Wanted: Better Script for Health System and Medical Group Transition to APMs

written by Theresa Hush | May 19, 2022

Health care has been suffering for a while—just ask any participant, including patients. You will hear about burnout, pressures to perform, changes in the market, pressures of new technology, fiefdoms, consumerism, and to top it off, the buildup of competition between traditional health care enterprises and new corporate health care businesses. Then there's the pandemic, which may be sidelined publicly but continues to ravage health and the business of health care.

Value-Based Care and its sidekick, Alternative Payment Models (APMs), continue to pressure health care finances. Providers, who have played cat-and-mouse with APMs for a while now, are beginning to recognize the need to capitulate and start moving into the APM mode.

Here's the problem: There isn't an easy way to transition. Multiple payer contracts, Medicare and Medicaid, and health care systems and processes are built to one type of specification—volume drives revenues and growth for the whole enterprise. Facilities,

practitioners and the various systems that track their performance are set up to measure their costs, but not “health care costs” as defined by the market, which actually are costs to the payer and patient. While there are many people with strong opinions, it’s rare to find people in health systems with experience in population-based payment, change agent capabilities, and data skills that are needed for APMs.

As a company that specializes in data-driven change technology—formed by people who have actually worked in capitated provider systems—we believe it’s helpful to develop a script for the great transition. In a new series of articles, we will dissect the design of APM requirements, analyze what the competition and consumers will demand, and explain how to create the path from A to Z. There is no set route for all, but there are choices along the way that can be customized.

Here’s why we think a new script is essential.

Health Care Might Be Stuck

Value-Based Care (VBC) has been a headliner in health care for at least 12 years—longer, if you include previous Pay for Performance iterations. Channeling announcements and reports like CMS strategies and rules, announcement of new ACO types, heath system articles on their innovations in patient care and savings, mergers and acquisitions, white papers, and conference agendas, you might assume that Value-Based Care is operational throughout our health care system, and Alternative Payment Models (APMs) are the predominate reimbursement type for provider services.

But it would be naive to believe the hype. Health care is not operating in a Value-Based Care mode. Not yet. That is worrisome because many organizations are losing physicians and patients to new, aggressive competition—the new corporate health care business.

Slow Adoption of APMs

The truth is that many health systems and medical groups have not moved forward in adopting APMs, the hallmark feature of Value-Based Care. The latest data from 2020 (reflecting 75 percent of all U.S. health care payments) demonstrates almost zero change from 2018 in the proportion of straight Fee-for-Service (FFS) reimbursement, at 39.3 percent. More optimistic, data shows a slight uptick in APMs with either shared savings or downside risk during that period, combined at 34.6 percent. However, only 6.7 percent of total reimbursements were based on population-based payments, up 0.4 from the previous year.

In fact, if health care seems a little stuck, it's not surprising, given the upheaval over the past two years. Most health care organizations have one toe in the water of Value-Based Care: either they are preparing for the VBC future while operations are paid through a traditional financial model, and services are delivered through traditional settings, systems, and relationships with consumers and patients; or, they are experimenting with small-scale APMs like Primary Care First. It is extremely hard to give up on a well-oiled revenue machine that has fueled your growth, industry consolidation, practice purchases, and financial stability. Health care is, after all, a business. And business has been extremely tough for traditional health care during the pandemic.

APMs Are Still Outweighed by Volume-Based Fee-for-Service Incentives

Why is the lack of APM payment models important? With FFS payments still predominating, FFS incentives reinforce the status quo. Investment in all the necessary components of Value-Based Care suffers. Failure to reinforce the goal of Value-Based Care drives administrators and physicians alike to still respond to old system incentives that reward them via compensation, resources, and reputation. The "value" goes to those who are still feeding the engine that emphasizes volume. A recent Deloitte analysis based on surveyed physicians reveals how mixed messages block changes to good physician-patient communication on costs, delivery of care according to adopted clinical pathways, and physician engagement in the opportunities for VBC.

The result: persistent health care cost escalation, little change in health care outcomes, and health inequities.

