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BUSINESS JOURNAL

SPECIAL REPORT

INNOVATIONS IN HEALTH CARE

The Texas Business Journals look at how the state is competing on the cutting edge of this key industry

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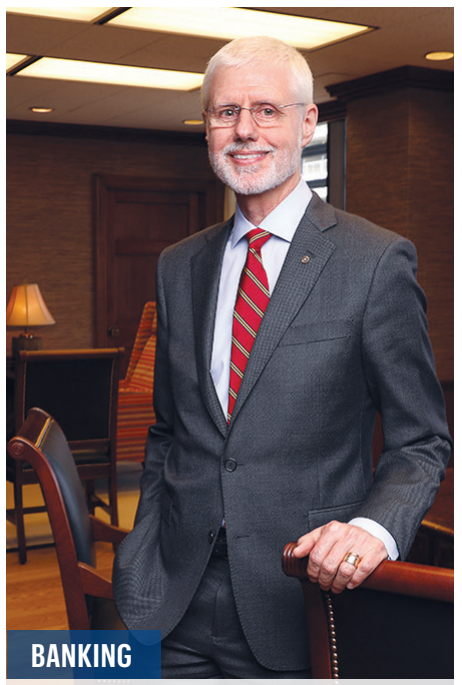

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Panelists from left to right: **Ann Laseter**, Vice President of Value Based Programs, Methodist Healthcare; **Cathy Starnes**, Ph.D., Chief Growth Officer, WellMed; **Wendy Bruns**, Vice President of Payer Contracting & Alignment, Methodist Healthcare; **Dave Milich**, CEO, UnitedHealthcare of Texas; **Andrew Grove**, Senior Vice President of Sales & Market Development, SWBC; and Moderator **Jimmy Holmes**, President and Publisher, San Antonio Business Journal

Value-based health care programs

We collectively spend more than $3 trillion a year on health care, which is three times as much per citizen as the average of other wealthy nations. Health care is now over 18 percent of our nation's gross domestic product, yet for all the enormous expenditure, the U.S. has poor health care outcomes.

Jimmy Holmes: ***As the cost of care continues to climb, our life expectancy is going down. How did we get there?***

Dave Milich: I think we were oftentimes focused on the wrong things. We were focused on, I'll call it, the unit cost of health care instead of helping individuals become healthier and arguably, we still are. What we're trying to do in partnership with certainly the folks in the room here is shift the thinking of the marketplace. How do we both improve quality and really focus on cost efficiency? Because that's what's going to help bend the trend curve and reduce the total cost of care. I understand how the system is there to help somebody when they're sick. But how is the system improving to help people have a better experience and get healthy?

Ann Laseter: It's certainly one of those things that didn't happen overnight. It's like moving the Titanic. You don't turn it on a dime. It takes a long time, and it's not just one individual group. It is the patients themselves, the employers and the providers. And then you have the payers. I think the biggest change in the landscape is trying to get all the parties at the table at the same time to do the best thing not only for the individual patient, but for all those parties. It's a very difficult system to navigate. And I think that the key to this is truly bringing everybody to the table, trying to simplify it.

Cathy Starnes: I think there are several facets that have gotten us to where we are today. I believe that we evolved to a place of reactive care versus preventative care, with costs exceeding what they should and the overall quality of care underperforming. I think we are in a transitional space. We're doing things in our businesses and our organizations to transform that situation, but I think a critical solution is from the provider perspective, health care practitioners being rewarded for performance, quality and patient outcomes, and changing the paradigm. So, from the provider perspective, that is one of the areas we are focused on.

Andrew Grove: We have the highest cost for all major health care services of any developed country in the world. It's a complex system. Administration alone accounts for 8 percent of total costs, which is also much higher than many other countries so that is a big chunk of it. Health care is different in that there are very few things in life that we buy where consumers have no idea what it costs. So, one of the themes must be transparency. We've gotten here because our prices are higher. The system — the administrative side of it — is a bit out of whack. Obviously, we've got a sicker population. We're a bit unhealthy and we've got 10,000 people a day turning 65 in this country. So we're aging, less healthy. There's a lot of inherent costs built in that are inefficient. So, I think to address that is a monumental task, but it's just the way it's financed, so we're getting to the reason for this discussion is value-based care, because right now, there's no incentive built into the system for people to change their behavior.

