Why Are APMs and Full-Risk Contracts Still Too Hot to Handle?

4sight Health Roundup Podcast

[Music by C. Ezra Lange]

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, November 30th. If today's the 30th. That makes tomorrow December 1st. Where does the time go? Two more weeks, and then we go into holiday hibernation until mid-January. Speaking of hibernation, we're going to talk about value-based payment models on today's show, and there's your transition. To tell us how we can snap out of value-based care hibernation are Dave Johnson, founder and CEO 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi Dave. Hi Julie. How are you guys doing this morning, Dave?

David W. Johnson: Dave, it's getting dark at 4:30 every afternoon now. More than the upcoming holidays. That's what makes me want to go into hibernation, get fat like the squirrels, go to bed and wake up next spring. Raring to go.

Ah, nature. Thanks, Dave. Julie, how are you?

Julie Murchinson: I just spent a week in my home state in Florida with my mom and family, and I will say I've never really understood Florida as much as I did this last week, warm, sunny November. It was lovely.

David Burda: Now, before we talk about value-based payment, let's talk about your hibernation plans. Dave, you brought 'em up. When does your system start shutting down for the long holiday season?

David W. Johnson: Well, I wrote my last book, the Customer Revolution in Healthcare during 2018, and by mid-October of that year, I had only a hundred pages completed of what became a 300 page book and a submission deadline to McGraw Hill in mid-January. So I shut down travel, got up at 5:00 AM every day and wrote my ass off. How's that for a metaphor on writing? Anyway, I met the deadline and the only days I took off were

Thanksgiving and Christmas. I mentioned that because Paul Kusaro and I are now working to finish our manuscript on the Megatrends book, and we're trying to get that done roughly the same time period early January. So we're over halfway done, but I only got a month to go or a little over a month to go. So I'm anticipating another forced march through the holidays, although hopefully not as bad as last time.

Deadlines trump hibernation, that's for sure. Julie, how about you? When does your travel stop and leisure begin?

Julie Murchinson: Well, travel officially stops next week, which is great. And my kids are off school roughly December 15th. So that begins the work while they sleep plan and then take a few hours to hang out with them in the afternoon. So that's kind of semi hibernation. Right?

I totally get that. I've been taking kids back and forth from college over the holidays for it seems like forever. Same this year. I'll get a little break in between Christmas and New Year's, but that's about it. On the plus side, no one can pack a car or a moving van like me and still see out the back window. I could teach a masterclass in it. So let me know if you guys need any help. What needs help is value-based care and value-based care needs help attracting provider participation. That's at least according to two new reports. The first report is from the American Medical Association. The report is based on a survey of about 3,500 practicing physicians. 64.3% of the docs said their practice got at least some revenue from alternative payment models last year. That's up slightly from 63% in 2018, or four years earlier. 30.9% of practice revenue came from APMs last year. That's up slightly from 29.7% in 2018. The AMA call physician participation in APMs stagnant. The second report is a study published in the American Journal of Managed Care. The study is based on a survey of 100 provider organizations that participate in the Medicare ACO program. It found that 48% of covered lives in value-based care contracts last year were in one-sided risk contracts. 42% were in two-sided risk contracts and only 10% were in full risk contracts. The study didn't say much about other than the usual more study is needed bit, but I'm sure you two have a lot to say about it. Dave, what word would you use to describe what the AMA survey found? They used the word stagnant, and

what would you do to get more physicians to participate in alternative payment models?

