QUALITY AND EFFICIENCY OF HEALTH CARE

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While most of the initial attention on the Patient Protection and Affordable Care Act (Act) has focused on expanding coverage, the legislation contains a number of provisions directed at improving the quality of medical care and overall health system performance. These include changes in how Medicare and Medicaid are administered and reimbursed, pilots allowing experimentation on new methods of healthcare delivery and payment, efforts to reduce fraud and simplify administration, comparative effectiveness research, and increased emphasis on primary care and greater system integration.

Taken together, these changes seek to advance the larger agenda of promoting *value-based health care*: achieving the highest possible quality at an affordable price.

Many of these issues have been discussed in past *Arizona Health Futures* reports.[1] Here, selected aspects of the Act are presented, and opportunities and challenges for Arizona are considered. The impact of the Act and earlier legislation on state health information efforts either under way or planned is also discussed, given the increasing importance of health information technology (HIT) and health information exchange (HIE) to improving quality and system performance.

KEY REFORM CHANGES

- **Provides grants and incentives for the development of new methods of team-based care delivery and alternative payment models for medical services.**
- **Promotes the development of value-based health care through incentives for value-based purchasing and reporting on quality metrics.**
- **Promotes the role of primary care through incentive payments, higher payments for primary care physicians and patient-centered medical homes.**
- **Takes steps to reduce preventable hospital readmissions and hospital-acquired conditions.**
- **Creates an Innovation Center, Payment Advisory Board and Patient-Centered Outcomes Research Institute to investigate and expand more effective and efficient methods of service delivery, payment and clinical care.**

VALUE-BASED PAYMENT AND QUALITY REPORTING

Efforts to improve the quality and efficiency of health care are of one piece: it is impossible to talk about different approaches to paying for medical care without also talking about changes to how care is organized, and vice versa. In the context of this integration, the law provides new opportunities to change how health care is paid for, potentially impacting the cost and quality of health care in Arizona in the near future.

Alternative Payment Models

The intent of the new federal law is to steer a course away from the potential excesses of straight fee-for-service by focusing on payment models that reward *quality* of service, rather than just *quantity*.

Some of the alternative payment models currently being investigated include:[2]

- **Bundled acute case rates** – a warranty for a given procedure, such as hip replacement surgery or heart bypass surgery.
- **Global fees** – each provider organization receives a fixed, per-person payment based on the patient's health condition or a risk-adjusted capitation rate.
- **Primary care medical home fees** – the medical home receives either a fee for all primary care or a blended payment comprising both fee-for-service and monthly medical home fees.
- **Gainsharing** – shared savings available to physician group practices and other accountable health systems that improve quality and reduce costs.

The *bundled payment model* is a case in point. Here, providers receive a single fee for an entire episode of care, rather than for specific procedures, and they then determine the optimal allocation of medical resources to deliver high quality care. In effect, all of the services associated with a patient's acute or chronic medical condition are "bundled" together and paid in a lump sum.

THE NATIONAL HEALTH CARE QUALITY STRATEGY

As a result of the health reform law, the Secretary of the U.S. Department of Health and Human Services is required to develop a strategic plan (January 2011) that will:

1. **Improve health outcomes, efficiency and patient-centeredness of health care for all populations**
2. **Identify areas that have the potential for rapid improvement in the quality and efficiency of patient care**
3. **Address gaps in quality, efficiency, comparative effectiveness information, health outcomes measures and data aggregation techniques**
4. **Improve federal payment policy**
5. **Enhance the use of healthcare data**
6. **Address the health care provided to patients with high-cost chronic disease**
7. **Improve research and dissemination of strategies and best practices**
8. **Reduce health disparities**

Bundled payments strike a middle ground between fee-for-service and capitated payment systems. Under fee-for-service systems, medical professionals are paid for every service delivered, potentially leading to unnecessary healthcare utilization and added costs. Under capitation, an entity is paid a single rate to care (usually prospectively) for an individual regardless of their health status. Critics of capitated systems note that they may result in underutilization of needed health care, or potentially expose providers to unnecessary risk.[3]

