Three Keys to Transitioning to APMs

Part 1: Build or Buy

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This presentation is for:

- Health systems and medical organizations considering APMs
  - ACO (MSSP or ACO Reach) in Medicare or Medicaid
  - CMS Specialty Care Model
  - Private ACO Agreements with health plans
  - Bundled payments
- Existing ACOs who are planning a transition to population-based payments

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What we'll cover

- Background on APMs and slow growth
- In what ways competition should guide APM structure
- Criteria for assessing options to build an ACO or participate in other APM type

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Co-Presenter: Tainn, 14 weeks

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About Roji Health Intelligence

- We provide Value-Based Care technology and services to improve outcomes, cost performance, and equitable health care.
- Our powerful tools identify patients with persistently poor or high-risk outcomes and target health interventions.
- We provide our clients with the ability to engage physicians and other clinicians on meaningful, clinical improvement for patients.

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What is an APM?

- APMs (Alternative Payment Models) are risk-based reimbursements for providers under a program, not the provider entity -- CMS and common usage is confusing
- VBC Alternative Payment Models reinforce accountable care vs volume of services (they aren't fee-for-service!)
- MSSP ACOs with no downside risk are called APMs, but the payment model itself is weaker reinforcement, while ACO Reach is strong

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Are APMs Really Essential for Changing Behavior?

- If reimbursement and physician compensation both reward volume, driving value is practically impossible
- APMs are meant to reward accountability, but they assume rewarding physicians similarly
- Changed incentives can work, if data and infrastructure, performance goals, practice support and interventions support
- Implementing APM reimbursement and expecting behavior change is magical thinking
- The ultimate APM: global population-based payments

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HMOs Were the Historical Equivalent of APMS – why did they fail?

- Organized by payers, not providers
- Focus on lower cost but not quality – led to denials of care
- Extremely unpopular with employees in benefit plans

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ACOs and Risk have grown slowly

- Zero change in proportion of straight Fee For Service
- Only 6.7% of total payments are population-based payments
- Volume of ACOs accepting risk is small
- Primary Care First has many organizations but few sites for each
- ACO Reach coming on board, but only 120 provisionally qualified
- ACOs are hesitant to proceed along path to financial accountability
- Dropout rate high after Pathway to Success introduced
- Continued pushback against changes that would alter finances

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What has changed?

