Alliance Payment
Alliance for Health Reform
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EDWARD F. HOWARD: I'm Ed Howard with the Alliance for Health Reform. On behalf of Senator Rockefeller and our board of directors I want to welcome you to this program that focuses on our fragmented healthcare system. Not the disorganized, some would say chaotic delivery system with its uncoordinated care among literally hundreds of thousands of providers, but rather the fragmented way we pay for care; different payers paying different amounts to the same hospital or physician and any given payer sending different amounts to different providers. We know for example that Medicare usually pays more for a given service than Medicaid and that private insurance usually pays more than Medicare for that service. Of course is the patient is uninsured, as 50 million Americans are or were in 2010, the payment may very well be zero for that service.

How disruptive is that payment differential that both insurers and providers deal with? If it is disruptive are there ways to minimize that disruption? That is what we are going to look at in some detail today. We are very pleased to have as a partner in today's program The Commonwealth Fund, which has maybe been the most vocal and high profile proponent of a high performance health system as we have today. That is, a system that's not as disjointed as today's delivery or payment arrangements. We've even more pleased to have as the

co-moderator and active participant in today's discussion Stu Guterman who is the Vice President at the Fund for Payment and System Reform. Stu, would you take it from here?

STUART GUTERMAN: Thanks, Ed. As Ed said, the emphasis today is on the fragmented healthcare financing system. There's been a lot of talk and thankfully a lot of movement toward trying to make the delivery system a more coordinated system. One challenge that is faced by providers who are trying to move in that direction is that we have a fragmented healthcare financing system that generates revenues that flow into that delivery system, and that creates an even bigger challenge to try to match up those divergent flows of revenues from various sources and the delivery system that we would like to see. That's what we've pulled together, some great examples of folks who are taking different approaches in trying to cope with that situation.

First I'd like to lay out some observations about this market. I'm an economist. They say that Washington is full of economists who are pretending to be doctors and doctors who are pretending to be economists. I think here we have an economist who's going to stick to being an economist, and we have some docs who are going to be talking about being docs, so that's reassuring.

Economists think about markets. The word market evokes a lot of controversy too because markets can be defined in different ways. For the healthcare market one of the things you think about is that the market produces prices which transmit signals which indicate the value of different services and that allows suppliers to decide how much of what combination of goods and services they should provide. You think of an orderly information filled mechanism. As you'll see in the next couple of slides here I'm going to present, the healthcare market does not correspond to that vision of the way markets should work. It to me is a symptom of a situation that needs to be addressed.

This is some data from New Hampshire on what different insurers pay across different providers for a set of fairly standard procedures. You see here that not only do different insurers pay very different amounts for the same procedure but each insurer pays different amounts to different providers, very different amounts, for the same procedures. There is a three to four-fold difference in fees paid for the same kinds of procedures. How do you make order out of that kind of situation?

In this slide people have paid a lot of attention to the amount of regional variation in Medicare spending per beneficiary. That is represented in the map you see on the

right-hand side of this slide. We have also, more recently, taken a look at how commercial spending per person varies across the country. You see that there is also quite a bit of variation in commercial spending across the country, but you see that patterns are very different. The dark blue is in each case the highest relative to the median and the light areas are the lowest relative to the median.

You see there is quite a bit of difference in the patterns you see between private and Medicare spending. When you look at them across the board they're basically all over the place. There are indeed areas that are high in both Medicare and commercial spending. There are areas that are low in both Medicare and commercial spending. There are areas that high in one and low in the other. That kind of gives you a sense that prices don't mean the same thing and they don't lead to the same level of spending in different areas.

Over time you see differences as well. This is a slide that we put together out of data from the American Hospital Association. It's just hospital payments and cost. What you see here is we took the 20 year period between 1988 and 2008 and split it into three periods. The '88 to '93 period I'll call the wild west because costs were rising at a very rapid rate, the costs are the left-hand most far were rising at 7.8-percent a year during that time period. Medicare payment rates

were rising at 6.8-percent a year during that time period. Medicare was a bad payer because it wasn't keeping up with the costs that were raising approximately three times the rate of inflation. The reason that costs rose that much was because private payments per case were rising at 9.3-percent a year during that time period. Medicare was a bad payer even though its payment rates were rising at about 2.5 times the rate of inflation. The Medicaid bar actually was an anomaly that's related more to the Medicaid disproportion share hospital increase in those payments during that time period.

Then you move to the next period which I'll call the heyday of managed care. You see that Medicare payment rates were rising at a rate that was well under half the rate that it was raising in the previous period. Medicare now was a good payer because its payment rates were raising twice the rate of hospital costs per case. Private payments were actually declining during that time period per case.

It just goes to show that these sands shift over time, and in fact that this whole notion of cost shifting that assumes that there's some fixed level of cost increase that has to be covers by payers, and if Medicare cuts their rates then providers are just going to have to make it up by increasing private payments kind of does not hold in all situations. Here you had a very different rate of increase in costs between the

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two periods. Then the more recent period everything has kind of settled down in between and Medicare settled back into its role as being perceived as a poor payer because its rates are actually going up faster than they were in the previous period when they were a good payer. Now they're a bad payer because costs are going up faster than their rates are going up. We have to think a lot about the relationship between the flows of revenue and how different they are, and the cost level and the rate of increase in costs that are necessary to provide service to the patients that providers treat.

We have a set of panelists today to represent really three approaches to trying to match every provider has to match the revenues they see coming in. With the costs that they perceive they need to lay out to meet the needs of their patients. We have three very different approaches. Steven Safyer who's President and CEO of Montefiore Medical Center in the Bronx. They've basically treated the community that they serve and really moved a lot of their base to capitated system where they take on the responsibility for dealing with their patients' needs.

Gregory Reicks from Mesa County Physicians in Grand Junction, Colorado. Grand Junction has been cited a lot recently as being a particularly well-coordinated system. They've actually taken the approach of pooling the flows of

revenues across payers to meet the needs of their patients equitably. Then John Colmers, who's Chairman of the Maryland Health Services Cost Review Commission, represents a statewide approach to trying to smooth the match between revenues and patient needs and costs. Then we have as a discussant and reactor Jim Bentley who's currently a private health policy consultant but spent years working with the American Hospital Association and the Association of American Medical Colleges.

What I would pose to all of the panelists are a set of questions. How do you match the flows of revenues that you get from different sources? How do you deal with the changes over time in those flows? What lessons can be learned from your experience that could be applied to other circumstances because a lot of areas are having to deal with these situations? Then what implications does your experience have for a federal policy?

I'll hand it over to Steve now.

STEVEN M. SAFYER, MD: What I'm going to try to do in a very short period of time is give you an overview of what we've been doing in the Bronx at Montefiore Medical Center. To just go back to some of Stu's comments to root what I'm going to be talking about, we came to a conclusion a very long time ago that the healthcare system needed to be an integrated one. We saw the compelling issues of integration really falling into

two large buckets. One was our delivery system. As I think most people know, academic medical centers are not known for integration period. The second piece is this kind of unusual payer system that we have, each sector of our country has its own slant. We needed to integrate that system and make it work better to drive towards overall integration. That's really where we've been coming from.

