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at the
Workshop on Issues Related to Accountable Care Organizations
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Thanks and Acknowledgments

- Thank you. I am delighted to welcome all of you who have joined us in person and by the phone. I'm proud to host this important exploration here at CMS, and I badly wish that we had enough space here at CMS such that everyone to attend in person. The interest all over the country in the topic of ACOs' is enormous and encouraging, and I promise that there will be many more opportunities for additional meetings and conversations.

- It is an honor to be here with –

    - Dan Levinson, Inspector General at the Department of Health and Human Services, and…

    - Jon Leibowitz, Chairman to the Federal Trade Commission.

- I know that Dan and Jon share my commitment to finding our way to a successful and long-lasting ACO program.

- We are working very well together. CMS is in constant dialogue with the IG's office and the FTC, as well as the Department of Justice. This meeting is just one part of our process of active and on-going communication among all of the agencies that will have a role in shaping the ACO program.

- In this, as in all we do, we have underlying statutory requirements. For example, CMS will have to enforce Stark provisions. But, we can interpret those statutes wisely and in a manner that, while still consistent with the plain language and intent of the applicable statutes, does not unnecessarily impede the development of ACOs. And, we can work together toward assuring the health care community clarity and uniformity of purpose and guidance.

- Prudence and wisdom require us to navigate our way carefully between two important objectives. First, we need to help integrated care thrive in America. We need to make it possible

for entirely new levels to emerge of seamlessness, coordination, and cooperation among the people and the entities that provide health care, so as to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and place. And, second, at the same time, we need to be proper stewards of appropriate markets and corporate behaviors. We need to assure both patients and society at large that destructive, exploitative, and costly forms of collusion and monopolistic behaviors do not emerge and thrive disguised as cooperation.

- Frankly, we want to have our cake and eat it, too – we want cooperation without corruption, we want aggregation without hegemony, and we want synergy without collusion. We believe we can have all of that, if we think clearly and work together.

Accountable Care Organizations

- In this workshop and in what precedes and follows it, we are trying to solve some important technical problems in designing the regulatory regime under which accountable care can thrive. I think we will do best at that if, first, we touch base with our goals in health care – what we in CMS are now calling the Triple Aim – better care for individuals, better health for populations, and lower *per capita* costs of care without any harm whatsoever to patients.

- What we know from decades of research is that, at the heart of capability to deliver better care, better health, and lower cost, is one core design concept: the "integration" of care. Let me explain a little more what integrated care looks like.

- You already know – indeed, I will wager that you know from personal experience – what "dis-integrated" care looks like. It is disorganized care. It is care in fragments. You have to tell your name and address and story again and again to everyone you see. No one seems to talk to each other. Your record is forgotten or unavailable. One doctor prescribes a medicine that conflicts with a medicine another doctor prescribed. You wait endlessly on hold, and you can't get the answer to your question. It's all in fragments. And you and your loved ones are holding the bag.

- Integrated care offers people journeys, not fragments.

- I have a message just handed to me for someone in the audience. I can't read the name – in fact, maybe it's my name. Maybe it's yours. But, I can read the message. Here is what it says:

- "I have bad news, and I have good news. The bad news is that you have cancer. You don't know it yet, but sometime in the next day or two, you'll have pain, and you'll go to your doctor.

She'll run some tests, and then she'll ask you to sit down. She'll say, 'It's cancer, and it has spread already. I'm sorry. But, don't lose hope. You've still got a 50:50 chance of complete cure.'"

- You are going to have a rough ride. In the next 12 months, you will see over 20 specialists, 50 technicians, in 10 or 12 institutions. You'll have 500 blood tests in 10 different places. You'll have surgery first, then chemotherapy, and radiotherapy, and you'll be on maintenance medications for the whole year. You'll probably get depressed, and will need some counseling. So will your spouse and your kids. The side effects will debilitate you, but we'll add in some physical therapy when it's time. You'll need pain control, and nausea control, and maybe some transfusions. And, we'll get you through it. We'll do that together. If, and only if, we're a team.

- If you get that note – if it's meant for you – you will be at the beginning of a long expedition through the technological storehouse of modern health care – with enormous potential to help and to heal. And with nearly equal potential to confuse, to misstep, to waste, and to harm. As Spiderman says, "With great power comes responsibility." Medicine has the power. Who has the responsibility? Who's got your back?

