Reducing Health Care Costs: Eliminating Excess Health Care Spending and Improving Quality and Value for Patients

Statement of

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Chairman Alexander, Ranking Member Murray, and Members of the Committee, thank you for the opportunity to discuss Montefiore's model for improving quality and value and eliminating excess health care spending.

My name is Dr. Steven Safyer, and I am the President and Chief Executive Officer of Montefiore Medicine, the umbrella organization for Montefiore Health System, one of New York's premier academic health systems, and Albert Einstein College of Medicine (Einstein), one of the top medical schools in the country with $175 million annually in NIH funding. We are the health care anchors in the Bronx, Westchester, Rockland and Orange counties, a region of close to 4 million people. We combine nationally recognized clinical excellence with expertise in accountable, value-based care settings that focus on optimizing patients' health and well-being, as well as the health of their families and the community.

Montefiore's mission is to heal, to teach, to discover and to advance the health of the communities we serve, and this mission continues a commitment that began over 130 years ago to provide equitable and socially-just care to all whom we serve. Throughout our history, Montefiore has modeled its services and research agenda in partnership with our communities, to address both the underlying socioeconomic factors that affect health and specific public health challenges: from the tuberculosis epidemic in the late 19th century, to infant mortality; from lead poisoning, to the HIV/AIDS epidemic in the 1980s; from the substance abuse epidemic that has never left the Bronx, to more recently, the high prevalence of diabetes, obesity and asthma. The majority of the communities for which Montefiore cares are under-resourced, and have high rates of chronic diseases, influenced by myriad socioeconomic factors and are significantly hit by the recent opioid crisis. Montefiore is responsive to both the health and socioeconomic challenges faced by the communities and serves as an anchor institution, providing economic stability and serving as the largest employer in the regions where we are located.

We are unique among safety-net hospitals in that Montefiore provides its patients the full spectrum of care—from comprehensive primary and ambulatory specialty care, to the most complex, quaternary life-saving care. We are an integrated academic health system that includes 11 hospitals, our innovative Hutchinson Campus (a hospital without beds), 250 ambulatory centers, 25 school-based health centers, a nursing home and a home care agency. Several years ago, we integrated medical and mental health care at all outpatient sites, including our pediatric clinics. We have a large mental health and substance abuse program in all our communities.

We are also the 9th largest teaching program in the country, with 1,500 residents and fellows in training, we study and teach the most complicated medicine in the country and we do it with a unique view into underserve populations, their needs and their challenges. And we do it within an environment of value-based care, teaching young physicians to be leaders and innovators in population health. We also value the role of primary care and have one of the preeminent social medicine programs in the country.

We are also unique as an integrated academic health system with a high percentage of Medicaid and Medicare patients in our care. Montefiore is one of the largest providers of Medicaid and Medicare services in New York State, with 1.3 million Medicaid and 433,000 Medicare beneficiaries living in the four counties we serve. Indeed, Montefiore provided over 2.5 million primary and specialty care visits to Medicaid recipients in 2016 alone. Fifty-five percent of our outpatient visits are Medicaid, and an additional 10% are the uninsured. With 85% of patients enrolled in either Medicare, Medicaid or both, we make the most of every single health care dollar by aligning financial incentives with payers.

For over 2 decades, Montefiore has led the healthcare industry in rewarding providers based on quality, rather than quantity of care. As early as 1995, Montefiore's leadership recognized the need for transformational change in a healthcare delivery system serving a preponderance of government program beneficiaries and formed the Montefiore Independent Practice Association (MIPA) to enable it to negotiate value-based contracts with health plans. An IPA is similar to an ACO. It is an organized group of providers, with its own governing body, that come together as an integrated network focused on improving the quality of care for individuals and a population while lowering costs. Montefiore Care Management (CMO) was formed to provide the infrastructure to manage the care of the patients covered by those contracts. Before the term was widely used, we employed a population health management approach, focusing on identifying and stratifying the at-risk population—primarily those with chronic conditions—and engaging them with targeted care management interventions.

Montefiore was one of ten organizations that participated in NCQA's beta testing of its accountable care organization accreditation standards and processes, and we eagerly applied to become a Pioneer ACO when that initiative was announced by CMS in 2011. As New York State's only Pioneer Accountable Care Organization (ACO), we refined our core capabilities in managing the health of beneficiaries.

Montefiore generated over $73 million in savings to Medicare as an ACO over the 5 years of the program. In its final year, Montefiore's Pioneer ACO had more than 3,400 providers responsible for almost 54,000 Medicare beneficiaries. Montefiore had an Overall Quality Score of 95.16% in the final year, and performed above the mean Pioneer ACO scores for the way clinicians communicate. It also received top scores for the way patients rated their providers. Significant gains were also seen in key measurements such as body mass index and high blood pressure screening, as well as flu and pneumococcal vaccinations. Our physician network comprises more than 3,800 primary care and specialty physicians, almost 30% of whom are in private practices in their communities. We worked hard to recruit non-employed (private-practicing) providers as partners in the ACO. While expanding our model was a goal, many were not experienced in quality reporting and did not initially have electronic medical records. We invested enormous resources in helping them be successful. The quality scores by the private practicing MDs, of note, improved by 50 percent attaining a level on par with our employed physicians.