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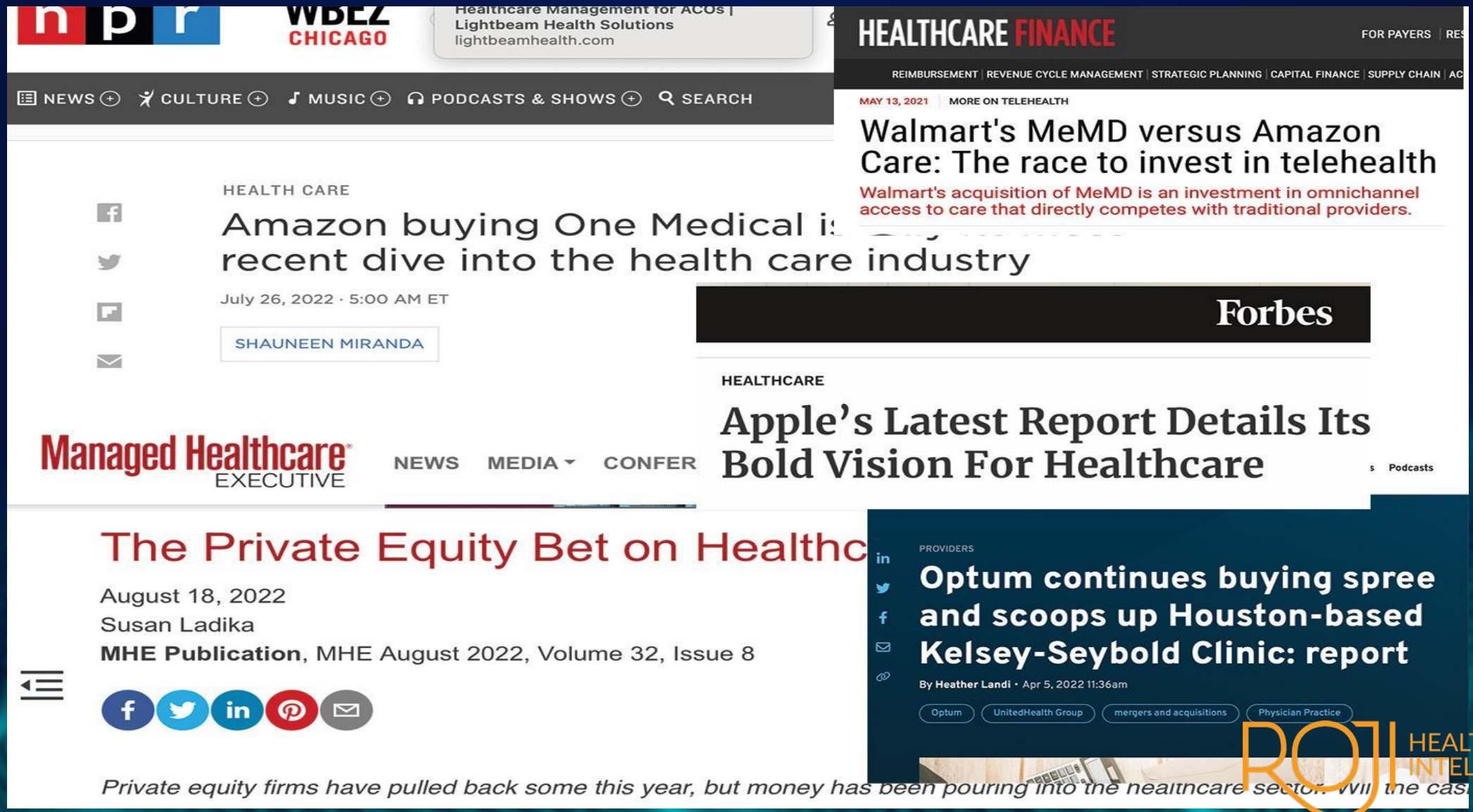
Everything is Changing



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Payers and Employers Have Changed

- Most payers have Value-Based Care contracts / APMs
- Insurers are implementing population-based payments more frequently
- Employers are contracting with physician groups
- CMS has reiterated a stronger VBC strategy
- There is stronger alignment among payers on changes to payment models to reward value over volume

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Physician Attitudes Have Changed

- Physicians hurt financially by pandemic
- Significant drop in volume caused losses for practices dependent on FFS
- Practices with prospective payments did well
- Result: largest single year of physician migration to employment

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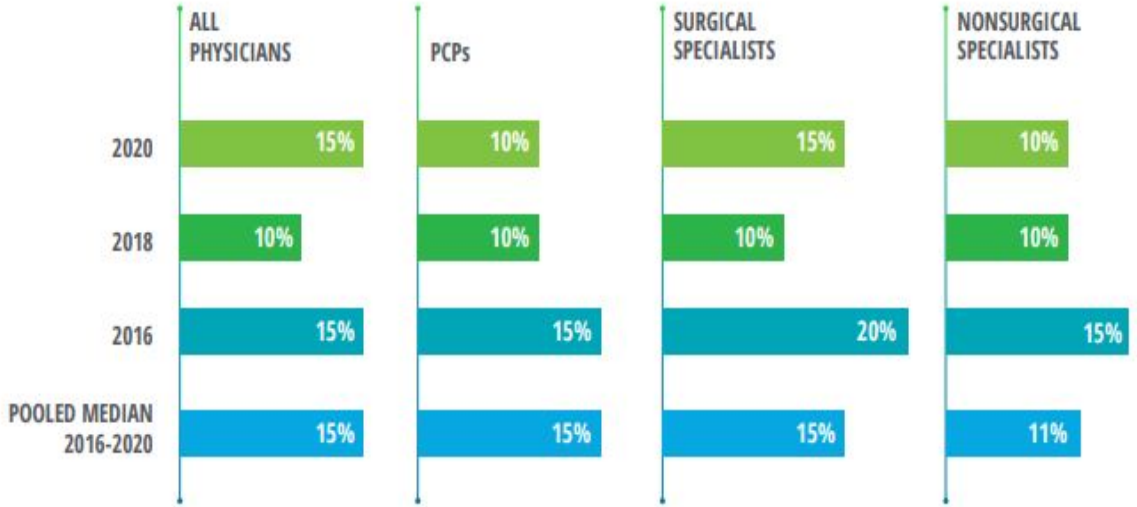
Physicians are more open to Risk

