[Music by C. Ezra Lange]

David Burda: Welcome to the 4sight Health Roundup podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules.

Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, September 14th. One of my favorite movies is “Oh Brother [Where Art Thou],” there's a scene toward the end of the movie when Pappy O'Daniel, the incumbent governor of Mississippi, tells the four Soggy Bottom Boys that they're his brain trust. To which Ulysses Everett McGill, the leader of the Soggy Bottom Boys, tells the other three that they're going to be the power behind the throne, so to speak. That scene came to mind when I heard about CMSs new value-based care demonstration project, and you'll get why in a minute.

The long name of the CMS project is the State's Advancing All Payer Health Equity Approaches and Development Model. The short name and the one we'll use in the podcast is AHEAD as in the AHEAD model to share their hopes and dreams. For the AHEAD model are Dave Johnson, founder and c e o 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi, Julie. How are you guys doing this morning, Dave?

David Johnson:

A host of our graduate school classmates and spouses are descending upon Chicago today for a long weekend of fun, friendship, frivolity, and very earnest public policy debates. I got to tell you, our houses never looked so good.

David Burda:

That's when the house is the cleanest right, in preparation for a party.

David Johnson:

Exactly. Exactly. Universal

David Burda:

Truth. Julie, how are you?

Julie Murchinson:

Well, I was just in New York with our team, actually had a great week and we toured the Intrepid, and if you haven't been there, it's a See all they have there. I got to say I was pretty impressed. It's a whole new view on technology and how it's shifted, that's for sure.

Now, before we talk about the AHEAD model, I want to talk a little football and get your early reaction to your favorite teams. Dave, your Vikings lost. Any thoughts

David Johnson:

Just like that? There go. My hopes for an undefeated season, the Vikings once again demonstrate their ability to snatch defeat from the jaws of victory. Unlike you, Dave, I am a totally Fairweather fan if the bikes are going to fail this season, which I hope they don't, but if they are going to, I hope they do it fast so I can pay attention to other things. On the plus side, on the plus side, I'm very grateful for the fact that I'm not a Jets fan.

David Burda:

Yeah, that was awful. Thanks Dave. Julie, your dolphins won a nailbiter over the Chargers. What's your first take on the team?

Julie Murchinson:

Well, I'm used to the Dolphins winning these early games and then tanking at the end of the season. So being a Dolphins fan is living a cautious life, but they looked pretty good, and if anything, we've got some more to do on the defense.

Well, my Packers won, which was great, but the best part of that is listening to all the hysterical Bears fans on sports radio here in Chicago. One minute they're going to win the Super Bowl. Three hours later they went the entire coaching staff head office and all the players fired. It's great. Nothing says Chicago like Angry Bears fans. It's the best reality show going.

Now let's talk about the reality of states adopting all payer global budget systems for their residents who are enrolled in Medicare and Medicaid. Here are some of the key features in the new AHEAD model. So bear with me here.

The program runs from 2024 through 2034, so 10 years up to eight states can participate in the program. Participation is voluntary.

States would set up Medicare global budgets for providers who participate in their state's program. Provider participation is voluntary.

Providers include health systems, hospitals, and primary care practices.

Participating providers would accept a predetermined fixed annual budget to treat their Medicare patients based on their past Medicare treatment costs.

States would roll their Medicaid programs into the model for both hospitals and primary care practices and states would use regulatory levers and authority to incentivize other private payers in the states to participate.

Okay. Ulysses Everett McGill. Give us the quick backstory behind the throne of the demo then. Tell me from a policy perspective where this program fits into your belief that the healthcare system will change more in the next 10 years than it has in the past 100 years.

