MILIsa Value Based Care Transcript – 29 March 2016, 6-7:30 PM

**Description**: The transition from the fee-for-service (FFS) reimbursement system to one based on value is one of the greatest financial challenges health systems currently face. MILIsa’s capstone event is centered around discussing the impact of this shift on key stakeholders in the healthcare marketplace. MILIsa is proud to welcome our esteemed panelists from UnitedHealth Group, Medtronic, MedPAC, The Chartis Group, and HealthEast. Dr. Mike Finch, MILI Director, will kick off the event with an introduction to the current landscape and followed by a structured Q&A with our experts to dive deep on how the coming.

Speakers

Moderator: Dr. Michael Finch, MILI Director, Executive in Residence

(JW)Jude Wimberger, Medtronic, Director of Value Based Healthcare Strategy

(LS) Dr. Lewis Sandy, UnitedHealth Group, EVP Clinical Advancement

(MW)Dr. Mark Werner, National Director of Clinical Care, The Chartis Group

(BK)Bill Knutson, HealthEast Senior Executive (previously), MILI Executive in Residence

(JC)Dr. Jon Christianson, MedPAC, Vice Chair

Finch Kickoff

1. Finch Kickoff
	1. Value based care intro, started many years ago, but is becoming more codified with the ACA lately
	2. Way to bake value into healthcare
2. Introductions/Industry impact of value
	1. JW - Medtronic, Value based health care strategy lead, 11yrs at Medtronic after CSOM MBA 2005
		1. How to position non-clinical portfolio at Medtronic
		2. After ACA, lead Medtronic to define how Medtronic plays in this space in collaboration with payers & providers.  System and process improvements to build in flexibility
		3. Two zones of awareness - US & Global
			1. Critical in all markets
			2. Focus on which points of care is different in all places
			3. Access to info is improving everywhere, challenges and opps from this are everywhere
			4. Domestically - required to prove out value beyond just clinical viability, need data to substantiate long term value, quantifiable impact focus, big pressure to collaborate to develop and document better treatment pathways

