Healthcare 3 (2015) 177–178

Contents lists available at ScienceDirect

Healthcare

journal homepage: www.elsevier.com/locate/hjdsi

Interview

Interview with Farzad Mostashari, MD, MPH

Jordan Douglas Anderson

Harvard Medical School, 25 Shattuck Street, Boston, MA 02115, United States

Dr. Farzad Mostashari currently works as the CEO and Founder of Aledade Health, a start-up created in 2014 focused on providing accountable care solutions to small independent primary care providers. Prior to starting Aledade Health, Dr. Mostashari served as a Visiting Fellow at the Brookings Institution and from 2011 to 2013 served as the National Coordinator for Health Information Technology where he coordinated efforts to build a health information technology infrastructure to accommodate changes in health reform. Before that, Dr. Mostashari also worked in the New York City Department of Health and Mental Hygiene as Assistant Commissioner. Dr. Mostashari is a graduate of Yale Medical School and trained at the Massachusetts General Hospital in internal medicine.

Jordan Anderson: *You are the CEO and Founder of Aledade. What influenced you to offer an accountable care solution to small independent providers?*

Farzad Mostashari: Throughout my career I've been searching for a way to bring together population health and healthcare. What I have learned is that you need all the pieces to come together. You need a business case for population health, you need tools and technology to understand your population, you need practice transformation, and you need the non-flashy work of changing workflows and changing culture at the ground level. That is the mission for Aledade: to go to the primary care providers – the quarterbacks – who are best-suited for population health management and to give them everything they need to make population health worthwhile.

JA: *As you are growing the company, how do you evaluate different markets? What makes for a good accountable care market?*

FM: Most importantly, there has to be a supply of independent primary care practitioners who plan to stay independent. More logistical factors include the availability of admission, discharge, and transfer notifications. This information is available in states like Delaware, Maryland, and New York, and it makes it so much easier for the primary care providers to be aware of what's happening with their patients. Many of the considerations regarding different markets have to do with the current regulations. It is harder to do well in a state that is already very judicious in terms of health care costs. We are not exclusively focusing on higher costs areas, but it is harder to compete in a shared savings model in Minnesota compared to Florida

JA: *As I understand the model, you are not including hospitals as participants in the ACOs. Is that correct?*

FM: That is correct and why that matters is that we really want to focus on the mission of the ACO – to do everything we can to lower costs. As the ACO focuses on it's core mission, hospitals stand to lose revenue from reductions in admissions as well as potentially unnecessary procedures and diagnostic imaging. This creates a real tension. Either hospitals will not be wholeheartedly enthusiastic in reducing admissions or they will try to shore up referrals to their high cost, high margin lines of business, neither of which would be in line with our priorities. While I was studying ACOs at the Brookings Institute, I was initially surprised that hospital-led ACOs were not nearly as successful as the scrappy physician-led ACOs. I think that it was in part due to these conflicted positions.

That being said, it's absolutely critical for primary care led ACOs to work with all other parts of the healthcare system that touch the patient. They need to partner with long-term care, home health providers, specialists, as well as with hospitals. Hospitals serve an essential function, but there is a difference between having partnerships and having a governing role. Where I think we are in good alignment with hospitals is on readmissions, since every hospital is actively focused on reducing readmissions.

But our work in Maryland has been very interesting in looking to the future. Maryland has a Medicare payment waiver that has allowed them to shift hospital revenue to global budget payments. Through this mechanism, hospitals have been provided an additional positive incentive to reduce admissions. This flips the polarity of incentive for the hospital in such a way that they really want to reduce admissions, and the opportunities for collaboration there are really great.

JA: *Shifting to the macro level – how do you see the national accountable care landscape evolving over the next decade?*

FM: Recently the Secretary of Health and Human Services announced that Medicare is setting a goal of making more than half of Medicare payments "value-based." I would expect this change in payments to help maintain the current momentum in ACO formation. To achieve this goal, Medicare and private payers must make alternative payment programs attractive for providers.

But there is also a larger question – what is the ultimate destination for these organizations? Will these organizations eventually transition out of accountable care and into full capitation, or just settle somewhere between fee-for-service and global capitation. I don't think we have a good handle on what the ultimate structure will look like yet. Currently, the methodology that CMS has implemented in the Medicare Shared Savings Program to set historical benchmarks and calculate shared savings has created a

E-mail address: jordan_anderson@hms.harvard.edu

http://dx.doi.org/10.1016/j.hjdsi.2015.04.006

difficult environment for ACOs to sustain long-term savings.

JA:*Medicare is in the process of revising the regulations for the Medicare Shared Savings Program. What are the most important changes you would like to see?*

FM: There are a couple things that I think would be key changes. The first is the benchmark. The current methodology of the Medicare Shared Savings Program does not accommodate the long-term sustainability of ACOs, because you are always trying to improve upon your previous year's performance, which will eventually have diminishing returns. A more sustainable model would be to change an ACO's benchmark to include regional comparators, rather than simply being a historical benchmark. The second is a move to make accountability more attractive to physicians. The current two-sided model isn't sufficient, it will be important for Medicare to create more opportunity for ACOs to gain from the increased accountability they are taking for these patients. The third change is around attribution; both the retrospective [attributing patients based on previous visits] and prospective [attributing patients based on expected visits] approaches to attribution are flawed. I would recommend that they combine the good features of both to create a single stable model where an ACO knows who their patients are in advance, but they are not responsible for patients who stop seeing a network physician. Ultimately this preserves the patient's choice and allows patients to opt-out if they would like.

JA: *One final question. You transitioned from over a decade of public service to being an entrepreneur. What have been your biggest challenges and greatest learnings?*

FM: Starting Aledade has been a lot easier than running a federal agency – so that has been a pleasant surprise! The challenge for any entrepreneur is to understand what the future possibilities are. You have to build your company in a way that will work now, but also when you are 10× or 20× your current size. You must build your team and your product and your strategy in a way that can scale. I think that is the most interesting challenge for a start-up with big ambitions.

Conflict of interest disclosure statement

This statement accompanies the article "ACO Model Should Encourage Efficient Care Delivery, co-authored by John Toussaint, MD (Corresponding Author); Co-authors: David Krueger, MD, MS, MBA; Bellin-ThedaCare Healthcare Partners, Stephen M. Shortell, PhD, MPH, MBA; US Berkeley School of Clinical Excellence Research Center, Arnold Milstein, MD; Stanford, Stanford Clinical Excellence Research Center; MPH, David M. Cutler PhD; Harvard University, Department of Economics, Harvard University, and NBER; Stanford, Stanford Clinical Excellence Research Center and submitted to Healthcare as an original article. Below all authors have disclosed relevant commercial associations that might pose a conflict of interest (if none, please write None):

Consultant arrangements: None

Stock/other equity ownership: None

Patent licensing arrangements: None

Grants/research support: None

Employment:David Krueger, MD, MS, MBA; receives a salary from Bellin-ThedaCare Healthcare Partners.

Speakers' bureau: None

Expert witness: None