

Achieving the Promise of Accountable Care Organizations

Progress in Arizona



October 2016 Approximately 30 percent of U.S. health care spending is simply wasted. Emerging Accountable Care Organizations manage the full care of their patients – a dramatic shift to how health care is provided and simultaneously seeking to fulfill the “Triple Aim.”

Achieving the Triple Aim: The National Context

According to experts, approximately 30 percent of U.S. health care spending is simply wasted. It's wasted on over-treatment. It's wasted because we don't provide adequate care. And it's wasted because we have a fundamentally flawed payment system.¹

Accountable Care Organizations – new models of care delivery and payment – are an attempt to dramatically shift how health care is provided to address such waste, improve quality, and control costs.

In 2006, at a meeting with the Medicare Payment Advisory Committee (MedPac), Elliott Fisher, MD, of the Dartmouth Institute coined the term Accountable Care Organizations (ACOs).² He and others believed that in order to improve quality and control costs, accountability for a patient's care should be shared among all providers.^{3,4}

There are many working definitions of ACOs, but generally an ACO is an affiliated group of health care providers held jointly accountable for achieving a set of outcomes and cost performance measures for a defined population over a period of time. If successful, an ACO should be rewarded financially for achieving quality and efficiency – results that might not otherwise be achievable.⁵ ACOs are taking on different forms, but many are on the cutting edge of delivering population health management and are accountable for the full care of the patient.

What are Accountable Care Organizations?

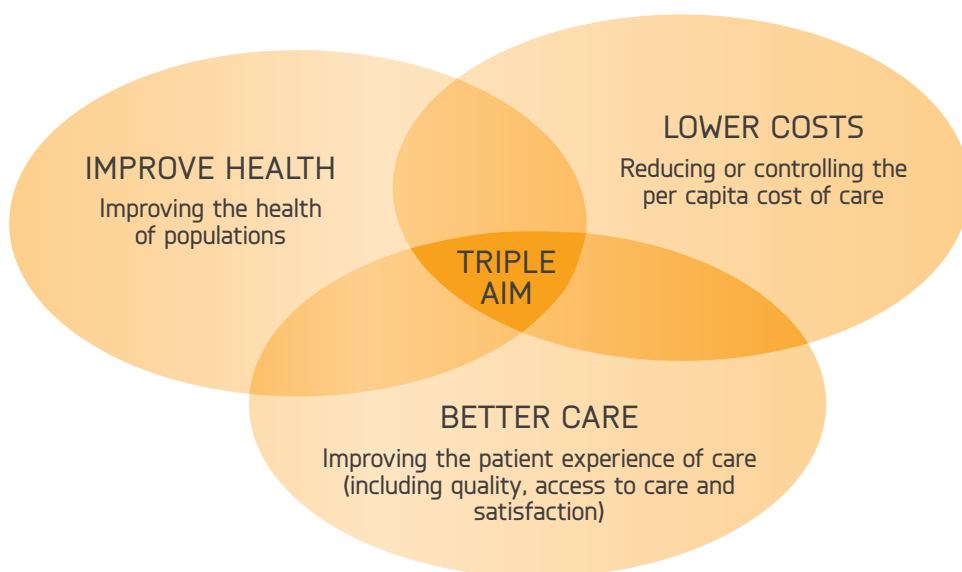
Accountable Care Organizations – emerging models of care delivery and payment – are an attempt to dramatically shift how health care is provided to reduce waste, improve quality, and control costs.

Elements of existing and emerging ACOs:

- 1. Local Accountability**
They recognize naturally occurring local networks and encourage responsibility for population health care costs.
- 2. Standardized Performance Measurement**
They develop standardized quality, efficiency, and communication standards.
- 3. Payment Reform**
They require provider collaboration and provide incentives to achieve quality and efficient outcomes.⁶

The Triple Aim

If done well, an ACO will fulfill the "Triple Aim" proposed by Donald Berwick, MD, in the 1990's prior to his role as the Director of the Centers for Medicare and Medicaid Services (CMS). The Triple Aim was incorporated into the National Strategy for Quality Improvement in Health Care by the Agency for Healthcare Research and Quality in 2011 while Dr. Berwick was at the Institute for Healthcare Improvement.⁷



Starting with Medicare ACOs

In 2010, an ACO model was included in the Patient Protection and Affordable Care Act (ACA). The ACA authorized CMS to create accountable care programs within Medicare that seek to reduce spending while maintaining or improving quality care at no increased cost.⁸ CMS then created a number of ACO payment models for Medicare providers and patients that include:

- The Pioneer ACO Model** – Designed for organizations with experience in managing population health (operating as ACOs, or in similar arrangements) to provide more coordinated care to beneficiaries at a lower cost to Medicare. The model tests the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients and reducing Medicare costs. The organization shares in the potential savings and is at risk for losses as well.
- The Medicare Shared Savings Program (MSSP)** – Rewards ACOs that reduce their growth in health care costs while putting patients first and meeting performance standards on quality of care. In the early model, there was no downside risk. If the expenditure target was not met, and if certain quality requirements were met, the organization shared in any cost savings with CMS. Now there are three tracks that organizations can participate in with varying levels of risk.
- The Advance Payment ACO Model** – Designed for physician-based and rural providers who are already in or interested in the Shared Savings Program and are providing coordinated high-quality care to Medicare patients. This model allows selected participants to receive upfront monthly payments, which they can use to make important investments in their care coordination infrastructure, such as purchasing electronic health

Arizona Medicare ACOs BY TYPE

ACO	Start Date	Ownership/Structure Service Area	PCPs	Attributed Members/ Number of Beneficiaries
Banner Health Network*	1/1/12	Banner Health, Banner Physician Hospital Organization, Banner Medical Group, Arizona Integrated Physicians <i>Maricopa and Pinal Counties</i>	1,020	78,000
Arizona Connected Care	4/1/12	Community Providers, Tucson Medical Center <i>Southern Arizona</i>	195	6,500
Arizona Care Network	1/1/13	Dignity Health & Abrazo Health <i>Arizona</i>	331	30,000
Commonwealth Primary Care ACO	1/1/13	Independent PCPs <i>Arizona, New Mexico</i>	100	16,000
JC Lincoln ACO	7/1/13	HonorHealth <i>Phoenix Metro Area</i>	126	14,800
Scottsdale Health Partners	1/1/14	HonorHealth <i>Maricopa County</i>	107	18,000
ASPA-Connected Community	1/1/15	Independent Physicians (ASPA) <i>Arizona, New Mexico</i>	35	5,200
North Central AZ Accountable Care	1/1/15	Yavapai Regional Medical Center, Northern Arizona Healthcare, Affiliates <i>Yavapai and Coconino Counties</i>	142	10,400
Abacus ACO	1/1/16	Arizona Community Physicians <i>Southern Arizona</i>	131	26,400
Optum ACO**	1/1/16	Optum Medical Network <i>Maricopa County</i>	203	37,000

ACOs are MSSP Model, except *Pioneer Model and **Next Generation Model.



records (EHRs) or hiring nurse diabetes educators. The hope is that advance payments will enable ACOs to realize cost savings.

- **The Next Generation ACO Model** – CMS approved the Next Generation ACO Model (NGACO Model) in 2015, and launched the model on January 11, 2016. The nineteen participating ACOs in the NGACO Model were chosen based on their significant experience coordinating care for populations of patients through other initiatives, including, but not limited to the Medicare Shared Savings Program and the Pioneer ACO Model. In this model, CMS is encouraging providers to take on greater financial risk in achieving cost savings and quality outcomes in return for greater financial reward. This model consists of three “Tracks,” with “Track 1” and “Track 2,” originating in the Affordable Care Act, designed to enhance the care coordination and cooperation among healthcare providers to improve quality and patient outcomes as well as lower costs. The new “Track 3” takes the successful aspects of the MSSP and Pioneer model to create a new MSSP Track with higher shared savings opportunities and greater risks.

In the combined Medicare programs alone, 477 ACOs serve more than 8.9 million patients in 2016.⁹ This means that 1-in-4 seniors with traditional Medicare are in a Medicare ACO. The medical literature supports an association between

Medicare ACOs and modest reductions in spending, hospitalizations, and emergency department visits. Beneficiaries with multiple medical conditions receive the greatest benefit.¹⁰

In January 2015, U.S. Secretary of Health and Human Services (HHS) Sylvia Burwell outlined steps toward transforming the payment system for Medicare. She called for 30 percent of Medicare payments to be based on alternative models (other than traditional fee-for-service (FFS) models) by the end of 2016 and 50 percent by the end of 2018. Additionally, CMS intends to have 85 percent of Medicare FFS payments tied to quality or value by the end of 2016. Burwell specifically cited ACOs and bundled payments as preferred alternative payment models.¹¹

In August 2015, CMS released the financial and quality performance data for its ACO programs. The agency recognized 20 Pioneer and 333 MSSP ACOs for significant improvements in their quality of care. In addition, these ACOs generated \$411 million dollars in savings in 2014.¹²

In August 2016, CMS released the Medicare Shared Savings Program performance data for 2015, and the results continue to be positive. More than 400 Medicare ACOs generated \$466 million in total program savings in 2015, and the results showed that more ACOs earned shared savings in 2015 when compared to 2014. In 2015, Medicare ACOs covered more than 7.7 million Medicare beneficiaries and they are in fact reducing costs. (Go to CMS.gov for the latest data.)

