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Day 4 Notes from the 41st Annual J.P. Morgan Healthcare Conference

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One of the topics I followed with keen interest this week at the J.P. Morgan Healthcare Conference is how our healthcare industry today is addressing the mental health needs of Americans. Like much of the rest of healthcare, it is a mix of exciting innovation, contradictions, siloed approaches and the entrepreneurial Wild West. Pull up your favorite couch or chair, and let's dive in and take a look together.

Mental Health, Virtual Care and the Healthcare System

As I noted yesterday, mental health issues are one of the top two causes of disability in the U.S. About 1 in 4 adult Americans have behavioral health conditions, which cost the economy about $900 billion annually – and that was looking at statistics from immediately before the COVID-19 pandemic. You all have seen the many published articles and studies detailing the effect of the pandemic leading to significantly increased anxiety, depression and other mental health issues. If you include substance abuse disorders (opioid, alcohol, other illegal and legal drugs) as well, the numbers and costs continue to grow. And we can't forget that co-morbidity is common among mental and physical health conditions and complicates and increases the cost of effective treatment. According to McKinsey, "the cost to treat the diabetes of a patient with depression is, on average, almost $20,000 higher than for a patient without depression, due to factors such as medical complications, reduced access to preventive care, and challenges with illness self-management." McKinsey & Company, "Behavioral health crisis in the United States: The fallout from the COVID-19 pandemic" (September 1, 2020).

Yet, per Russell Glass, the CEO of Headspace Health, the systems we have are not structured to support the full need we have today for mental healthcare services. Access continues to be an issue and, in many parts of the country, there are few to no geriatric or child psychiatrists. It can take weeks or months to get an appointment, and patients with mental health issues, and especially children and adolescents in crisis, that go to the emergency room often have to be warehoused there for days or weeks before an inpatient bed becomes available. Looking at the scale of what is being reported as current mental health needs, Russell Glass concluded that there are not enough providers to solve today's needs.

That is why perhaps we have devolved (because I don't think it is beneficial evolution) to the

proliferation of psychiatric medications being prescribed at such high frequency by primary care physicians and nurse practitioners, psychiatrists, psychiatric nurse practitioners and other professionals. The core problem is too difficult to solve under the current system, so “here, have a pill.” We also have latched onto “evidence- based” treatments such as cognitive behavioral therapy (CBT) that is manualized to make it easy to be undertaken by lesser-trained professionals. But CBT, according to multiple studies I have seen, is not solving the underlying issues people have and instead is treating symptoms only or, put another way, effects but not causes. For to treat the causes, I would suggest you actually have to put in hard work on a more frequent basis than once a week over a few weeks or months. Think of it this way – if you want to get really good at a sport, get yourself into excellent shape, learn to play an instrument well or learn to speak a foreign language fluently, in any of these activities do you make enough true and lasting progress by doing it only once a week? I know from taking my kids to soccer practices that you have to practice at least twice a week, and hopefully three times, in order to build that muscle memory, to master the necessary skills and to get good. I believe we all need frequency of treatment to effectively rewire our brains into something different and better. Wasn’t it Malcolm Gladwell who popularized the idea that it takes at least 10,000 hours at something to become an expert? And so why do we really expect to fix ourselves if we spend a single hour (or more likely 45-50 minutes) just once a week? It just won’t happen, and yet the healthcare system supports once a week therapy by a broad range of variously trained therapists as the appropriate approach to deal with troubles to our most important organ (no, look up, not down, it’s your brain).

And mental health issues hurt in so many ways. Besides the intense personal cost and pain, the costs of employers having to deal with disability, absenteeism, impairment and lower productivity, the costs of the federal government having to fund treatment for mental health disorders and substance abuse issues, through higher healthcare costs and the other costs that arise as we try to do indirectly what we should be doing directly (why are we paying such high costs for prisons, police, the mentally ill homeless on the streets and other impacts instead of spending directly on addressing healthcare for impacted people?). One estimate I heard this week was a $6 trillion annual economic cost by 2030 for mental health issues in America.

Okay, the need is clearly there. When a start-up pitches an idea, first it establishes the pain point it is going to address – which we’ve just done. Then, it suggests a solution – and, at the conference this week, it clearly seemed to be virtual mental healthcare. We listened to interesting presentations by Teladoc, Talkspace, Headspace, Babylon and Cigna (discussing Evernorth’s MDLIVE). And it was very clear that virtual mental healthcare services are growing very rapidly.

Teladoc Health’s CEO, Jason Gorevic, spent a significant portion of his presentation discussing Teladoc’s behavioral health subsidiary, BetterHelp. He reported that BetterHelp provided therapy to one million people in 2022 and achieved revenue of $1 billion. Ali Parsa, Babylon Health CEO, said today that at least 50% of Babylon’s virtual consultations are for behavioral health. Babylon also is expecting to have about $1 billion in total revenue (primary care and behavioral health) for 2022.

