: ICD defibrillator request — clinical reviewer recommended 90-day GDMT trial; ICD request never resubmitted; plan savings >$22K for that single case (excluding prevented hospitalizations)

### Close: ask for the next step

**"Let's find a time to walk through your numbers."** Never end a presentation without naming a concrete next step — a follow-up meeting, a data request, or a one-page collaboration of care document.

## 2. KEY STATS REFERENCE

Use this table as your source of truth when citing figures live. All stats are generalized national figures unless noted. Do not cite client-specific numbers unless cleared for that audience.

| Metric | Value | Source / Notes |
|---|---|---|
| Years of CV experience | **20+** | Evolent cardiovascular program |
| Managed under cardiovascular risk | **~$1.2B** | Evolent cardiovascular program |
| Cardiovascular physician bench | **65+** | General cardiologists, interventionalists, EPs, vascular surgeons |
| Scientific Advisory Board members | **8** | Independent Cardiovascular SAB |
| Provider satisfaction | **78%** | 2023 Provider Satisfaction Survey, Interventional Cardiology |
| Cardiologists who shift after P2P | **88%** | 2023 Evolent Cardiology prior authorization requests |
| Auto-approval rate | **68%** | 2023 cardiology auth requests by status |
| Manual approval of initial requests | **28%** | 2023 cardiology auth requests by status |
| Modified or withdrawn rate | **3%** | 2023 cardiology auth requests by status |
| Denial rate | **1.3%** | 2023 cardiology auth requests by status |
| Savings from modified requests | **55%** | Savings by auth status, example health plan partner |
| Savings from withdrawn requests | **24%** | Savings by auth status, example health plan partner |
| Savings from denials | **21%** | Savings by auth status, example health plan partner |

| Metric | Value | Source / Notes |
|---|---|---|
| GDMT adherence pre-Evolent | **28%** | Multi-state Medicaid payer, pre-EVH involvement |
| GDMT adherence at full penetration | **65%** | Multi-state Medicaid payer, EVH expectation at full penetration |
| Mortality reduction with GDMT | **29%** | McCullough et al. (2021) |
| Savings per ICD avoidance case (GDMT) | **>$22K** | Evolent analysis of client claims data (excludes prevented HF hospitalizations) |
| EP Ablations value per authorization | **$15k–$20k/case** | Evolent clinical value pool analysis |
| HF Implantable Devices value per auth | **$15k–$20k/device** | Evolent clinical value pool analysis |
| Atherectomy value per authorization | **$10k–$15k/case** | Evolent clinical value pool analysis |
| PCI value per authorization | **$7k–$10k/case** | Evolent clinical value pool analysis |
| FL network contracted MDs (owned) | **800+** | Evolent proprietary network |
| Example payer: cardiology spend reduction | **-$6.6M** | $45.8M → $39.2M for ~31K Medicare members |
| CVD direct medical cost projection 2035 | **$749B** | AHA / RTI International, Circulation 2017 |

## 3. OBJECTION-HANDLING APPENDIX

**"This just sounds like more prior authorization."**

Evolent goes beyond traditional UM. The model is built on provider alignment and clinical behavior change, not gatekeeping — 78% of providers report being satisfied or extremely satisfied, and 88% of cardiologists voluntarily change their approach after a peer-to-peer conversation. Denial-based auth programs don't produce those numbers.

**"How do we know the savings are real?"**

The savings structure is transparent. In 2023 Evolent cardiology authorizations: 55% of interventional savings came from modified requests, 24% from withdrawn requests, and only 21% from denials. The majority of the value comes from cardiologists agreeing to a different — and more appropriate — care path, not from Evolent saying no.

**"Will our cardiologists push back?"**

88% of cardiologists change their approach after a subspecialty-matched peer-to-peer conversation — the key word being subspecialty-matched. An interventional cardiologist is reviewed by another interventional cardiologist, not a generalist reviewer. That's the design that keeps abrasion low.

**"We already have a UM vendor. Why change?"**

Ask what conditions and procedures their current vendor actually manages. Most traditional UM vendors cover diagnostic imaging only; no interventional or surgical scope. Evolent covers the full

cardiovascular spectrum end-to-end: diagnostic, interventional, and vascular surgery. Ask specifically about their GDMT program — if it doesn't exist, that's a measurable gap.

**"What's the financial model look like?"**

Evolent offers a PMPM fee or full capitation — Evolent takes the clinical and financial risk. Traditional UM is fee-based only with the payer retaining 100% of clinical risk. Multi-specialty point solutions typically retain most risk at the payer. Full capitation is available if the plan wants to move risk entirely off the books.

**"We don't see our state in your footprint. Do you operate here?"**

Evolent's clinical infrastructure — physician reviewers, GDMT pathways, medical policies, provider engagement tools — is national. The owned FL network (800+ contracted MDs) is an additional layer available where applicable. The national program operates wherever the health plan operates.

**"GDMT sounds interesting, but how do we know it actually changes outcomes?"**

29% reduction in mortality with appropriate GDMT, per McCullough et al. (2021). More concretely: in Evolent's GDMT program, a single ICD request that was redirected to a GDMT trial produced >$22K in plan savings — and the ICD was never resubmitted, meaning EF improved. That's a clinical outcome and a financial outcome in the same case.

**"The pathway-level numbers look impressive, but how do they apply to our population?"**

Offer to size a population-specific estimate using their actual membership and cardiology case mix. The value pool analysis in the deck is based on similar health plan experience and can be adapted to their specific member count, condition distribution, and current spend.

## 4. CERTIFICATION CHECKLIST

Use this checklist to confirm a trainer is ready to present externally. All four items should be satisfied before sign-off.

- ✓ **Teach-back:** presents the problem, scope, model, and results sections back to the group in under 8 minutes, unscripted
- ✓ **Objection drill:** responds live and accurately to at least two objections from the appendix, no notes
- ✓ **Accuracy:** cites only the generalized national statistics in this guide — no invented or unsourced figures; no client-specific numbers unless cleared
- ✓ **Language discipline:** consistently uses "partner," avoids naming specific clients, distinguishes PMPM vs. capitation models accurately, and closes with a concrete next step

**Sign-off authority:** trainer's manager or designated Evolent enablement lead. Route any objection encountered live that isn't covered in this guide back to the enablement team so it can be added to the next revision.