I just would begin by saying that in partnership with the Albert Einstein College of Medicine we look at feel like most any academic medical center of note that you all are familiar with across the country. We educate 800 medical students, 8,700 programs, 1,200 interns, residents, and fellows. We do heart transplants, liver transplants, complex cancer surgery. We have a children's hospital. It's ranked among the top in the country. We develop new knowledge; significant portfolio of NIH supported research. In that respect we're like every other academic medical center.

Where I think we've really moved the needle is that we don't fulfill our missions, patient care teaching research, the traditional ones, and community service within one very large hospital with attendant super sub-specialty care, ambulatory sub-specialty care nearby. That being said, we're a very large hospital. We're 1,500 beds; one of the largest in the country. Yes, we do a lot of sub-specialty care. What is different

about us is that we do 3.5 million ambulatory visits, of which about 60-percent are ambulatory primary care in the community; internal medicine, pediatrics, and family practice. We employ the faculty, not the medical school. We employ the faculty that are clinicians. That's about 1,200. We have about 400 physicians who are in our primary care medical group. Overall we have about 2,500 to 3,000 physicians. The vast majority of the work is done in an employed model that is integrated.

This delivery system is in traditional clinical settings and non-traditional clinical settings. About 30 of them are in the community and they look and feel like a doctor's practice as you might imagine one, but we're in homeless shelters. We're in 30 schools. We're in a variety of specialized centers where people require close supervision and care. We are providing in many very unusual settings. In addition to that we have over 500 home health visits from our own home healthcare agency. The only thing that we don't own and operate is a nursing home, but we partner with a few of those very good ones that are in the Bronx.

That kind of delivery system which has most of the care that a patient or their family may need in a lifetime is provided within our single delivery system. I think that is truly unique for an academic medical center. Where we really distinguish ourselves is our commitment to our community. The

community at the Bronx, one of the largest on a stand-alone basis would be the sixth largest city in the country, 1.5 million people, has some of the most significant health and economic challenges across the country. We stayed steadfast in our support of that community and our embracing of that community. In a sense we are an accountable care organization before we knew what that term was.

Kid with the Yankees hat is named Jeter who was born of Mexican immigrants. I'm not going to comment on whether or not they're documented or undocumented. At six-years-old he received a heart. The kid is doing fantastic. Our patients tend to be, and reflect, the burrow that we care for. We don't measure ourselves by people traveling long distances, but they do travel long distances to come there. Destination in the Bronx is essentially a bus and a subway train.

Just a few more words about the Bronx. The effective unemployment rate, the measured one, is over 12-percent. It's probably 25-percent because so many people have left the workforce. It is a very poor sector, among the poorest in the country. Childhood poverty; huge and very significant. There is a very large group, hard to get the exact number because it's not always measure well because a lot of the un-insurance is undocumented immigrants. It is about 250,000 or 300,000 individuals who don't have health insurance. About half of

them are in the immigrant's status. Very little upside in healthcare reform because of the lack of immigration reform that has been achieved in this country.

Every way you would want to measure the health of the Bronx it is challenged. I would say obesity and diabetes is the biggest issue we're facing. Kids 12, 13 years old are obese by any measure. BMIs over 30. We're seeing adult onset diabetes in kids that are in their teens. There is also a significant amount of hunger despite the fact that we have this obesity epidemic. Basically if you look at this, the payer in the Bronx is Medicare and Medicaid with a very small commercial insurance component. Montefiore's commercial insurance component is 20-percent. Twenty-five-percent of that 20-percent is blue collar insurance. A lot of academic medical centers wouldn't consider that commercial insurance. Montefiore is 40-percent Medicare, 40-percent Medicaid, and as I said, 20-percent commercial.

Word about the safety net. The concept of the safety net to me is invariant [misspelled?]. Every other western country has uniform health care that is not permeable for all people living within their country. They don't grapple with the issue of the safety net. These countries have sometimes two or three levels of care. If you can afford it you grab a trapeze and you go up. You don't fall through the cracks. In

America, and I can tell you in New York, there's at least four or five levels of health care. It really is only down. That concept is one that I have trouble with because I believe that health care is a human right and a social justice issue.

Just very quickly, the salient features. I already told you we're a learning institution. I already told you that we seek to be a system. That is a holy grail. Not easy; very difficult. I'm humble about where we stand, but we've been moving along on that pathway. We care coordinate. We use health information technology. We've been 100-percent physician order entry since 1998. We have an employed physician model. That's important I believe. We have focused for many, many years on quality, safety, and the patient experience. I told you about our commitment to the community. We have regional partnerships. In many ways we have created healthcare reform without the government in the Bronx. We have a RiO [misspelled?]. We share information with 90-percent of the providers.

We have a care management organization with 500 people that manage prepayment and/or capitation. Essentially the model for us; commercial, Medicare, Medicaid since 1995 has been to move as much of our payments into a prepayment or capitated model. The model is essentially 10-percent of the premium goes to the insurance company for marketing and profit.

We work with 90-percent. We manage the care with that revenue stream. In 2000 we were at 150,000 lives, 850 million dollars. Our overall economy is three billion. This organization is in the home, on phones, focuses on when we had 150,000 about 30,000 patients that have high needs. We manage them to wellness, not wait for them to become ill.

Based on that, we were awarded the Pioneer ACO designation. We're proud of that. We're the only one in New York that achieved that and 1 of 32 in the country. For that we added another component of prepayment because it's shared savings now, but within two years it will be capitation. It's actually about 21,000 lives. There is a vehicle to expand that greatly over time. It's one of the biggest ACOs. In it we are tasked to quality metrics and savings all based on providing the very best care for the patients. We believe that that's the right way to do it.

I'm going to very quickly just not go into details here but because of the Pioneer ACO a couple of new products and challenges we're taking on with the state of New York, and working with the commercial payers that are not in capitation. Over this next year we will move to 50-percent of our revenue and 50-percent of our activity in a capitated or prepayment model. We consider that a watershed moment because we've

become a culture that is focused the majority on prepayment and wellness as the objective.

In conclusion I would say that integration, bridging the multiple payers, and creating the very best patient experience and overtime lowering the expense, which I acknowledge is far out of our control is a goal of ours and an objective. As I said earlier, I am humble in terms of where we stand, how difficult this is, and how much more work we have to do. The final just sort of opening comment I would make is I think it's important because we have a number of examples here of high excellence and great leadership, but what tends to happen with government and institutions is that there are noble goals but the demands of government demand turnaround much more rapidly. I'll center on the state of New York. We have an excellent governor, but he basically has a four year horizon. To change a healthcare system I believe it takes many years, hard work, mistakes, and investment. That's something that I think we all have to grapple with. Thank you.

EDWARD F. HOWARD: Is Greg next? I'm sorry. We had John next. You can relax.

GREGORY REICKS, DO: I guess I'm here to share a contrast because we're nothing like the Bronx. I admire what you've done there with your work and your population. We have a different population where I come from in Grand Junction,

Colorado. We've done a little bit different type of model to achieve some quality and efficiency results that have become well-known around the country now. As some of you are probably aware, this is where for Grand Junction we gained our notoriety.