Well, stagnant is a good word, but I think my word would be, meh. Let's not forget that the AMA is a membership organization and at the end of the day, what it cares most about is getting its members paid. So I just think it's really hard for these associations to really advance the type of value-based payment reform that we're all talking about. -All of this has me sort of thinking about a report I saw by Paul Keckley, and for those of you who don't know Paul, and probably most of you do, he might be even more of a curmudgeon on payment reform than I am. And that's saying something. Anyway, Paul commissioned a poll called the Keckley Poll, which was out this week that looked at which of five institutions are best positioned to solve health system problems. And he looked specifically at insurance companies, hospitals, physicians, the federal government and national retail health companies, and the results weren't great. First off, 69% agreed that the health system is fundamentally flawed and needs major change. And then you kind of look at the relative level of trust in the five categories of institutions to fix it. And is his question was, how much trust and confidence do you have in insurance companies, hospitals, physicians, federal government, national retail health companies to develop a plan for the US health system that maximizes what it has done well and corrects its major flaws? And the truth is nobody's got much confidence in any of these groups, slightly more in hospitals and physicians than the other three. But Paul's concluding remarks I found were pretty interesting. Let me just summarize 'em for you. This is his take, these data confirm a public view that the status quo healthcare is unsatisfactory to the vast majority of Americans. While each of the five institution asserts its unique role and value proposition in the scheme of US healthcare, none stands out for its differential commitment to the greater good, lacking fresh solutions, new voices and honest insight, the health system's problems will get worse and the system will devolve into two tiers, a private system of a la carte programs and services accessible to those who can afford it. This polling suggests it's time for the industry to consider the public we serve instead of ourselves. Some do it better than others today, but lacking a systematic strategy, engaging all sectors to address the health and wellbeing of the entire population, affordably, incrementalism will continue,

sectarianism will prevail, and the system effectiveness will erode. well, how's that for a good New Year's wish? So Paul's hitting the nail on the head. Now interestingly, one group he didn't look at was he did look at the federal government, but he didn't look at the state governments. And that's where I've been putting much of my confidence to the extent I have it in pro-market, pro-consumer reforms, I can imagine a few of the states really stepping out under the pressure of finances that are gone awry and healthcare that is not delivering for the people in their state really pushing fundamental reform.

Got it. Bet on the states. Thanks Steve. Julie, any questions for Dave?

Julie Murchinson: My question for you is really around whether what we're trying to do in value-based care is focused on the right thing today. We've been talking financial models out of CMS bundles, a lot of specialty focused activity. But from reading this report, I read something that for each care delivery model, doctors and practices with primary care physicians were more likely to indicate that their practice belonged to an ACO or medical home than those in a practice without primary care physicians and between a 12 and 22 percentage point difference in 2022. What's happening? Are we trying to take risk too much end to end? Do we need the primary care function to actually deliver on the specialty financial models? Where are we in what we're trying to really achieve?

David W. Johnson: Primary care properly structured and administered is really in the business of competing on health. So prevention, health promotion, early identification of chronic conditions, integrating behavioral health into physical health, all those very good things. And it's just more likely to happen in a group practice if they've got some primary care physicians hopefully being more than just pure referral machines andtrying to advance the overall health and wellbeing of the population of patients they see. My guess, Julie, and it is a guess is that's what's manifesting the difference that you're seeing this non-trivial difference in between practices that have primary care as part of it and practices that don't. At least I hope that's the reason.

It's like having a good utility infielder on your team.

Exactly right, exactly. Fewer errors.

Thanks, Dave. Julie, let me ask you about the second report. First, does the poor showing of full risk contracts surprise you? And second, what can the market do innovation wise to get more providers interested in full risk contracts?

Julie Murchinson: Full risk is hard. And we know that there are models in this country that have been able to make full risk work and they are largely the best of the best, have been highly integrated. So we're still far from that in many places. I mean, why does Ryzen even exist as an option at this point? But when I just take a step back and look at what we're seeing, provider enablement has a lot to do with any kind of risk that's being taken. Smaller states like Rhode Island are pulling out all the stops. Martha Wofford, CEO of Blue Cross Blue Shield of Rhode Island seems to be making this her hill to die on. She's actually really making waves in that state. Blue Cross Blue Shield of Michigan has done a lot of work to enable their provider network as well. And I'm not sure that the value-based activities among larger plans and states stand out quite as much. And there's certainly the larger, in many cases, the harder it is to move to full risk. I think, and I've recently talked about systems like TriHealth and other providers that are significantly reshaping their business models, and I think those models will be better positioned to take full risk in the longterm. When you look at the AMA report talking about how physician owned private practices were substantially less likely than hospital owned practices to be part of ACOs. And this all makes sense too, right? It comes back to enablement. So where health systems can use their financial maturity and work well with their medical groups, it works. Everyone else, frankly, ADE should work with. And Dave, I know you love ADE on your second question about market innovations. Market innovations work where the problem is ripe to be solved, and we do see some innovations in really helping to move the ball forward in places where factors are ripening. Companies like Stellar that we're invested in that help health plans enable specific actions that close care gaps, and they reward not just doctors, but everyone in a physician's office.We all know that bio-based care models

