Testimony by Stephen Rosenthal
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Thank you, Mr. Chairman and members of the committee.

My name is Stephen Rosenthal. I am Senior Vice President for Population Health Management of Montefiore Health System and the Chief Operating Office of the Montefiore Accountable Care Organization.

I appreciate this opportunity to discuss solutions to one of the most vexing problems facing the nation's health system: how to effectively and efficiently care for the growing numbers of Americans who suffer from chronic conditions. I commend the Committee for its unrelenting focus on this topic.

Montefiore Health System is a premier academic health system and the University Hospital for Albert Einstein College of Medicine. We serve the 3.1 million people living in the New York City region and the Hudson Valley, a combination of rural, urban, and suburban communities. Approximately eighty percent of the patients discharged from our hospitals are enrolled in Medicare, Medicaid, or both programs, or are uninsured. The Health System includes eleven inpatient hospitals and more than 200 outpatient sites, including a rehabilitation hospital, a state of the art surgical/specialty center campus "hospital without beds", a multi-county ambulatory network, a skilled nursing facility, a school of nursing, two home health agencies and New York State's first freestanding emergency department. With our new member and affiliate locations in Westchester, Rockland and Orange counties, our regional integrated delivery system focuses on delivering patients highly specialized clinical expertise close to their home.

Our model is unique among our colleagues in that we have for many years combined nationally recognized clinical excellence with accountable, value-based care that is delivered where, when and how patients need it most.

Montefiore has deep roots in treating chronic disease, dating back to our founding in 1884 by Jewish philanthropists as a care facility for patients with chronic illnesses. Today, we are one of the largest health systems in the country, and we have more than 400,000 patients in risk arrangements across Medicare, Medicaid, and commercial insurance. We take a great deal of pride in the role we play as a national leader in the movement toward value-based care, and in sharing our journey and learnings with colleagues and policymakers.

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.

A year later, CMO, 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.

More than a year before the passage of the Patient Protection and Affordable Care Act, Montefiore's President and CEO, Dr. Steven M. Safyer, long an outspoken advocate for accountable care, established a high-level planning group in anticipation of federal, state and private payer opportunities focused on population health management.

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 Model ACO when that initiative was announced by CMS in 2011. The Pioneer ACO program, established as part of the Affordable Care Act, 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. As one of the original 32 Pioneers, we have achieved overall savings for Medicare of nearly $70 million out of a total cost of care of more than $2.2 billion. 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 13 hospitals and three federally qualified health centers and extends to the whole of New York City and to Westchester, Rockland, Orange and Sullivan counties in New York State's Hudson Valley, beyond the Montefiore Health System itself, in fact. The network comprises more than 3,800 primary care and specialty physicians, almost 30% of whom are in private practices in their communities.

Yet it is our decades-long experience providing care for the 1.4 million residents of the Bronx, 75% of whom receive their health care services through the Medicare and Medicaid programs, that gave us the expertise to successful manage the care of the beneficiaries attributed to our ACO.

In addition to being the nation's poorest urban county (almost one third of its residents live in families with incomes below the federal poverty line), the Bronx is the most disease-burdened county in New York State, ranked last among 62 counties on both "health factors" and "health outcomes", and with highly elevated rates of diabetes and chronic cardiac and pulmonary conditions.

CMO 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 CMO'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 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. We identify all of the providers they are seeing to develop with them a comprehensive care plan and to help them coordinate their care.

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.

And that is why we applaud the committee's focus on helping healthcare systems care for their patients with chronic conditions, which are difficult to deal with under the best of circumstances and often require multiple providers to properly control.

If you have any doubts about the importance of this concentration—for the health of the patients as well as the nation's health system, consider this: In our experience 5% of the 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.

As I said, Montefiore has enjoyed success in managing value-based contracts, including the ACO model. But we have learned that to be continually successful an ACO has to continually evolve and build its arsenal of interventions and incentives that promote primary care, and adherence to personalized care plans, as well as efficiently use scare financial resources. To that end, I applaud the ACO provisions included in the CHRONIC Care Act, some of which build upon provisions included in the NextGen ACO program, and offer you our support for them.