It was kind of an interesting day when this article was published by Dr. Gawande. When the article came out the next few days we started receiving a number of phone calls and requests for information about, "How do you guys do that in Grand Junction? What are you doing there that's so different?" I can remember at our IPA executive committee meeting we were sitting together when this first came out. We kind of looked at each other and we said, did you know we were doing anything differently here than anywhere else. We were as surprised by the data as I suspect the people in McAllen were as surprised by that data.

As we got more questions about, what is it that you do differently, we really had to step back and take a look at what we'd been doing in our community for many years and truly what was it that we were doing differently to achieve these kind of cost and quality metrics that were showing us in the Dartmouth data. I'm going to share a little bit of that with you today.

Here's the data. This is the 2008 data. This is the Medicare. Medicare data shows that we are near the bottom in

terms of Medicare spend per beneficiary compared to the rest of the country. I'll set the stage of what it's like in Grand Junction. Grand Junction, we've had a unique environment. About 35 years ago a group of local physicians came together and formed an HMO, a health maintenance organization, in Grand Junction. They were primarily reacting to what they saw as potentially a threat, particularly to non-HMO type of payer lines, like Medicare and Medicaid. They saw that there was a potential for an HMO business to dominate the market and there were concerns about access for Medicare and Medicaid members. What are we going to do with those folks in the area of HMOs?

They formed an HMO that accepted both Medicare and Medicaid patients into the HMO. As an offshoot of that development of the health plan they decided they needed a physician network as a contracting entity with that health plan. That's where the Mesa County physicians' IPA was born was out of the desire basically to have a network of physicians who would be able to contract with that health plan.

The original intent was to bring both the payer, which was Rocky Mountain Health plan, and the physicians together in a financial alignment. At that time we felt that the best way to do that was through risk contracting. There are very different forms of risk contracting that I'm sure you're aware of. Our type of risk contracting that we've embraced over the

last 35 years has really been withhold risk. I'll talk a little bit more about the difference between withhold risk and capitation a little bit later.

However, we recently also received the blessing of the Federal Trade Commission to move forward and contract under a clinical integration model also. We're now exploring relationships with other payers in a clinical integration possibly non-risk model. We have 295 physician members, all specialties. About 40-percent of them are primary care physicians.

I think the key thing that also has been part of our success is that collaboration with that payer in our market has been a big factor in our success. About 40-percent of a primary care physician's practice in our market is Rocky Mountain health plan members. That can be commercial. That could be Medicare. That could be Medicaid. When you've got that sort of volume of patients that you're managing under a risk-type arrangement it really affects the way you practice for all your members.

One of the things that we've seen in our community is that other payers outside of Rocky Mountain health plan have benefited from all of the activities that we've done to try to manage that risk under the Rocky contract. I think a good example of that is fee-for-service Medicare. As you can see,

that type of data that's a part of the Dartmouth atlas study was achieved on a non-risk basis for those types of patients. The activities that we do in our practice really apply to all our patients.

With Rocky we really have several lines of business. We have the traditional commercial plans, a private plan, an HMO, and an ACO plan. We also have a Medicaid plan and a Medicare plan. Rocky actually has a contract with the state as an administrative services only arrangement. Essentially the way that works is Rocky gets paid on a fee-for-service basis claim by claim for Medicaid members that they manage within our network and then Rocky pays the physicians on a fee-for-service claim by claim basis. There is a withhold. We also have dual eligible and Medicare patients. The thing that's unique is up until about four or five years ago we had a uniform fee schedule for all those lines of business.

In other words, when a Rocky Medicare, Rocky Medicaid, Rocky commercial member came to my office for an office visit I was paid the same irregardless of what line of business they were in. The way we were able to do that is by pooling our withhold risk. For example, each line of business currently has a 15-percent withhold risk. A patient comes to see me in my office. The IPA has negotiated a fee schedule with the health plan. I get paid a fee-based on that fee schedule minus

15-percent. That 15-percent is held back into what we call a risk pool. That is for every physician in our network for every visit that they see patients.

Then the way that these withholds are released is on our profit sharing formula. We've contracted with Rocky to where if there's profits, and I'll talk about how we define a profit, that is split 55-percent with the physicians and 45-percent with the health plan. The physicians are not assuming full risk, but we're actually sharing risk with the health plan for the care of these members.

Here's a visual picture of the way that that works. We really have three major lines of business; Medicare, commercial, and Medicaid. Within Medicaid there's CHIP Plus [misspelled?] Plus and Medicaid and within the commercial there's a traditional type of PPO type plans as well as HMO plans and we have Medicare. Each line of business within those systems generates what we call a profit sharing pool. That profit sharing pool is basically just looking at the gross operating income for that line of business plus the amount that's been withheld for seeing those patients in that line of business. Each line generates a profit sharing pool. Then at the end of each year we pool all of that together into one risk pool. Then we split that between the physicians and the health plan.

If you think about how that works, you can imagine if we're paying physicians on the Medicaid patients commercial rates basically to see those patients that Medicaid profit sharing pool is never a profit. It's always a loss. That's always a negative profit sharing pool, but because we have the ability to blend lines of business together we're able to offset that loss with the profit sharing pools from the other lines of business. The thing that's done in our community that is somewhat unique we think is it's really allowed access for Medicaid members in our community every physician in town. We don't have any FQHC. We have no federally supported clinics in our community. The Medicaid members in our community can see any physician in town as part of our agreement with Rocky Mountain health plan. I think that's been a big benefit to that population and has actually helped us to achieve some fairly good quality and utilization targets for our Medicaid population also.

Here's our historical withhold return that we've returned to the physicians. When we set up the budget, I guess you could say for our network, what we negotiated with Rocky Mountain health plans is we take a look at their commercial membership and using the actuarial analysis we determine what we think the spend will be in the commercial line of business for the upcoming year. Then we add 3-percent to that. We

allow the health plan a 3-percent margin basically. Then how we perform within that budget basically determines our withhold return. As you can see, it's varied quite a bit across the years. Most of the variance is related to unpredictable changes in utilization. Last year the withhold return was unusually low. Part of that was because of this phenomenon; rapidly expanding Medicaid enrollment. I suspect this is not unlike most communities in this country, but in our community with the economic downturn, as well as opening up of eligibility requirements, our Medicaid population has grown 53-percent in just about three years.

You can imagine with the way that we do our risk sharing as the Medicaid population grows there's a built in loss basically, a per member per month loss for every Medicaid member that we enroll in our system. What we've done to address that is over the last year we've actually had to reduce the fee schedule that we pay our physicians for Medicaid members. It's still above state Medicaid rates. We still do the combined withhold and risk sharing across plans. We have had to reduce that to try to reduce the potential losses.

