

REGIONAL SUMMIT SUMMARY REPORT

Greater Detroit Area Health Council (GDAHC) Regional Health Improvement Collaborative: Moving from Volume to Value: A Multi-Stakeholder Perspective



December 14, 2016
Detroit, MI

Introduction

On December 14, 2016, the Greater Detroit Area Health Council (GDAHC) held a Regional Payment Reform Summit that brought together experts and interested parties from across the healthcare spectrum. About 80 influential leaders from healthcare and other sectors participated in the summit with the desire and expectation that they would play a pivotal role in crafting a multi-stakeholder approach to payment reform for southeast Michigan.

The Southeast Michigan Regional Payment Reform Summit convened with help from the Network for Regional Healthcare Improvement (NRHI) and support from the Robert Wood Johnson Foundation. It was an important regional follow up to the national Payment Reform Summit held in June, 2016. GDAHC is one of three NRHI member Regional Healthcare Improvement Collaboratives (RHICs) selected for regional forum support. Each event focused on the unique and critical roles of four stakeholders—employers, providers, patients, and payers—in making the transition from volume to value in their communities. As the healthcare industry continues to move toward alternative payment models that reimburse providers for outcomes, the events explored why a multi-stakeholder approach is essential to success, and the role each stakeholder plays.

It's no secret that payment reform is a hot topic on the minds and agendas of everyone in the healthcare sector. Indeed, payment reform is the new

reality in healthcare; it's now the price of admission for playing in the healthcare sector. Yet, given the many avenues and shapes that payment reform is taking, there is much noise and confusion and a seeming lack of clarity on roles, responsibilities and direction.

Important questions addressed at the summit included:

- What does the shift to alternative payment models that reimburse for outcomes (also known as paying for Value instead of paying for Volume) mean to each healthcare stakeholder?
- Why is a multi-stakeholder approach so important and what do we gain from coming together to collaborate on payment reform?
- What role does each stakeholder play?
- How can communities best support providers as they continue to move through this transition?
- What can we do in southeast Michigan to facilitate payment reform?

This Summary Report details the key takeaways and next steps that were identified for the region.

The Burning Platform: Setting the Stage with Dr. Want

Jay Want, M.D., Owner and Principal of Want Healthcare, LLC, and Chief Medical Officer of the Center for Improving Value in Healthcare (CIVHC) in Colorado gave the opening keynote speech, during which he framed the continual increases in healthcare costs against the greater context of material and societal problems we face as a nation. As Dr. Want explained, we are not working together to address the problems of increasing costs and at times questionable quality—rather, “we are spraying hoses in all directions...at each other.” Dr. Want’s presentation set the framework for the ensuing panel discussion and breakout groups.

Here are some of the chief points from Dr. Want's speech:

- With healthcare costs running at ⁵3 trillion, American healthcare is consuming the American economy. At a time when healthcare is often the only major employer in many communities, healthcare is devouring any income gains. This is a material problem and a societal problem, not a math problem.
- Our response to any other national crisis would be similar to the way we respond in a coordinated way to wildfires. Dedicated resources would be marshaled from across the country and be targeted in the same direction until the fire is put out. Yet with healthcare, we are spraying the hoses in all direction and at each other. The consumer, drenched and confused, is left caught in the middle.
- We are wrestling with each other instead of acting as a coordinated team. We have reached the point where businesses will leave the negotiating table unless we get costs down and quality up so consumers want to buy the product.
- American healthcare is caught in *three tsunamis*:

Debt:

- In 1960, healthcare was 6% of GDP.
- In 2016, it is 18% of GDP.
- That is a 3-fold increase, in unadjusted terms. In other words, healthcare eats up all profits.

Information:

- Moore's law: we can double the computing power every 18 months.
- It has made information that used to be hard to get readily available.
- This flood of information is changing the healthcare game.

The Decider

- The empowered consumer has more information, is being forced to take on more financial responsibility, and therefore is a new market force. We will see more wielding of this power under the new Administration.