In our experience, prospective attribution is one of, if not the most critical component to success in two-sided risk models. While retrospective assignment of patients may be appropriate in one-sided risk models, in two-sided risk arrangements, prospective attribution allows us to quickly identify those beneficiaries with a history of high costs and high utilization of services, as well as those whose medical records indicate the potential for becoming high cost and high utilizers. Without prospective attribution, it is difficult to effectively deploy resources to generate savings, because patients that the ACO provides care coordination services during the performance period may not be attributed to the ACO for a sufficient period of time to have an impact on their care, or be attributed to the ACO at the end of the year.

(As an aside, when we send out the notification letter to our newly attributed beneficiaries each year, it is not unusual for us to be asked by some beneficiaries if their spouse, who did not have the claims history with a particular provider to merit attribution, could also become part of the ACO so they could benefit from our care coordination services.)

Another component to an ACO's success is increasing patient access to services necessary to manage chronic disease. Your proposal to expand the ability of ACOs to employ telehealth solutions is an estimable way of doing that. To serve our urban population that faced challenges getting to office appointments, Montefiore initially focused its attention on a home visiting program. But as the evidence has built that telehealth technology can be as successful in urban settings as it is in rural areas—and as our service area has expanded beyond the high rise neighborhoods of the Bronx—we have begun to investigate solutions that we believe will be cost effective and contribute to improved quality of care, including telehealth and other technology-based interventions.

In fact, we are presenting a paper at a session of the annual meeting of the American Psychiatric Association next week that describes preliminary results from a pilot of a smartphone behavioral care management platform. The data indicate a threefold increase in the number of contacts Montefiore's care managers were able to make with behavioral health patients and enables them manage caseloads of up to 120 patients, a significant measure of efficiency given the low-income, ethnically diverse population in the pilot. This application does not fit the traditional definition of telehealth but it is typical of the innovative approach you are looking to advance.

I urge you to contemplate an expansion of the definition of telehealth to include audio-only and all modalities that allow communication between providers, care managers and patients in a seamless fashion, especially in low-income communities that may not have access to videoconferencing

technology. The potential for technology to improve patient engagement and care is not only applicable to chronic care, but to the vulnerable elderly as well.

Finally, I am intrigued by your proposal to ACOs to offer beneficiaries incentives to obtain primary care services from its network providers. We—and I suspect, most other ACOs—already offer incentives to our providers for meeting both quality and cost metrics. Why not allow us to offer similar incentives to their patients? While there may be a cost to developing the infrastructure to administer the benefit, it seems to me to have the potential to be a win-win-win-win proposition. It could benefit the patient directly, both financially and in terms of improved health; the provider, by improving his or her quality scores; the ACO itself by increasing its potential for shared savings; and the Medicare program by lowering the total cost of care to the system. Such an incentive may be especially effective in a low-income, price-sensitive population like the one we serve. We know that patient outcomes are significantly improved if they access their providers regularly and when needed. Providing an incentive to promote compliance is likely to encourage that.

Research demonstrates, and our actual experience shows, that patients who regularly fail to keep scheduled appointments with their physicians or other providers are at higher risk for complications and deterioration of their health status. While it is difficult to track with exactitude, the no-show rate among the population that Montefiore has care management responsibilities for is in the neighborhood of 20%, a rate that potentially endangers the health of the individuals and our ability to meet quality metrics and cost saving targets associated with the value-based contracts covering them.

An added benefit to an incentive is the potential to encourage patients in the fee-for-service program to stay within the ACO network, without limiting their choice in anyway. Keeping patients within the network is a fundamental challenge for ACOs in a fee-for-service environment, and you have proposed an innovative solution to this issue.

It is exactly that kind of creative thinking that has led Montefiore to continually evaluate and modify its approach to population health. The result for us has been an increased 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.

On behalf of the Montefiore ACO and the entire Montefiore Health System, I thank you for your efforts to advance accountable care with proposals that I believe have the potential to improve quality and lower costs. 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.