1. LS - EVP for clinical advancement at UHC
	1. Payer POV, physician by training, did primary care for 20 years, been with UHC for 13 years
	2. Push to value is one of the 2 huge meta trends driving health care
		1. Why now? Much broader recognition that we pay a lot and don't get so much in the US, beyond just policy wonks into business community and workers
			1. All data and analytics point to an unexplained variation in care outcomes at all levels, better analytics have made this more visible.  Far from the efficient frontier
		2. All participants in healthcare feel that the system doesn't work for them, lots of impetus for change
		3. Impacts UHC, big challenges and opportunities for both Optum & UHC
		4. Rise of the consumer is #2 mega trend
2. MW - pediatrician, started in academics but moved into practice, integrated clinics/community based
	1. Started one of the first ACO in the country in 2008
	2. Lots of community health work
	3. Worked with Medica Health Plan, good way to get visibility to healthcare value chain from another angle
	4. Currently works for Chartis
		1. Strategy, accountable care, clinic integration
	5. Think about value based care as fundamentally holding doctors and nurses accountable for performance (public + transparency)
3. BK - focused on HealthCare operations, Health East, currently runs ~5000 beds of nursing home care
	1. Views value as a capstone,
	2. Currentlly working with CMS to build a pricing model for nursing home care
4. JC - faculty in MHA, vice chair of Medicare payment advisors, independent org to advise congress on Medicare and the like.
	1. Value is a huge deal for medicare, often messaged by CMS
	2. All in to move from fee for service to quality+cost
5. Q#1 - Value has been driven for a while, HMOs, Kaiser, but the ACA really put an exclamation point on it.  What happens if the ACA is repealed?
	1. JC - for CMS, (insurance aspect is what will be repealed), repeal is broadly supported.  Value based purchasing will likely be retained, "keep the good stuff, lose the insurance requirements"
	2. BK - agree with JC, train is leaving the station in many ways, expectations for clinical data is well beyond repeal
	3. MW - consumer engagement is high enough, data is robust enough that patient/dr playing field is more level
		1. Expert Dr. model is changing to more a consultant role, Consumer is more able to make informed choices, consumers will become more aware of healthcare variability, no more "blind consumers"
		2. Health cost burdens are growing for all, so there will be insurance alternatives will continue to be developed, (high deductibles, etc)
	4. LS - over half of all health spending is by govt, only going to increase from here.  Have to focus on value to stay viable
	5. JW - not a question of if change will occur, but how fast will it occur.  Medtronic has to be flexible to handle different paces of change in different locations
6. Q#2 - Clinical Process, and it's fit with new structures for healthcare?
	1. LS - UHC can be a payer, and a provider
		1. As a payer - role is to partner with best in class providers to create more value, different approach than vertical integration
		2. As Optum - provides data services/consulting to provide better results, do it in a payer agnostic way.  Willing to "disrupt themselves"
	2. MW - healthcare is ultimately a clinical activity - cant change without evolving clinical/operating/financial model together
		1. Often clinical is left behind, contract offices get far ahead because clinical is harder to change
		2. Have to change how dr.s are willing to practice.  Reduce variability in styles of practice.
		3. Structural changes to clinical model are a necessary part of forward progress
	3. BK - Dr.s Still live on fee for service and volume, this is all mostly still theory
		1. Don't over develop for the core audience, physicians might not use over sophisticated tools
		2. Still have to make the actual transition
	4. JC
		1. Value based payment is built on fee for service basis, fee for service was based on Medicare system, which is based on relative value scores from Medicare, that are politically challenging to change.  With a flawed relative value basis foundation, all new innovation will still be flawed
	5. Finch to Jude - what does clinical transition mean for Medtronic
		1. For Medtronic - closer collaboration with dr's.  Increasing challenge is to document and prove outcome quality
7. Finch to BK - What do you think about Medicare value based purchasing for hospitals, how did you used to get paid
	1. Used to get paid on a cost plus basis, used to just turn in costs and get paid
	2. Shift to DRG in 1985, all could survive even though they thought it was all over
		1. Hospitals weren't interested in containing costs, aimed to enroll as many drs as they could to drive revenue and ultimately profit
		2. Hospitals provide nursing care were directed by independent physicians
			1. Now many are working to better include dr's in care development
		3. Primary care gave up intensity for volume
8. Finch to all - With what's going on with Value, what are the aspects that are most relevant now, and what will be in 3 years to help move this value thing forward
	1. BK - hospitals could shift losses from Medicare to private insurers historically.  Medicare is too big now, so cost shifting is difficult, commercial can no longer sustain those high premiums
	2. LS - 3 things
		1. hard to do
		2. healthcare is ultimately local, very different by market,
		3. Org and finance of healthcare is really complex, push to value has created massive consolidation,  which may offset benefits from value shift
	3. MW - all health care is local, do not think that healthcare market will reward them for making improvements
		1. Why give up on fee for service, for the hope that value orientation will drive growth?
		2. Most healthcare orgs have gotten all the cost out of items, labor, processes
		3. No longer about reducing cost, but changing the nature of how you provide care