- Truth to tell, every single one of us in this room will get that note someday. Oh, it may not be cancer. It may be diabetes, the threat of a stroke, chronic depression, or an auto accident and disability. It may be your child with asthma or your mother with macular degeneration. But, somewhere, sometime, more than once, life will throw you a curve-ball, and you'll need integrated health care to hit it.

- We are now engaged in a great national expedition to seek, expand, and design systems of health care that can create journeys where now we have only fragments. We have lately come to call such systems, "ACO's" – Accountable Care Organizations – and, with American ingenuity and local concern, we are going to craft those into realities. But, the term "ACO" – charismatic though it has become – is just a label for a deeper idea: that we need stewards to help us all make sense of the complexity of modern medical care. I mean, "us *all*." Because it isn't just patients and families who need help through those journeys, it is the caregivers – the clinicians – themselves.

- I had the opportunity to practice pediatrics for 20 years in an organization remarkably close to what we probably mean by "ACO" today – the Harvard Community Health Plan. I remember one little boy in particular – let's call him "Timmy" – from my days in pediatric practice in a

superb integrated care system – which, if it existed today, might well be called an "ACO." I practiced there with seven other pediatricians, serving mostly an inner-city, poor population. I was the "officer of the day," seeing walk-in patients, and I entered the consulting room to meet a four-year-old child, breathing heavily with an acute asthma attack, and his teenage single-parent mother.

- This kid was sick, and in normal American health care I would have had only one choice – send him straightaway to the emergency department of the children's hospital where he would likely be admitted – fast.

  But that's not how this story went. Before I had even begun to talk, this young mother handed me a chart of Timmy's breathing tests at home – his so-called "FEV1" levels, which she had been taught by a visiting nurse to measure with a simple machine that she gave her. She had been responding at home –immediately and expertly – to Timmy's problem with appropriate changes of his medications. She then told me that she thought that Timmy needed next a different medicine, which she did not have at home.

  I was starting to respond when we heard a knock at the door, and in walked his allergist, whose office was one floor above mine in our multi-specialty clinic. He was carrying a vial of the exact medicine that Mom had mentioned.

  He knew that that was what Timmy needed, because the visiting nurse, who was also employed by our "Accountable Care Organization," and who knew Timmy well, had spoken to Mom on the phone, and then called his allergist while Mom was coming to my office. Of course, I knew much of this already, because our "ACO" had long ago adopted an electronic medical record, which was handed to me as I entered Timmy's room in the first place.

  Within ten minutes, Timmy was getting the new medicine his mother had suggested, and one hour later, he was on his way home, much improved, and with a visit from the nurse scheduled that afternoon, just to be sure.

  No emergency department. No hospital stay. No scary trip for a four-year-old. And lower cost for everyone. *That* is integrated care, and every single person in America can have it, if we play our cards right.

- If we keep our wits about us, we can build it. I am certain that we can develop, under the banner of "ACO" inventive forms of health care organization and delivery that help transform health care so that our patients can count on getting the care they need and want, exactly when and how they need and want it, every single time, at a cost we can afford.

- To achieve that, ACOs will need to have certain common characteristics and capabilities. I do not regard an ACO as a financing mechanism; I regard it as a care delivery organization. We need to work together to refine those design specifications, but here, for starters, are some of mine:

    - An ACO will put the patient and family at the center of all its activities. It will honor individual preferences, values, backgrounds, resources, and skills, and it will thoroughly engage people in shared decision-making about diagnostic and therapeutic options;

    - An ACO will have memory about patients over time and place, rather than amnesia. In its care, people will find themselves not having to repeat their stories; not having to carry the burden of making sure that everyone taking care of them has the information they need. They'll feel like teamwork is in place.

    - An ACO will attend carefully to handoffs, especially as patients journey from one part of the care system to another. It won't drop the baton; it will pass it.

    - An ACO will manage resources carefully and respectfully. It will make sure that waste is continually reduced, and that every step in care adds value to the patient. It will be able to make investments where investments count, and to move resources to where the patients' needs are. Because it will be so capable at prevention and anticipation, especially for chronically ill people, it will be able to continually reduce its dependence on hospitals. Instead, its patients will be able to be home, where they want to be, and, when they do go into a hospital, they can be assured that their discharges will go smoothly, and that they won't bounce back with complications.

