Keynote Speech (As Prepared for Delivery)
U.S. Senator Ron Wyden
National Accountable Care Organization Summit
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Thank you for the opportunity to open this Accountable Care Organization summit. Being asked to comment on the issues and possibilities surrounding Accountable Care Organizations by Dr. Elliott Fisher and Dr. Mark McClellan means having the chance to run with the right crowd.

This audience has decades of experience and a passion for health reform, so this morning I'd like to put before you what I believe is the premier challenge for America's premier health program. Of course, that program is Medicare.

Notwithstanding the recent bit of good news from the Medicare Trustees, Medicare faces unsustainably high costs because the program has never been about what most drives costs - chronic disease. Seniors entering the Medicare program today are sicker than when their parents enrolled, with more cancer, more heart disease, and more diabetes. Unfortunately, too few policy makers and health providers have recognized this fact, and that needs to change. That covers just about everybody in my profession and most people in yours.

Currently, about 70% of Medicare patients have two or more chronic health conditions and account for more than 90% of Medicare spending, or almost $500 billion a year. Yet when chronic care even gets a rare mention with policy makers in Washington, it is usually dismissed with a "we've got to improve care coordination" and everybody nods and moves on. Similarly, conversations with providers rarely seem to move beyond reimbursement.

The Medicare guarantee is a godsend and lifeline for millions of older and disabled Americans. Improving quality and controlling spiraling costs for the chronically ill deserves a more thoughtful response than the health care equivalent of "whatever."

I'll start by describing our chronic care challenges through the experiences of a fictional heroine, Mrs. Jones. While fictional, Mrs. Jones is quite typical of senior Medicare patients today. She illustrates the urgent need to refocus the program on chronic care.

Let's say Mrs. Jones turns 65 and isn't feeling so hot. She hasn't been to the doctor in a while, and wants to find someone who specializes in treating seniors. Unfortunately, there are no geriatric practitioners available in her area. But after considerable hassle she finds a family physician willing to see new Medicare patients.

Mrs. Jones goes to her "Welcome to Medicare" visit, and her physician finds evidence of three chronic conditions - Type 2 diabetes, chronic obstructive pulmonary disease and heart disease. The family doctor refers Mrs. Jones to a cardiologist and pulmonologist for further examination and tests, and also recommends visiting a nutritionist to review her diet and exercise regime.

Medicare fully covers Mrs. Jones first doctor's visit thanks to the Affordable Care Act. Unfortunately, that's her last real break. Her specialist visits will require a 20% co-pay after she

reaches her Part B deductible. She'll also have co-pays for any new prescriptions or tests. While Medicare covers "nutrition therapy," she decides she can manage her diet on her own and doesn't go to the nutritionist.

Despite her efforts at self-treatment, the diabetes gets worse. Since the family doctor referred Mrs. Jones to specialists outside his group practice, the fact that Mrs. Jones skipped the specialists' visits was not reported to the family doctor.

Soon after, Mrs. Jones forgets to take her insulin and she ends up at the emergency room. She gets admitted to the hospital because of the risk factors associated with her worsening diabetes. She's stabilized, told to keep up her insulin regimen, and sent home with a bill for the inpatient hospital deductible - $1,184 to be exact.

At this point, Mrs. Jones can't remember the name of her family doctor, or provides the wrong name, so the hospital does not know where to turn in describing Mrs. Jones' condition to the appropriate physician.

Now many of you in the audience may be thinking, "Yep, I know patients like Mrs. Jones. That's why the health care law was passed - to help people like her. In the future, Mrs. Jones will be assisted by ACOs, group practices and health plans in the Medicare Shared Savings program and other demonstration projects."

All those thoughts have some validity. Unfortunately, here's why the challenges facing the hypothetical Mrs. Jones are going to remain the norm, rather than the exception, without further reform.

Our first hurdle is the attribution rule for ACOs in the Affordable Care Act. Under this well-meaning rule, ACOs must serve everyone coming through the door. This rule exists because there has been a legitimate fear that too many providers want to shed risk and avoid the sickest patients.

However, the unintended consequences of attribution for improved chronic care are significant. In its present form, the attribution rule limits ACOs that want to specialize in chronic care from reaching out to the sickest seniors and providing them with the highest-quality, integrated, affordable chronic care services.

The second issue is the current gap between where ACOs are now, and where the largest number of sick seniors live. For example, the evidence shows ACOs are not being set up in Alabama, where there are a lot of seniors in very poor health. But there are going to be plenty of ACOs in Massachusetts, where the seniors have the good fortune of being some of the healthiest in the country.

Massachusetts and Alabama have roughly the same percentage of people on Medicare. Massachusetts spends more than the national average on Medicare while Alabama spends less. Healthy seniors in Massachusetts can access six Medicare ACOs, and more vulnerable seniors in Alabama have none.