Bundled payment projects are not new. Studies conducted on Medicare bundled payments for Coronary Artery Bypass Graft (CABG) surgery in the 1990s estimated that they reduced spending for such procedures by as much as 15.5 percent.[4] Bundled payment encourages two behaviors that fee-for-service payment discourages: collaboration of physicians, hospitals and other providers involved in a patient's care; and efforts to reduce avoidable complications of care and their related costs. The bundled payment case rate reimbursement model accommodates benchmarked performance incentives by integrating evidence-informed clinical science with aligned incentives that address the current, siloed fee-for-service model.

The Act accelerates experimentation with bundled payments specifically and with alternate payment models generally. The Act:

- Establishes a demonstration project in up to eight states to evaluate integrated care around a hospitalization by studying the use of bundled payments for hospital and physician services under Medicaid (2012-2016). (Sec. 2704).
- Develops a national voluntary pilot program to encourage hospitals, physicians and post-acute care providers to improve patient care and achieve savings in Medicare through bundled payment models (2013-2018). (Sec. 3023)

- Establishes a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS) to research, develop, test and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care in both public programs (2011). (Sec. 3021)
- Establishes a Medicaid demonstration program in up to five states to study changing the payment structure in safety net hospitals from fee-for-service to a global capitated payment structure (2010-2012). (Sec. 2705)

Both opportunities and challenges exist for implementing bundled payments in Arizona. On the opportunity side, the impetus is building among both providers and employers to pay for value rather than volume. The pressure to stem the rising tide of medical costs is intense, and there is a growing awareness among providers that the straight fee-for-service model is most likely at its apex and cannot be expected to continue upward without significant economic and political backlash. Conversations with Arizona hospitals and physicians indicate an interest in exploring innovative payment models like bundling, gainsharing, medical home fees and some aspects of capitation as alternatives.

On the challenge side, it is easier to implement models like bundled payments in systems where provider groups are tightly aligned and integrated. On a comparative basis, Arizona has fewer large integrated health systems than other parts of the country. Physicians in this state tend to practice in smaller groups, with few-multi specialty practices. Although there are signs that this is beginning to change, we are starting at the back of the pack.

CENTER FOR MEDICARE AND MEDICAID INNOVATION

Effective January 1, 2011, the Act establishes a new Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and service delivery models and rapidly deploy the best of them to reduce healthcare costs and enhance quality of care. Several things are notable about the CMI:

- The CMI would run pilot programs rather than demonstration projects. The Secretary of HHS could expand the pilots if they did in fact lower costs and improve quality. This is a departure from the past, when the need for congressional approval either delayed or derailed past initiatives.
- The CMI would have broad authority to consider a multitude of payment and delivery models for testing.
- The CMI would not have to require projects to be "budget-neutral" during their initial testing period. This will encourage potential applicants whose innovations may require initial upfront investment that increase costs in the short term but hold the promise of significantly reducing them long term.
- The CMI has a $10 billion appropriation through 2019. This will give it flexibility to pay for services not covered by traditional Medicare and support activities such as electronic data sharing and quality improvement.

Source: Mechanic, R., & Altman, S. (2010, March 3). Medicare's opportunity to encourage innovation in health care delivery. *New England Journal of Medicine*. Retrieved September 17, 2010 from http://healthcarereform.nejm.org/?p=3108

MEDICAID

The Arizona Health Care Cost Containment System (AHCCCS) – Arizona's Medicaid program – is well positioned to take advantage of alternative models like bundled payments:

- AHCCCS is a mandatory managed care program for the vast majority of Medicaid patients. It has contractual relationships with managed care organizations (MCOs) that can serve as the underlying structure for experiments with service arrays that drive quality over quantity.
- AHCCCS is more integrated with a cross section of Arizona's healthcare providers than other states that rely on a designated "safety net" system. This may lead to more opportunities for experimentation around episodes of care in diverse settings.
- AHCCCS has a history of innovation in cost control and quality improvement. It has a reputation as one of the best run Medicaid programs in the country.