- We think we make decisions based on logic, but in reality it is our limbic system that drives much of our thinking. So does homophily—the tendency of individuals to bond and associate with similar others. If you want to get buy-in on volume to value approaches, use trusted relationships to develop early adapters. Use homophily to get past a limbic system.
- Incentives for buy-in:
 - Money: the new system can't be seen as punishment
 - Social/People: the group must see it as valued behavior
 - Ethical:
 - We are all in this game to be the best person
 - Volume to value must be part of our identity
 - Must fit/enhance how I see myself
 - Must fit/enhance how others see me
- Final thoughts:
 - This feels slow because it is—this is a huge task
 - Change is more about culture than tactical work—leaders must cultivate that
 - Success centers around recognizing that “Will you help us?” must change to “Will you help each other?”

Moving From Volume to Value in Southeast Michigan: Cross-Sector Panelist Advice

A panel of six experts representing purchasers (and consumers), providers and payers discussed what payment reform means to their respective sectors while offering suggestions for a path payment reform might take in southeast Michigan. Suggestions were also offered for appropriate multi-sector collaboration as well as first-hand guidance in taking the next steps. Local health visionary Denise Christy, President of iSelect Custom Benefits Store, moderated the panel posing provocative yet practical questions to the panelists.

Summaries of the panelists' (arranged alphabetically) perspectives follow:

**Randall A. Bickle—DO, JD, CPE, FACPE, Family Practitioner, President
and Medical Director of Olympia Medical LLC**

- We have to reboot the way we approach the crisis: we all talk but we don't DO.
- We talk about paying for health but as a system, we pay for sickness.
- Olympia Medical participates in an ACO (Accountable Care Organization). We've been in risk contracts but we need to do more about population health.
- The Primary Care Provider (PCP) is missing from the conversation.

Three things to do for PCPs:

- Lessen the administrative burden
- Control costs of medical education
- Increase income

Michael Koziara—Chief Operating Officer, Priority Health

- Priority Health is a leader in value-based work; we have been in this space for a long time.
- We are optimistic about opportunities to work with and improve the overall delivery system.
- Payment reform is not just about value-based payment. There are multiple other approaches and paths that need to be considered as well.
- Priority Health's Partners in Performance program is based on five foundational elements that will transform the delivery of care:
 - Access and experience
 - Fair and transparent cost
 - Continuous quality improvement
 - Economic alignment
 - Clinical collaboration

- The overarching strategy—particularly behind payment reform—is to work with providers to take on more risk to reach economic alignment because without that, you cannot move forward.
- As a health plan, we are interested in working with our customers, patients, and providers to make payment reform work. We also seek to coordinate methodologies with other plans/payers.

**Mary Beth Kuderik—CPA, CMA, Chief Financial Officer,
UAW Retiree Medical Benefits Trust**

- UAW Retiree Medical Benefits Trust is a purchaser of care.
 - 75% of our members are in Medicare. We are a retiree organization.
 - We have a longitudinal outlook.
 - We carry a great disease burden.
- Comments on Payment Reform:
 - What we want is healthcare that gives our members what they deserve.
 - We would pay for that value, but it's not available.
 - Our members are paying out of pocket and it is a growing cost—so we focus on affordability.
 - Michigan has ACOs but we are not as far along as we could be.
 - We would like to see the community really embrace ACOs.

**David R. Nerentz—Ph.D., Director of the Center of Health Policy
and Health Services Research, Henry Ford Health System**

General Comments:

- We have to recognize that health care dollars flow from employer to health plans to the delivery system and eventually to individual providers.
- Each step in the payment chain is revenue at that step but is a cost at the prior step(s). Cutting costs at any one step is hard because it inevitably means cutting revenues at the subsequent step(s).

- We can all find alignment around “more is not necessarily better”. Cutting revenues at any one step then might be associated with cutting costs at that same step.

What is working? What ideas do we have to make the system work better?

