PCMH, ACO measures help prepare groups for value-based care

Over the next four to six years there will be a substantial shift in the way healthcare providers, including hospitals, primary care and home health providers, are reimbursed for services. Payers, including Medicare and private insurance companies, will pay or reward providers based on the value of care delivered. Pay will be based on patient outcomes. Some programs already enhance payments based upon quality measures.

Practices should start focusing on measures found in the patient-centered medical home (PCMH) or upcoming rules for accountable care organizations (ACOs) so they are ready for these new reimbursement models.

Recently the Centers for Medicare & Medicaid Services (CMS) released an online brochure1 that details value-based purchasing (VBP) in fee-for-service programs. Some of the goals include financial viability, payment incentives, joint accountability, effectiveness, ensuring access and EHR adoption. The document defines these concepts in detail. For instance, “ensuring access” means that patients can access care they need when they need it. A patient of a primary care physician should be able to access urgent care without resorting to a hospital’s emergency department. The primary care office should offer extended hours or have a clear pathway for patients to access care when the office is closed. Most of the goals outlined in the document are based on patient-centered care as defined by the Institute of Medicine’s publication titled Crossing the Quality Chasm.2

The VBP brochure lists programs that reward physicians for delivering better patient outcomes. One of these is the Physician Quality Reporting System (previously PRQI), which requires physicians to report on quality measures.3 Results can impact payments from 1.5 percent to 2.0 percent of a group’s annual Medicare receipts.

New delivery, payment structures

Several other programs highlighted in healthcare media will likely get CMS and private payer support, including PCMH, ACOs and bundled payments.

PCMHs are usually primary care groups that meet standards defined by a variety of certification bodies and based on those found in Crossing the Quality Chasm and Wagner’s Chronic Care Model. Wagner’s Chronic Care Model is detailed in a paper published in 1996 titled Organizing Care for Patients with Chronic Illness,4 written by Edward Wagner, Brian Austin and Michael Von Korff. The focus is to deliver safe, effective and coordinated quality care, especially to patients with chronic conditions such as diabetes.

ACOs are vertical integrations of care units that manage the care of patients of payers with whom the ACO has a contract. The ACO typically manages care for a fixed sum and profits if it successfully provides quality outcomes for patients. A typical ACO is an organization of primary care physicians, specialists and hospitals bound together by a legal contract to provide coordinated care to its payers.

Bundled payments are a fairly new concept in healthcare although transplant units have been using them for some time. In this program a payer agrees to pay a fixed sum for a procedure, such as hip replacement surgery, to a group that

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performs the surgery. This group typically comprises surgeons; a hospital where the surgery is done; and other medical groups involved in the process, such as imaging groups and anesthesiologists. The group divides the payments.

Organizations at the primary care level for all of these organizational types will probably be structured according to the medical home guidelines issued by American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association.5

The National Committee for Quality Assurance (NCQA) is one of several organizations that accredit PCMHs. NCQA lists 27 standards in its scorecard for providers and six are must-pass standards:

- Access during office hours
- Use of data for population management
- Chronic care management
- Support of self-care processes
- Referral tracking and follow-up
- Implementation of continuous quality improvement

The organization lists, in great detail, its expectations for each standard, how it is scored and the three levels of accreditation. Achieving the first level of accreditation will require significant changes in the care processes employed at most primary care sites. For starters, groups will need to form coordinated teams of clinical and nonclinical staff.

The standard “access during office hours” lists four elements:

1. Providing same-day appointments
2. Providing timely clinical advice by telephone during office hours
3. Providing timely clinical advice with secure electronic messages during office hours
4. Documenting clinical advice in the medical record

To pass this standard the provider must meet at least two of the elements, including the first bullet.

Changing from the standard triaging of patients to same-day access will require a logically reasoned approach, including sample data collection and an implementation scheme.

The starting point is to measure same-day access with the “third available appointment,” which measures the length of time between a patient’s appointment request to the third next available appointment on his/her clinician’s schedule.6

Toyota’s production system and approach to solving problems and implementing change provides an excellent strategy to solve this challenge. It is based upon the scientifically sound approach of Plan-Do-Check-Act. The first thing to determine is takt time, the number of same-day appointments requested by patients on average. The goal is to have open appointments outpace demand for each physician in the practice.

Several other factors need to be assessed, including the type of requested appointments. Annual physicals take longer than a typical acute care visit, and we need to plan slightly longer visits for chronic care patients. Of course, there are seasonal variations, such as flu season, which increases same-day appointment requests.

On days when more same-day appointments are requested or when doctors are out, midlevel clinicians such as nurse practitioners and other physicians can meet the same-day demand.

Medical practices may be reluctant to adopt this type of scheduling; however, doing so generally leads to an improvement in income. The reason is that patients who take same-day appointments are less likely to be “no-shows.” Hence, as same-day access is optimized over time, the percent of “no-shows” decreases and income improves.

Also, patient outcomes generally improve since patients have enhanced access to physicians rather than opting for urgent care at a walk-in clinic or emergency facility. A diabetic who is able to see his physician in an emergency will receive better care, which will most often result in improved outcomes for the patient.

Adoption of the PCMH model makes sense for medical practices. Studies by TransforMED of Leawood, Kan., a partner of American Academy of Family Physicians, have shown increased income for practices that adopt this model that range from 3 percent to 12 percent.7 These studies also show that patient outcomes markedly increase, staff morale improves, and physicians spend more time with patients and less time completing necessary work outside of office hours.