Because AHCCCS is further along than many other states when it comes to plan-provider integration through MCOs, there may be fewer opportunities to take advantage of pilot and demonstration programs around bundled payments, which target the transition from more traditional fee-for-service models.

Nevertheless, AHCCCS intends to maximize funding opportunities under the Act. Currently, AHCCCS is attempting to modify the federal waiver under which it operates to experiment with methods of improving quality using alternative payment methods. If it receives federal approval for these waiver changes, AHCCCS will use federal matching dollars to cover expenses and share cost savings with providers, plans, the state and federal government when they are achieved through bundled payments and other innovations in payment reform and new service delivery configurations.

The key is program flexibility. For AHCCCS to continue to explore new models of organization, integration and payment, CMS must provide some measure of programmatic leeway for experimentation. An overly prescriptive approach to defining and implementing bundled payments, accountable care organizations (ACOs) and other organizational configurations will serve neither the states nor the federal government well.

MEDICARE

On the Medicare side, much of the emphasis on episode-of-care bundled payment is a continuation and refinement of CMS's Acute Care Episode (ACE) demonstration project that began in May 2009. Acute care episodes – e.g., gall bladder surgery, a hip replacement – may have only one hospital and doctor group participating, limited medical codes, and clearly delineated and controlled conditions of care. The Medicare voluntary pilot program on payment bundling for acute episodes of care, set to start in 2013, allows providers to share in any savings, subject to quality performance. It provides a means for providers to experiment with bundling services on the acute side before moving into the more complex arena of chronic diseases and coordination of care across acute, ambulatory and home settings.

These changes will impact Arizona in a number of ways:

- **Integration.** Physicians and hospitals that are integrated through formal practice arrangements will be in a better position to participate in bundled payment pilot programs than those that are not. There is a clear trend in Arizona and elsewhere toward system integration and consolidation (hospitals employing more physicians, for example). Integration of primary care with behavioral health should be a clear focus. The state has some good candidates for pilot demonstration sites.
- **Infrastructure.** Bundling requires a robust, transparent exchange of clinical data. Electronic medical records (EMRs) and health information exchanges (HIEs) are beginning to populate Arizona, but progress is sporadic and unevenly distributed. It makes little sense to automate and digitize the exchange of clinical information if the processes on which that information is based – e.g., relationships between providers, coordination and documentation of care – are not well established in the first place.
- **Alignment of Purpose and Value.** Bundling, pay-for-performance, gainsharing and other approaches to payment reform require a shared commitment to practicing evidenced-based medicine, measuring processes and outcomes, reporting out, and being assessed and paid based on value. Hospitals and physician groups that choose to reorganize their practices and payment systems based on value must carefully select partners who share that commitment. This isn't a financial arrangement alone.
- **Accountability of Care.** Bundling payments for medical codes such as diabetes and pneumonia is more difficult than for straightforward surgical procedures; managing a chronic disease through the continuum of the doctor's office, hospital, home and other settings is more complex than in the acute setting alone. Not only is it challenging to determine who is responsible for what, but it is hard to prospectively plan for all of the complications that could arise, the prevalence of outliers in the patient mix that skew performance on quality metrics, and patient noncompliance. Providers rightly resist being held accountable for – and measured by – outcomes beyond their control.

PAYMENT AND QUALITY REPORTING

The Act extends efforts that have been under way for some time toward developing and reporting on quality metrics, and paying for value – effectiveness and efficiency of outcomes – rather than straight fee-for-service payment alone that incentivizes volume of services over value.