Talkspace, which began with a 12-week course of therapy only through asynchronous text messaging with therapists (which was well adopted by younger people), now provides video therapy as well as self-guided content and assessments. It is a much smaller revenue generator, with 2022 estimates being under $200 million, and experienced significant recent executive turnover. At the conference, Talkspace sounded as though they were pivoting and de-emphasizing their direct-to-consumer offering going forward, looking more to employers, health plans and employee assistance plans. All of these companies focus on therapy, supportive resources, and, in some cases, psychiatry.

Headspace Health, which is the result of the merger of Ginger and Headspace, is focused primarily on a B2B strategy of servicing employers and health plans. They do have a consumer business, with about 2 million paid users. Their CEO, Russell Glass, had some interesting perspectives. He noted that today's business funnel in the behavioral health sector is toward therapy and/or medications and suggested that this resulted unfortunately in huge overutilization of healthcare resources (and interestingly created some of the access issues). What should be done instead? Glass suggested that most people need someone to listen to them, to provide some structure and/or to help them be more mindful of their own abilities and needs. While that can be done in a therapy setting, it does not have to be. So, a wellness approach that is relationship-based, with a coach or other appropriate person, can meet the needs of the majority of the general population. We all need someone to care for us. Glass cited two examples as guidance. First, he noted a McKinsey study as to an employee population. Of a 100 employee population, they found that about one employee had an acute mental health need, 24 of the 100 could use some moderate level of care, and the remaining 75 employees did not need care and/or only needed wellness support. In Headspace's launch last year of its Blue Shield of California relationship, Glass reported that of the 35,000 employees who signed up for the Headspace benefit/program, 80% went into wellness programs, 16% went to therapy, and 4% went into therapy together with medication management. Glass suggested therefore that behavioral health, much like we see with pharmacy benefit management programs, could try a "step treatment" approach to better identify and utilize needs. Of course, this needs to be done after a safety/risk assessment is completed. Headspace reported that they are providing services to 20% of the Fortune 100 employers now, and that their payment model is value-based with bonus payments tied to outcomes.

Given the activities of the above companies, I was not surprised to hear that ***40% of all mental health visits in the US are now accomplished through telehealth, and that 65% of all telehealth visits are for behavioral health services***. So, quite a trend and these market leaders are aggregating data, conducting studies, creating new products and growing market share, revenue and profitability.

But few, if any, of them are conducting their behavioral health work on an integrated or coordinated basis with other healthcare providers for the patients they treat. We therefore are continuing to see the split or "carving out" of behavioral health from "mainstream" physical health. How can this be good for people being treated? We are aware of the high level of depression and anxiety co-morbidities with diabetes, musculoskeletal conditions, cardiovascular issues and others. How does it make sense to split them off and treat them separately, much like we do in today's fee for service environment?

A lot of the week was spent with health plans and Medicare Advantage or Medicaid focused providers or management companies extolling the virtues of "whole person health," "coordinated care" and other similar approaches. Oak Street Health touted its integrated behavioral health program that is part of its overall medical care offering. Centene's CEO, Sarah London, said, as to the Medicaid program, "for both pharmacy and behavioral health, the math doesn't make sense when you do it separately. Management of members is hard if you can't do it holistically. It is far more efficient to do it together…it's not as good an outcome for carve-outs." Yet, isn't that what we are seeing today with the proliferation of siloed virtual behavioral health companies?

We all are glad to see people getting some care and hopefully alleviation of their symptoms. But will it last? I asked the question of one of the behavioral health company CEO's today as to whether they had done follow-up studies a year or more later to see whether their short-term, once a week virtual therapy or text messaging therapy had proven a lasting beneficial effect. He did not know the answer

to that one…

One other fun note on this topic. Jon Cohen, the new CEO of Talkspace shared that, based upon their internal data analysis, men are less likely to start with video therapy than women. Men generally seem to prefer in person therapy first to establish a relationship and trust, before moving to video-based therapy. Not sure what this means, but I am sure you have thoughts on this.

Deep Thoughts on Drug Costs

David Cordani, Cigna's CEO, shared an interesting "big picture" perspective. There are a lot of "blockbuster" drugs coming to market today and in the near future with eye-watering price tags. Some of them are cures or drugs that bring the first rays of hope to conditions like Alzheimer's. That would seem to suggest though that healthcare costs will continue to climb unchecked, to the detriment of the economy, consumers and healthcare payors. David Cordani took a different view. He noted the tremendous societal opportunity to create more affordability as new high-cost drugs come forward. 7% of specialty drugs have biosimilars available currently, which if adopted would substantially lower costs, much like generic prescriptions do when used instead of brand-based prescriptions. While 7% seems low, Cordani noted that there will be a three times increase to 25% in the next few years. If we as an industry facilitate the greater use of biosimilars at a markedly lower cost, that can create more affordability room for curative new drugs. Definitely worth thinking further about this interesting idea.