		4. Consumerism - battle ground for patients is increasingly moving upstream, need better engagement from systems
			1. Easier than ever to lose customers, they don't just follow Dr's anymore
		5. Ability to get to this work, is based on better physician/clinical alignment, you need the dr.s on board
			1. Need to move from "buy-in" to "ownership" make dr's accountable
			2. This will separate haves/havenots in 3-5 years.
	4. JC - healthcare spends $580B/yr, it’s a huge player, Medicare is much bigger than any euro system
		1. The growth in this program is beyond all historical comparison (10000 new people join Medicare a day)
		2. Pressure on Medicare to hold down costs, political pressure, increased enrollment in Medicare (demo driven), will drive a shift in focus to pull out cost by reducing costs without shrinking monitored quality scores
			1. Will we notice the reduction in quality that we get when we pull out costs?
9. Q#6 - is value a new idea?  Or just a recycling an old set of ideas?
	1. JC - this is recycling old ideas, ramping up now because we're so much better at measurement than before, it's a critical improvement beyond what we had in the 90's
	2. LS - pieces are recycled but 2 things are new
		1. Better data and analytics
		2. Insurance has learned from the mistakes of the 80s.  Difference between performance risk and financial risk
10. Q#7 - is more tech and big data going to help or hurt us?
	1. JW - access to data is critical, balance incentives to optimize, right data to drive right outcomes,
		1. Ability to use it in a timely way, clinically effective is really tough
		2. Has to connect longitudinally over the life of the patient, really hard to pull together in a patient centric way
		3. Connectivity, data logging, is a huge component of new device development
	2. LS - Tremendous opportunity for UHC, but most problems are still basic
		1. Big opp to drive clinical standards, tailored to individual circumstance
	3. MW -  20% of health outcomes are influences by health providers, the rest is economic, environment, socio
		1. Data won't fix that unless we expand what we include in big data
		2. Public health problems can't be solved via the acute care system
	4. BK - big data can help actual treatment, but its got to be accessible on the ground floor (shiny object)
		1. Most of what they found in SOUTH MINNESOTA counties, most useful data was social determinants
	5. JC -
		1. Big data could be used real time to help docs make decisions especially on rare conditions
		2. Mining data to learn more about macro health trends
			1. Medicare has tons of data, but won't release it due to privacy concerns, politics is stopping quick progress
11. Q#8 Consolidation and it's impact on quality/outcomes?
	1. JC - general data on cost is that cost goes up with consolidation, quality is higher/more consistent in larger systems but this is less established than the cost increases
	2. JW - Covidien acquisition helps Medtronic grow & diversification, better longitudinal access to more points of care for a single patient
12. Q#9 - How does uncertainty translate to future opportunities for your organization and it's strengths
	1. JW - tremendously optimistic, longitudinal, preventative, and diagnostic care to help out earlier in the care continuum, opportunities to reduce long term costs.  End game is unclear, but it's important to get in the game and contribute to innovation
	2. LS - exciting time!  Uncertainty about how & when, but megatrends are set
		1. Mega #1 - great field to be in, spending will keep growing, dynamic and growing, going forward community will have to define what value is and how to reward it
	3. MW - great time for healthcare, lots of opportunity for those who like uncertainty and vagueness; but it will be extra important for health systems that know who they are and what they do uniquely well, and especially what they don't do as well.  Disaster if we all flock to the same few "shiny objects"
	4. JC - positive development, core measure of quality initiative, goal is to get all to agree to a set of quality measures, starting to make forward progress on decreasing confusing and provider burden by making it clear which measures are best!
13. Q#10 - Audience - In regards to value based purchasing, will this help reduce healthcare disparities
	1. MW - not clear that it will but I hope so, "accountable community" groups are starting to spring up in smaller communities, how to have a community that owns it's health outcomes, really tough to do for health markets.  Opportunity to think about how to serve diverse communities differently, better targeting of healthcare and delivery
14. Q#11 - Audience - besides being a destination medical center, what other roles will a health center play if not a population health manager
	1. MW - some will have to, but most will participate in someone else's vertically integrated system (more regional system), the right level of aggregation for that will be trickier (will vary by region)
		1. Always be a need for critical access; how will this integrate with larger systems
15. Q#12 - audience - what do you see as top opportunities for quality and cost with the coming value orientation
	1. MW - consolidation in less dense markets, especially critical access; marketplace can't solve these problems directly
	2. LS - lots of opportunity to improve -
		1. on the quality side - getting care to align to what the patient really wants
		2. On the cost side - clinical programming, focus on what your org is there to do
16. Q#14 - Largest obstacle to getting to value based care is coming up with data to prove new clinical practice is best, how does your organization get past this
	1. JW  - larger test sets require more and more expense, care provision can have huge variations, by picking at those opportunities with most volume/variation they can maximize their returns by giving best care to minimzie long term costs
	2. JC - can we come together as a society to build a value based purchasing strategy for pharmacuticals
		1. Q - what would prompt this?  JC - pharma spends 275k per congressmen each year,