Wendy Bruns: It's complex. I think that's the bottom line. It's very difficult to explain the finances of health care, and even transparency, because of the way the system is set up to pay. You've got governmental payers. You've got private payers. You've got the huge underserved population, and it's difficult to get somebody that is not in the industry to really understand those costs and how it works and how we must finance health care. So as Ann said, it's going to take a lot of time. In five years, it will look very different than what it looks like today, but it's very complex. And it's interesting; we were meeting with a very large payer in the state, and their vice president of sales said, "My employers don't want to hear about quality. They want to hear about cost."

Laseter: We're hearing different messages.

Bruns: Right. While it's refreshing to hear what UnitedHealthcare is saying, you've got other entities out there, that it's still just cost, cost, cost. So it's difficult.

Holmes: ***Are businesses — small, medium, large — constantly looking at reevaluating their carriers, providers?***

Grove: That's our life right now. Fourth quarter is the busiest time of the year in our industry, because most employers do renew their benefits in January. You're right. It's a yearly dance. It's very difficult to get consistency with an employer and a carrier because the pricing changes so much from year to year. It's hard for us to keep an employer with the same insurance carrier for an extended period where you can really get folks engaged in disease management, wellness programs and value-added services that the carrier offers. Every year they're looking at rate increases. We can't raise deductibles anymore. What else can we do?

Milich: One of the challenges around things like wellness has been — especially if you're in an industry that naturally has high turnover, like retail — it's an ROI discussion. The thought process is — I know I'm going to attrite 30, 40, maybe 50 percent of my people. Do I really want to invest in the wellness of those folks because I'm going to pay for it? And then somebody else is going to benefit from it. I think that's, again, why it's important that the system shift away from a fee-for-service [model] to something that is more focused on episodic quality of health, population health management, improve the health of the population in San Antonio, because then everybody is benefiting from it regardless of the payer.

Starnes: Providers are changing the way that they are delivering care in the evolution from a fee-for-service model to value-based care driving these quality and patient outcomes. We've learned and adapted to do that very well through CMS, the Centers for Medicare and Medicaid Services. They fund 37 percent of national health care expenditures, so they drive care delivery change and performance with these benchmarks.

Holmes: ***You mentioned value-based care. That is the big buzz word in the health care industry. How do each one of your organizations define that concept?***

Laseter: I think for us it means that it's all about the engagement — that we're coming together and that the physician is driving that, hopefully, as the aggregator, and they're looking at the patient differently. We've talked a lot about the dollars, and certainly, of the trillions of dollars that are spent, the majority are spent on a very small number. With value-based care, you take those that need to be touched more often, you touch them more frequently, you guide them through the system, you help them make better decisions. You're spending more time with them, so that they can become educated, so they understand that some of the choices they're making are affecting them. Dr. [Jonathan] Perlin, our [chief medical officer], used to work at [Veterans Affairs], and he always uses the example of a patient [he had] who had asthma and chronic lung issues, and was in the hospital constantly. They bought him a window A/C unit for his apartment and kept him out of the hospital. Sometimes it's not about clinical care.

Starnes: Absolutely.

Panelist Dave Milich shares his thoughts in a lively discussion about the current and future state of value-based health care.

and the impact on the economy

Laseter: It's about the whole individual.

Grove: When I look at what value-based care means, two words come to my mind: common sense. It's a common-sense approach, spending more time with the patients and education.

Bruns: I think what everyone is saying is spot on. It is about getting you the whole care of the patient, looking at different aspects, social, clinical, financial, and just really looking at the whole picture, and making sure that everyone is coordinating that, whether it's just within that primary care physician office or somebody that has many issues, many problems, making sure all the doctors are on board and everybody is working in the same direction for that patient.

Milich: The only thing I would add is alignment of incentives. We all know what we should do. We shouldn't have the cheeseburger and fries. We should get up off the couch. Because when we talk about consumers in health care, we talk about incentives. The carrot or the stick or the carrot-flavored stick. Increasing deductibles, increasing transparency, but oftentimes those incentives didn't exist on the provider side. So I think value-based care, one, realigns incentives, and then it focuses us on where we should be focused, which is how do we increase value to the employer, because that's what they want.