Beyond Medicare ACOs

CMS started ACOs initially for traditional Medicare patients, but over time the ACO concept has expanded to cover many other people, far beyond traditional Medicare patients. Now, there are a variety of private ACOs covering commercially insured patients, Medicare Advantage members, and managed Medicaid beneficiaries.

Nationally, there are at least 838 public and private ACOs, with an additional 1,200 accountable care contracts across health care organizations. Today, ACO providers treat approximately 28.4 million patients, and this number is growing rapidly,¹³ with a 12.6 percent increase in the number of ACOs over the past year.¹⁴

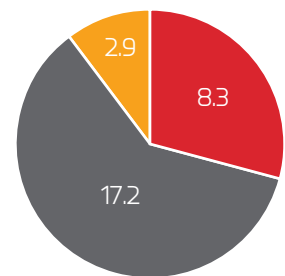
Payment Modernization

Most ACOs work with a number of health plans in addition to Medicare. Many health plans have started their own ACOs. Medicaid itself is engaged in ACO pilot projects across the country. Arizona’s Medicaid program, called the Arizona Health Care Cost Containment System (AHCCCS) has set similar goals to provide quality health care for those in need. Payment modernization initiatives such as value-based purchasing aim to move value-based purchasing requirements for plans from 10 percent in 2014 to 50 percent by 2017.

In addition to the ACA, another major legislative change occurred in April 2016 with the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). This congressional action pushed the overall health care system even further down the “risk continuum” with its move away from fee-for-service billing and toward payments for quality and more coordinated care.

ACO Lives per Payer

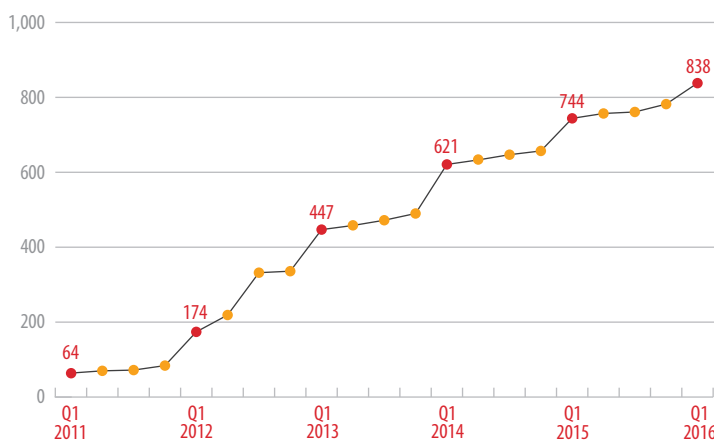
IN MILLIONS



■ MEDICARE ■ COMMERCIAL ■ MEDICAID

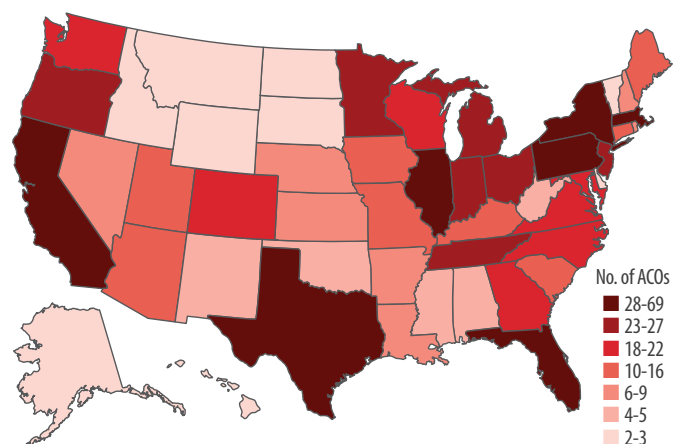
Source: <http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/>

ACOs Over Time TOTAL OF ALL TYPE



Source: <http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/>

ACOs by State

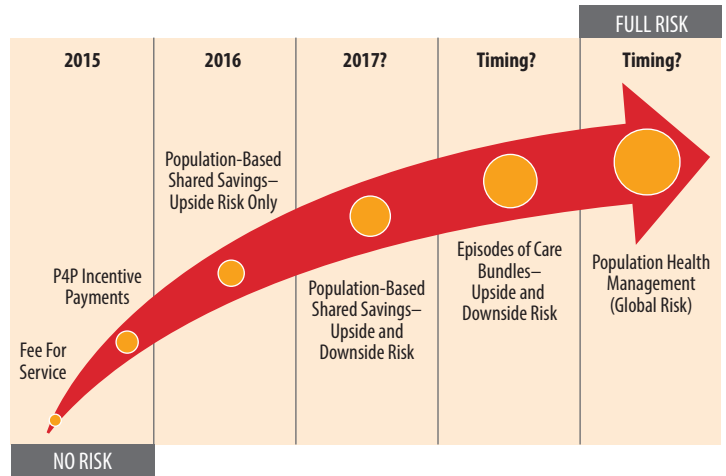


Source: <http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/>



It's clear CMS is fully backing ACOs as a means to better control costs and improve quality within the Medicare program. And since Medicare is the largest health care purchaser in the country, these policy shifts in payment and care delivery are having repercussions across the nation's health care system. Private insurers that have been hesitant to engage in ACOs or payment reform are beginning to follow Medicare's lead.

Value-Based Products and Risk Continuum Model



Source: National Association of ACOs

What is MACRA?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is a bipartisan piece of legislation that replaced the Sustainable Growth Rate formula with a new method of paying clinicians. On April 27, 2016, the Department of Health and Human Services issued a Notice of Proposed Rulemaking to implement certain provisions from MACRA to create a unified framework for clinician payment called the "Quality Payment Program."¹⁵

The Quality Payment Program consists of two paths: The Merit-Based Incentive Payment System (MIPS) and Advance Alternative Payment Models (APMs). MIPS comprehensively measures the value and quality of care provided by doctors and other clinicians through four performance categories: cost, quality, clinical practice improvement activities, and advancing care information. By improving and streamlining Medicare's method of measuring quality of care, MIPS provides more relevant and in-depth information to determine Medicare's value and quality based payments. It also increases flexibility for clinicians to choose measures and activities appropriate to the type of care they provide. MACRA requires MIPS to be budget neutral. To do this, clinicians' MIPS scores are used to determine a positive, negative, or neutral adjustment to their Medicare payment rates.

CMS will begin using MIPS measurement standards in January 2017. The payment rate adjustments determined from those measurements will begin in 2019. The majority of Medicare clinicians will initially participate in the MIPS portion of the Quality Payment Program.

Clinicians who participate in APMs are exempt from MIPS payment adjustments and qualify for a 5% Medicare Part B incentive payment. In order to qualify for incentive payments, clinicians must receive enough of their payments and/or see enough of their patients through Advanced APMS. MACRA lays out criteria for what qualifies as an Advanced APM. Some models listed in the proposed rule that would qualify as Advanced APMS include the Comprehensive End-Stage Renal Disease Care Model, Comprehensive Primary Care Plus, Medicare Shared Savings Program - Tracks 2 and 3, Next Generation ACO Model, and Oncology Care Model Two-Sided Risk Arrangements (available in 2018). This list will be updated annually.

Update: Recent changes are being proposed to delay some of the MACRA requirements. Check HHS updates for the latest policy news.

Aim of This Report

This report is designed to summarize the qualitative experiences of many of Arizona's ACOs in delivering on the promise of changing health care delivery for the better. It offers key observations from ACOs and other health care leaders on what is working and not working in ACO implementation. It also proposes recommendations for further strengthening ACOs in general and payment and delivery reform in particular. Finally, the report provides some thoughts on the potential for Arizona to implement other types of innovative models aimed at improving health and reducing costs.

Report Methodology

In preparation for this report, Arizona's 12 original Medicare ACOs (as identified by Leavitt Partners) were initially contacted by letter to introduce the project and to outline its expectations. A face-to-face interview was requested.

Representatives from nine different Arizona ACOs agreed to be interviewed. The interviews were conducted over a six-month period beginning August 2015 and ending January 2016.

Discussions included the ACO's history, the governance model employed, the types of quality measurements utilized, the role and model of care coordination, technology, and health plan relations.

In addition, directors of both the Maricopa County and Pima County Health Departments were interviewed to hear their perspectives on the growth and development of ACOs in Arizona. The leadership team of AHCCCS also agreed to be interviewed for the project.

The Arizona Experiment

In Arizona, numerous Accountable Care Organizations are now operating. Each is unique, allowing for experimentation and innovation in health delivery to flourish. The adage applies that "if you've seen one ACO, you've seen one ACO."

Throughout the state, there are:

- Medicare ACOs
- Medicare Advantage ACOs
- Medicaid Managed Care ACOs
- Commercial Insurance ACOs

Across the country, ACOs are organized in a variety of ways. The most prevalent model in Arizona is that of a hospital system that works with employed and independent physicians and, in some cases, Federally Qualified Health Centers

Arizona ACO Interviews

- **Ken Adler, MD**
CEO, Abacus ACO
- **Mark Hillard**
Former, CEO, Arizona Care Network
- **Dan McCabe, MD**
CEO, Arizona Connected Care
- **Jeff Selwyn, MD**
CMO, Arizona Connected Care
- **David Yarger**
COO, Arizona Connected Care
- **Lisa Stevens Anderson**
CEO, Banner Health Network
- **Shaun Anand, MD**
former CMO, Banner Health Network
- **Edward S. Kim**
President and General Manager
Cigna Healthcare of Arizona
Cigna Medical Group
- **Lance Donkerbrook**
COO, Commonwealth Primary Care ACO
- **Kote Chundu, MD**
President and CEO
District Medical Group
- **James J. Dearing, DO**
CEO, CMO, HonorHealth ACO
- **Ami Giardina, MHA, BSN, RN**
Chief Accountable Care Officer
North Central Arizona ACO

(FQHCs). Other models in Arizona include ACOs organized by independent physician groups, and ACOs fully owned by insurance companies such as Cigna Medical Group (CMG) and UnitedHealth Group's Optum ACO.