Third, even if you are a senior in an ACO, you may not be lucky enough to have an individual care plan, which is the centerpiece of top-quality, coordinated chronic care. This is because the current ACO rule is ambiguous about who is entitled to an individual chronic care plan. The rule says that "high-risk" individuals have to have a plan, but who knows whether Mrs. Jones is going meet that threshold. Even if Mrs. Jones could find an ACO in her area, improbable since she had trouble even finding a doctor, it's unlikely she would have received an individual care plan because her physician didn't consider her chronic conditions high risk.

Fourth, ACOs are barred from creating incentives, or better health rewards, that encourage seniors to be as healthy as possible. Mrs. Jones' doctor saw that she had diabetes, but had no way to encourage her to go for a retina scan or to see a nutritionist. For some people, these may seem like small things. But they often have a huge impact for people like Mrs. Jones, and it can mean much lower costs in the long run. The Cleveland Clinic and the Oregon Health Sciences Center have helped Senator Portman and I pursue bipartisan alternatives along these lines.

There are places to look for answers.

One of the presenters for this conference, Dr. Ken Coburn of Health Quality Partners in Doylestown, Pennsylvania, is succeeding in promoting quality chronic care for the elderly. Health Quality Partners was created more than a decade ago as a demonstration project.

From the beginning, Dr. Coburn and his team at HQP have sought out some of the sickest seniors. These patients are treated using a thoughtful list of interventions tailored to their individual needs.

The results have been a clear success - hospitalizations reduced by 39%; net health care costs cut by 28%; and, overall mortality reduced by over 25%. Unfortunately, our government has not given Dr. Coburn the green light to expand and tap the program's full potential. For example, the government has limited his ability to grow the program on the ground that it's just a demonstration project. It seems to me, the whole point of demonstrations is to let the successful efforts grow and serve more people.

What Dr. Coburn has been able to do doesn't happen by osmosis. It's about active engagement; active management; and, active care coordination from both the provider and the patient. As he would tell you, this has required an intense and impressive system of protocols, standards, training, advanced analytics and the list goes on. It's also meant doing something really innovative - seeing patients at home.

The current system remains mired in the assumption that patients need to do what they've always done - go to the doctor's office. That ignores the fact that it's very difficult for many patients to get to their doctor whether they live in a city or a rural area.

Now, another system, Montefiore in the Bronx, demonstrates why Dr. Coburn's principles of care management are important no matter where you live. Montefiore doctors understand the challenges their Medicare patients face because they visit them in their homes at the top of old,

seven-story buildings without elevators. Access isn't just a problem for people living in rural area.

A third promising approach is used by Providence Health and Services, which operates in my home state of Oregon and four other western states. Providence functions as both a provider and a Medicare Advantage plan. Even in my low-cost state of Oregon, they are successfully managing the needs of chronically ill seniors by working closely with their patients, and by rewarding physicians who deliver results.

These patients are less likely to be hospitalized than those in traditional Medicare, and they are getting better treatment at a lower cost – which is really something in a low-cost state like mine. Why shouldn't people in Alabama have access to what Oregon has? The Medicare guarantee should not depend on where you live.

Because many think the Pacific Northwest is unique, I asked Dr. Jack Wennberg, the amazing and pioneering researcher from Dartmouth, to examine the latest Medicare data from across the country. He looked at high-quality, high-performing systems that treat patients with the most intense needs in high- and low- cost states.

As usual, he did some great work, and found that chronically ill patients can be treated at lower costs all around the country. In fact, the evidence shows high-performing systems spent 13 to 24 percent less than the state averages for patients with the same needs. Those are huge savings.

Here's my take on how they are doing it. First, high-performing systems are successfully identifying high-need patients during their first visit. This allows them to implement a coordinated chronic care plan early, and, as a result, they keep more patients out of the hospital. They have a different approach. Patients are cared for differently, and that's what Medicare should be all about.

Washington has been stuck for ages in tired, circular Medicare debates about increasing premiums on the wealthy and raising the age of eligibility. Those are important issues. They do not, however, reform the health care delivery system for the sickest seniors. That ought to be a priority for the days ahead. Fortunately, this room is full of people who care about Medicare and the millions of seniors who rely on it.

To recap, here are several solutions to the challenges described this morning:

One, the attribution rule needs to be changed to allow providers to specialize in chronic care. Our objective should be to make the adverse selection issue disappear, by creating specific consumer protections for seniors in plans that specialize in senior chronic care, while fully retaining the current protections against discrimination for all other seniors under current law.

Two, Medicare should guarantee high-quality, coordinated care to chronically ill seniors throughout the country. Medicare reimbursement should be reconfigured to target areas with the highest incidence of chronic illness, and reward practitioners, in those areas, who improve care and hold down costs.

Three, individual care plans need to be the rule, rather than the exception, for seniors with more than one chronic condition.

And four, incentives should be available to help keep seniors as healthy as possible.

These solutions are within our grasp, and, I hope, this will be considered the beginning of a new debate.

I know that I've given you a lot to chew on. Over the coming months, I intend to work with colleagues from both political parties to turn these proposals into legislation. These ideas will protect the sacred guarantee that is Medicare, and help tackle one major force behind America's debt and deficit. Seniors and taxpayers deserve no less. Thank you very much.