Holmes: ***What issues do you see in San Antonio [regarding] how value-based programs work in San Antonio?***

Milich: One of the challenges is how do you understand the population that you're serving. What are all of the co-morbidities, the disease burdens that they have? And then we've got a range of solutions that we can deploy. One treatment may not necessarily be as effective for one individual as it is for the next. So again, it's understanding the population that we serve.

Laseter: One of the things that [this] landscape is changing, there is more data. As you begin to look at these individual subsets of groups, you have more information to better care for them. I think we're on the cusp of being able to have the data and spread it across the continuum.

Starnes: I would say that we have segmented maturity in how we are attacking population health and value-based care here in our great city. I think we've done a really great job with some of the providers here. Folks from Arizona, Utah, New Jersey, Massachusetts, they're coming to San Antonio and asking, "What are your providers doing? How are you treating these patients? How are you aligning with your hospital system? How are you aligning with your payers to solve these issues?

Grove: You talked about data. Data is key. It must be actionable data. Then we can start engaging the membership within these commercial clients. As Dave mentioned, there are good programs for folks that have chronic conditions, but it's getting that information to them, so they even know it's available and to access it. It's incumbent upon us on the commercial side to translate that down to the employers allowing us to have the access to provide data and to get information out.

Holmes: ***In the San Antonio market, where are we as a community, as we shift from fee-for-service to value-based care?***

Milich: I can only speak for UnitedHealthcare. Contractually, I think it's fair to say almost all our provider contracts have some value-based component tied to them. Again, you've got different providers, different steps on the ladder of the continuum of value-based care. Our goal, nationally, is to have $75 billion running through value-based contracts by 2020, and we're already at about $64 billion today.

Starnes: I'll echo that from the provider perspective. Almost all our agreements with payer partners are value-based as we want to help our providers navigate the paradigm of fee-for-value rather than fee-for service.

Holmes: ***How will we invest in value-based care? Which employers are we investing in?***

Milich: This is the future, and it's the right path to be on. I would ask employers to have an open mind and seek to understand what value-based care is and what it isn't and the important role that they play and the ultimate success of not only value-based care, but getting control of the health care system for all.

Grove: I think it's high level buy-in. It's like any other thing that we introduce to our customers. If the CEO and leadership are not engaged in it and filter that down into everybody else, employees see it as not being important. We've got to get the folks down to the consumer level, the employee level, learning and understanding that they're a part of it, they're paying for it, it's coming out of their pocket.

Milich: The irony in that is to [senior leaders] it actually makes sense. To the people who don't have a history of insurance, value-based care makes perfect sense because it's intuitive. It's a total cost of care viewpoint, which is exactly the way they run their businesses. They don't just focus on the unit cost of something. They focus on total cost.

Starnes: The next evolution of [accountable care organizations] is rolling across the nation now. The new terminology is CIN, clinically integrated networks. It's taking what everybody here has discussed, taking disaggregated networks and disaggregated philosophies and combining those to leverage effective and comprehensive care management and care delivery solutions that are replicable and scalable.

Laseter: A CIN allows you to become almost vertically integrated so that you can look at that continuum and everybody's incentives are aligned.

Holmes: ***Does anybody have anything to add?***

Laseter: I think if you put the patient in the middle and try to figure out what's right, solve around that, we'll all be good.

Grove: Economic forces will drive innovation every time. We're at a point now where we don't have a lot of other options. We've got to come up with innovative solutions.

Laseter: Back to your point earlier: Other businesses have always used data to make good decisions, and I think, again, we're finally getting some information to help the clinician provide better information, and then to look at those subsets to figure out within a market how you manage this subset differently, and how do you put those community resources around it in an efficient manner to help those individual groups that are caring for them, or the individuals themselves get what they need to improve their care.

Milich: Large multisite employers are getting much more inquisitive around what I call "the why." Why is care more expensive in one city versus another? Is it my people? Is it the delivery models in those systems? Is it unit cost in that market? When you talk to companies who are selected to help employers pick — like if they want to relocate their headquarters or they want to do a major business expansion in a given city — when they look at health care costs, ironically, cost is usually not in the equation. It's quality and access. Cost is assumed to be relatively consistent across the country. When that flips, and it will, that's when economic forces are going to take over, because it starts to impact the economic climate of the metropolitan area.

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If you'd like to participate in an upcoming roundtable panel, contact Liz English at 210.477.0854 or LEnglish@bizjournals.com