For example, the Banner Health Network (BHN) ACO was one of the first 33 Pioneer ACOs to operate nationally in 2011. It continues as one of the now 12 ACOs remaining in the Pioneer Program. Several Pioneer ACOs have dropped their efforts completely, but most have transferred to the MSSP Program. In April 2012, Arizona Connected Care, the ACO started by Tucson Medical Center and its affiliated physicians, became one of the first 27 ACOs chosen to receive an MSSP contract.

The newest addition is Optum ACO, which was the only Arizona ACO chosen to participate in the Next Generation ACO Model Program.

Estimated Value-based Contracted Lives in Arizona

Organization Name	Medicare*	Medicare Advantage	Commercial	Medicaid	Estimated Total Lives	Estimated Number of PCPs
Abacus ACO	26,400	28,700	17,100	10,900	83,100	131
Arizona Care Network	30,000	20,000	0	0	50,000	331
Arizona Connected Care	6,500	8,500	9,000	0	24,000	195
Arizona Priority Care	N/A	13,253	0	0	13,253	554
ASPA Connected Community	5,200	0	0	0	5,200	35
Banner Health Network (Banner Health, Banner Medical Group, Banner Physician Hospital Organization, Arizona Integrated Physicians)	78,000	80,000	243,000	0	401,000	1,020
Cigna Medical Group	N/A	0	15,000	0	15,000	150
Commonwealth Primary Care ACO	16,000	1,200	25,000	0	42,200	200
District Medical Group	N/A	0	0	87,000	87,000	60
Equality Health	N/A	Emerging ACO, no covered lives at time of report				
Health Choice Preferred	N/A	WND	WND	WND	27,000	WND
Innovation Care Partners	N/A	14,200	24,100	0	38,300	251
Iora Health	N/A	WND	WND	WND	WND	WND
John C. Lincoln ACO	14,800	N/A	N/A	N/A	14,800	126
North Central Arizona Accountable Care	10,400	0	0	0	10,400	142
Optum ACO	37,000	51,500	0	0	88,500	979
PathFinder ACO	N/A	0	5,400	0	5,400	159
Scottsdale Health Partners	18,000	N/A	N/A	0	18,000	107
TOTALS	242,300 26.2%	217,353 23.5%	338,600 36.7%	97,900 10.6%	923,153	4,440

N/A: Not Applicable; WND: Would Not Disclose

*All of the attributed lives in the Medicare column are through the MSSP program, except Banner which participates in the Pioneer program and Optum ACO, which is part of the Next Generation ACO program.

This table illustrates attributed lives for many ACOs in Arizona. While this list is comprehensive, we know there are other ACOs in Arizona not accounted for in this report and table.

In summer 2016, HonorHealth announced an integrated care network (Innovation Care Partners) that provides management services to both John C. Lincoln ACO and Scottsdale Health Partners.

The data was collected by Vitalyst Health Foundation and The Hertel Report. It was sourced from Leavitt Partners and interviews with ACO leaders listed in the table, and supplemented by responses directly from the ACOs.

Characteristics and Challenges for Arizona's ACOs

Arizona's ACOs share some similarities in how they are organized. However, they also embody significant differences, illustrating how each is an independent laboratory for experimentation.

Governance and Leadership

The majority of Arizona's ACOs are hospital-owned and governed by physicians. ACOs participating in the Medicare Shared Savings Program are required to have a board made up of 75 percent participants that share in savings (accept Medicare). Various types of ownership and governance structures exist in Arizona. One is physician-owned and several others are supported by a hospital. Cigna Medical Group (CMG) is wholly owned by a health plan. CMG has achieved positive results in quality and affordability due to a strong focus on patient and improved care coordination. Similarly, Optum ACO in Phoenix is part of UnitedHealth Group.

All of the ACO boards have quality and finance committees. Some have a patient engagement committee made up of consumers. A few have network, utilization and performance committees. One has an evidenced-based medicine subgroup of the quality committee.

A more detailed description is available at vitalysthealth.org/acos-progress. Outlined below is a summary of the various types of ownership and governance structures.

Abacus Health ACO

- This is a recent ACO formed by Arizona Community Physicians and supported by Tucson Medical Center (TMC).
- Abacus has a seven-member board made up of five primary care physicians, one Medicare beneficiary, and one TMC representative.
- The Chief Medical Officer (CMO) and the Chief Executive Officer (CEO) report to the board.

Arizona Care Network

- The ACO is 50 percent owned by Dignity Health (a non-profit national health system) and 50 percent by Tenet (a for-profit national health system).
- This 21-member board is made up of 76 percent physicians.
- The ACO is primary care provider-centric and works with both employed and independent physician groups.

Types of Organizational Structures FOR ACO'S IN THE U.S.

- **Independent Physician Group**
A single organization that directly provides outpatient care
- **Physician Group Alliance**
Multiple organizations that provide outpatient care
- **Expanded Physician Group**
Directly provides outpatient care and contracts for inpatient care
- **Independent Hospital**
A single organization that directly provides inpatient care
- **Hospital Alliance**
Multiple organizations with at least one that directly provides inpatient care
- **Full-Spectrum Integrated**
All services provided directly by the ACO. May include one or multiple organizations

Source: Tu T, Muhlestein D., Kokot SL, White R, The Impact of Accountable Care: Origins and Future of Accountable Care Organizations. Leavitt Partners, May 2015.

Other Variations IN ARIZONA

- Primary Care Physicians only
- Independent Physicians with multi-specialty physicians
- For-profit investor model
- Payer mixed model – employed by an insurer with network physicians

Arizona Connected Care (AzCC)

- Arizona Connected Care is 75 percent physician-owned with Tucson Medical Center owning the other 25 percent.
- The eleven-member board is made up of 75 percent physicians, including one hospitalist and one specialist; all others are primary care physicians.
- A Medicare beneficiary and a community member is represented on the board.
- Physicians have to pay a subscription fee to join AzCC.
- AzCC has four federally qualified health centers in the ACO.

Banner Health Network

- The Banner Health Network (BHN) is owned by four providers:
 - Banner Health
 - Banner Medical Group (BMG)
 - Banner Physician Hospital Organization (BPHO)
 - Arizona Integrated Physicians (AIP)
- Each provider has four seats on the 18-member board. Usually, a consumer representative and a Medicare beneficiary serve on the board. The CEO and CMO are non-voting members.
- BHN is an extensive network of primary care and specialty physicians (3,000 Banner Health-affiliated physicians and advanced practice providers), 15 Phoenix-area, Banner Health hospitals, and 19 other medical facilities throughout Arizona.

Cigna Medical Group

- This group is a wholly owned subsidiary of Cigna Healthcare of Arizona. (All primary and specialty caregivers and clinical support staff are employed by Cigna Medical Group.)
- They have a clinical advisory group consisting of 12 physician leaders who participate with four accountable care entities including: Banner Health, Commonwealth Primary Care ACO, HonorHealth, and Cigna Arizona.
- They participate in the Medicare Shared Savings Program through their affiliation with Dignity Health (Arizona Care Network).
- Cigna Medical Group is considered a “full-spectrum integrated model.”

The Commonwealth Primary Care ACO

- This ACO is a partnership of independent physicians in Phoenix and throughout Arizona. It is solely physician owned and governed with no hospital involvement.
- The board is made up of 10 independent primary care physicians. The Chief Operating Officer (COO) and a Medicare Beneficiary Member make up the rest of the board.
- Additional committees and key leadership personnel include the clinical coordination committee; compliance and ethics subcommittee; operations subcommittee; and the clinical and quality improvement subcommittee.

The District Medical Group (DMG)

This group is a non-profit, physician-run corporation. DMG is a closed medical staff model. All caregivers are employed by DMG.

- The District Medical Group board consists of nine members. Five are community representatives and the rest are physicians.
- The affiliated hospital, Maricopa Medical Center, is not represented on the board.
- The CEO must be a practicing physician.

HonorHealth/Innovation Care Partners/ John C. Lincoln ACO

- In summer 2016, HonorHealth announced an integrated care network (Innovation Care Partners (ICP)) that provides management services to both Scottsdale Health Partners (SHP) and John C. Lincoln ACO (JCLACO). ICP will also work with other payers on value-based and risk-sharing models. (Source: Hertel Report)
- Innovation Care Partners holds agreements with two ACO's:
 - The John C. Lincoln ACO (JCLACO): This ACO consists of a hospital employing ACO professionals serving Medicare beneficiaries.
 - Scottsdale Health Partners (SHP): This physician-led, clinically integrated network and Medicare Shared Savings Program (MSSP) ACO is divided equally among primary care physicians and specialists. In 2014, SHP was the only MSSP in Arizona to earn performance payment, generating a cost savings of more than \$3.7 million for CMS, and a shared savings of \$1.8 million for SHP.
- Physicians paid a subscription fee to join Scottsdale Health Partners ACO; in contrast, John C. Lincoln ACO is fully owned by the hospital.
- JCLACO's 14-member board includes: ACO participants, a Medicare beneficiary, a chairperson, associate general counsel, compliance officer, medical director, and the Chief Finance Officer (CFO). The CEO and CMO lead three subcommittees: the finance committee, medical management and quality committee, and the patient engagement committee.
- SHP was originally a joint venture between Scottsdale Healthcare Hospitals and Scottsdale Physicians Organization (SPO). HonorHealth has since purchased SPO. This ACO has a 10-member board with four associated committees: the quality and performance committee, operations and finance committee, information technology committee, and membership/credentialing.