Bring on the Robots

ApolloMed is a publicly traded IPA and management company combination that serves a heavily Latino and Asian-American population in California and other states. They reported, among other things, a 90+% automation rate for their claims processing function. That caught my attention, as much of the country is not delegated for claims payment at the downstream provider level, and health plans (such as Humana) hold onto claims processing and payment functions. For groups that are full risk and delegated, such as in California, it is more common for provider entities and their management companies to perform utilization management, credentialling, claims processing and payment functions for their network. Doing both your own provider level utilization management and claims functions allows for a more integrated structure and, in our experience, often can save between 50 to 100 basis points in Medical Loss Ratio (MLR), which at scale translates into millions of dollars. Groups that don't do utilization management and claims, or that only do utilization and the plans retain claims tend to give up between 0.5 – 1.5% in MLR. To do claims well and to keep labor costs down, it is important to automate claims processing to the greatest extent possible so that additional human review and labor is not required. For years, I have heard of provider entities at the 40-60% automated claims range, which is far below the 80-90% needed to be maximally efficient. With newer technology and better process management, some entities are starting to reach the goal.

More on Primary Care

There were additional interesting discussions during the conference this week about other primary care focused provider and management entities, such as VillageMD, Aledade, CareMax, P3 and Privia. To touch on a few items of interest, let's first look at VillageMD.

Roz Brewer, Walgreens Boots Alliance CEO, took much of her presentation to discuss the $9 billion acquisition by VillageMD (majority owned by WBA) of Summit Health (Sheppard Mullin led that transaction for VillageMD), as well as establishing a strategic alliance with Cigna. Brewer noted,

among other things, that the Summit transaction would increase the number of primary care physicians for the combined entity by over 50% and would result in VillageMD having approximately 4,100 providers with over 680 locations in 26 markets. She also explained the opportunities that can be created when looking at the New York/New Jersey market for Summit's CityMD urgent care centers, Walgreens' pharmacies and VillageMD/Summit's physician clinics. The transaction also will accelerate the WBA US Health Services movement to value-based care and turn that WBA business segment EBITDA positive in 2023.

Taking a different approach, Aledade partners with physician practices, multi-specialty clinics and federally qualified health centers (FQHCs), with over 1,000 practices now. But – and here's the catch – they won't help practices with their fee for service business, only with their value-based care and risk-based models. That ability to work with both smaller and larger practices and to assist practices in moving to value-based care makes Aledade of interest to the health plans. As Farzad Mostashari, Aledade's CEO, said, "Fee for service incentives are perverse and no one is in charge." He then described the technology and workflows that Aledade provides to practices and which allow for insights and predictions to be delivered at the point of patient care delivery when needed. This allows for physician behavior change to occur without having to put in place an ownership/acquisition model. It also helps that Aledade shares with physicians 50% of its MSSP profits after recapture of direct costs (~5%). Aledade also is seeing benefits from its end of life counseling line of business, which it acquired, and will be launching kidney care partnerships to bring onboard that capability for its practices. This is one of the more interesting models in the market, as it allows smaller practices to be onboarded and transitioned into value and risk, without the higher capital cost of practice acquisition. For payors who value moving physicians up the risk "staircase," Aledade is offering an aggregating partnership model that can be impactful in total cost of care reduction, given their performance historically as a leader with MMSP ACOs.

CareMax is digesting its acquisition of Steward Healthcare's value-based care physician business and now has both its owned/employed physician clinic model and its management services organization (MSO) line of business. The latter will be used to manage the Steward VBC business and to grow CareMax beyond its current footprint. CareMax has more of a full-service wraparound approach in its owned clinics, providing not only primary care, but dental, vision and select specialty physician services, in addition to the fitness/wellness classes and transportation we see in other Medicare Advantage center models. CareMax is looking to do more "pathway to risk" contracting to move over time more fully into risk and to take advantage of the opportunity to transition its target membership in the Steward network. CareMax now has about 60 owned centers with 110 employed doctors who see on average 14 patients per day. It will be interesting to watch their progress, as the model has elements of what we described in earlier blog posts for JenCare and Oak Street, but goes beyond or varies in some material ways. Looking at outcomes, efficiency and growth support for risk models allows us all to better understand best practices.

And while there was much more that went on at the 41st annual J.P. Morgan Healthcare Conference (including an "atmospheric river" that swept through the Bay Area), it's time now to get back to work and see if we can all make 2023 the year that we want it to be.

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