Here's a summary of what we've learned. We've been fortunate in Grand Junction to be the recipient of a Beacon grant. Many of you are probably familiar with the Beacon program. We were one of the 17 communities to receive a Beacon

grant. That grant has funded practiced transformation and health information technology expansion into 50 primary care practices across western Colorado. The thing that we've learned in terms of our financial model and that type of activity is that really fee-for-service medicine does not support the type of activity that we want our primary care practices to do. We're asking our primary care practices to really transform the way that they deliver care, more team-based care. What we found is for that to be most effective we need a physician champion in every practice that we work with. In order to get a physician champion to be involved we need their time. In a fee-for-service environment a physician's time is not spent in doing administrative work.

We're planning to move away in our primary care practices from fee-for-service medicine, look at more of a risk-based capitated model that some of the others have presented. Thank you.

EDWARD F. HOWARD: Greg, before we go on I wonder if you could clarify something. On the withhold graph that you displayed, what is it a percentage of on that vertical axis?

GREGORY REICKS, DO: It's a percentage of the total dollars that were withheld.

EDWARD F. HOWARD: I see. Okay. Very good. We'll turn to John Colmers. John, glad to have you with us.

JOHN M. COLMERS: It's great to be here. Late is better than not at all. I'm going to be very brief and talk a little bit about the Health Services Cost Review Commission; the most mature of the models that you are looking at. We have been in place in Maryland for 40 years.

As you saw from the initial slide, my day job is as Vice President for Healthcare Transformation and Strategic Planning for Johns Hopkins Medicine, an academic medical center some repute in Baltimore. I was appointed as Chairman of the Health Services Cost Review Commission by Governor O'Malley this past July before one wonders about the inherent conflicts of interest associated with having a provider in the commission model. It has been that way since its inception.

There are seven members in this independent commission. Independent means that the decisions of the commission are appealable directly to the court systems and not through an administrative appeal. Three of the seven members may have a tie to the industry that is being regulated, the majority do not. The first chairman of the HSCRC was a hospital administrator. It has been a model that as they say has worked remarkably well over a long period of time.

During an earlier period in my career I spent 13 years working for the commission, including serving as its executive director. We have 31 professional staff there. The reason

that the commission has lasted as long as it has in part is driven by its very broad statutory authority. There are no formulas written in the law. There are no specific technics that are applied. Very broad charges given to the commission to be sure that hospital costs are reasonable, that the rates are reasonable related to cost, that rates are set equitably without undue discrimination. You can have due discrimination. You can have rates that are different but they have to be based on cost. You can allow for differentials and differences in rates, but they have to be cost justified. There's broad authority to experiment with alternative rate methods.

Also included in hospital rates is a provision for uncompensated care. Last year Maryland provided approximately 900 million dollars in uncompensated care to patients across the state for hospital services. There are no public hospitals. No hospitals of last resort in Maryland. Notwithstanding the fact that we have, in parts of the state, faced many of the same economic challenges that you've heard already mentioned. It is made possible by a waiver granted by the federal government, originally in 1977. It's what makes the system all-payer. We keep that waiver on the basis of a test that compares the payment per admission in Maryland for Medicare payments relative to the rest of the country as measured from the first of January 1981.

The second part of the test is that we remain all-payer; that everybody has to continue to pay on that same basis. We continue to meet those tests over the years. There is significant transparency and a culture of transparency for payers, providers, and patients. Much of the cost information of all hospitals are in the public domain. Much of the case mixed information is readily available. The commission conducts its work in public. The rates are regulated for hospitals but not for physicians. As we'll see in a moment, we have the lowest mark up, that is to say the difference between cost and charges in the country.

The basic components of the rate system I won't go into detail. It is by full admission; an incredibly complicated system, but it could be made much simpler by having a single rate that goes to everybody and it wouldn't be fair or right. It begins with departmental unit rates. The commission actually does set rates for things such as patient day in a medical surgical unit, laboratory tests per RVU, emergency services, and so forth. Hospitals are required to charge those rates and there are considerable penalties for failure to do so.

In addition to the departmental unit rates there is a cost per case constraint akin to a DRG payment, although not precisely payment on a DRG basis. There's an inpatient cost

per case constraint that is case mix adjusted, and an outpatient cost per visit constraint as well. Each year hospitals are evaluated across the board ranging from Johns Hopkins hospital on one end of the distribution to McCready Hospital in Crisfield, out on the eastern shore with 30 beds on the other end of the constraint. Each are measured for relative efficiency.

Those hospitals that have poor performers are in line for greater scrutiny. Importantly we regulate cost, not profits, to the extent to which hospitals are able to generate a bottom line performance are allowed to keep that and to use that as they see fit. As I say, this system is made possible entirely by having very accurate and timely financial information.

We have been relatively successful in being able to bend the cost curve over time. We began this experiment being 25-percent above the national average in payment per admission. We are now 3-percent below the U.S. average on an all-payer basis. As this chart shows, and to make the point that Steve made earlier, this was not accomplished in any one year, but it was done over the magic of multiple years beating that number by 1 or 2-percent a year, the magic of compounding of results in savings that could be estimated as the area between those

two lines of about 45 billion dollars; a significant amount of money to say the least.

I did mention that one of the things that makes the system unique is a much more equitable payment system. On the left-hand side of this chart you can see the relative difference between what the actual cost of care is and what payment levels are by various providers. These are not charges but what actually is paid. As you can see, it is all over the map. It is consistent with the data that Stu placed earlier and points that had been raised previously. In Maryland, to the right in contrast, all-payers pay hospitals on the basis of the same set of rates in any hospital. Now we do permit, as I mentioned earlier, cost justified discounts. Medicare and Medicaid receive a 6-percent discount. They pay 94-percent of charges, which is as I say, a far more equitable system.

One way of measuring that inequity elsewhere is by looking at the relative markup; how high a hospital has to set their charges in order to hope to recover the shortfall that they're receiving from certain payers. It is akin to the sticker price of a car, which few but the suckers among us pay. As you can see here, among the states, there's broad variation in that. Payers that are dominant are able to effectuate lower payment levels, in many instances well above cost, nevertheless. The people who take it in the neck most or the

ones who pay charges typically are those without health insurance at all.

The system has evolved considerably over time. We are continuing to evolve. We began very much in a day where cost-based reimbursement was a system we needed to beat. We are now moving to a system that is much more population-based. Ten hospitals in the state for example on what are called a total patient revenue system. These are hospitals in rural parts of the state, much of the eastern shore, and western Maryland. Those hospitals are on a global budget. They have very strong incentives to eliminate not only readmissions but admissions in the first place. In many of those jurisdictions you've seen the development of the type of integrated delivery systems that you heard Greg and Steve talk about before.

We have an all-payer, all-cause readmission incentive in place now that virtually all of the hospitals in the state are functioning under with very strong incentives to eliminate readmission levels. Admittedly Maryland has high readmission rates. This is an attempt to bring them down. We have allowed bundle payments already for private payers that have come in. We would like to do that for Medicare as well, and have very robust quality payment mechanisms both process and outcome measures where there is roughly 20 million dollars on the line each year for institutions to be able to respond to.

We're also quite interested in responding to CMMI solicitations to allow Maryland to begin to bundle a number of opportunities that are made available by CMMI and to do so on an all-payer basis. It is in our DNA to think about the world across payers and to provide a set of incentives that are uniform to the providers in the state regardless of the payer. We think it is an important way to bring about that change.