North Central Arizona ACO

- This ACO is fully owned by Yavapai Regional Medical Center (YRMC), while operating expenses are shared by Northern Arizona Healthcare.
- The board has 13 members including four primary care physicians, a community member, the CMO and the chief accountable care officer. The rest of the board is made up of specialists.
- Physicians on the board are mostly employed by affiliated hospitals. Hospitals have no representation on the board.



“CHANGING PHYSICIAN CULTURE IS DIFFICULT. IT’S HARD FOR THEM TO GET FROM VOLUME-BASED CARE TO VALUE-BASED CARE.” *Jeff Selwyn, MD, Chief Medical Officer, Arizona Connected Care*

According to Leavitt and Partners, the most successful ACOs to date are physician-owned or led. Arizona’s ACOs appear to have strong physician leadership, even when a hospital is the backbone of the organization. Several of the larger organizations are investing in training physician leaders who will be part of the clinical and governing structure. In smaller ACOs, the organic growth of physician leaders is attributed to their desire to better understand their own developing organizations.

Physician training and support will likely be the key to the future success of ACOs and achieving the Triple Aim. Physicians both old and young understand that our current health care system is unsustainable. These physicians want to help lead the change. As Jeff Selwyn, MD, the Chief Medical Officer of Arizona Connected Care observed, “Changing physician culture is difficult. It’s hard for them to get from volume-based care to value-based care.”

Academic centers such as the University of Arizona Center for Rural Health (AzCRH) (housed within the Mel and Enid Zuckerman College of Public Health) has responded to the needs of rural populations with limited access to quality care. Since 2010, 76 rural hospitals in the United States have closed, and an additional 673 are vulnerable to closure.¹⁶ Last year, a rural hospital in Douglas, Arizona closed, forcing individuals to travel long distances to access care, and 60 people lost their jobs.¹⁷

The Mel and Enid Zuckerman College of Public Health announced on July 13, 2016 that the AzCRH was awarded \$348,000 in federal funds to support the Small Rural Hospital Improvement Program (AzSHIP).¹⁷ The grant supports 13 small rural hospitals with fewer than 50 beds for health system reforms in three key areas:

(1) Value-Based Purchasing (VBP) activities to improve data collection and

facilitate quality improvement and required reporting,

(2) ACOs, or shared savings activities to develop and implement programs,

(3) Prospective Payment System (PPS) or Payment Bundling (PB) activities to improve hospitals’ financial performance.

Participants include small rural hospitals (for-profit, not-for-profit, and tribal organizations) that provide short-term, general acute and 24/7 emergency care for their communities in nine of Arizona’s 15 counties.¹⁷ This funding opportunity illustrates the value of collaborating with local academic institutions that work closely with rural hospitals and share a vision of improving population health. Jennifer Peters, AzCRH program manager added, “Ensuring rural hospitals have the tools and training they need will help transform our rural health care system to provide quality health care in these communities.”¹⁷

Value-Based Care

$$\text{Value} = \frac{\text{Health Outcomes}}{\text{Cost of Delivering the Outcomes}}$$

- Outcomes are the health results that matter for a patient’s condition over the care cycle.
- Costs are the total costs of care for a patient’s condition over the care cycle.

Source: Michael Porter, Harvard Business School <http://www.hbs.edu/healthcare/Documents/2012%2003%2007%20SUT%20HCI%20presentation.pdf>



Health Plan Relationships

Industry leaders – both nationally and locally – agree: ACOs can only achieve maximum effectiveness in controlling costs and improving care when they work closely with payers toward achieving diagnostic, utilization, and cost data goals. Health plans have access to much of the diagnostic, utilization, and cost data that will allow ACOs to succeed. This information can be used to manage risk.

There are good examples across the country of health plan relationships that have helped ACOs achieve success:

- In Texas, the Texas Medical Association (TMA) partners with the Blue Cross Blue Shield Association (BCBS) to help provide infrastructure support to independent Texas physicians. Texas, like Arizona, has many smaller practices. TMA believes that in order for these practices to continue to be successful in the changing health care environment, they need to provide physicians in TMA with access to the necessary tools that help coordinate and collaborate the delivery of patient care.
- In Louisiana, BCBS began a partnership with primary care providers that have electronic medical records (EMRs). They increased per member per month payments (PMPM) to the practices, embedded care coordinators and invested in infrastructure in order to reduce emergency department visits and hospital admissions. The preliminary results are encouraging.
- In Massachusetts, BCBS has had an Alternative Quality Contract (AQC) in place for a few years. AQC is an innovative payment model that has improved patient care and lowered costs. This is one of the largest private payment reform initiatives in the U.S. and has become a model for other states. Atrius Health Medicare Pioneer ACO was among the earliest to sign BCBS's AQC. Under the AQC, BCBS of Massachusetts holds providers accountable to a global, risk-adjusted budget, and includes incentives for quality. In turn, providers agree to a two-sided risk model that allows them to share not only in savings, but also in the cost of care that exceeds targets.¹⁸ They realized a 10 percent savings over a four-year period compared to a control group. They accomplished this by reducing radiological imaging, using more appropriate levels of care and reducing hospital admissions. The AQC generated 8.7 percent less spending on procedures, 10.9 percent less on imaging, and 9.7 percent less on tests.¹⁹
- In Sacramento, a partnership between Dignity Health, the Hill Physicians Medical Group and BCBS of California resulted in a \$24 million savings in costs related to 24,000 state employees. They accomplished this through integrated discharge planning, managing care transitions, engaging patients in their care and creating a robust health information exchange (HIE). They provided their physicians with a visible dashboard of timely data that helps them actively manage their patients. In addition, they focused attention on the 5,000 patients that account for 75 percent of the costs.²⁰

- In California, Blue Cross Blue Shield (BCBS) and its ACO provider affiliates were able to save \$325 million in health care cost savings in the program's first five years. The program began in 2010 and has now expanded across 35 organizations treating as many as 325,000 patients in the state and available to nearly 200,000 additional residents throughout the state, including: the San Francisco Bay Area; Silicon Valley; the Sacramento area; Los Angeles, Orange and San Diego counties; the Inland Empire and the San Joaquin Valley. These cost savings were largely from reducing emergency room visits and hospital admissions. According to Kristen Miranda, senior vice president of strategic partnerships and innovation at BCBS of California,

"We achieved solid results in the first five years of our ACO program, and we are just getting started. We continue to deepen and redefine the work we are doing with our ACO providers to ensure our members receive the right care at the right time and in the right setting, all the while helping to make health care more sustainably affordable."²¹

Unfortunately, it appears the relationships between health plans and the existing Medicare ACOs in Arizona are relatively weak. When the subject of relationships with health plans was raised during our interviews, ACO leaders expressed a uniform sense of disappointment. They felt that interactions continued to be more like traditional payer-provider relationships, rather than a partnership. Overall, the relationships were characterized as being less than collaborative, despite ACO efforts to the contrary in other markets.

There is some consensus that there has been greater collaboration with Medicare Advantage health plans (private insurance companies contracted by the government to administer Medicare) versus commercial insurers. Since Medicare Advantage plans follow the same set of rules, have the same reimbursement structure and report to one payer

(the United States Government), coordination and shared goals may be easier to achieve.

Collaboration with commercial insurers was characterized as being more problematic.

In three instances on the commercial side, a provider-payer relationship was identified that demonstrated true collaboration. In one instance, the payer meets monthly with the ACO and has agreed upon quality metrics that matter. They share real-time data and work together with their care management programs. Together, they have work flow maps to better review their monthly data and track high utilization, then proactively take action. Such collaboration – especially in data sharing – is important to the overall effectiveness of ACO efforts to control costs and improve quality.

The CMO of that ACO says about this relationship, "It's about how we succeed together." Nonetheless, he added that "only a handful of health plans are willing to engage and work together."

Another ACO leader characterized the attitudes toward cooperation in some health plans as "talk to us when you're ready to take full risk." ACOs are moving in the direction of accepting risk, but most have not yet developed the level of infrastructure necessary to accept full risk and to measure the indicators that promote the Triple Aim.

Yet a third ACO leader observed that the relationships were "terrible, and consistently inconsistent."