- We need a system that allows investment in value; we need a payment model that enables innovation and value. Right now, providers must take a loss (e.g., investment in care coordination infrastructure) before they can gain.
- We need to go there together. Currently, if you take risk or try an alternate payment model, you go it alone.
- We need to involve patients in conversations.
- We need to start with the end game in mind—in some ACO models and bundled payment models you spend \$4 to save \$1. How can this be sustainable over time?
- We need to develop ACOs in innovative ways. ACO is a potentially good model but is not there yet. Payers and providers need to coordinate around and commit as partners—with clear benefits on both sides.

Timothy A. Peterson—MD, MBA, FACEP, Assistant Professor, Emergency Medicine, University of Michigan Medical School and Executive Director, Physician Organization of Michigan Accountable Care Organization (POM ACO)

- We’ve been involved in value-based work for a long time with a focus on the Medicare/Medicaid market.
- We’ve done a good job driving revenue into our organization but the problem is we all expect someone else to take a pay cut.
 - Example story: A radiologist identified an opportunity to cut \$1.7m in costs but it would require cuts to the system, including FTEs, so it was not pursued.
- In the “cost” side of the question we often debate, if the “revenue/income” for an entity is on the other side of that question. As we try to rein in costs we are implicitly talking about taking revenue away from someone/something. None of us

want to lose revenue, but if we all continue to grow our revenue, the cost of providing healthcare in this country will only continue to increase.

- Patients must remain in the center of these conversations. Talking about business models and revenue protection/maximization loses sight of the fact that the reasons our organizations exist are to heal when possible and to always prevent suffering.
- As we work to develop payment models that incentivize doctors and hospitals to provide the right care to the right people at the right time, we need to spend more time talking about what patients need and deserve.
- There is no reason to pay for sub-optimal or sub-standard care. Unnecessary/non-evidence based care is similarly wasteful. None of us would keep a car that started burning oil two months into our ownership of it, but we expect to get paid the same amount regardless of the outcomes our patients experience.

**Thomas L Simmer—MD, Senior Vice President and Chief Medical Officer,
Blue Cross Blue Shield of Michigan**

- We have a low performing healthcare delivery system, because:
 - Payment structure fractured
 - Lack of focus
 - Lack of engagement
- Fee for service constrains the system so it cannot address the root causes of system failure.
- Our current coding/payment system does not support quality efforts. We have quality services that don't meet current procedural terminology (CPT) descriptions so providers don't get paid.
- The payment model must evolve in tandem with and coordinate efforts with the care model.
 - Transparency is an important aspect to be vetted and included appropriately.

- Payment reform plays an important role in achieving the triple aim for healthcare delivery.
- Blue Cross Blue Shield of Michigan has played a pivotal role in advancing payment reform in Michigan through its development and support of Patient Centered Medical Homes as well as the Physician Group Incentive Program (PGIP), which uses practice transformation to reward physician organizations for improved performance in healthcare delivery.

Putting Attendees to Work: The Breakout Groups

Attendees gathered into breakout groups organized primarily by purchasers/payers and providers. Armed with background information from Dr. Want, and the insights and guidance offered from the multi-stakeholder panel, attendees were asked to participate in a robust dialogue that would help formulate a vision of a multi-stakeholder approach to payment reform in southeast Michigan. Dianne Hasselman, Executive Director of Federal and New Programs at NRHI, facilitated the final plenary, wherein she synthesized the recommendations from the individual breakout groups.

Attendees were put to work in these sessions and many reported that it was the most valuable agenda item of the summit. Attendees were sorted by the sector that they represent (provider vs. purchaser/payer) from which they were assigned randomly to one of two breakout groups. Participants who did not fit neatly into one of those categories—for example community organizers—were assigned to either a provider or purchaser/payer breakout group based on their areas of interest or work that they do.