We're often asked, why Maryland. We're the only state that has such an all-payer system in place. New York had one at one point in time, as did Massachusetts and New Jersey. Here I've listed some of the reasons why we think that that might be the case: a significant role that hospital trustees have played in the Maryland Hospital Association, strong political support and a very non-political process, a focus on cost and less on price manipulation, very broad authority, as I've indicated, to evolve over time, certainly the ability to do this as a system across all payers which is made possible by our waiver is critical to that authority.

Those are components that are not necessarily the case that others are going to adopt, but I think one of the basic messages that you've heard here is that local communities can often do best to figure out what works for the culture, the politics, and the economics of their own communities. Thank you.

EDWARD F. HOWARD: Great. Thanks, John. Jim Bentley spent a long part of his life, and as someone once said, “Have you been in strategic planning all your life,” and the answer of course was, “Not yet.” You have been in a position to make thoughtful observations about the impact of potential changes on hospitals and the hospital sector for about as long as anybody I know. Having heard what you have heard from three different very successful models, what kind of conclusions and reactions do you have to the prospects for either these models or other kinds of models for helping us improve the cost and quality that’s delivered in the healthcare system?

JIM BENTLEY: Thanks, Ed. That’s probably the most polite I’ve ever heard anybody say, “God, he’s getting old.” I’d make eight points. Some of which are influenced not by what you’ve heard today but by what I’ve heard across a little more than four decades in this town.

There often in this town is a temptation by government payers, whether it’s federal or state, to think of revenue which comes from the different payers and unlike Maryland and all the other states varies in amount as if the dollar stayed separate. That is, if there were pink dollars, green dollars, blue dollars, yellow dollars. I know of no hospital in which it operates that way. Essentially when you put together the budget and you’re looking at income you will take those

different strings, which do in fact vary, but you will aggregate them into a single amount. In that sense all money is fungible, and then you will set expenses based more on programs than on who sponsored the patient.

You often see in this town a debate about the profitability by payer. I'd make two points about that. One, that's almost always a retrospective calculation looking at the amount of money and the expenses. The second point I would make in that is if you look at hospital financial reporting, which has improved tremendously since my early days in the 60s, it still is often made up with the smallest portion being direct cost. That is, you can say this amount was actually spent on this patient funded by that payer. The larger amount in many, many cases is what are called allocated costs. That is, you're spreading them across patients on some measure, which allocates those costs. As a result all of the cost margins we see on different payers are in some ways creative accounting. Creative accountants can make it look a little different.

Second point I'd make is that profitability though does impact service decisions, apart in many ways in my view from what happens in terms of payers. That is, take when Medicare started and the early DRGs. It was very easy for institutions and for physicians to realize that cardiac care was profitable,

even if they had a margin of error in their calculations. We saw a huge increase in the number of institutions across the country seeking to provide cardiac care. Likewise, even today behavior health, whether we're talking about mental illness or whether we're talking about substance abuse is seldom profitable, and we see institutions not adding it; in fact institutions dropping it.

A third point to make that I owe to Stu Altman, and let's give him credit for it. It was at a hearing when he was chair of MedPAC I believe or maybe before that and the ways and means on the other side of the hill. The committee was really trying to enact in Medicare payment a specific change in hospital behavior. The point that Stuart made to the committee was you're trying to do a very reasonable action by changing Medicare payment to make this resulting behavior change in hospitals, but he cautioned them that the hospital executives could only make the changes that were possible within the time period under their control.

If you were to make a rapid change in Medicare payment that you thought was going to have Impact A, the change that might be happening was B because that was the change the institution could make. It has lead to both the political argument and the political frustration that sometimes you'll see institutions or associations on their behalf saying if you

reduce Medicare payment pediatric care is going to suffer. It's not because Medicare payment is a big payer, if you will, for pediatric care. Once that budget is created, when you shrink that budget the savings that you may be able to obtain in the period of time ahead may be in the pediatrics area or the emergency room or something not as directly related to the payer as the regulator or legislator thinks.

The fourth point I would make is particularly with Greg and Steve. You heard descriptions of relatively integrated systems. That is, they have some approval in the Rocky Mountain area to let money flow between the entities. The employed Montefiore allows money to flow between the entities. In most of the country at this time, even with the number of employed physicians that are growing, it sometimes is very, very hard to make a change in one part of the healthcare system, lose money there, and subsidize it with the savings from some place else. Whether it has been what we've seen in HMOs, whether it's Montefiore, whether it's what's happening out in Colorado there are constraints by antitrust where you have the health systems siloed. You can take changes. You could make changes. They would benefit both the system and the payer and the provider, but you just can't move the money around from one pocket to another legally.

Fifth point I would make is that I would underline what Greg said about physicians treating patients alike based on medical condition not on payer. A number of years ago there was a lot of work saying if we told physicians what different payers pay us would they change their behavior. The answer is clearly not very much, if any. You can put a note in the electronic medical record if you want that says this is a Medicare patient or a Medicaid patient. It doesn't change physician behavior very much.

If you want to change behavior what people have found is you take for a diabetic patient and you put in there, remember to check this patient's feet, or ask this patient if she or he has had an ophthalmology visit in the past year or certain kinds of lab work. That the physician will respond to, but if you think that simply telling the physician we get paid more or less for this patient and therefore you can do more or less for them, that doesn't have a very good track record.

Sixth, labels on payment sometimes have unintended consequences. In the Medicare system, one of the labels is the indirect medical education adjustment. That has lead to lots of within institution tension. That is, because the last two words are medical education the medical education component of the institution may feel that that money should be theirs. Then if you look at the history of where that came from it was

really a very statistically-based adjustment trying to make sure that teaching and non-teaching hospitals had relatively similar cost to income ratios. As payers have looked at things they have found that don't put so many labels on things or make so many separate buckets to the institution because you can set in place an unintended consequence where a clinical service or a service line or a function like education believes those monies are theirs and yet they were designed to be bundled.

Seventh point I would make is about bundling. There's a lot of attention in this town, and there's some good work on the left-hand side of your folder today about bundling and aggregated payment. I would remind you that you can bundle at one tier, but what happens at the tiers below the bundle may or may not depending upon the decisions made by the entity that receives the bundle may or may not meet what you're trying to do. You create a bundle. You pay, say the hospital institution or another entity, and say we want you to have a certain set of incentives. They may still distribute the money on a fee-for-service basis to the various pieces of the delivery system. If they do that may undermine some of what you sought to accomplish by paying in a bundled way.

Lastly, just one point to make that I hope you take away from listening to the three that preceded me. Communities and health systems differ. They differ by their history and

they differ by their characteristics. Particularly as we sit in a room in a legislative building, this building wants to provide equal treatment under the law. At least that's what we say in this building. That gets very hard sometimes to reconcile with the fact that there are different traditions, different history, different opportunities in a given community than in another.