David Johnson:

Oh, Brother, Where Art Thou? When Brad Smith was the CMMI program or administrator at the end of the Trump administration, he undertook a comprehensive review of all 54 of CMMI's value-based payment models. And I don't know if you remember this, but only five of them achieved savings at all, and it didn't include some of the big ones like bundles and the cancer program. And what Brad said was that the ones that did succeed had a clear thesis, a clear thesis on cost and quality improvement, and he particularly signaled out the Maryland all payment program, all payment model with the global budgets, and that is projected to save over a billion dollars by the time the second waiver period is done in a couple of years. Brad's comments were on my mind early last year when Zeke Emanuel, Merrill Goozner and I wrote the two-part series in health affairs on state-based payment reform.

And evidently that series influenced CMMI's thinking in developing the head program, which is pretty cool. At the time, I was channeling my inner Uwe Reinhardt and saying, "It's the payment model stupid." And you've both heard me say this a million times that we're not going to change the way we deliver

care until we change the way we pay for it. And Maryland does that, all payers, so providers receive the same amount regardless of the insurance sponsor, commercial, Medicare, Medicaid, self-pay. And the beauty of the federal model is that the states are laboratories. So it works in Maryland, so copy it or at least use it as a basis for further experimentation. So Maryland is working all payer model, the global budget, really important in reigning in costs. So why did Maryland work or why does Maryland work when the other CMMI initiatives didn't? And what implications does that have for the AHEAD program?

A similar all-payer model with Global Caps have for states that want to jump into it. Well, my opinion, here's what you need to get real payment reform has to be big. So think statewide, it's got to be mandatory. You got to be in, nobody can opt out. It's got to be comprehensive. So you can't gain parts of the system. The program should be administratively easy and it should be long-term. So how does the AHEAD program stack up on these criteria? It's big supplying to entire states or major sub regions within states surpasses that test. Is it mandatory? No. And that's bad. Really unfortunate. So they're going to have to win participants with carrots and no sticks comprehensive. I think it on balance passes that test emphasizes primary care, incorporates Medicaid with Medicare into the payment model. It encourages participation of commercial plans as well. So this could be true, devil will be in the details, but it could be true for those providers who decide to participate.

So a plus on comprehensive administratively easy. Let's see. Too early to tell and long-term, absolutely. Yes. 10 year program. So participants that are going to play in this field know that they can have confidence around their payments for 10 years to come. Really, really important. But perhaps the biggest benefit of all of this program is it creates a pathway for really ambitious governors to get real payment reform by negotiating the mother of all waivers with CMS. And I actually believe that could happen that a governor and a state that really wants to push mandatory payment reform far beyond or Maryland is so imagine an all payer system on steroids that they can go to CMS and say, Hey, you were doing this in a small way. We want to do it in a big way. Help us out in terms of your question about the extent to which the head program will contribute to my proclaimed announcement or conclusion that healthcare will change more in the next 10 years than it has in the last a hundred years.

I don't think it's going to change it that much because the whole basis for my conclusion is that the change coming to the healthcare industry is going to be more outside in than inside out. This is a totally inside out program. What it does do though is give some providers those that are in states that win or participate in the program and providers that choose to participate in the program. So two conditions there, it gives them a chance to get on train before it leaves the station. And that's important because I think there will be some providers that make the transition truly to a value-based payment system where we have more health and less healthcare, but most are going to fight this whatever we fiber they're being until they absolutely have no other alternative. So will it help? Probably helps on the margins. I don't think though Dave, we should look for salvation, for value-based payment, value-based care in this program. It's helpful, but it's nowhere near enough to get us there.

David Burda:

Got it. Yeah, I think the tough sell will be the doctor, so we'll see how it plays out. Thanks Dave. Julie, any questions for Dave?

We've talked a lot about some of the challenges that provider consolidation is creating for the industry from a rate perspective. So many perspectives. And when I look at this program, I think to myself, there's more to it than just the reimbursement change here. Do you think that there's some kind of impact that this global budgeting could have on provider consolidation as a movement?