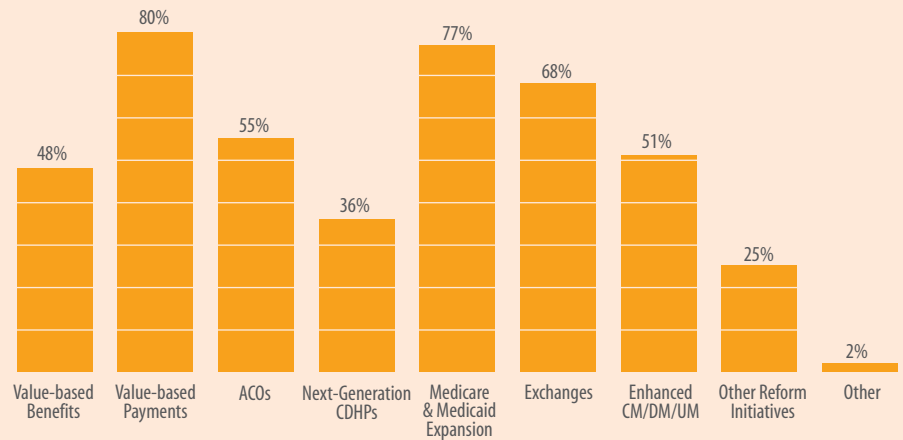
One ACO leader cited a payer that wants to move forward on "value-based payments, but [was] unwilling to pay for it." The CEO warned the payer, "Don't cut rates in primary care!" But increasing payments to primary care providers are critical in building the model of care necessary to effectively manage their patients. Primary care groups are adding nurse practitioners, physician assistants and care coordinators to their teams in order to be successful.

"ACOs ARE STILL TRYING TO COBBLE TOGETHER THE HEALTH INFORMATION SIDE OF THE SYSTEM, THE PHYSICIAN SIDE OF THE SYSTEM, ETC., BUT THEY DON'T HAVE THE FULL SCOPE OF ALL THE INFRASTRUCTURE NEEDED TO STAND ALONE WITHOUT THE PAYERS."

Tom Betlach, Director, AHCCCS

Survey Question

Which of the following healthcare delivery models is your organization planning to participate in or support over the next three years?



Source: HealthEdge

This lack of collaboration is discouraging. At national meetings and industry developments outside Arizona, there is a different story. Health plans profess support and are investing money and resources in the development of ACOs.

Even though there was early ACO development in Arizona, support seems to be missing from the health plans' side. It is difficult, if not impossible, to move forward in controlling costs and improving care without both sides working together.

Despite challenges associated with operating ACOs, health plans and providers around the country continue to invest in new alternative payment arrangements and move away from traditional fee-for-service reimbursement. HealthEdge's State of the Payer Industry Survey showed nearly 55 percent of polled medical establishments are looking to pursue ACO development over the next three years. Furthermore, four out of five surveyed organizations are planning to participate in value-based care reimbursement in the next three years.²²

According to recent survey data from 465 hospitals and health plans across the country, a majority of providers have either joined an ACO or plan to join an ACO in the near term. This year, 63 percent of hospitals are members of ACOs, an 18 percent increase over 2016, according to the survey. Of hospitals not participating in an ACO this year, 47 percent plan to join an ACO in the next five years. Another significant trend includes the percentage of hospitals participating in

tiered or narrow networks. This year, 60 percent of hospitals reported that they are in tiered or narrow networks with payers, an increase of 13 percent since 2014. Among hospitals, 63 percent reported tracking improvement in patient outcomes to assess the impact of value-based reimbursement models. For health plans, 74 percent reported tracking improvement in patient outcomes.²³

In a June 2016 press release, the National Association of ACOs (NAACOS) recommended the following steps the federal government and CMS can take to ensure more ACOs share in cost savings and stay in the Medicare Shared Savings Program:

- 1) Primary care physicians operating through ACOs will need to strengthen their relationships with Medicare beneficiaries.
- 2) CMS and the federal government will need to consider that some communities struggle more to achieve cost savings based on quality performance benchmarks scoring. It is beneficial to reduce the number of penalties and integrate financial incentives when quality improvements are achieved.

Clif Gaus, CEO of NAACOS emphasizes that ACOs still remain the most promising solution to improving quality and lowering health care costs if ACOs can work with the federal government to make adjustments to the program so that more ACOs can financially survive and grow.

Quality

Monitoring quality is an essential task for all ACOs. While ACO efforts are aimed at bending the cost curve, they must also demonstrate consistent or improved health outcomes for patients. Cost reduction without quality is not an acceptable outcome.

In 2011, the “Implementing Performance Measures” work group of the Brookings/Dartmouth ACO Learning Network identified more than 400 quality metrics providers were expected to meet. In the summer of that year, CMS (under the leadership of Dr. Donald Berwick) issued the first draft of ACO regulations and asked for comments. Initially, they asked ACOs to report on 60 quality measures, but settled for 33. At the time of this report’s printing, the same 33 metrics are used. That number will expand in the near future. ACOs have had success when informing physicians and nurses of the 33 quality measures required by CMS. This has helped providers understand that compliance with these measures affected the calculation of shared savings. (For a complete list of the 33 quality measures, visit vitalysthealth.org/acos-progress)

Currently, CMS, the National Quality Forum, the National Academy of Medicine (formerly the Institute of Medicine), the National Quality Measures Clearinghouse and a number of health plans are meeting to try to streamline the types and number of quality measurements. In addition, The Institute for Healthcare Improvement and the Dartmouth Institute are working on a whole set of system measures grounded in prior practice. The direction is moving predictably toward outcome-based measures. One of the big stumbling blocks has been the lack of technology needed for reporting.

Most of Arizona’s ACOs are tracking the 33 CMS quality metrics and additional metrics for the health plans with whom they are working. Medicare Advantage contracts are graded on the “Star” ratings and based on the Healthcare Effectiveness Data and Information Set (HEDIS, described below). Medicare Advantage’s Overall “Star” Ratings score each plan based on the quality of the health services the plan offers. Scoring is broken down into five categories: 1) staying healthy – screenings, tests, and vaccines; 2) managing chronic conditions; 3) member experience with the health plan; 4) member complaints and changes in the health plan’s performance; and 5) health plan customer service. For plans that cover drug services, the scoring is broken down into four categories: drug plan customer service; member complaints and changes in the drug plan’s performance; member experience with plan’s drug services; and drug safety and accuracy of drug pricing.²⁴

WHILE INDIVIDUAL ACO EFFORTS TO IMPROVE QUALITY ARE STRIKING, IT IS NOTABLE THAT THESE EFFORTS APPEAR TO BE HAPPENING IN SILOS. EACH ACO APPEARS TO BE OPERATING IN ITS OWN SPACE. ACOs IN ARIZONA RARELY SHARE MUCH INFORMATION ABOUT WHAT IS EFFECTIVE (OR INEFFECTIVE) REGARDING HOW TO REDUCE UNNECESSARY UTILIZATION OR TO IMPROVE HEALTH OUTCOMES.

The Healthcare Effectiveness Data and Information Set (HEDIS)

A set of quality standards for health plans established by the National Committee for Quality Assurance (NCQA). These include guidelines for effectiveness of care, access/availability of care, experience of care, utilization and risk adjusted utilization, relative resource use, health plan descriptive information, and measures collected using electronic clinical data systems.

Source: <http://www.ncqa.org/hedis-quality-measurement>

"PHYSICIANS ARE 'HUNGRY FOR DATA AND INFORMATION.'"

Shaun Anand, former Chief Medical Officer, Banner Health Network

Some ACOs implement commercial quality of care standards as a supplement to the above standards in order to best address the particular needs and nuances of their patient community.²⁵

Unfortunately, success in monitoring and reporting quality is directly related to how well ACOs are able to execute on their integrated technology needs. As Shaun Anand, the former CMO of the BHN stated, "The key to success in improving quality performance is to have an integrated electronic medical record."

Many ACOs are making great strides sharing individual performance data with their physicians. Sharing such data allows physicians to better manage utilization and monitor progress in meeting patient outcomes. However, this very much remains a work in progress. In general, physicians are "hungry for data and information," according to Dr. Anand.

Major challenges include the different EMR platforms that don't "talk" to each other and the changing expectations related to quality measurement. Most Arizona ACOs must piece together quality information for CMS because of the variation in provider reporting methods, ranging from paper to fully electronic reporting. Providers who still operate in paper-based systems also present challenges.

Individual ACOs are using a number of practices to enhance their quality efforts. Arizona Connected Care (AzCC) has a practice enhancement team that meets with each practice monthly and reviews all its quality data. The team consists of the CMO, the leader of the care coordination team, and an analytics and contracting person. AzCC reports that such strategies have helped them to achieve their quality goals.

Cigna Collaborative Accountable Care has 50 quality metrics that compose a quality index as well as a cost index. These combine to form a performance index. "Quality metrics are embedded in the Cigna Medical Group DNA," according to Ed Kim, the president and general manager of Cigna Health Care of Arizona.

Medicare ACOs continue to improve year after year on quality scores. They trend toward a higher average performance than other Medicare fee-for-service providers on corresponding measures. For instance, Medicare ACOs as a group performed highest on reducing readmissions.²⁶

The Banner Health Network provides a good example of early savings. As a Pioneer ACO, it achieved an impressive start:

- **Performance Year 1 (2012)**
 - Savings: 4 percent
 - Gross Savings: \$19.10 million
 - Earned Shared Savings: \$13.37 million
- **Performance Year 2 (2013)**
 - Savings: 2.8 percent
 - Gross Savings: \$15.15 million
 - Earned Shared Savings: \$9.22 million
- **Performance Year 3 (2014)**
 - Savings: 5 percent
 - Gross Savings: \$29.48 million
 - Earned Shared Savings: \$18.7 million
- **Performance Year 4 (2015)**
 - Savings: 5.5 percent
 - Gross Savings: \$35.11 million
 - Earned Shared Savings: \$24.58 million

According to CMS, 23 Pioneer and 220 Medicare Shared Savings Program (MSSP) ACOs generated more than \$417 million in Medicare savings, from the first and second year, respectively. In addition, ACOs qualified for shared savings payments of \$460 million.²⁷

While individual ACO efforts to improve quality are striking, it is notable that these efforts appear to be happening in silos. Each ACO appears to be operating in its own space. ACOs in Arizona rarely share much information about what is effective (or ineffective) regarding how to reduce unnecessary utilization or to improve health outcomes.