The Act:

- Prohibits Medicaid payment for services related to a healthcare-acquired condition. (Sec. 2701)
- Establishes a Medicare hospital value-based purchasing program (2013). A percentage of hospital payments will be tied to hospital performance on quality measures related to common and high-cost conditions such as cardiac, surgical and pneumonia care. (Sec. 3001)
- Extends the Physician Quality Reporting Initiative (PQRI) through 2014, which provides incentives to physicians who report quality data to Medicare. Reduces payment to physicians who do not submit measures to PQRI (2014). (Sec. 3002)
- Develops a value-based payment modifier under the physician fee schedule in Medicare. A budget-neutral payment system will adjust payments based on the quality and cost of care (2015). (Sec. 3007)
- Creates Medicare payment penalties for conditions acquired in hospitals (2015). (Sec. 3008)

Over the next three years all acute care prospective payment system hospitals in Arizona with sufficient volume will participate in the Medicare value-based purchasing initiative. How 'value' will be defined and rewarded will not be determined until the regulations are written, but the overall direction is clear. Financed by DRG payment withholdings, bonuses will be based on how hospitals meet established process measures for heart attack/failure, pneumonia and surgical care; clinical outcome measures such as hospital-acquired infections; patient perceptions; and efficiency measures such as Medicare spending per beneficiary.[5]

Beginning in 2012, hospitals will also face penalties for high readmission rates for heart attack, heart failure and pneumonia. Other diseases and procedures may be added in the future for all patients with the target conditions, not just those covered by Medicare, when determining rates.

Other sections of the law establish a path toward value-based purchasing for long-term care hospitals, inpatient rehabilitation facilities, hospice, skilled nursing facilities and home health agencies.

Physicians face the same "carrot and stick" approach. The PQRI, which provides incentives to physicians who report quality data to Medicare, is extended through 2014. Beginning in the same year, physicians who do not submit quality data will have their Medicare payments reduced.

Conversations with Arizona stakeholders reveal the following opportunities and challenges:

- Without exception, Arizona healthcare leaders interviewed regarded prospective changes in payment, value-based purchasing (VBP) and pay for performance as inevitable. There is a shared sentiment that the current system is unsustainable, and that something has to be done to improve quality, increase efficiency and control costs. More people are willing to get on board with quality metrics and VBP as a result.
- Some Arizona hospitals and physician groups are already ahead of the payment and quality curve. At these organizations, there is a shared commitment to reporting on, and being assessed by, quality metrics and to practice evidence-based medicine. The most important factor in changing organizational culture to foster this shift is key physician and executive leadership at the outset. Lessons learned at these leading organizations can be applied elsewhere. There is a wholesale change in physician culture taking place, with major implications for training programs.

- Being committed to pursuing value and coming to a consensus on what and how to measure value are two different issues. With changes being proposed in the value-based purchasing measures at a rapid clip, hospitals are challenged to keep up. They are well advised to keep focused on the Hospital Compare measures. "Because VBP is a zero-sum game, hospitals will have to compete to maintain full payment."[6]
- VBP for both hospitals and physicians requires access to clinical and claims information when it occurs, not months after the fact. Providers can't very well manage patients if they don't know where they've been, who they have seen, and what was done in a timely and accurate fashion. This requires not only interoperable ways to populate health records electronically, but also agreements to exchange data between the appropriate participants. Arizona is beginning to build this infrastructure, but progress is spotty, and there is a long way to go.
- Setting readmission expectations is difficult. An Arizona hospital with a higher than average readmission rate may be in a catchment area comprised of a large number of elderly Medicare patients with multiple chronic diseases. That may not be taken into account in applying penalties. Current measures also don't take into account whether readmissions are planned. These challenges will need to be addressed.

KEY TAKEAWAYS:

- The value-based healthcare train promoted in various sections of the Act has already left the station. Arizona providers, payers and other stakeholders in the healthcare system know they have to get on board or be left behind. The status quo is unsustainable.
- It is a mistake to think Arizona can't leverage resources provided through the Act to realize greater practice integration, coordination of care and better patient outcomes at an affordable price. Arizona providers are hooking up in new configurations at a rapid pace to do just that. This will only accelerate in the future.
- AHCCCS is a national leader in state Medicaid innovation. It is in a strong position to leverage bundled payments, ACOs and other innovations in healthcare payment and delivery.