David Johnson:

Julie, I'm not an economist, but I'm going to give you an economist answer sort of on the one hand and on the other hand. So on the one hand I think it could slow down consolidation. It takes the immediate financial pressure off because the global cap guarantees a certain amount of payment, albeit a little bit less than they probably got the year before and going down each year. But it takes the revenue pressure off, which means that health systems and hospitals, doctors can focus on real performance improvement knowing that they're going to have a certain amount of revenue coming in the door. And also this program is going to take some time to figure out, and that almost always slows down strategic moves like consolidation on the other hand, maybe it'll speed it up. Combining creates more opportunities for real savings. If you've got two systems that, or one system that's underperforming and it combines with another one that's underperforming that much more opportunity for savings, cutting overhead and so on.

And you can do that without the traditional focus, what you were just referencing on using market leverage to push up commercial payment rates won't be able to do that presumably. And by the way, there should be consolidation. We have far too many providers and they operate independently with enormous amounts of duplication of waste. So on the one hand, it could slow it down. On the other hand, it could speed it up.

Interesting to see how the importance of market share changes under this model.

Thanks Dave. Julie, they say a necessity is the mother of invention. If all payer global budgets are the necessity, where is the healthcare innovation? Is this a deterrent or an accelerant?

Julie Murchinson:

Well first of all, Dave, I loved your analysis, really thoughtful on so many dimensions and I looked at it totally differently. So this will be fun. Great. This kind of concept of global cap is one that we've been on the road towards for I don't know, decades now. And I looked at the bones of what they're doing with the AHEAD program. There are specific places where you would imagine innovation will happen based on how it's designed. So participants in the program need to focus on behavioral health integration and health related social needs and care management, specialty coordination. So in those areas I would hope that you would need to innovate to be able to deliver with a more controlled revenue model. And then when you look at the goals of the program, it's really to strengthen primary care and again, improve care coordination.

So there's a lot of places in primary care where you can imagine there's tremendous innovation that could happen to really manage care in a way where again, revenue is more controlled, it's not a fee for service playground. So there should be a lot here. What I liked about the program addition is that there is some room for incentive payments. And Dave, you didn't like the fact that there might need to be more carrots and sticks, but I actually think incentives could be used really creatively with more of a capped model here because it allows for some direction of how to think about shifting or think about focusing on specific parts of care or specific segments to really do what the hospital needs to achieve in that market. So I do think there's some creativity here that I like and there are some specific little nuances around the hospital's health equity plan needing to do health related social needs screenings and demographic data collection.

So there are some nuggets of what needs to happen as part of the foundation where you can imagine there needs to be new data capture capabilities and workflow tools that will need to enable all that. So I'm very net positive on the types of things I see in the head program. However, I've spent years off and on talking to my friend Mark Shaver, who currently runs strategy and a number of the physician operations at University of Maryland. And he used to Hopkins before Will Tower. He has seen a lot and is very thoughtful on this, and I've always been surprised by his perspective that the Maryland system is

amazing, but it actually suppresses innovation because it suppresses hospital margins. And what's more fascinating to me is when you look at the Medicare Advantage position in Maryland, they're running like, I don't know, 20%, 30% below the rest of the states in the country that are more advanced on Medicare Advantage.

And what does that mean and why is that important? MA has really been the driver for innovation in many other parts of the country. And with MA being so low, Dave, you'll love this, you actually don't get the oak streets or the churn meds or the outside innovation coming into Maryland as a state and really pushing those health systems to do what they do better. So what happens I think, is that the health systems deliver as much as they can deliver as well as they can deliver it to the revenue cap that they have. So it creates some weird, I think disincentives. And I think Mark would probably also say that the Maryland program is amazing because it does allow a provider to treat a patient like a patient regardless of how that patient is being paid for. So there are a lot of really good, I think, conceptual aspects of the Maryland model that really do allow for less cherry picking, more treating patients as part of a broader community. But I worry about the innovation that he's seen in the Maryland market and what that might mean in general here.

David Burda:

That's interesting. A lot of short-term gains and long-term risks. Thanks Julie. Dave, any questions for Julie?

My question for you this morning, Julie is, and it's a hypothetical one, which are always dangerous, but I know that you're a huge admirer, as am I of Janice Nevin, the CEO of Christiana Care, which is Delaware's largest health system.

