BACKGROUND

Arizona Connected Care (AzCC), a physician-driven ACO, was one of the original 27 participants in the Medicare Shared Savings Program (MSSP) starting in April 2012. The organization struggled in its early years to generate shared savings and, in 2014, hired a new CEO with experience in care management and risk-sharing arrangements. Under new leadership, it was determined that the ACO needed to adopt a “total cost of care” approach to its clinical strategy by improving its understanding of utilization patterns and the cost implications at both the patient and individual provider levels. After having two average performance years, leadership felt pressured to justify continued participation in the MSSP but also to prove the long-term potential of the ACO model.

APPROACH

AzCC had, from the beginning, been engaged in substantive clinical efforts to improve care for patients, but new leadership felt that individual providers needed broader cost and quality context to see significant improvements. The goal then became to help doctors understand what care actually costs both at an individual and systems level, and how different procedures and pathways related to outcomes. The goal was to move from a system where each doctor was simply trying to do his/her best to one where the decision-making process was data-driven.

For this approach, the ACO first had to ensure that the contracts with its payer partners included data sharing—potentially to a degree to which most insurance companies were not yet accustomed. Fortunately, CMS made claims data available as part of the MSSP and the ACO was also able to obtain robust data from the commercial payer partner for their Medicare Advantage population. The next step was to ensure that the ACO had staff that could perform light analysis to get basic systems-level statistics—like hospital admissions per thousand for their attributed population—which required a dedicated data analyst. At times, AzCC used outside actuaries to handle higher level questions but prioritized developing the competency internally. To support the new cost analysis efforts, the ACO had to ensure that staff had adequate computer systems to handle the large number of claims data, which required more storage and memory than was existing from prior electronic operations.

Early analysis focused on three main categories of services: 1) hospital admissions, 2) skilled nursing facility (SNF) admissions, and 3) specialty visits and procedures. The first category, hospital admissions, included items like low-acuity admissions that represent opportunities to provide the same or better care in much less expensive settings. One example would be avoiding admitting a patient for intravenous antibiotic administration if the patient could receive the same drug orally or at their residence from a home health provider. Also included in this category were readmission opportunities that overlapped with other Medicare programs which justified additional resource investment. Another element of the hospital analysis included knowing how many ED visits occurred per thousand patients, which in turn led to the ACO hiring an extra physician to handle urgent care situations, including the expansion of office hours to 10pm. The second category, SNF admissions, involved ensuring that if an admission was clinically justified, the social worker member of the care coordination team visited the facility to ensure that the patient received the needed occupational therapy immediately rather than days later, resulting from certain SNF practices needlessly extending the length of stay. The third category AzCC analyzed was specialty visits per thousand patients, assessing the cost effectiveness of those visits. For example, leadership determined that it could be cost-effective for an endocrinologist to provide primary care for a diabetic patient, while a spine surgeon handling the first instance of back pain would not be. This enabled them to reassess when, how, and to whom primary care providers make referrals.

RESULTS TO DATE

In the third year of the MSSP, Arizona Connected Care reduced costs by 8.3% which resulted in approximately $2.3 million dollars in shared savings for the system. On the quality side, the ACO had some areas where they excelled but, for the most part, performed on par with their cohort. The system’s providers also demonstrated a newfound confidence that they are sending patients to a quality, cost-effective specialist or SNF facility—something that many physicians may have intuited in the past but now have data to support.
TOOLS & VENDOR PARTNERS

Arizona Connected Care had used vendors for previous initiatives and felt the need to build this competency in-house, especially considering their new CEO brought a significant amount of care management experience. In order to process and analyze the enormous amounts of associated data, the ACO needed to ensure that the data analyst had a more powerful computer and greater data storage capacity, and was able to do the work in spreadsheet software.

CHALLENGES WITH IMPLEMENTATION

Impediments to implementing a “total cost of care” approach stemmed from three main issues. First was that, at the core of such a strategy, it meant an eventual decrease to certain lines of revenue, especially hospital services. The hospital CFO charged with short-term survival was somewhat at odds with the long-term sustainability goals. The second impediment had to do with getting physicians to change the way they provide care, a common barrier in most situations where the status quo is being challenged. The third impediment, and the most specific to this competency, was that the organization was perhaps looking too far into the future and spent too much money trying to scale from the beginning. ACO leadership recommends that organizations, whether big or small, start with a subset of the population before trying to scale up.

KEY LEARNINGS

- **Change should be data driven** – Physicians operate better when they have data to support practice change.
- **Analyze cost trends** – Analyzing the cost trends of your population will direct you to the clinical areas on which you can focus and achieve the return for your invested efforts.
- **Scale gradually** – When developing a competency of this nature, start on a smaller scale and then work toward larger applications.

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