I think one of the challenges, whether it's commercial payer, a state-based Medicaid program, the Medicare program is they're often trying to take one template and apply it across the entire community. One of the things I would underline to make sure you understood from John is when he talked about the Maryland Cost Review System it looks at each of the hospitals individually. It makes some adjustments for that. I remember when Hal Cohen, who was the original staff director of the commission, was kind of chastised for a hospital that was build in Easton on the eastern shore. It was an all electric hospital in the era when people thought that nuclear power was going to make electric energy very cheap. That isn't what happened. It turned out to be a fairly expensive hospital, in terms of its energy costs at least.

On that basis the commission made a decision about that hospital and its history and its characteristic. While the logic could apply to other hospitals, but because you paid one

hospital or recognized its cost didn't apply to others. In that sense I'm not championing the Maryland system, although I've lived under it for the 40 years John described, but you have to be able in the payment system somehow to adapt and understand the kinds of things that have happened in Colorado in Greg's organization. Work in that setting has worked across time, reflect the history. I hope we would all remember that as we go forward. There is, in my opinion, no single magic cookie cutter.

EDWARD F. HOWARD: Okay. Thank you, Jim. We've got to the point where we want to hear from you. You have the opportunity to ask questions on cards that are in your kits. There are microphones that you can use to ask your questions orally. I wanted to just remind you that, Jim made a reference to the materials in the kits, they are extensive. They are duplicated electronically on our website allhealth.org.

You can follow-up if you need to with those, including the presentations that you've seen on PowerPoint slides. There are biographic notes much more extensive than we were able to give to our speakers in the information. They'll be a webcast available of this briefing on Monday through the courtesy of the Kaiser Family Foundation. Thanks very much to them. You can look at their website on KFF.org and find that webcast. Transcript will be available in a few days on the Alliance

website as well. Finally, as we go to the Q&A session we'd ask you if you would to fill out the blue evaluation form to help us plan these sessions and improve them for you in the future.

Before we go to the microphones I just wanted to make sure that our expert co-moderator might not be able to get started with a question that has arisen as a result of the presentation. Stu?

STUART GUTERMAN: Thanks, Ed. I had a question for each one of the panelists. I can maybe start that off and maybe we can get to the questions for those who have stepped up to the microphone, and then kind of work the answers in as we go along. For Steve, I wanted to ask, you do capitated rates and you have a number of different payers flowing into your system. I presume they don't all pay the same amount to you. How do you deal with that? Jim has stated that kind of money is fungible and that certainly appears to be true on one level. How does it affect how you deal with each of the payers and how you decide how to pool the money together to provide services to your patients?

STEVEN M. SAFYER, MD: I thought Jim said it very well. I'll give you my version. We don't have Medicaid nurses or uninsured doctors; doctors that take care of uninsured or ancillary people that work on the commercial patients. In the end, in the 1,500 beds, 100,000 discharges, and 3.5 million

visits it's an effort that is, for the practitioners, one that is opaque. They just see a patient and they take care of their patient. By the way, nurses and doctors and professionals like it that way. I forgot who mentioned this but I think it's important to delineate this. I agree that in general the noble mission of the practitioners is preeminent. The reality is that if you're in a system where you're tasked to see patients that pay better you do notice whether or not somebody is commercial, Medicare, or Medicaid. Many faculty practices across the country, you basically make what you earn. The system is not opaque in the majority of the places.

In our system it is. A patient is a patient. Obviously if we didn't have a margin at the end of the day we couldn't invest in ourselves and we couldn't underwrite what we lose money at. In fact, most things at Montefiore with an 80-percent governmental payer mix lose money. Medicaid loses money. Medicare at best breaks even. We make money on commercial.

Another way to slice it is on the capitated business there is a margin, but it took a while and time and effort to be able to generate a margin. Our margin overall on a three billion dollars last year was 2.5-percent. The average academic medical center in this country is generating 7, 8, or 9-percent; the big names. I guess in the end there's a panoply

of payers. Underneath it the economics are important and compelling. We have to pay attention to that.

The last time I checked, I don't have a lot of leverage with Medicaid or Medicare. I'm a regulated utility from that point of view. I do have leverage with the commercial insurance. Before someone asks me this, 20-percent of the activity which is commercial, generates one-third of the revenue. Obviously the commercial insurance either capitated and/or fee-for-service where it's fee-for-service is a payer that is underwriting the loses elsewhere.

EDWARD F. HOWARD: Greg, do you want to add to that? We'd ask the folks who are asking questions orally to identify themselves and be as brief as you can.

BARBARA TOMAR: Hi. I'm Barbara Tomar from the College of Emergency Physicians. This has been really enlightening. I've learned a lot about each of the systems that it was very interesting detail, even in Maryland where I've lived along with Jim Bentley for years. I'm curious for each of you how you think all things being equal and health reform goes forward the influx of several 16 million new Medicaid patients, subsidization of other folks in the private sector, and a huge pressure on commercial payers to start lowering their own payments so that people have affordable health care is going to affect your current operations.

GREGORY REICKS, DO: It's interesting. You have the influx of Medicaid new enrollees in our market has already had a dramatic impact on our model, and we've had to change the model because of that. I think as we move forward we're going to be looking at, particularly with Medicaid, a different model. In fact, it was kind of interesting. You made the comment about how governmental agencies are sometimes wanting to find one solution for every market. We actually met with Medicaid just last week, our IPA. We proposed a capitated model. We went to them and said we'd like to be paid on a capitated model for Medicaid members. They said, "We can't." We said, why not. They said, "Because the rest of the state doesn't want to do that." I think that from our perspective it is going to put a significant strain on our current financial model. Hopefully the Medicaid for one will respond with a better system.

The other thing that we're learning is what we're trying to do in our market in terms of primary care services, we understand that with this influx of newly insured people as well as Medicaid there's going to be some access issues, particularly for primary care. What we're doing in our Beacon program is we're trying to teach our primary care physicians a different way to practice in terms of team-based care, using electronic tools to deliver services so that they can actually

expand their panels because we realize you just can't create primary care physicians out of thin air. There's not a tremendous number in the pipeline.

That's our model is really trying to change the way that primary care physicians deliver care so that maybe they can manage a bigger panel.

STEVEN M. SAFYER, MD: Just a quick comment. All health care is local. It cannot be more dramatic in terms of the ACA and what it will accomplish. Background; 2007 to now we have lost 5-percent of commercial insurance with a direct switch to Medicaid. People lost their jobs. They had insurance. They understood insurance. Then they got in the Medicaid roles. That's a cut of another name; significant one.

In terms of going forward, unfortunately, and I said this earlier, because of the lack of immigration reform in the country there's not a very big upside. New York, as everyone in this room knows, has a very liberal Medicaid system. There are seven million of the 25 million that live in New York are on the Medicaid roles. There is very few. I think it's adult men without children will get insured under the Medicaid program. The last time I checked in the Bronx they're not coming in to get insured.

I'm concerned. Much of our commercial insurance will probably be switched to the exchange, which will be an

additional cut. There is very little upside. That's why the issue of, somebody's going to ask it, disproportionate share is huge going forward because of the way we're paying as a hospital industry for healthcare reform.