will be less mature without systems that support this kind of action. And their models, models like Apre, which we're also invested in that practice, advanced primary care invite based arrangements, and it might just take entirely new delivery models like this or TriHealth or like others to really move the needle on full risk.

And we need innovation to give providers the tools to make it happen. That's great, Julie. Thank you, Dave. Any questions for Julie?

David W. Johnson: In the limitations section of the AJMC study, they noted that only 21% of the contacted ACOs responded to the survey. That's pretty dismal. And respondents, as you mentioned, tended to be larger ACOs and those affiliated with hospitals. To what extent do the anemic response rate and the skewed respondent composition compromise the survey's findings? I guess big picture, what I'm trying to figure out, are participation rates in value-based contracting even worse than those revealed in the survey? And if so, where are we on the road to value-based care? Are we in a ditch?

Julie Murchinson: I do think we might've driven off the road a little bit. I'll give you that. Yeah. I mean, first of all, the response rates for so many things, these days are terrible, but that was terrible. But let me just, I guess give perspective. I recently heard the CFO, Rick Horter of Texas Health Resources talk about their value-based relationship with their medical group specifically around Medicare Advantage. And on the positive side, they work really well in tandem. I think Rick is kind of writing the playbook on how to make this work and how their medical group can deliver and realize value for the broader system and not just be managed as a medical group to that contract. I mean, he and the head of the medical group were really thoughtful on this, but on the flip side, they talked about how hard it is and how financially questionable MA is for them in the longterm as a system. That's not good. So I'm not saying that they have it perfected and they've figured it all out to optimize what they're doing in MA, but it's a little bit concerning when you hear the positive and the negative in a way that makes them question whether it's going to last. But even scarier than that, talking to CFOs lately, a lot of them are trying to actually figure out the basics of value-based

care, and these are health system CFOs, right? So when you have CFOs asking for better information on, well, really what is value-based care and really how does it work? In some ways I get excited about that and other ways I think to myself, good God, is that where we are? So yeah, maybe we're trying to get out of the ditch right now. I'm not sure.

Yeah, a lot of people are still square one, but it is interesting. I think everyone else's business sinks or swims based on how well they serve customers except healthcare, and it's time to change that. So thanks Julie, and thanks Dave. Great discussion. Now let's talk about other big news, Julie, anything else happen that we should know about?

Julie Murchinson: Well, I saw that the FTC is meddling in John Muir's ability to acquire the rest of a tenant hospital that they are partial owners of, so partial acquisition and FTCs blocking it. And at the same time, I also read that Novant is reportedly buying three tenant hospitals. So tenant is on a selling spree, and the FTC seems to be on it.

David Burda: Yeah. Yeah. They're following the trail. Thank you. Dave, what other news should we take note of?

David W. Johnson: I had a conversation this week with the staff at CMMI regarding the ahead program, and I came away from it actually pretty pumped. They're in the pre-implementation period, so the first batch of applications are due in March. Ultimately, they want to give grants to eight states for this concept, Maryland Lake concept, Vermont Lake concept of all payer rates within global budgets. Lots of flexibility given to the states in terms of how to create an all-payer program under a global budget. And they're expecting more than eight states to respond. So there'll be competition for this. And I mentioned at the end of my longer remarks that maybe the states are where the engine of innovation will occur in healthcare. It's where the rubber meets the road since we're trying to get out of a ditch. And so I'm actually encouraged by this, and it's something we collectively should be paying attention to.

David Burda: It'll be interesting to see what states stick their neck out. 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. Look for the picture of the cauliflower, 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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