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ProHealth Physicians ACO, Background

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Formed in 1997, ProHealth is the largest primary care physician group practice in Connecticut. ProHealth has grown to include 351 practitioners at 88 practice sites, including 220 physicians, 66 Advanced Practice Registered Nurses, and 50 Physician Assistants. Practitioners concentrate in one of the following primary or specialty care divisions: Family Practice (128), Internal Medicine (111), Pediatricians (87), and 25 specialists.

Practitioners provide care to 341,368 active patients throughout Connecticut, approximately 10 percent of the Connecticut population, through 750,000+ encounters annually. The patient demographics show a real world population, including all ages, genders, races, nationalities, and special populations. Females comprise 52.8% and males 47.2% of the population. Elderly comprise 17.9% and children 27.0%. Over 46 different primary languages spoken by the population have been recorded, but 98.5% are English, 1.0% Spanish, and 0.5% all the remaining languages. The ProHealth population exhibits the full range of disease mix.

ProHealth has developed a central organization and administrative structure that provides support for most practice business functions. These centralized services include billing, accounting, financial reporting, human resources, payer contracting, credentialing, medical management, quality assurance, ancillary service development, technology assessment, continuing education, and legal services. The majority of laboratory work ordered by ProHealth practitioners is processed by the ProHealth laboratory, the third largest in Connecticut. ProHealth rolled out a new Practice Management System (Allscripts) in late 2008-2009, a new Electronic Health Record (Allscripts Enterprise) in 2009-2010, an information repository in 2010, Medical Home in 2011 (71 practice sites received NCQA for recognition as Level 3 Patient Centered Medical Homes (highest) in August 2011), practice site workflow improvements in 2012, and has been approved by CMS as an Accountable Care Organization (ACO)/ Shared Savings designation beginning January 1, 2013. ProHealth currently has six major payer contracts (Anthem, Cigna, Aetna, United Healthcare, ConnectiCare, and the State of Connecticut Employees/Retirees) that support medical home principles. By January 2014, ProHealth plans to have ACO contracts in place with Medicare, Anthem, Aetna, Cigna, ConnectiCare, and United. Seven payers cover 91.1% of the ProHealth lives: Anthem (99,411), Medicare (57,403), Aetna (42,372), Cigna (38,548), Medicaid (27,921), ConnectiCare (25,891), and United (19,460).

All practice sites utilize both the Allscripts Practice Management System and the Allscripts Electronic Health Record. ProHealth has assembled a variety of electronic health data into its repository database linking information from all these sources by unique patient identifier: practice management system, electronic health record, laboratory information system, clinical disease registry, care coordination system, hospital daily census, continuity of care documents, provider credentialing database, pharmacy medication claims, payer claims, imaging system, and patient portal.

GAPS, BARRIERS, ISSUES

1. Antiquated Federal and State systems

a. National Government Services (NGS) is a roadblock for timely processing of provider credentials. Provider approved on August 9 still does not have approval letter to submit claims. Delays impact all aspects of ACO program.

b. PECOS is a major problem for provider/supplier attribution to ACO. PECOS paper process may take up to 8 months. Newer updates to PECOS moving better but paper backlog still exists. PECOS delays greatly impact beneficiary assignments. Providers leaving provider group may look like they are still assigned to provider group for 8 months – impacting beneficiary assignment on patients that provider group can no longer impact. New providers joining provider group may take 8 months to work through PECOS, meaning their patients are assigned to their old tax ID (now defunct) and beneficiaries are long delayed in getting attributed to ACO. It is unclear how CMS reconciles billing under the ACO tax ID by providers who have not been resolved by PECOS.

c. State agency systems unprepared to participate. Duals program will require lead care managers to coordinate with a large number of state agencies/contractors, none of which have capability to integrate electronically with PCP EHR, making it difficult to reconcile medications and care plans.
   i. HUD Healthy Home assessment liaison
   ii. Beneficiary enrollment vendor,
   iii. care management,
   iv. Behavioral health homes for serious and persistent mental illness,
   v. "Paper Card" EHR vendor
   vi. Consumer ombudsmen
   vii. Transportation vendor
   viii. Dental care vendor
   ix. Money follows the person coordinator
   x. Waiver care manager
   xi. Access agencies
   xii. Home care program for the Elders

2. Quality Measures – Duals program metrics reporting process will not use GPRO, and will be state specific, meaning redundant, duplicative reporting process. Each private payer choses different metrics adding to the workflow challenges.

a. Some of the proposed measures depend on hospitals (i.e. real time hospital admission notifications) who may not be part of the ACO/Medical Neighborhood – how do we avoid being dinged for something not under our control?

b. Benchmarks for state metrics don't exist – another black box for providers.

c. Some metrics are outdated – i.e. A1C and lipid medications should match updated guidelines and be adjusted by patient specific attributes, risk, age, etc.

d. Our ACO utilization metrics are down (good) but costs are up (bad) – PCP driven ACO cannot control growth in facility fees as physicians are acquired by hospitals and add facility fees to charges. Physician driven ACOs cannot afford such risk.