As quality data becomes more available and accurate, there is increasing evidence of significant variation from practice to practice in health care costs. This is particularly evident in specialty care. As data becomes more transparent, the next frontier in reducing costs will be removing excess waste from the system by reducing variation, a system-wide goal from the start. Variation is the enemy of quality. It is this progress that should eventually "bend the cost curve," limiting future growth in medical spending.

“IT WOULD HAVE BEEN NICE TO HAVE A ‘CRYSTAL BALL’ SO THAT MORE WOULD HAVE BEEN INVESTED IN TECHNOLOGY AHEAD OF TIME.” *Lisa Stevens Anderson, Chief Executive Officer, Banner Health Network*

Technology

“Information technology still has a long way to go.” This was a common theme heard throughout our interviews.

Health information technology is vital to transitioning from a fee-for-service payment system to a value-based, outcome-driven system. In order for the latter to be successful, the seamless sharing of information between patients and providers becomes crucial. Decisions will need to be made in real time to address the patient’s needs at the point of service. Ideally, this would mean that providers have predictive analytic tools to address a patient’s needs at each contact point, either in person, online, or by remote telemonitoring. What that means is information derived from clinical sources (e.g. labs, imaging, medication, and physiologic), resource utilization (e.g. claims data, supply chain and other costs), and social and behavioral health determinants are used to enable providers to identify patterns in data, which can be leveraged to drive decision making and predict future outcomes.²⁸

Despite the importance that information technology plays in the potential success of ACOs, problems with technology were a common theme in the interviews. Each ACO began with its own choice of software, yet there does not seem to be any one program everyone raved about. A common complaint: information systems don’t “talk to each other.” Known as interoperability, the user interface seems to be the biggest problem. Everyone knows where IT needs to be, but it’s a struggle to figure

out how to improve provider and patient engagement.

There are some success stories, for example: e-prescribing. Providers have left behind handwritten, scribbled prescriptions that caused multiple errors and have embraced a new era of sending scripts electronically to pharmacies. This has resulted in a huge drop in adverse medication events.²⁹

Interoperability and the sharing of data remain challenges. Struggles in interoperability have been exacerbated by federal efforts to encourage adoption of health information technology.

Ken Adler, MD, the CEO of the Abacus ACO, thinks the federal government’s meaningful use program was “fabulous in getting a slow moving target to move more rapidly toward adopting EMRs through incentives and fear.” He adds that the downside is that, “it has stymied development on interoperability and usability.” Fortunately, the head of CMS, Andy Slavitt, announced the end of the current meaningful use program in 2017. CMS and the office of the National Coordinator for Health Information Technologies has developed guiding principles on how the meaningful use program will fit with the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), building on the Merit-Based Incentive Payment Systems or Alternative Payment Models (ACOs and Bundled Payments). In New Jersey, the Hackensack Alliance ACO used data analytics tools and vendors to manage large volumes of data.³⁰ They

Meaningful Use

“Meaningful use” means providers have demonstrated that they are:

- Using a certified electronic health record (EHR) in a meaningful manner
- Electronically exchanging health information to improve the quality of care
- Using certified EHR technology to submit clinical quality and other measures

Still More Challenges

Another overwhelming problem is that timely patient attribution data is not being provided by Medicare to ACOs in the MSSP program. ACOs often receive data indicating which patients they are financially at risk for managing months after they begin to be held responsible for managing outcomes and utilization. Understandably, organizations find it difficult to manage patients when they don't even know who they are. Indeed, Mark Hillard, former CEO, Arizona Care Network (ACN), noted, "One of the biggest challenges with the Medicare Shared Savings Program has been 'who is your patient?' Do you know when they were registered and if they are attributed to ACN?" Managing Medicare Advantage (MA) patients is more reasonable since ACOs know who the patient is upfront. The MA program has been the only way that many ACOs have been able to survive financially.

recognized that information would be imperative to their success and identified a data analytics firm to help determine which practices were performing or not. Other Medicare ACOs in Arizona could benefit from this valuable resource as a way to digest the data and translate it to more actionable information.

Early on, there were difficulties getting Arizona's Health Information Exchange (HIE) up and running, which further stymied information exchange. In response to slow progress meeting early goals for information exchange, Arizona Health-e Connection (AzHeC) combined operations with the Health Information Network of Arizona (HINAz) to create "The Network" in an attempt to upgrade the state-wide HIE platform. It was hoped that a bi-directional health information exchange with a secure online portal would be available by 2015 to facilitate the growth of providers included in HINAz and to improve care coordination and interoperability across health care systems.³¹ Unfortunately, this has yet to be achieved. However, there has been recent progress in the percentage of hospitals and number of connected organizations and providers in The Network.

AHCCCS announced plans to provide a 0.5 percent bump in payments to hospitals that join and share data in The Network. Such financial support may help facilitate organizations joining the exchange. AHCCCS is also actively working on bundled payments and alternative payment models with their contracted AHCCCS Plans.

Unfortunately, some physician offices within ACO networks are not yet using electronic medical record (EMR) systems. Such physician offices still run on paper. Lance Donkerbrook, COO of Commonwealth Primary Care ACO believes that if these physicians are still providing quality care, there should be a place for them within ACOs. However, getting such offices integrated into a network where data needs to be shared remains a challenge.

"YOU NEED TECHNOLOGY IN THE HANDS OF DOCTORS SO THEY CAN EXECUTE ON IT."

Edward Kim, President and General Manager, Cigna Medical Group

"AT REGISTRATION SITES, PROVIDERS AND HOSPITALS ARE NOT AWARE THE PATIENTS ARE MEMBERS OF ACN."

Mark Hillard, former CEO, Arizona Care Network (ACN)

Ami Giardina, chief accountable care officer for North Central Arizona Accountable Care Organization, stated a common theme among Arizona ACOs: Independent physicians are reluctant to sign up for a hospital-sponsored electronic medical record, even though the cost could be minimal. Giardina stated she often hears doctors saying, "If I connect, they are going to steal my patients or they are going to see everything that goes on in my practice."

Currently, analytics are beginning to improve. According to Shaun Anand, former CMO of BHN, "The focus needs to be bringing the analytics to the point of service for the physicians. The 'Holy Grail' is predictive modeling data. There should be a combination of four data elements: claims information; patient care information (electronic medical records); diagnostics; and demographics."

Most ACOs are dealing with multiple IT platforms, especially if they are working with independent physician groups. Arizona Connected Care (ACC) for example, deals with 10 different IT platforms. In order to connect with each physician, the vendors would charge many thousands of dollars to create the interface.

Much of the data provided to Medicare and the health plans is still manually extracted because of the difficulty getting information from physician's offices that are not using or just beginning to use an EMR.

At the March 2016 Healthcare Information and Management Systems Society (HIMSS) meeting, Secretary Sylvia Burwell kicked off the event with a pledge from major health care players to promote patients' access to their own electronic health records. The pledge

was from 17 major health IT developers, 16 large health care provider organizations and 17 health care associations and medical societies. The pledge included three promises:

- To help consumers easily and securely access their electronic health information, direct it to any location, learn how their information can be shared and used, and be assured that this information will be effectively and safely used to benefit their health and that of their community.
- To help providers share individuals' health information for care with other providers and their patients whenever permitted by law, and not block the sharing of electronic health information (defined as knowing and unreasonably interfering with information sharing).
- To implement federally recognized standards, policies, guidance and practices for electronic health information, and adopt best practices including those related to privacy and security.³²

"YOU HAVE TO KNOW WHO YOU ARE ACCOUNTABLE FOR."

Edward Kim, President and General Manager, Cigna Medical Group



In summary, technology continues to be a significant thorn in the sides of ACOs, and technology always tends to lag. The other crippling issue is the tremendous cost involved. However, in order to be successful long term, interoperability will be a hard fought necessity. With the progress being made with the Health Information Network of Arizona and Secretary Burwell's announcement at the HIMSS meeting, there seems to be a veneer of guarded optimism under which lies considerable frustration.

Primary Care

Another issue that arose in the interviews was the challenge of adequately addressing and supporting primary care within ACO networks. In many ACOs, primary care physicians can only join one ACO, whereas specialists can join multiple ACOs in a market. Primary care physicians are the essential element to coordinated care, because they are the ones who actually “own” and manage the patients.

One of the critical factors for ACOs to succeed is that there needs to be a sufficient number of primary care providers to care for the patients and coordinate care efforts. Unfortunately, Arizona has a significant shortage of primary care professionals.

ARIZONA RANKS 40TH AMONG ALL THE STATES IN PRIMARY CARE COVERAGE.

In 2015, the Association of American Medical Colleges issued a report about the looming shortage of primary care providers across the country. They estimated that by 2025, the United States would have to produce 44,900 more primary care physicians than current slots in medical schools and post-graduate medical training programs will provide.

In 2015, there were 290,396 primary care providers in the U.S. The average was 91.1 providers for every 100,000 patients. Nineteen percent of all patients live in an area of primary care shortage.³³

Primary Care: A Concern

Measure	National	Arizona
Number of Primary Care Physicians (PCP)	290,396	5,306
Number of PCP per 100,000 Patients	91.1	78.8
Percent of Patients Living in a PCP Shortage Area	19%	41%

Source: Designated Professional Shortage Areas 2016. Association of Medical Colleges 2015, AMA Physician Masterfile, United States Census Bureau 2014.