The breakout groups ultimately recommended actions to be undertaken in southeast Michigan to further payment reform. In some breakout groups the participants were asked to identify strategies and tactics they could promote in their sector to advance payment reform as well as what their counterpart sector could do. It is interesting to note that it appeared easier for at least one group to develop suggestions for their counterpart sector than to introspectively identify actions for their own sector, underscoring Dr. Want's thesis that this work is difficult.

The breakout recommendations are listed below (note that some, but not all, groups used sticky dots to vote on and rank their recommendations):

Breakout Group 1: Purchaser/Payer

- **Facilitator: Roger Panella—Chief Operating Officer, GDAHC**
- **Scribe: Lisa Mason—Vice President, Program Partnerships, GDAHC**

Question One: Identify one of two things that your stakeholder group needs to change in order to make regional alternative payment reform models successful:

- Purchasers (Employers) communicate with each other to define what we want, prioritize and communicate to providers (9 votes)
- Competitive bid, direct contract between provider and purchasers (6 votes)
- Require Providers to commit to complete and predictable price/cost transparency (6 votes)
- Define affordability—total consumer cost—premium and out of pocket (5 votes)
- Share Data (actionable)

Question Two: Identify one of two things that your counterpart stakeholder groups need to change in order to make payment reform successful:

- Use a coordinated team approach (15 votes)
- Be willing to assume down side risk at least incrementally (9 votes)
- Demand payer community simplify payment models (9 votes)
- Introduce a social determinants tax (everybody pays in—regardless if self-funded or not) (5 votes)
- Develop a method to invest in socio-economic factors to prevent or offset long-term use and future demand (3 votes)
- Make data understandable to consumers (2 votes)
- Support State Innovation Model principles (1 vote)
- Deliver care in either the commercial or public markets, but not both (0 votes)
- Don't let perfection be the enemy of good (0 votes)

Breakout Group 2: Provider (note: these are the same questions asked of Group 1, but are answered by providers instead of purchasers/payers)

- **Facilitator: Jonas Goldstein—Director of Strategy, Renaissance and Amplify Health**
- **Scribe: Kathy Nichols—Communications Manager, NRHI**

Question One: Identify one of two things that your stakeholder group needs to change in order to make regional alternative payment reform models successful:

- Reframe the conversation (11 votes total)
 - Who needs to be part of the care team—including patient—to reach desired future state (7 votes)
 - Structure payment system to support a patient centered mode and reach patients' desired outcomes (4 votes)
- Integrate community partners and services (4 votes)
- Healthcare workforce development/training (internal and external) (3 votes)
- Focus on patient engagement (3 votes)
- Provider supported consumerism—Help provider to help the patient navigate the system (1 vote)
- Expand care team services (1 vote)

Question Two: Identify one of two things that your counterpart stakeholder groups needs to change in order to make payment reform successful:

- Support better information exchange (6 votes)
- Pay for new outcomes (5 votes)
- Instill discipline in payment for new technologies (5 votes)
- Use firm fee schedules for managed payment models (4 votes)
- Support and pay for resources needed to transformation delivery (4 votes)
- Shift stated goals/compensated outcomes (at risk of pushing providers into public health) (1 vote)

Breakout Group 3: Purchaser/Payer

(note: this group did not prioritize the recommendations)

- **Facilitator: Kimberly Wixson—Vice President and Health Consultant, Segal Consulting, Detroit**
- **Scribe: Dianne Hasselman—Executive Director, Federal and New Program, NRHI**

Question One: Identify three near-term actions that can be taken to move the needle on regional payment reform within the next 12 months:

- Leverage CPC+ and MACRA as a true multi-payer effort to reform payment
- Encourage/foster collaboration across plans
- Bring Medicare up to the level that the commercial sector is in Michigan
- Help employers—particularly self-funded—better understand what's happening and how to leverage and adjust to the changes
- Define a common language that everyone uses and understands
- Address risk stratification with common definitions and a common methodology on how to underwrite that risk with the goal of an aligned, standard method to stratify patients
- Develop a common attribution approach

Question Two: Identify the role of multi-stakeholder collaboration in making those near term actions successful:

- Rely on existing collaboratives to convene stakeholders to have these foundational conversations, etc.
- Leaders need to commit to showing up for hard conversations
- Leaders need to stay in the discussion
- Identify key change agents if everyone comes to the table. Identify how to create "the ripple."
- Identify an alternative payment model where payer and providers align around a model that creates a "win-win" for both—can't end up "killing" hospitals

- Balance costs with greater transparency because costs need to come out
- Consider using existing collaboration and infrastructure to develop a strategy on how to foster—but not force—a more formal commitment
- Pursue a collective commitment for our community to be well and address care gaps

Breakout Group 4: Provider (note: these are the same questions asked of Group 3, but are answered by providers instead of purchasers/payers)

- **Facilitator: Terrisca Des Jardins—Administrative Director, Physician Organization of Michigan Accountable Care Organization**
- **Scribe: Lisa Braddix—Director, Population Health and Health Equity, GDAHC**

Question One: Identify three near-term actions that can be taken to move the needle on regional payment reform within the next 12 months:

- Payers empower PO-level to develop solutions for high cost areas and support Choosing Wisely (5 votes)
- Reduce administrative burdens/barriers to providers (4 votes)
- Support team based care models (3 votes)
- Provide incentives to PCPs to change behavior—in addition to infrastructure support and regular payments (0 votes)
- Align measure/reporting requirements across payer programs (0 votes)
- Identify regional leadership with authority to assist with alignment

Question Two: Identify the role of multi-stakeholder collaboration in making those near term actions successful:

- Align incentives—will require local leadership commitment (7 votes)
- Re-engage PO and physician leaders first and then bring in others (5 votes)
- GDAHC should be the convener (2 votes)
- Grade payers, in addition to providers, relative to supporting patients and providers (0 votes)

- Require local leadership commitment (0 votes)
- Encourage community to be honest with intentions and facilitate honest conversations (0 votes)
- Build trust (0 votes)

Next Steps: Putting It All Into Action

GDAHC is pleased with the outcome of this summit. The energy and enthusiasm for alternative payment reform and the opportunity to develop a collaborative approach in southeast Michigan were palpable at the summit. Several doable short-term recommendations were advanced and GDAHC will convene appropriate teams in the first quarter of 2017 to move these proposals forward.

There was not enough time at the end of the summit to discuss fully and prioritize the breakout group recommendations. The next steps identified are:

- GDAHC will survey participants on select actions to be undertaken in the short term (within 12 months).
- GDAHC will convene workgroups based on the survey results who will be responsible for achieving at least two of the recommendations.
- GDAHC will discuss with its Executive Committee a plan to increase involvement of those with the authority to make commitments and decisions for their respective organizations on how they will continue to engage in ongoing activity defined from this summit.

Acknowledgments

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About the Greater Detroit Area Health Council

The Greater Detroit Area Health Council (GDAHC) is the nation's longest-standing multi-stakeholder collaborative dedicated to improving the health and wellbeing in our communities. GDAHC was founded and incorporated August 14, 1944, as the Detroit Hospital Council with the primary goal of improving the management of community health resources city-wide, providing health facility planning to hospitals.

As the state of healthcare and healthcare delivery changed, the Council changed its focus from hospitals, to becoming a coalition dedicated to the cost-effective allocation, management and use of healthcare resources. The Council continues its mission through innovative planning and strategies with strong collaborations and partnerships.

About the Network for Regional Healthcare Improvement (NRHI)

The Network for Regional Healthcare Improvement is a national organization representing over 35 regional multi-stakeholder groups working toward achieving the Triple Aim of better health, better care and reduced cost through continuous improvement. NRHI and all of its members are non-profit organizations, separate from state government, working directly with physicians, hospitals, health plans, purchaser, and patients using data to improve healthcare. For more information about NRHI, visit www.nrhi.org.

Acknowledgments (cont.)

Summit Sponsors

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With special thanks to . . .

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