FIGURE 2

Physicians' tolerance for risk is in the 10–15% range (as a proportion of compensation)

Survey question: Imagine you are a physician executive developing a physician compensation structure for your organization/practice where a certain portion of compensation must be tied to quality and cost. As a physician executive, what percent of physician compensation would you be able to put at risk and get physician buy-in? (Medians)

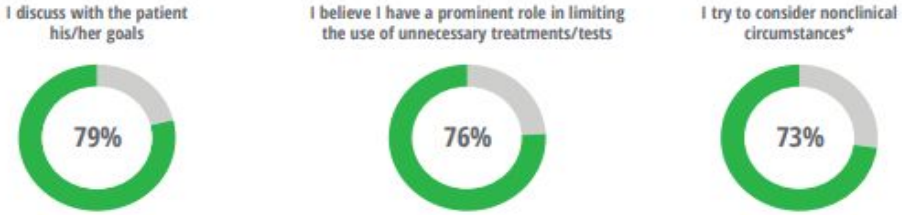


2020 base=680; 2018 base=624; 2016 base=600.
Sources: Deloitte 2020 Survey of US Physicians; Deloitte 2018 Survey of US Physicians; Deloitte 2016 Survey of US Physicians.

FIGURE 3

Physicians recognize their role in managing costs but don't have the tools to do so

Survey question: When treating patients, which of the following apply to you?



Note: Examples of nonclinical circumstances include patients' living conditions, work demands, access to transportation, and support at home or in the community.
Base=680 (all physicians).
Source: Deloitte 2020 Survey of US Physicians.

Source: Deloitte

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The Health Care Market Has Changed

Where did physicians go?

They went to corporate health care practices.

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Changing physician workforce

- 74% of physicians now employed
- Practices now backed by corporate health care giants: Amazon, CVS, Walgreens, large scale MSO/ACO enablers, Optum
- MSO/ACO enablers are aggressively buying practices away from health systems and ACOs
- Private equity is financing practice acquisition in specialties

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Pandemic disrupted health care and changed health care

- Telemedicine
- Practice adaption to predictive payment
- New business competitors that saw opportunity to engage physicians in APMs

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Competitors are Different, and Physicians are Responding

- Providing physicians with confidence of successful APM participation
- Incentives tied to success for APM
- Have technology without the hassle
- Offer alternative to physicians who believe they have become “cogs” in the volume machine