CHANGES IN THE DELIVERY OF CARE

The Act continues and expands efforts to provide more coordinated and cost effective care to all Americans, and especially to the growing number of persons with chronic diseases. In order to maximize the ability of providers to respond to new payment incentives, the law encourages the development of such care delivery approaches as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMHs).

ACO Definition

"ACOs are defined as groups of providers that have the legal structure to receive and distribute payments to participating providers, to provide care coordination, to invest in infrastructure and redesign care processes, and to reward high quality and efficient services."[7]

PCMH Definition

A PCMH is a clinical setting centered around an integrated team of primary care providers that provides first contact and continuous care, coordination of care, comprehensiveness of care (referring out to specialists as needed) and a focus on the whole person, wellness and prevention.[8]

The ACO is the broader concept, and may include a constellation of PCMHs centered around a hospital, for example. In one sense, PCMHs are the building blocks for the ACO "house."

Highlights on ACOs and PCMHs include:

- **Sec. 2703.** Provides states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home comprised of a team of health professionals that would provide a comprehensive set of medical services, including care coordination.
- **Sec. 2706.** Establishes a demonstration project that allows pediatric providers to be recognized and share in cost savings as ACOs under Medicaid (2012).
- **Sec. 3022.** Allows voluntary ACOs that meet quality-of-care targets and reduce the costs of care relative to benchmarks to share in the Medicare cost savings they achieve (2012). Provides flexibility to implement innovative payment models currently used in the private sector. ACOs must have adequate participation of primary care physicians, define processes to promote evidence-based medicine, report on quality and costs, and coordinate care.
- **Sec. 3502.** Establishes and funds community health teams to support the development of medical homes by increasing access to comprehensive, community-based coordinated care. Sec. 10321 clarifies that NPs, PAs and other primary care providers can participate in community care teams.

PATIENT EDUCATION AND INCENTIVES

There is a huge amount of patient education that needs to occur before American health care can make a successful transition to value-based care. If American consumers find their choices of providers limited to defined ACOs and PCMHs, or otherwise perceive little value in choosing to sign up with a particular plan and/or group, then it won't be value-based health care.

Currently most Americans don't make their own healthcare purchasing decisions, and they certainly don't have access to comparative and reliable information on services and outcomes. Many are spoiled by on demand, fee-for-service procedures that cost them little. That has to change. New configurations will have to both educate patients on the benefits of joining these new networks and provide incentives for ongoing, preventive care, medication and disease management, and wellness programs. What is a hospital-centric system today could well evolve into a patient-centric system tomorrow, with home-monitoring and a suite of outpatient services defining the core.

Whatever the evolution of the model, patient behavior has to change with it.

Opportunities and challenges for Arizona with regard to evolving delivery-of-care models mirror those in the payment arena:

- **Diversity of Structure.** There are multiple models of ACOs: integrated delivery systems, multi-specialty group practices, physician-hospital organizations, independent practice associations and "virtual" physician organizations. There is no "one best way" approach. It would be a mistake to assume that Arizona can't experiment with ACOs because of the preponderance of small, independent practices and the relative lack of large, integrated systems. There are some interesting models being pursued right now, and more are planned for the immediate future. An innovative ACO project being undertaken by the Tucson Medical Center and its affiliated physician groups is one of three sites selected for a national pilot project undertaken by the Brookings Institution and the Dartmouth Institute for Health Policy and Clinical Practice. Others are under way. There is no reason, for example, why a payer like AHCCCS couldn't link independent primary care PCMHs in rural Arizona in a virtual ACO, borrowing from models developed in North Carolina[9] and elsewhere.
- **Eligibility.** The federal policy challenge is developing eligibility criteria for ACOs that strike a balance between being so restrictive that they discourage healthcare organizations from applying, and making criteria challenging enough to ensure a return on the investment. There will probably be several levels of eligibility criteria, which would allow both smaller configurations (one hospital, several PCMHs, a specialist referral panel, 15,000+ patients, basic lab and medication data, etc.) to larger configurations with a full portfolio of chronic care model processes, formal quality improvement programs and fully functional EMRs. The central idea is to have enough flexibility in terms of qualifying as a PCMH or ACO that practices can "get in," participate in higher levels of payment as more criteria are met, and access technical assistance and support.
- **Clinical Infrastructure.** Groups experimenting with PCMHs in Arizona – such as UnitedHealthcare and federally qualified health centers – know that providing technical assistance and support to practices is critical. This includes EMR systems (patient registries, health record "banks," etc.) to gather and exchange clinical and claims data in a timely, efficient and

transparent manner as well as practice redesign to facilitate continuity and integration of care. One common approach is to contract with outside vendors of EMR and medical practice support. Another model that Arizona might follow is to establish clinical guidelines and a practice collaborative, similar in structure to something like the Colorado Clinical Guidelines Collaborative.[10] Arizona is developing HIT/HIE collaborative capacity, but what is required as well is a broader collaborative of organizations focused on clinical guidelines, practice redesign, PCMHs and ACOs, and other innovations.

- **Established Ground Rules.** Trust between the stakeholders in Accountable Care Organizations and Patient-Centered Medical Home projects rests on agreement on, and a firm commitment to, principles and ground rules. For example, some PCMH projects might adopt joint principles developed by the Patient-Centered Primary Care Collaborative,[11] a common three-tier payment model (fee-for-service, care coordination per member per month, and a pay-for-performance component), and the PPC-PCMH three-level recognition program.[12] Reaching agreement on a common framework for conducting business and assessing progress – all of it in an open, transparent manner – is critical for success. This is something that an Arizona clinical guidelines and practice collaborative could help to provide.

KEY TAKEAWAYS:

- Value-based health care is as much about developing a culture of team-based, evidence-based care as it is about rearranging financial incentives. Build shared values first. Nurture trust and leadership. Practice will follow.
- There is no "one right way" to achieve greater quality and efficiency in health care. Arizona should encourage a diversity of practice arrangements and innovations in care.
- Arizona may want to develop an Arizona Clinical Guidelines Collaborative similar to what was done in Colorado. It could become a true learning, dissemination and technical assistance community of practice.
- There is a huge need to involve and educate consumers in the value-based healthcare movement. If targeted outcomes aren't valued – and sought – by consumers, it's not value-based care.

PRIMARY CARE

The Act seeks to reestablish primary care as the foundation of U.S. healthcare delivery to help improve health outcomes and begin to bend the cost curve. The Act authorizes funding to stabilize and expand the primary care workforce, increases primary care provider rates, provides for adjustments in the resource-based relative value scale that potentially favors specialist over generalist services, and encourages innovations in primary care practice, such as the PCMH discussed above. (Also see the Workforce section of this report for more discussion on primary care.)

The Act also includes numerous provisions aimed at strengthening primary care by altering how primary care providers are paid and practice:

- **Sec. 3024.** Creates the Independence at Home demonstration project to provide high-need Medicare patients with primary care services in their homes and allow teams of health professionals to share in any savings if they reduce preventable hospitalizations and readmissions, improve health outcomes and efficiency of care, reduce the cost of health services and achieve patient satisfaction (2012).
- **Sec. 1202.** Increases Medicaid payments for primary care services provided by primary care doctors (family medicine, general internal medicine, pediatric medicine) to 100 percent of Medicare payment rates for 2013-2014. States will receive 100 percent federal financing for the increased payment rates (2013, 2014).
- **Sec. 5501.** Provides a 10 percent Medicare bonus payment to primary care physicians and general surgeons practicing in health professional shortage areas from 2011-2015.