If Delaware somehow now became one of the eight states, and Janice were to ask you for your advice on whether Christiana Care should participate in a head, what would you tell her? And put another way, can a head become the type of forcing function that you were just describing for a health system like c e o and a really fantastic, I'm sorry, for a health system like Christiana Care and for a really fantastic CEO like Janice to accelerate implementation of real value-based care delivery, which I know she's passionate about. What do you think?

Julie Murchinson:

Janice is already on the forefront of doing a lot going down this road. They have a relationship with Highmark where they're really looking at how they make progress together in a state where they both have significant market share and can really move the needle. So she's already doing a lot and experimenting quite a bit. If she were pretty ahead, I think Janice would already know that AHEAD would have to be something that she takes what she's already doing with some of the social needs work that they're doing and a lot of the value-based care work that they're pushing and use it to push towards what will be an ultimate system that includes a lot of innovation along the way. And I guess that's how I feel about the AHEAD program period, which is, sorry, hold on one second. Still funny. I guess that's how I feel about the AHEAD program period, is that if you use the AHEAD program as a step towards what the end goal is in value-based care and you leave room to innovate in ways that make sense in your market and update your systems and update your business strategy along the way to get towards how to work in that kind of revenue environment, then the AHEAD program can be super useful as a stepping stone. So I'd be interested really in how Jana would react. Janice would react to this,

David Burda:

Right? She doesn't want to go backwards, she wants to keep going forward. So great point. Thanks, Julie. I'll just say this, when someone gives me $50 and only $50 to spend on a tailgate party, I can get pretty creative, but if someone here gives me the debit card, I'll end up with a lot of expensive leftovers. So it really all comes down to football, doesn't it? Right. And food and food and food

Julie Murchinson:

Wings, it's really all about the wings

David Burda:

Right? Yeah. Yeah. Football, food, wings. Got it. All right. Thanks David. Thank you, Julie. That's a great discussion. I know we'll be revisiting this topic many times in the future. Now let's briefly talk about other news that happened this week. It wasn't all bad, was it Julie, anything else worth mentioning today?

Julie Murchinson:

Well, on the heels of our recent podcast about EHRs, Oracle shares fell 13%. And if you read what the C e O is saying, a lot of the blame is really going to Cerner. And it seems like maybe it's a bit of a one-time charge kind of situation, but I don't know if that's really right. But they're talking about, it's the transition from some of the headwinds that Cerner's had and also in transitioning Cerner to the cloud, which is shifting their revenue model. But I don't know, I'm worried about Cerner.

David Burda:

Yeah, we time that topic perfectly. We'll see how that one plays out too. Dave, what else caught your attention and why?

David Johnson:

Oh, I conclude completely different. Who knew we had so much influence on the market? Unbelievable. Good for us.

Well this is pretty interesting. One of the friends coming in this weekend is Jay Walter, the former chair of the M T A, the big transit system in New York. And he needs to have some pretty simple meniscus surgery. And it turns out his insurance company changed their model for paying for out of hospital or out of network physicians last month. So he thought he was going from 80% of reasonable charges and having to pay whatever on top of that two, one where his insurance company is now just paying 275% of Medicare rates and the doctors charge, which we know is fictitious as 12 grand, he's willing to take five. Medicare's willing to pay 1400. And while I feel badly for Jay, I like the fact that the dysfunctional pricing of healthcare is coming down so directly to him as a consumer and it's going to affect behavior. So pretty interesting what's going on in the payment world. The only other thing I am following is Walmart's the announcement this week that Walmart is looking at acquiring Chen Med, another one of these retail enhanced primary care provider deals. Be interesting to see if that comes to fruition,

David Burda:

And we'll see if we pull some market clout with that one too. That's a great mention. Thanks Dave, and thanks Julie. That is all the time we have for today

If you'd like to learn more about the topics we discussed on today's show, please visit our website at 4sighthealth.com. And don't forget to tell a friend about the 4sight Health Roundup podcast. Subscribe now and don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.

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