3. Financing –

a. CMS Advanced Payment Approach insufficient. Larger PCP driven ACOs not qualifying for advanced payment still don't have the capital to invest in the needed systems. Shared savings, if any, come two years later. Need better cash flow and sources of capital.
b. Capital is needed to retrain entire workforce in new models.
c. Duals Infrastructure development for a 1.5 year duals program is not cost effective. Need long term Medicaid commitment to payment reform.
d. Duals "shared savings" is a misnomer. Individual PCP will be grouped with all providers in state– all ships sink together. No recognition of existing ACO infrastructure. ACO attribution will get overruled for all new providers, all new patients, all current patients not yet attributed. All worsened by PECOS issue. Medicaid participation in shared savings questionable - no way to tell if patient "would have gone to a nursing home" – other patients simply fill empty bed.
e. Risk models are insufficient – HCC coding differential for chronic kidney disease for example not even close to the actual spend differential by a CKD patient.
f. Need standard risk assignment methods – not payer specific risk assignments. The duals risk assignment/adjustment methodology for example is not spelled out and is therefore a black box to providers.

4. Privacy Issues

a. Approximately 50% of the Duals population has behavioral health Issues. CMS won't provide ACOs with Behavioral Health claims. Behavioral Health Providers are not able to send behavioral Health data. Duals require greater care coordination but major gaps in data mean large gaps in quality and patient safety. Medication reconciliation is compromised.

b. CMS doesn't allow changes to wording of patient notification and authorization paperwork, PCP workflow cannot accommodate wording unique to each payer. ACOs need common language/ handouts across all payers. Patient authorization process needs to consider all community and extension staff like pharmacists, dieticians, social workers, community health workers.

5. BeneficiaryAttribution

a. Each payer has different approaches, different black boxes, making it difficult to manage populations.
b. Patients of PCPs who join an ACO after the start date of Dual program, and patients of current ACO providers who based on plurality are not yet assigned to the ACO, will automatically be defaulted to the dual program, creating major coordination issues.
c. Patients can opt out of duals program. Need monthly reconciliation of attribution across Medical neighborhood, DMHAS behavioral health, ACO.

6. Payer restrictions

a. CMS rules won't allow beneficiary incentives for new models of care.
b. Part D not part of MSSP ACO, but Part B does include injections. Huge spend on ophthalmology: wet macular degeneration monthly injections adding up to millions

spent in our ACO. Cheaper alternative not approved by FDA. Medicare rules hamper. FDA rules hamper. No way to incentivize beneficiary.

c. Narrow networks meeting optimal triple aim – no way to incent Medicare beneficiary to utilize. ACO not allowed to waive Medicare or other payer copays/deductibles . Therefore not able to incent medication adherence i.e. no copay for high risk patients.

7. Information Technology

a. ONC – misplaced reliance on state government for Health Information Exchange– no state money; no political interest in topic; set back private efforts by years.

b. HIE DIRECT currently insufficient. Providers are joining/leaving provider group routinely. Trust fabric needs real time credential issuance and revocation. Need to encrypt messages to ACO entity, to care coordinators, to referral managers servicing the provider.

c. Need Standardized statewide provider directory , including how and where to send data

d. Need Community wide master patient index including PCP/care coordinator relationships. As a patient walks into the primary care practice, how will the practice identify that the patient is a dual patient? Which dual lead care manager has the patient selected? Is the patient defaulted to a DMHAS Health Home? Who is their local Mental Health Authority case manager? Who is their Social Services waiver care manager? The PCPs practice management system is not connected to any such outside systems.

e. Continuity of Care Documents are insufficient for transitions of care efforts. Need real time Hospital and SNF ADT messages. Hospitals are unable to provide ADT messages in a consistent and complete way. SNFs have little electronic record capacity.

f. Need standardized care coordination software interfaces. Care Coordination systems are a unique breed of software not integrated with PCP EHR. Each state agency, hospital, payer utilizes different care coordination software, all not integrated. Need 2 way interfaces with EHR.

g. All providers need parallel access to the care plans. Care plans cannot be treated as a serial data push. Home care and primary care providers may be seeing patient routinely. Standardization of W10 referral/care plan forms- will require multiple electronic signatures. Common exchange of orders will need to incorporate care plans.

h. Each payer, hospital, agency is setting up unique Provider Portals – they don't understand provider workflow. Cannot expect provider to leave EHR and browse multiple specific provider portals (including Medicare-Medicare dual eligible portal) patient by patient. Payers including Medicaid need to provide electronic access from EHR systems.

i. Each ACO, hospital, payer is setting up unique patient portals – patient will not tolerate each payer, PCP, hospital, etc. having different patient portal solutions.

j. All care providers in state need to have access to common real time information.
   i. Monthly claims data not useful for real time patient management. Need daily claims and ADT Data.
   ii. Medicaid (Duals) needs to provide claims download similar to Medicare claims so ACO can work data in its own system across multiple payers.
   iii. ACOs need more data as discrete data elements and less as text notes.
   iv. Timeliness of data is essential, particularly medications. Pharmacies should push all prescription fills to PCP even when ordered by a specialist. Pharmacy will need statewide provider directory linked to statewide beneficiary attribution.

v. Automated patient-event notifications across care settings is essential, i.e. notifications utilizing hospital admission, discharge, transfer feeds to notify primary care practitioners when a patient has been admitted or discharged from the hospital or SNF is needed. Few SNFs have electronic data capabilities. PCPs have no indication when patient transferred out of SNF/rehab facility.

vi. Most Community Service providers left out of the bi-directional electronic record equation.

- HUD Healthy Home assessment, ACO enrollment, care management,
- Behavioral health homes for serious and persistent mental illness,
- Transportation providers
- Dental care providers
- Community Health workers
- dieticians,
- pharmacists
- ambulance
- SNF,
- Home Health
- state agencies (Public Health, Mental Health, WIC, Social Services,)
- specialists