- **Sec. 3134.** Stipulates that the Secretary of the Department of Health and Human Services has the flexibility to identify and adjust potentially misvalued Medicare service codes (which may discriminate against primary care services).

It is unclear whether these provisions will make an appreciable dent in reconstituting primary care as the center of U.S. health care, and in Arizona specifically.

- **Paying Primary Care Physicians More.** While it is easy to argue that primary care physicians (family physicians, general internists and pediatricians, geriatricians, etc.) ought to be paid more, an increase of 10 percent (in health professional shortage areas) is probably insufficient to make much of a dent in enticing more people into the field. What is required is a long-term, significant correction, not a five-year modest "fix." With regard to bringing Medicaid primary care provider rates up to 100 percent of Medicare rates, AHCCCS traditionally reimburses primary care physicians at 95 percent of Medicare rates. (Without doubt, these rates are less today, given no automatic medical inflation adjustments to rates over the past several years because of state budget cuts.) The impact here is likely minimal, especially in light of potential cuts to Medicare rates themselves.
- **Adjusting the Resource-Based Relative Value Scale (RBRVS).** The RBRVS, launched in 1992, has become the accepted method for determining physician payment for most practice settings. Unfortunately, CMS "has not maintained the accuracy and relative valuation of the evaluation and management service codes to reflect the expanded content of modern generalist care."[13] Because primary care physicians spend much of their time providing cognitive services (coordinating care, counseling, acquiring and managing information, etc.) relative to performing medical procedures, their compensation has declined to levels that are 30 percent to 60 percent lower than specialists. It is one thing to say that the Secretary has the flexibility to make "adjustments" in these "skewed" codes, and quite another to think that specialists who profit from the status quo will go along with it, especially if the increases in primary care payment come out of their rates.
- **Innovations in Practice.** There is significant potential in engineering practices around ACOs and PCMHs, and using new methods of payment such as bundled payments and forms of capitation coupled with fee-for-service and pay-for-performance. But will patients willingly join medical homes if they perceive it as limiting their choice of providers? Will specialists who believe they can effectively organize and provide the care of patients with chronic diseases like diabetes and arthritis be willing to "cede" coordination and managing functions to primary care providers in these new organizational arrangements?
- **Increased Local Interest.** Interviews confirm a great deal of interest in, and activity around, innovations in primary care-based practice and payment. The coordination of and management of chronic diseases is a growth industry, especially with an aging population. More hospitals are entering into relationships with primary care providers to provide community-based services; health plans are demonstrating early success in improving patient outcomes and reducing unnecessary and expensive care (ED visits, hospital readmissions, etc.) through the use of primary care PCMHs; community health centers continue to innovate with strong primary care services for vulnerable populations; AHCCCS is investigating bundled payments as one way of integrating the coordination and management of care by primary care clinicians into the entire continuum of care to achieve better health outcomes at a more affordable cost.

KEY TAKEAWAY:

- The incentives provided by the Act to establish the "primacy" of primary care in the U.S. system are insufficient, by themselves, to move the needle. A much larger, longer-term commitment is needed.

HEALTH INFORMATION TECHNOLOGY (HIT)

The Act generally emphasizes the continued development and deployment of HIT on issues such as care coordination, quality reporting, health disparities, population-based medicine and research, among other areas. It also focuses on standards for financial and administrative transactions in the electronic realm, such as standardized provider enrollment processes in health plans.

Of more immediate interest in Arizona is the implementation of the Health Information Technology (HITECH) Act as part of the 2009 American Recovery and Reinvestment Act. This legislation provided significant financial support to encourage the adoption and use of HIT in the form of certified electronic health records (EHRs) and electronic health information exchange (HIE). The idea, similar to sections of the Act summarized above, is to provide a series of "carrots and sticks" to bring healthcare providers to standards of "meaningful use" – applying HIT to improve the quality and delivery of care.