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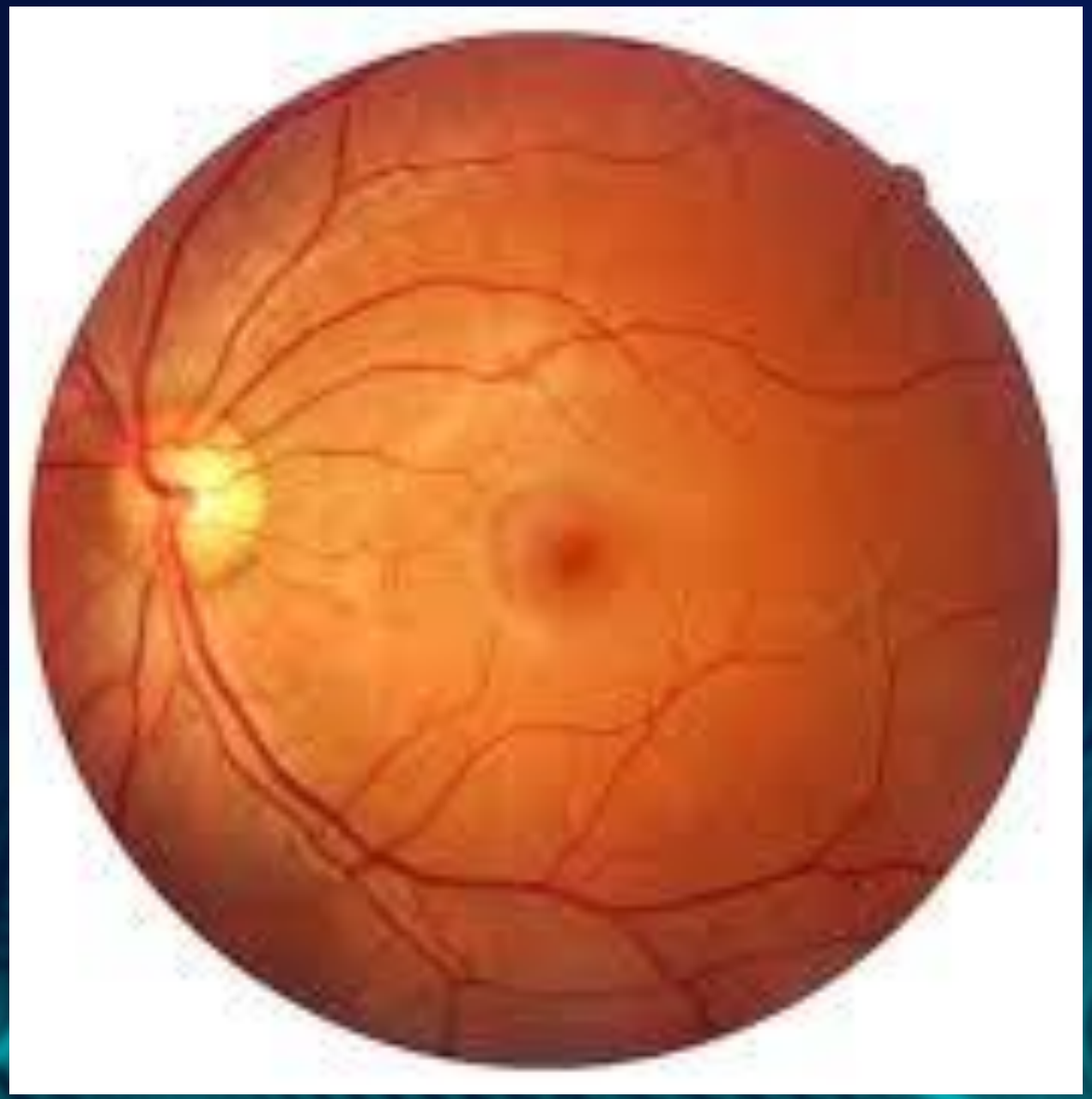
Technology is Changing Health Care Possibilities



- New technologies
  - Artificial Intelligence
  - Gene editing and therapies
  - Cancer Therapies
- Diagnostics will radically change predictive risk
- FFS cannot support access