JOHN M. COLMERS: I can say from both my hat as the commission chair and wearing my hat from Hopkins, whatever problems I identify are problems I'd be very happy to live with given what the current status is, and having waited my entire career to get us to the point where we have moved towards expansion of coverage. For us in Maryland, because of the payment structure, the movement from one payer to the other, at least on the hospital side, is not as significant. We will continue to have roughly half of our uninsured remain uninsured and will continue to be that way in large measure because of their immigration status. I would agree with Steve that that is going to remain a significant issue and certainly would agree with the points with respect to physician supply.

All of this, independent of whether health reform, whether the Affordable Care Act is upheld, whether or not the president is reelected, I think these are in inexorable changes that we're going to have to confront nevertheless. I think the payments systems are changing dramatically regardless. The pressures that are going to be placed on us because of budget decisions are going to have to be made with respect to Medicare

and Medicaid, and the impact that commercial insurers are going to have. It is forcing us all on the providers' side to fundamentally reexamine the way in which we are delivering care.

Those are problems I think we ought to be prepared to live with. It's certainly a guarantee of employment.

EDWARD F. HOWARD: Yes? Go ahead.

CAROLINE POPLIN, MD: I'm Dr. Caroline Poplin. I'm a primary care physician. My question is to the gentleman from Hopkins, from Maryland, which is where I live also. The impact on payers; have you noticed or can you measure any way that the savings from the transaction costs that ensue when every payer has to make a different arrangement with every hospital? There are the transaction costs in doing it. Then it introduces a certain element of irrationality in the system. It's very hard to compare on hospital to another. If you're a patient there are restrictions on which hospital you can go to because your Blue Cross Blue Shield has a deal with this one but not a deal with that one. Taking that element out should make this system better.

JOHN M. COLMERS: I think there are people who would argue that that is part of the basis for how we've been able to beat the cost increases over the years is to make a more rational system. That doesn't mean that our payment system

doesn't have its own share of irrationality built into it still. It remains to a large extent a fee-for-service system. I think that the steps that we would like to see the system evolve to is one that moves away from fee-for-service. The way we've described it in the past has been because hospitals don't have to negotiate payer by payer by payer they can spend their time not so much on the revenue side of an income statement but on the cost side of the income statement to become more efficient.

CAROLINE POPLIN, MD: Thank you.

EDWARD F. HOWARD: Mike, are you at the microphone or just standing there? It's a question for I guess Greg and Steve both. How do you handle behavioral health integrating it or not into your systems? How are you measuring the impact of behavioral health, either the causes or the outcomes?

GREGORY REICKS, DO: I wish it was more integrated. In our market right now in Colorado there's a behavioral health organization that's actually a carve out for Medicaid. Behavioral health is really handled almost in a different system in Colorado and under a capitated model. That's for Medicaid. Obviously for Medicare and commercial populations most of the behavioral health care that's delivered in our market is delivered by primary care physicians because we're woefully under served by psychiatry and other mental health

professionals like I suspect most of the rest of the country is.

Our goal is eventually to bring that behavioral health organization into a risk arrangement with us for all those three lines of business like we talked about.

STEVEN M. SAFYER, MD: It's a very important question. A couple of things. I neglected to mention that we have a behavioral health organization that takes risk, which has 125,000 lives; plays a significant role in concert with the care management organization for managing our capitated business. That being said, the big challenges ahead in the urban city I believe are in the dual eligibles and the previously exempt Medicaid patients from managed care programs, especially in a state like New York.

As an example I told you there's seven million Medicaid recipients in New York State. One million of them are outside of the managed care programs. The rest are in managed care one sort or another. The majority has been nonprofit PHSPs, but there is tremendous interest from the for-profit insurance companies, low and behold, because of the incredible amount of revenue that exists in the exempt patients. There are 700,000 dual eligibles in New York State. 70,000 reside in the Bronx. The overall spend in the Bronx is 15 billion dollars. If you

take Medicaid and Medicare spend on the 70,000 it approaches four billion.

The for-profit companies are keenly interested because there's a revenue stream that they can take out of the mix. We are determined to bring them to us in a capitated model because again we believe that that's the best way to integrate the care. In the end they're the most dramatic and integrate the Medicare and the Medicaid because their Medicaid in the nursing home and Medicare in the hospital, which makes no sense, which I've been talking to Stu about since he was at CMS. I've made many proposals. Those are just two parts of a large agency I guess. Maybe somebody is here from CMS.

If you look at our Pioneer or you look at our other capitated business or you look at our fee-for-service business mental health issues and/or substance abuse are huge and play a gigantic role in the very expensive patients. They are a significant challenge for us going forward. We need to grapple with it.

EDWARD F. HOWARD: Go ahead.

TATE HEUER: Tate Heuer with Senator Pryor. I have a question for Steve and Greg.

EDWARD F. HOWARD: Would you get closer to the microphone?

TATE HEUER: Tay Hure with Senator Pryor's office and a question for Steve and Greg. One of the issues that I hear from providers in our state about our fragmented payment model is with the different private payers out there the amount of time that goes into things like utilization review and filling out forms and getting approval for procedures, and having really a different approach and a different set of forms that goes with each payer. As you move to a more integrated setting and bundled payments, capitated payments, that type of thing do you move towards your organization doing more of that and dealing less with the private payer in terms of doing that? Would you say more of your resources go toward providing care and less in administrative expense? Or is really that discussion all separate and apart from the one we're having today? Thank you.

STEVEN M. SAFYER, MD: Just very quickly. Something John said earlier caught my attention. I can't tell you how many people literally work for me that are dealing with the commercial payers to fight over the revenue. That's basically what it is. It's a very civil system and I admire it.

I also have of the 18,000 employees easily 600 individuals that spend all their time trying to get paid for what we've done, whether it's capitated and/or fee-for-service because there's always a tug-of-war. There's a tough of war

with the governmental payers and a tug-of-war with the commercial payers. As far as I'm concerned I'd like to convert them to caregivers. I'd like to hire 600 social workers to take care of the mentally ill that we were just talking about. I think that's a huge waste.

I can't neglect to mention medical malpractice, which appears nowhere in any of the reform that we've seen coming down the pike. Montefiore's medical malpractice despite outstanding results across the board by all kinds of measures and awards was 120 million dollars this year. That is, I could double the bottom line with tort reform.

In the end what you have now, when I move towards the capitated model I can create for the most part my own standards and the noise kind of gets more refined. I can tell you that the hardest part with the commercial payers that I'm trying to convert into shared savings and/or capitated, the ones that remain outside, has been to get them to all do the same thing. I'd like them to do the Pioneer because I'd have to hire 50 people to just report out on the important things I think we need to report out. We need to, I think, harmonize and across the board create the same quality and cost standards so that the system can do what it should do, but do it less expensively.

EDWARD F. HOWARD: We've got a question that we'll maybe start with John Colmers because we've got a second piece of it that comes in another question. The way it's asked is, is not Montefiore ACO model the only one of the three presented today that's scalable through a national level. John, the twist on that is why is it that the states besides Maryland that had all-payer systems don't have it anymore? Do you have anybody coming around to you saying that's a great idea, can we learn how we might replicate it?