Arizona Health-e-Connection, a broad membership-based organization established in 2007 as the result of a state planning effort, received a $10.8 million award in 2010 to develop the Arizona Regional Extension Center (REC), which is charged with assisting primary care providers in adopting EHRs and meeting meaningful use requirements. Further, the Governor's Office of Economic Recovery received a $9.3 million award to establish a statewide health information exchange. Projects already under way to create HIEs – the Arizona Medical Information Exchange (AMIE) and the Southern Arizona Information Exchange (SAHIE) – have combined their efforts to form a new statewide exchange. Stakeholders involved in all of these efforts will closely coordinate their efforts and collaborate in the critical years ahead.

HIT AND ARIZONA PHYSICIANS

Recent research on the use of EMRs and Arizona physician attitudes toward HIE found, among other things, that:

- **Almost 20 percent of Arizona physicians have neither internet nor email access at their practice setting.**
- **Paper remains the prevalent storage medium for medical records – only 28 percent of Arizona physicians have eliminated use of paper records.**
- **Cost is the most frequently cited reason for lack of EMRs, followed by time/training.**
- **More than 45 percent of physicians practicing in Arizona use some form of EMRs.**
- **Over half (54 percent) of EMR users transmit medical data electronically to other parts of the system, such as labs or pharmacies.**
- **The most trusted organization by physicians to manage an HIE is a hospital system, followed by a regional health information organization (RHIO).**

Source: Johnson, W., et al. (2010). The use of electronic medical records and physicians' attitudes toward a health information exchange. Center for Health Information and Research, Arizona State University.

Arizona will face a number of opportunities and challenges in implementing HIT as they relate to innovations in practice and payment promoted in the Act to move toward a value-based healthcare system. One sees the same issues come up over and over again:

- **Governance.** Sharing health information electronically between various parts of the healthcare system in a transparent manner with full patient privacy and confidentiality protection requires a robust, representative governance structure. SLHI recently commissioned an Arizona HIE Governance and Collaborative Capacity Assessment[14] that found a broad measure of trust and collaboration among Arizona HIE stakeholders, but with limited functional capacity – the operational resources necessary to implement HIEs. The opportunity is a willingness to collaborate and form HIE governance structures. The challenge is to find the resources to implement the actual exchange of information.
- **Expectations and Timelines.** There is a potential mismatch between the expectations and timelines of HIT implementation of EHRs and HIEs outlined in federal programs and conditions of readiness on the ground, especially in states like Arizona that have been decimated by budget deficits. For example, bringing over 2,000 Arizona primary care physicians up to standards of meaningful use in less than a two-year period through the REC may be unrealistic. Recent CMS rules lighten meaningful use requirements and increase the odds of qualifying for incentive payments, but the timeline is still tight. Other states are in a similar position. There is a need for federal officials to provide additional flexibility in execution and timelines.
- **Technical Assistance.** Implementing HIT, like implementing ACOs and other changes in payment and care delivery organization, requires significant resources in the form of education and technical assistance for system design, product selection and installation, and ongoing support. This is a central function of Arizona Health-e-Connection, the state REC, but it requires more resources than the REC currently can provide on the front end. Public-private partnerships are one viable solution, but these, too, require financial resources – a challenge in the current economic climate.

- **Getting Clinical Processes Right.** There's a well-known "cart before the horse" problem with HIT: hospitals, physicians and other providers may install and implement EHRs before they have thoroughly thought through and designed optimal clinical and practice management systems. The problem is that providers are "under the gun" to get up and running with EHRs, and some may not be ready in terms of clinical practices and relationships (not to mention a lack of capital). "Too much, too soon" can be as problematic as "too little, too late" in HIT.

KEY TAKEAWAYS:

- Federal HIT expectations and timelines are out of whack with conditions on the ground in Arizona and most other states. The feds need to provide more flexibility – and time.
- Despite the challenges, half of Arizona physicians appear to be moving forward with health information technology.

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