    - An ACO will be proactive. It won't wait for trouble; it will help prevent it. It will reach out to people with reminders and advice that can help them stay healthy, and, when it's time for a checkup or a test, it will make sure that people know it and can get it.

    - An ACO will be data-rich. I will be able to measure what it achieves for patients and communities. It will be able to track outcomes over time, and to learn about how to do better and better. It will use registries mindfully, and will be transparent with its patients and community about its successes, its failures, and its progress, including its costs.

- An ACO will be innovative in the service of the Triple Aim: better and better patient care, better population health, and lower cost without harming anyone. It will draw upon the best advancing models of care, using modern technologies, telehealth, electronic health records, and more to continually reinvent care in the modern age. It will be curious about who performs better than it does, and will have ways to find those better approaches, study them, learn from them, adapt them, and adopt them.

- An ACO will continually invest in the development and pride of its own workforce, including affiliated clinicians. It will maintain and execute plans for helping build skill, knowledge, teamwork, and joy in work every day.

- The transition from a fragmented system to an integrated person-centered delivery system – to integrated care – will not be an easy one. The ACO I imagine is not the *status* quo repackaged; it is a new, better way to organize care. It will involve changes for almost every stakeholder. Further, there is no one-size-fits-all model for an ACO. All, I believe, ought in their own way to pursue the Triple Aim, but I suspect that many different breeds will be needed to match the enormous diversity of settings, communities, and histories in this textured nation. A rural ACO may not look much like an urban one. An ACO led by a hospital will follow a different plan of development than one launched by a group of physicians or one especially closely aligned with Federally Qualified Health Centers. We will need to assure the space and time for these many, adaptive forms of accountable care to harvest success.

- What every single form of successful ACO will have in common, also, I believe, is a strong and consistent commitment to cooperation among those who care for a patient on behalf of that patient. To allow that to occur, we will need a regulatory framework that nurtures cooperation, even while it guards against the lingering threat of inappropriate practices. We are here today to discuss ways to create a framework consistent with integrated care consistent with both of these goals.

- Throughout the phase ahead, CMS will be a strong partner in stewarding the success of ACOs. We will find ways of our own to encourage cooperation and simplicity for providers who intend to integrate care. We will also support learning networks to help spread new care models and lessons learned.

- And one way we will try to be a strong partner is to work with our colleagues in government to craft a regulatory framework that provides clarity for providers and organizations around anti-trust rules, enforcement of Stark, anti-kickback provisions, and related concerns.

- We in government need to do this together, and we know that. It will not be acceptable if organizations to hear one message from CMS and different messages from other agencies, both within and outside of HHS. You who wish to leap into this new era of care integration need consistency, clarity, and predictability about the relevant regulatory regime.

- You will help most if you do not only identify the legal issues and barriers that you see, but also help to outline the solutions you would like to see emerge to overcome those barriers.

- I hope you will feel free to raise any and all concerns. For starters, we are particularly interested in hearing views on:

    - How CMS should exercise its waiver authority under Section 3022 of the Affordable Care Act;

    - And, if such fraud and abuse protections are waived, how CMS can and should ensure that our regulations appropriately protect patients, promote health, and lower costs.

Conclusion

- None of this will be easy. All of us will have to change the way we do business. And there's plenty of work ahead. I see the problem-solving we are doing today to be part of a much larger – I daresay majestic – process that we have now engaged in America to help a new and better health care delivery system emerge – better for patients, better for the health of the public, better for our economy as a whole, and, not at all incidentally, better for the dedicated professionals and managers who come to work every day to try to relieve human suffering and to restore and maintain health.

- One thing that I do know is this: We will either build the new health care system for America together – patients, hospitals, physicians, organizations, managers, employers, and communities – together – or we will not build it at all.

- Let me be clear, in closing, about one final, serious matter: *authenticity*. Authenticity matters. Those who wish only to preserve the *status quo* are not going to be constructive contributors to our nation's future. They cannot be effective partners, and we simply do not have time to pretend that they are. We just do not have time for games anymore.

- But those who agree that now is the historic opportunity – perhaps the last in my lifetime – to navigate our nation to better care, better health, and better costs – to navigate us to the care we can be proud and confident to hand to our children – those who welcome change and will agree to lead it will find a friend in me, levers in the new law, and gratitude in communities they serve.

- Thank you.