Health Systems Have Underpinnings to Support APMs

Numbers on APMs don't reveal that health care systems have taken steps toward that goal. Efforts to align data, physicians, and payer contracts together is a massive undertaking. Readiness for APMs is determined by two essential changes that must be in place, and evidence that progress has been made:

> Digitized clinical and transactional health care data from EHRs. Since 2010, use of electronic health records (EHRs) by office-based physicians has moved from 28 to 72 percent (it actually declined in 2019 from a previous high of 80 percent), and in hospitals from 9 to 96 percent. Nevertheless, one of the issues we see in digitized data is the quality of EHR implementation, an issue that will stymie good information to fuel the next step.

> Data-activation into a Value-Based Care Infrastructure, designed to conduct clinical as well as administrative interventions. Data must be aggregated, activated and curated to be used in identifying outcomes, cost drivers, and performance metrics. Larger health systems have invested in data repositories and have either collaborated with vendors or created their own solutions for Value-Based Care, and mid-sized hospitals and systems are at some point in the process. But one issue is that data is not obvious—and this becomes crystal clear when you give data back to practitioners! In order to make data useful for improvement in cost and quality performance, it must be packaged and subjected to scrutiny by conditions, patients, risk level, and so on. Engaging clinicians in data analysis and infrastructure redevelopment is an ongoing process. Organizations must determine whether this part of the APM strategy is "build" or "buy," but data-activation and infrastructure are not optional if the APM is to be solvent and fuel growth.

Waiting Is a Losing Game When the Health Care Environment Is Changing

Physicians, at the center of the health care vortex, have become disillusioned and burned out by the pandemic and, realistically, by the volume-driven machine. Financial losses for practices under the pandemic led to the biggest single year of physician migration to employment in 2021, with 74 percent of all physicians now employed and over half of all medical practices owned.

Meanwhile, the environment around traditional health care has changed considerably, partly due to pandemic experience and partly from a hot financial market. Business is on the move in health care. Walmart, Amazon, CVS Aetna, Walgreens, Apple, Google and others are all active on the health care front. And there are other new entrants into the acquisition activity: payer purchases, capital-backed practices, and the growing hybrid of MSO-ACO are competing with traditional providers for physicians and patients. Not to be left behind, employers are also buying practices or purchasing ready-made capabilities that compete with services of traditional providers in the interests of cutting costs and avoiding hospitalizations.

With practice ownership almost equally split between hospitals and corporations, it is easy to miss how much the last few years have been won by health care corporations, which grew their physician employees by 86 percent over the last three years.

Physicians Are Voting for their Future by Moving to Employment

By making employment decisions, physicians are showing their alignments with APMs and Value-Based Care by choosing employers. The half of medical groups owned by hospitals is generally (not always) aligned with a slower ramp-up to higher risk APM payment models. The other half, and growing faster, are practices acquired by corporations (including insurers, employers, and equity-backed practice companies), most of which are deriving their market value from APM growth strategies. The practices that agreed to those purchases believed in embracing the APM future.

Consumers and patients are not only receptive to new avenues of care, but also eager for them. The convenience, ease of getting data, and self-management focus of non-traditional providers feeds into the growing health care consumerism trend.

A Better Script to Transition to APMs for Health Systems with Medical Groups

There is no instructional manual for building a new growth engine fueled by new reimbursement types, while tightening the bolts on excess short-term or long-term costs. But it is time to craft a detailed script. In coming weeks, we will address these key factors:

> Breakdown of the competition and what it implies for the overarching APM strategy or its components;
> What your market wants: payers, employers, consumers, governmental players, traditional patients;
> Data sufficiency and infrastructure you need to identify cost drivers, understand outcomes, prevent avoidable events, and create improvements;
> Payer contract negotiations, conversion strategies, and APM features/safeguards;
> Consideration of APM alternatives that fit your medical group/health system strengths;
> Medical network development and engagement;
> Improvement activities;
> Health equity initiatives;
> Development and marketing;
> Consumer-focused strategies.

We invite your feedback as we lay out ideas. If you think we're on target or if there is another angle to consider, we'd like to hear from you. Please contact us at info@rojihealthintel.com.

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