In Arizona, there are 5,306 primary care physicians. That means that there are 78.8 primary care physicians per 100,000 patients in this state. Forty-one percent of the population lives in a primary care shortage area, and Arizona ranks 40th among all the states in primary care coverage.³⁴

This shortage must be addressed if we are to be successful in moving toward a value-based system dependent on primary care. Experts like Elliott Fisher, MD, director of the Dartmouth Institute, believes that as the USA moves to team-based care, increasing the number of nurse practitioners and physician assistants will help alleviate the dire shortage of primary care providers.³⁵ For much more analysis on Arizona’s health care workforce, go to vitalysthealth.org/health-workforce-development/.



In addition to augmenting the primary care workforce, it may also be necessary to train (or re-train) primary care providers and support them differently. Said Dr. Ken Adler, CEO of Abacus:

“The biggest challenge in all the change that is occurring for physicians is that they feel bombarded with all these new expectations and don’t feel like it’s what they signed up for – what they were trained to do – and so I think it’s dissatisfying for people in health care right now. The question is how to get people to recognize the good in this, but then try to take some of the burden off them. We have changed the rules.”

Dr. Adler added,

“To me, as someone trying to help run a group practice, it’s about keeping people feeling positive, but also performing in a different way. That is a huge challenge.”

Dr. Kote Chundu, CEO, District Medical Group added:

“One of the hardest parts is educating physicians to the new reality; physicians and providers need to buy into the process.”

Care Coordination and Consumer Focus

Coordinating care is seen as important to improving both health outcomes and efficiency in our health care system. It is also seen as an essential component of ACOs. That said, Arizona’s ACOs are still at the early stages of implementing care coordination and searching for models that work best.

Broadly speaking, care coordination can be defined as “the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”³⁶ By this definition, all providers working with a particular patient share important clinical information and have clear, shared expectations about their roles. Equally important, they work together to keep patients and their families informed and ensure that effective referrals and transitions take place.³⁷

The pieces of this puzzle are many (hospitals, doctors, nurses, post-acute care, etc.) and moving (admissions, transfers and discharges). There are different approaches being developed and utilized, and a number of examples are listed below. But all agree there is not yet a good answer to complete the puzzle of care coordination.

When ACOs began in 2011-2012 as part of the Affordable Care Act, it was evident that in order to control the cost of care for Medicare patients, ACOs needed to be able to reduce hospital readmissions. It was during this same timeframe that Medicare began punishing hospitals financially for excessive readmissions. Hospitals are a huge cost center, so most ACOs began developing care coordination teams to prevent emergency department (ED) visits, inappropriate hospital admissions and readmissions.

The key was to develop care coordination from the hospital to post-acute care. Early on, it became evident that this was not easy to do. There were problems with perceived invasion of the hospital domain by outside care coordinators. Trusting, respectful and working relationships had to be developed over time.

A study in the June edition of the American Journal of Accountable Care examined a Medicare Shared Savings Program (MSSP) ACO that received shared savings for two consecutive years. This has proven to be a major challenge for most participants in the program. ACOs that have been successful in shared savings arrangements through an MSSP offer best practices for new and emerging ACOs.³⁸

First, the Hackensack Alliance ACO was able to reduce hospital admissions, readmissions, and emergency department visits by increasing care coordination through the patient-centered medical home. Second, the ACO promoted patient-centered care and coordination by providing larger practices with a nurse care coordinator who is responsible for pinpointing high-risk patients and developing a relationship with them.

Despite its success, the ACO recommended several areas of improvement for CMS, including the suggestion to simplify its methodology for determining cost savings, consider regional differences on costs, and address competition from other alternative payment models, such as bundled payments and the Comprehensive Primary Care Initiative.³⁹

The Arizona Connected Care team has been successful in reducing hospital readmission rates into the single digits. They work closely with the care coordinators in multiple practices and monitor daily information on hospital admissions, discharges, ED and urgent care visits. Through the practice enhancement team, they provide data to

practitioners on specialty care usage, redundant imaging, diagnostics and the use of pharmaceuticals. They have scorecards for providers in the post-acute arena. They are using a web-based platform to facilitate communication between the team and the providers. However, the group is not totally satisfied with the current technology being used.

The BHN has found deploying “boots on the ground” is more successful than having health plans contact patients. BHN added a telehealth program for a subset of their high-risk patients; patients have a computer tablet to communicate with the care coordination team from home. The team, including health coaches, also provides home visits. In addition, BHN uses an ED de-escalation program with case managers in the EDs of its hospitals. They determine if the patient has options other than admission. In March of 2015, the ACO launched a nurse triage line available 24/7. The line is staffed by RNs who can pull all known ACO patient records. The nurses notify the ED of the patient’s status prior to arrival. If for some reason the patient doesn’t show up to the ED, the nurses follow up to find out what happened.

The new Abacus ACO has 10 care coordinators – eight RNs and two MSWs. Two RNs are embedded at TMC and focus on transitional care management. The other eight are currently centralized but provide chronic care management for all ACP patients. Staff has background primarily in home health, hospice and hospital case management. Several of them have done all three.

The HonorHealth ACO has two unique methods of care coordination. On the John C. Lincoln side, it employs former military medics with a medical home certification to do home care. It also employs patient navigators. Both interface directly with hospital case management. This ACO received a national award from the White House on the innovative nature of its medic program. On the Scottsdale side, it has teamed with the Scottsdale Fire Department to launch the city’s first mobile integrated health care program that specializes in home visits.

In the recently developed North Central Arizona ACO, its care coordination program includes employing several RN case managers who communicate with patients within 24 hours of discharge to review next steps.

Arizona Care Network has a notification system where its care coordination team is made available whenever a patient is registered at a Dignity Health or an Abrazo Community Health Network facility. This can be either an inpatient or an outpatient encounter. In addition, the ACO receives a notification when a patient is in the ED and, as a result, can intervene early.

At Cigna, care coordinators are assigned to the larger offices. They coordinate services with hospitals, home-based services, and ancillary and specialty services.

There are also numerous examples all over the state of community paramedicine programs, where fire departments

“THE GOAL IS TO HAVE THE PROVIDER-TO-PATIENT CONNECTION. THE CARE COORDINATION TEAM IS THE GLUE BETWEEN THE ACO, THE PATIENTS AND THE PROVIDER.”

Lance Donkerbrook, Chief Operating Officer, Commonwealth Primary Care ACO

"IF WE COULD DO IT ALL OVER AGAIN, THE WHOLE SYSTEM SHOULD BE DESIGNED AROUND THE CONSUMER."

Lisa Stevens Anderson, Chief Executive Officer, Banner Health Network

and districts are beginning to partner with hospitals to take the lead on care coordination of high-utilizers of EDs. Innovation is springing out across the state with medical providers of all types collaborating to reduce hospital admissions and improve the quality of care. (Visit vitalysthealth.org/community-paramedicine/ for a primer detailing these innovations).

Lance Donkerbrook, COO of the Commonwealth Primary Care ACO, calls this a "high touch issue." With 15 employees, the Commonwealth team consists of RNs, Licensed Practical Nurses (LPNs), and Medical Assistants assigned to different offices divided into "pods." The team performs discharge and transitional planning as much as possible.

The District Medical Group has a fairly mature care coordination process. When a patient presents at the ED, they are immediately screened to determine if the problem is emergent. If not, the patient is referred back to the primary care physician. Appropriate patient information is relayed to the site manager and sent to the physician's email inbox. The ACO works with both discharge planners and care coordinators. It has a relationship with a home care service that follows patients and care coordinators. Examples include: diabetic coordinators, burn care coordinators and pediatric coordinators. The missing piece, according to Kote Chundu, MD, CEO of District Medical Group, is communication. "The timeliness of feedback from post-acute care and home care is critical."

This is another common theme among all ACOs. There don't seem to be good technology platforms for doing care coordination and population management. According to Dr. Chundu, there are three impediments to a good care coordination program:

- Adequate payment mechanisms – This addresses how providers in new models of care will get paid. A few examples:

- Home visits by community social worker or a dietician for diabetics
- Paramedic visits for non-urgent calls (paramedicine)
- Home visits by providers
- Home rehabilitation
- Appropriate changes in state regulations – Addressing the licensing/payment/funding changes for the new type of care delivery providers
- Robust data transfer

There are some promising developments on the horizon. In October 2015, the Dartmouth-Hitchcock Health System and Microsoft launched a highly coordinated, intensely personalized solution that encompasses physical, mental and emotional health called ImagineCare. They are piloting the system with their employees.⁴⁰

ACO leaders consistently communicated the importance of a consumer focus. Dr. Shaun Anand, former CMO of BHN, added that ACOs have learned the importance of starting with "a service model that is built around the customer." He also added another important component for ACO success, namely recognizing that medical care is "only 20 percent of overall health." Building a system that is patient-centric and which addresses a person's broader health needs is not easy, but it is something that is needed if a system is going to reduce costs and improve outcomes.

Care coordination needs to not only encompass coordination of medical services, but coordinate linkages to a broader array of resources that patients need to stay healthy. Such needs can be housing, food and safety – a broad array of resources that help individuals maintain health and stay out of the hospital. ACOs are just beginning to scratch the surface of understanding such needs, and how to address or coordinate them.