The Pioneer ACO program was a catalyst for the expansion of ACO and risk-based programs. It also allowed us to create aggregate-level population health interventions for the Medicare fee-for-service population. We are now participating in the Next Generation ACO program with 55,000 beneficiaries, and we are optimistic that we will continue to achieve savings for Medicare and reinvest our share of those savings in our delivery system.

When we applied to become a Pioneer ACO, Montefiore was a four-hospital system serving primarily Bronx County, one of the nation's poorest and most disproportionately disease-burdened counties. Today, the Montefiore ACO's network includes both Montefiore and non-Montefiore sites with 13 hospitals, scores of primary, specialty and mental health outpatient sites, including federally qualified health centers in New York City, Westchester, Rockland, Orange, and Sullivan counties.

We have learned that to be successful an ACO has to build an arsenal of interventions and incentives that promote primary and preventive care to efficiently use scare financial resources. We focus on the early identification of illnesses and where possible shift care to lower-cost settings. We shifted many services, such as blood transfusions, that traditionally involved a hospital stay to being outpatient procedures when possible. We have increased our focus on the socioeconomic determinants of health; partnerships with government agencies, community organizations and businesses to provide the full range of services our patients require; and special arrangements with providers such as skilled nursing

facilities to ensure that our patients are ensured the highest quality, most cost-effective care across the continuum of care.

We reach out to our highest risk patients who have multiple chronic and acute care problems to conduct comprehensive health assessments that cover both medical and behavioral problems and socioeconomic challenges including housing, employment, nutrition and access to health care. If you have any doubts about the importance of managing chronic disease for the health of the patients-- as well as the nation's health system-- consider this: In our experience 5% of the more than 400,000 individuals covered by Montefiore's value-based contracts, including the 55,000 Medicare beneficiaries currently attributed to our NextGen ACO, account for 65% of the total cost of care—and that is largely because of chronic conditions.

We support all physicians and other providers in our ACO to develop with them a comprehensive care plan and to help them coordinate care. Montefiore has care management teams with expertise in diabetes, chronic kidney disease, cancer, heart disease, asthma and COPD, and behavioral health as well as one team that specialize in helping patients and their families with care transitions and one composed of pharmacists that assists patients with understanding and adhering to their medication regimens. The Montefiore's quality improvement and provider relations staff assist physician practices on quality improvement and data reporting and transformation of practices into Patient Centered Medical Homes (PCMHs).

We appreciate that our patients need access to high quality providers, who understand their language and culture, are available when needed and are willing to coordinate with the other providers our patients see. Our patients need information about their conditions, help in learning self-management skills and linkages to community and government sponsored social service agencies to resolve their socioeconomic challenges. If we don't accommodate these needs, we cannot succeed in accountable care.

For example, we greatly improved management of patients with End Stage Renal Disease (ESRD). To do so, we partnered with all providers involved – Nephrology, Dialysis, Interventional Radiologists, and Device Manufactures. Early identification is crucial to help prevent unnecessary inpatient utilization. We leveraged technology solutions to create a registry of ESRD patients in the electronic health record in order to more easily identify patients upon presentation to the emergency department. This also included notifications to the entire care team, the attending nephrologist, and the patient's dialysis center upon patient

presentation to the emergency department. This resulted in improvement of ESRD spend by 3.9%.

Patients with substance use disorder also have disproportionately high costs. Based on our experience, patients with substance abuse disorder have 89% higher costs. This represented the most prominent indicator for increased costs to the system. If a provider is to be held accountable for the health outcomes of its patients, we must have access to information about substance abuse. Hence, we support revising the privacy protections included in SAMHSA's 42 CFR Part 2 regulations to align the standards for all personal health information with HIPAA standards, in particular for those operating in predominantly accountable care models.

While we've learned much over our twenty-plus years of taking risk, perhaps the most important lesson is that stability is the key to success when you are taking risk. Patients need stability in insurance coverage and access to care. For example, mental health clinics and school-based health centers are absolutely crucial yet run at a loss and are constantly at risk due to financial instability.

Providers need stability in reimbursement (with accountability built in) and prescription drug costs. As a provider that runs on low margins, we depend on the payments that account for financial implications of caring for the uninsured, Medicaid patients, and dual-eligibles (disproportionate share funding and the 340B program) and the losses that come as a teaching hospital that takes all patients regardless of ability to pay (direct and indirect graduate medical education funding). These needs are real.

And the government (federal and states) need stability in health care costs. I believe we can enable greater stability if providers have more autonomy to thoughtfully deploy resources to patients, with aligned financial incentives and a high bar for quality and health outcomes. Accountable care is not a panacea for every market, but it works in some, and we are proof.

We are confident that learning from Pioneer successes in improving quality and value and re-deploying health care resources will strengthen the future of healthcare. In addition, we believe that organizations such as Montefiore, who care for a preponderance of Medicaid and Medicare beneficiaries and who are successful in containing costs through value-based programs, should have a different payment structure. This is becoming especially important with the loss of DSH payments. On behalf of the Montefiore, I look forward to working with you to achieve our shared goal of a better health system for all Americans.

Thank you. I will be happy to answer any questions you have.