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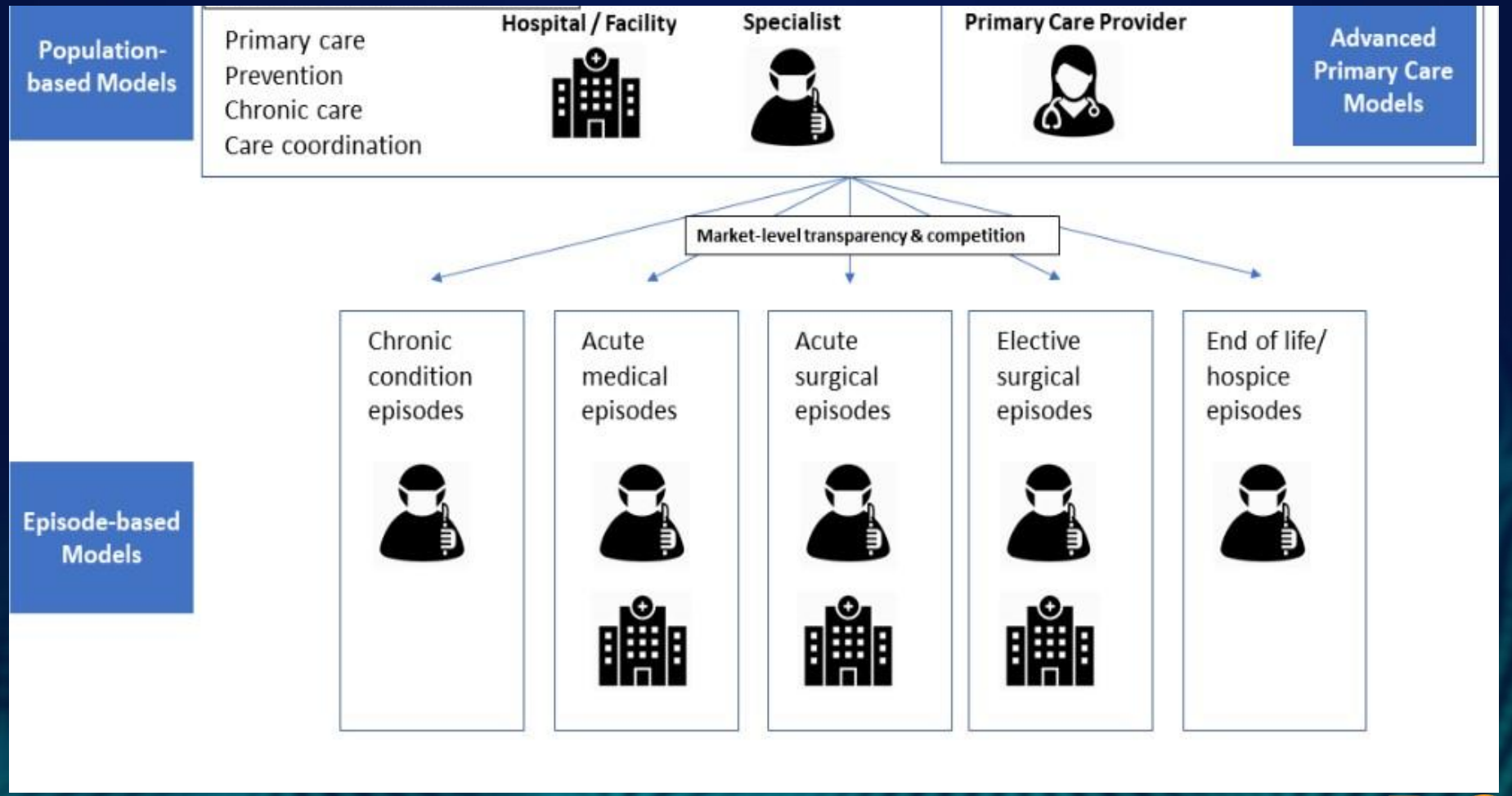
Some imagine a different future health care system with APMs



Source: Health Affairs, "Medicare Payment Reform's Next Decade…December 2020

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What this Means:

Your #1 Strategy for APM Transition:

Meet the Bar Set by Market Competitors

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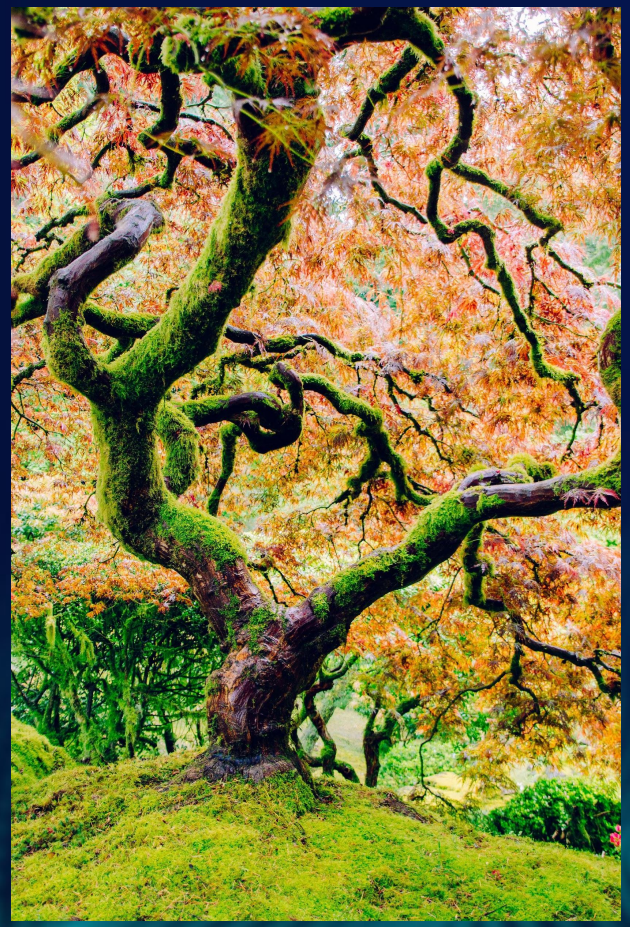
Fork in the Road Decision: Build it or Participate



Can you do this by building your own APM organization

or

do you need to participate in another?

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Questions to ask

- What's your market positioning – are you a "must have?"
- What other APMs exist?
- Who are business competitors? Traditional competitors?
- What is the status of your technology / infrastructure?
- Is your culture focused on efficiency or does volume govern value?
- What is your payer mix?

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Your size is not your biggest issue

- You may be important as a “niche” network, even if small, for some patient groups (e.g., disadvantaged or elderly) or have reputation for certain services
- Your patient care costs (measured by payers) may be lower
- You may consistently meet quality standards
- BUT… if you don’t know these facts, then you need to improve your data and analytics

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What you really need to build your own APM Entity

1. Enough money to staff and purchase/build infrastructure, and expert guidance
2. Strong physician leadership
3. A primary care network or, if specialty APM, the specialty core & reputation for excellence/outcomes
4. A culture and energy for change and physician collaboration

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What you really need to build your own APM Entity (cont)

5. An already-implemented electronic health record

6. The stomach for distributing money based on performance

7. The technology to identify costs, outcomes, equity, and for interventions to improve

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Value-Based Care Technology

- VBC technology can be purchased
- VBC technology is not the same as an EHR – Your EHR is one source that is aggregated by VBC technology
- Think about what you will need to create value from all data sources: financial, transactional, clinical, providers, patients
- You must have sufficient data to feed the technology!

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Value-Based Care Technology Requirements

- Patient centric, captures all demographic, SDOH, financial, clinical (EHR), and claims
- High integrity of data sufficient for cost, quality and equity analyses
- Identifies appropriate clinical and population health interventions
- Captures longitudinal outcomes and risk
- Calculate patient costs per year, cost variation, low-value services, differential outcomes
- Episodes of care are ideal for examining differential outcomes and cost outliers
- Claims payment functionality

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Essential:

Physician view of analytics on cost and outcomes

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No longer enough to use pop health as retroactive tool.

Data in episodes enables you to target interventions based on clinical severity & outcomes.

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If You Can’t Build, What are Participation Options?

- Joint Venture with another organization
- Participating provider in another ACO
- Medicare advantage option

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Participation Advantages and Disadvantages

Advantages:

- No investment cost
- Maintain options to participate in VBC vehicles

Disadvantages:

- At the bottom of the food chain
- No decision authority on key issues or distribution of money

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Special issues about Medicare Advantage

- Your own Medicare Advantage plan and your own ACO
- Participation in an external Medicare Advantage plan while having your own ACO
- It is hard to make both options work without sabotaging your ACO success

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Conclusions

- Your starting point for transitioning to Alternative Payment Models is the decision to create your own organization for risk, or join another
- In either case, you must be able to match the benefits of competitors in the market for physicians and consumers
- No shortcuts on requirements for going into APMs if you want to be successful, either infrastructure or leadership

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Questions and Answers
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Thank You

Contact us to make your transition to APMs a successful venture!

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