Strengthening and Improving Arizona's Efforts to Achieve the Triple Aim

Arizona's ACOs are innovating and moving Arizona closer to a value-based health care system. However, many opportunities remain to further strengthen these ACO experiments and further facilitate achievement of the Triple Aim.

Governance and Leadership

Arizona has a strong foundation for its ACOs in its physician leadership. This foundation could be further strengthened with additional training and support of physicians. Physicians both old and young want to lead change.

The Arizona Medical Association (ArMA) sponsored a Physician Leadership Conference and devoted a whole issue of *Arizona Medicine* to "The Evolving Physician." Organizations such as ArMA and the Arizona Osteopathic Medical Association could play pivotal roles in further preparing and supporting physicians in transforming our state's health care system.

Others could also help train and support physician leaders. The American Association for Physician Leadership offers multiple courses related to management and leadership development both online and in-person for physicians. The Eller College of Management at The University of Arizona provided leadership training for physicians at the Phoenix Children's Hospital several years ago. The courses offered included Healthcare Economics, Accounting and Finance, Leadership and Change, Leadership and People, and Strategy and Analytical Decision Making. Such training could once again be replicated or built upon in the future. Other groups such as the Arizona Hospital and Healthcare Association, the Maricopa County Medical Society, and specialty physician societies can also serve to further educate and train their members.



Health Plan Relationships

Interviews noted a lack of collaboration with health plans. Only a few ACOs mentioned good health plan relationships. In one of the ACOs interviewed, its leaders meet monthly with the health plan, share real-time data, and coordinate care management programs. They review timely data and track high utilization. This should be a model of cooperation and collaboration that works for all parties, especially the patient. ACO-health plan relationships will need to improve as alternative payment models move forward, particularly as MACRA implementation evolves.

There are a number of excellent examples of collaborative efforts in Texas, California, Louisiana and Massachusetts (described previously) that could be used as an example to develop better relationships with health plans. There is no reason why these models cannot be used in Arizona.

Improving Quality, Accelerating Success

Improving quality will depend on the ability of ACOs to integrate, analyze and share data. That capacity, in turn, will be influenced by ACO-health plan relationships and the ability to integrate technology.

Nonetheless, quality improvement and achievement of the Triple Aim might also be influenced by the capacity of ACOs to share best practices and lessons learned among one another.

In the interviews, it was impressive to hear the passion expressed by ACO leaders, and the innovations that each are achieving. They all had much to share about what they and their organizations were learning and accomplishing. As noted earlier, what is unfortunate is that each ACO appears to be operating in a vacuum. The opportunity to learn from one another has not yet been realized. As Lisa Stevens Anderson of BHN pointed out, “We know more than we did four years ago. It feels like we are learning at an exponential rate...We have the opportunity to learn from other organizations doing the same thing.”

It would seem that there should be a way to convene Arizona’s ACO leaders routinely. The state’s Medicaid program (AHCCCS), public health agencies (county or state health departments), foundations or health plans could take the lead in facilitating such meetings.

Attendees might also include players beyond ACO leaders, such as public health officials or health plans. Including these other groups might further build collaboration, and enhance efforts to achieve the Triple Aim. Indeed, Dr. Francisco Garcia, director and CMO for the Pima County Health Department, noted in the inter-

“WE KNOW MORE THAN WE DID FOUR YEARS AGO. IT FEELS LIKE WE ARE LEARNING AT AN EXPONENTIAL RATE...WE HAVE THE OPPORTUNITY TO LEARN FROM OTHER ORGANIZATIONS DOING THE SAME THING.”

Lisa Stevens Anderson, Chief Executive Officer, Banner Health Network



views that it would be helpful for public health departments and ACOs to work together to understand how they could better support one another and drive improvements in population health.

Data and Connectivity

At every step, from reporting data to Medicare and health plans, to sharing data among providers, technology continues to be a huge barrier. It's apparent that technology lags behind the work being done, necessitating awkward and burdensome "work-arounds" on the part of ACOs.

In order for ACOs in particular, and value-based health care in general, to succeed, technology development needs to pick up the pace. Technology is costly, so it is important to develop the right technology solutions. As Ed Kim from Cigna points out, "You need the right technology, not a lot of technology."

Primary Care Capacity

The primary care physician is at the center of the ACO process as the first and most frequent contact in the system, and as the coordinator of care for ACO patients. It is widely accepted and now proven that the improved delivery of primary care and better coordination of care will improve quality and reduce costs over time.

Since the future success of the new health care models depend on primary care capacity, the state needs to address this directly. It should be possible to create some "attractors" for medical students to choose primary care. There are many examples of this in other states for Arizona to emulate.

One idea might be to offer loan forgiveness or repayment of medical school debt, since such debt burdens are known to push medical students to more lucrative specialties. Arizona could, for example, expand its current state loan repayment program to meet the needs of additional primary care providers willing to serve in medically underserved areas.

Efforts could also be employed to improve compensation for primary care to reflect both the importance of the role to the system as a whole and how much time it takes to coordinate care. Health plans including Medicare need to recognize that the success in moving forward in this new health care environment is dependent on the primary care model succeeding. There needs to be a shift in compensation away from specialty care toward primary care. This includes not only physicians but nurse- and physician-extenders, care coordinators and medical support for patients 24/7. This is important for the future of health care in this country.

Care Coordination and Consumer Focus

The interviewed ACOs are in the process of developing care coordination programs. Currently these programs are the key to successfully managing patients and preventing ED visits and hospital readmissions.

There are many different approaches to care coordination in Arizona, but all focus on managing care through the health care continuum. It seems the most difficult part of managing population health is the inability to communicate effectively across other parts of the social and health care systems. Once again, organizations are waiting for a technology solution. Right now, communication is done by telephone or fax. There are systems that use newer technology, but most are unsatisfied with the current level of sophistication. There needs to be improved levels of communication that are seamless and easy to use. The current approach for ACOs is to continue communicating as best as they can until a satisfactory technology solution is available.

In the area of customer focus, there is a lot of current work happening locally and nationally to address patient engagement.



In the fall of 2014, a group of MBA students from the Eller College of Management at The University of Arizona did an “experiential project” for Arizona Connected Care as part of their course work. They interviewed more than 1,000 patients electronically and more than 100 in person to determine what factors the patients felt were most important to them in their care.

UofA Study Results

Below are the five key areas that explain patient satisfaction in descending order of importance:

- The care I receive is personalized according to my preference.
- My health provider works with my schedule.
- My health provider and I work together to improve my health.
- My health provider talks with my other health professionals.
- My health provider gives me the information I need to manage my health.

This study was unique because it provided to the ACO information on what patients want rather than what the health care system thought they wanted. The current thinking is that health care needs to listen to the needs of the patients. Having them involved in their care is vital if the transformation in health care is to be successful.

Population Health Management and the Future of ACOs

Amy Oldenburg, vice president of network and product strategy, of the Accountable Care Solutions at Aetna explained that true transformation is a long-term endeavor:

“We know that it takes at least three years for motivated ACOs to make changes necessary to impact real savings and quality improvements. We believe transforming health care will help reduce waste, improve quality, improve member/patient satisfaction, and improve overall employee health and productivity.”

ACOs have numerous benefits and many stakeholders obtain advantages from this model of care. The patient community also gains a wide number of advantages including improved outcomes, better quality of care, greater engagement with providers, and an overall reduction in out-of-pocket costs. Another major benefit of ACOs is their ability to improve population health management and patient outcomes. Medicaid ACOs, for example, have shown a greater focus on preventing disease and promoting wellness that leads to stronger population health improve-

ments. Furthermore, this reduces the likelihood that diseases will progress and lead to more costly hospital stays.²⁰

Understanding regional differences has proven to be crucial for ACO success. Regional differences need to be examined to understand how an ACO could reduce expenditures when compared with its initial benchmark. In response, CMS recently announced it will update its regional benchmarks annually to account for any changes in fee-for-service spending. This applies to any county where an ACO has beneficiaries and across all Medicare beneficiary types. Starting in “Track 1” of this benchmark evaluation, ACOs can receive savings payments for strong performance but will not be held accountable for overspending and penalties assessed for low quality scoring. The final rule will give participating ACOs in Track 1 the option to extend their participation in that track for another year if they sign up to take part in “Track 2.” This is intended to encourage more ACOs to move on to this risk-sharing track.

CMS has responded to ACO concerns. For example, the National Rural Accountable Care Consortium recently received an award for up to \$31 million from the CMS Transforming Clinical Practices Initiative to develop Practice Transformation Networks that prepare providers for the movement to value-based payment models. The program is offered at no cost to providers and assists them in setting up an on-site billable care coordination program, prepares providers to become a Patient Centered Medical Home, increases provider revenue through improved primary care billing, and redesigns practice workflows to manage population health.⁴¹

Arizona Could Lead the Way

For many years, Arizona was a nationally recognized leader in health innovation. Even though it was the last state to join the federal Medicaid program, it was one of the first states to implement Medicaid managed care, and led the rest of the country in implementing home and community-based care within Medicaid. In addition, Arizona was early in adopting the ACO strategy with BHN as one of the original pioneer models. Arizona Connected Care was one of the first MSSP participants and now the Optum ACO is one of the first Next Generation ACO designees. As new efforts to drive value-based health care evolve, Arizona could once again take the lead. The key will not only be experimentation, but collaboration, especially as these efforts to achieve the Triple Aim expand our focus to include the social determinants of health and broader population health.

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