JOHN M. COLMERS: I tried to describe why Maryland did it. I think there's pretty good case studies on why New York, New Jersey, and Massachusetts gave it up. It was in large measure because the hospitals there thought they could make more money under Medicare PPS than they could under their system that they were operating under. They gave it up. I think those systems also were far more complicated than Maryland or far more prescriptive, particularly in the statutory authority.

I would agree with the question. This is not a system in Maryland that is scalable nationally. We have never proselytized and tried to suggest that other states should try it. What I do think states should do and jurisdictions should do too is to figure it out on their own and broad waiver authority and broad demonstration authority by CMS to allow for

all-payer and multi-payer models I think is in fact scalable and something that ought to be tried and done in different jurisdictions.

The point that Steve just made about wanting to have a common set of rules across payers for an ACO-like model is precisely the type of work that we are trying to develop in Maryland to apply it not just to Medicare but the other payers so that ACOs and medical homes and bundle payment can occur under a common set of rules so we can focus our attention on actually delivering care and less on the administrative differences that exist on the margins.

EDWARD F. HOWARD: Steve and Greg, do you agree with the premise of the question?

STEVEN M. SAFYER, MD: I think that you've really heard two different models here. The Montefiore model I think has certainly a lot of merit. The problem is that a lot of health care in our country is not delivered in areas where you have a Montefiore. A lot of it is delivered in communities where you have maybe one hospital, a few hundred providers or less. What kind of system will work in that type of market? When I go around and talk to physicians there's still a lot of physicians, surprisingly in this country, who don't want to be employees of health systems. They want to remain independent. We're seeing a little bit of a resurgence in the IPA model

where potentially physicians can come together in some sort of entity and begin to become more integrated and start to share some risk with payers.

As we've talked before, I think our model is scalable. It's just a much smaller scale.

GREGORY REICKS, DO: Comment on New York and Nifrim [misspelled?], which was the all-payer system for 18 years in New York State at Sunset and 95. I agree with what John said. I would add though that it left hospitals in New York across the board capital served because the rates were set at expense. Kind of a funny system; the more you spent the more you got. It was just at expense. It didn't take into account capital needs.

I think this is a truly terrific model. I'm flattered by the question about Montefiore, but I do not believe it's actually a model that is reproducible in every part of the country, especially because of Greg's comments. I think there really are different settings. I do believe that over time, and beyond the time that I'm in the position I'm in, there will be a single payer in this country. They just won't call it a single payer because it's America and it will seem socialistic. There'll be a system that is essentially single payer.

The Maryland system is essentially single payer the way I understand it. It's just a single payer in the sense that

France is some ways a single payer. It's private insurance and private provider, but there are rules of the road. When I get back to New York I'll be on a highway that's crowded. I was going to say, even in the Bronx, for the most part people stop for red lights and go on green; for the most part. I'm not sure about Gypsy cabdrivers.

Rules of the road make sense. By the way, the roads were built by the state and federal government. What we don't have in this country are rules for the road that create standards across the board and normalize how we're paying for health care, and that's why we have the system we have. The left and the right are unhappy with it no matter what they say.

EDWARD F. HOWARD: Jim?

JIM BENTLEY: I'd make a couple of observations as a Maryland resident that I think Maryland did some things right and had some things fortunate. One, the commission you will recall John said has seven members. I think that has been a strength because most of the people who have been commissioners don't wear a single hat. They may be on the board of something and a CEO of a hospital or involved in an NGO and this, that, and the other thing. They've come to the table in a small enough group that they've had to weigh all their interests rather than saying I'm here simply as the out state hospital person or the Baltimore City Hospital person or whatever.

The second thing I think they've benefited from is just a fabulous leadership. John may not want to say this, but whether it's Al Cohen or John or Gram or anybody who's been there as the executive director, they have really been very, very thoughtful and very, very realistic. I think part of that realism is a third thing. There are John, what 53 to 55 hospitals under the—

JOHN M. COLMERS: Forty six.

JIM BENTLEY: Forty six. You can't take that model, in my opinion, to Texas or California, New York, or some other states. There has been an advantage, and they were able to start by looking at each, individual hospital and setting its own rates for that hospital. I would not be surprised if we got where Steve just said, a single payer with some set of characteristics, though we won't call it that. I think doing that is going to be harder in many other states than it would be in a state like Maryland.

Emily Jones: Hi. I'm Emily Jones from the Bureau of Primary Healthcare in the Health Resources and Services Administration. This is a question for Steve. Congratulations on getting into the Pioneer ACO program. I think a few of your ambulatory centers are federally qualified health centers. I'd be curious to hear about the role of the section 330 funding in what you're able to do and any restrictions on that funding

that you'd like to tell me about, how HRSA can better support you in all the great work you're doing.

STEVEN M. SAFYER, MD: We have in on our way to hopefully 15 FQHCs. Some of them are the oldest in the country. They are very, very important because they give us, in poor communities, the ability to provide wrap around services that would not be available without that extra support, especially for pregnant women and a number of the other health and social needs of the patient. It's absolutely a terrific program.

340B, we should have expanded it and multiple purposed it in healthcare reform in my opinion. It would have nothing to do with mandates or severability. I think it's a terrific program that we need to work together on in expanding. I'll give you a very important thought. With 18,000 employees I'd like to be able to purchase their medicines through the 34B program because I think it would make a significant dent. There's probably 60 or 70,000 dependents all in for those employees that live in the Bronx. The program would be a very effective and important program.

There were a couple of other areas like in the hospital proper where I'm not able to buy in that program. It would be very good. Thank you. I was a National Health Service Core

Scholar recipient and HRSA designated where I worked. I appreciate what you did.

EDWARD F. HOWARD: We have one more question I think we have time for. It's directed to Dr. Reicks. What are the advantages, the questioner asks, of an IPA serving as the lead organization in forming an ACO versus a hospital system?

GREGORY REICKS, DO: What we've discovered in our organization is that physician-driven, physician-lead efforts seem to gain much more traction than efforts that have been promoted by our hospitals or our payer. For us, I think having physicians in our organization who serve on all our committees, our physician-lead physician committees. We invest a lot of resources in our physician committees. We feel that that's been a key component to the success that we've had. The physicians who design our quality programs, the physicians who design our efficiency programs, they all either benefit or not from being part of those programs.

I think that just having that type of physician involvement is key to our success.

EDWARD F. HOWARD: If anybody has any 15 second final comments we have time to entertain them. Thank you is a good way of starting because I have several of those up my sleeve if you will. Thanks to the Commonwealth Fund for the excellent participation and the shaping and the co-sponsorship of this

briefing. Thanks to you for asking good questions. Remember, you can check out the webcast on Monday. The transcript is probably at the end of the week or early the following week. Commonwealth is going to be doing a blog post on commonwealth.org. Is it commonwealth or commonwealthfund.org? Commonwealthfund.org.

I'd ask you to A, fill out those blue evaluation forms if you haven't and pass them in if you have. B, join me in thanking our panel for taking a great shot at a tough, tough topic. [Applause].

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