ACO or PCMH: Making a crucial decision for your practice

How to weigh the risk and the benefits to your practice of these care delivery and payment models

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By Jeffrey Bendix

Is becoming a patient-centered medical home (PCMH) and/or affiliating with an accountable care organization (ACO) right for my practice? It's a question that many primary care physicians find themselves asking as they struggle with rising costs, stagnant reimbursements, and frustration with a payment system that rewards volume of services over outcome quality.

Because the PCMH and ACO share common goals of lowering costs and improving patient outcomes, physicians often think of them interchangeably. But they differ in that a PCMH is an approach to care for an individual practice, whereas an ACO is a method of reimbursing a network of providers. "Basically, the PCMH is a care delivery mechanism, while the ACO is a payment mechanism," explains David Gans, FACMPE, senior industry affairs fellow with the Medical Group Management Association (MGMA).

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Both approaches also require patience and determination—as well as substantial resources to implement and to make function effectively. So it is important to understand both concepts before deciding which—if either—is right for your practice. Of the two, the PCMH model has been around

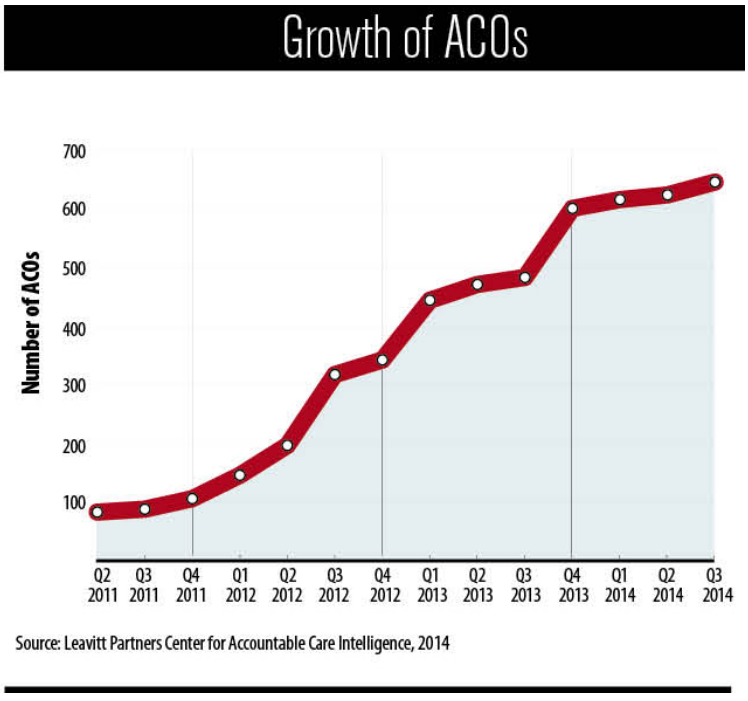
the longest. First articulated in the late 1960s by the American Academy of Pediatrics (AAP), today the term has somewhat different meanings depending on who is using it. In general, however, PCMH describes a practice that:

- treats patients holistically,
- provides patients with extended access to providers,
- provides team-based care,
- effectively coordinates care with other providers,
- focuses on quality and safety, and
- engages patients in their own care

A 2014 study by the Medical Group Management Association found that many organizations and payers have created standards for designating a practice as a PCMH, but only four—the Accreditation Association for Ambulatory Health Care, the Joint Commission, the National Committee for Quality Assurance, and URAC had PCMH programs that were national in scope, PCMH-specific, had a published set of standards, and were used widely as a model PCMH.

Whereas the PCMH approach to care is practice-specific, an ACO requires coordination—if not outright affiliation—among multiple practices to lower costs and improve outcomes. Under an ACO, providers receive a pre-determined payment to care for, and meet quality targets, for a designated patient population. If the ACO can meet the targets for less than the payment, it keeps the difference. If it exceeds the payment, the ACO is responsible for the difference.

The idea behind the ACO is to improve coordination among the clinicians and institutions delivering care to a designated group of patients, thereby improving quality and lowering costs, says Chuck Peck, MD, managing director with Navigant Healthcare consultants and interim chief executive officer of the Athens Regional Medical Center in Athens, Georgia.



"Most patients get care from more than one physician," Peck says. "So the question is, how do you get the providers thinking in terms of teamwork and making sure that everyone caring for that patient is focused on outcomes, and doing it in a financially accountable way?"

While commercial payers are beginning to experiment with ACOs among their provider panels, the main catalyst for their development thus far has been Medicare, through the establishment of its Shared Savings and Pioneer ACO programs.

The Centers for Medicare & Medicaid Services says that as of December 2014 424 ACOs, serving about 7.8 million beneficiaries, were participating in Medicare's Shared Savings program. A recent study by the consulting firm Oliver Wyman estimated that public and private ACOs together provide care to between 25 million and 31 million people.

NEXT: How to make the decision to adopt the PCMH model or to afficilate with an ACO

Making the decision.

So how should physicians go about deciding whether to adopt the PCMH model, and/or affiliate their practice with an ACO?

"The first question to ask is, why do you want to do this?" Gans advises. "Being a PCMH or joining an ACO are major undertakings. So you have to ask, what is the motivation? How does this fit in the culture of the practice, and with plans for the future?"

The biggest hurdles most practices face in achieving PCMH status are:

- finding the money to pay for additional personnel such as care coordinators and non-physician practitioners;
- adopting electronic health records (EHRs) and using them to exchange information and analyze data;
- creating a practice culture that is patient-centered; and
- engaging patients in their care

Southeast Texas Medical Associates (SETMA) a 50-provider, 375-employee practice in Beaumont, Texas, has spent nearly $9 million on EHRs and other IT equipment and software, says James Holly, MD, s chief executive officer.

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"We didn't think it was possible to do 21st century medicine without the ability to perform analytics and the other functions you can achieve with EHRs," Holly says. Now the practice measures its performance by tracking 300 quality metrics on all its patients. Its providers also use EHRs to record the status of its nursing home patients. "Everywhere our patients are seen, their care is documented in the EHR, so there is always real continuity of care based on that record," he says

SETMA finances the additional personnel and equipment it needs by looking for payers and programs that will pay higher than the standard evaluation and management reimbursement rates, such the diagnoses codes that fall under Medicare's Hierarchical Conditions program. SETMA also receives about $50,000 annually from Blue Cross and Blue Shield of Texas for diabetes treatment because of its PCMH accreditation by the National Council on Quality Assurance

"We anticipate payments through programs like these will increase to the point where the majority of our revenue is due to our demonstrated quality," Holly says. "That's why we continually challenge ourselves to meet quality metrics."

NEXT: Creating the right culture for your practice

The right culture

Creating the right culture starts with a leader with a clear vision of what the practice is capable of achieving and how to get there. After that, "you need to look for people who are learners, and will adopt your vision," says Holly. "Then ideally, they develop their own vision and expand yours, so it's not just my vision anymore, it's our vision."

Patient engagement requires moving away from the paternalistic approach of simply telling the

patient what to do. “We know that patient adherence to a program is much lower if they’re just told to do something. But if they understand why, and are engaged in shared decision-making, they’re far more likely to do what you’ve asked them to do,” Holly says.

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For Gregg Stefanek, DO, a family practitioner in Alma, Michigan, the impetus for adopting the PCMH model for his five-provider practice was higher reimbursements available through Michigan Blue Cross Blue Shield’s Provider Group Incentive Program (PGIP.) Through PGIP the practice receives 25% more for every office visit for patients covered by Michigan BC/BS, which comprise about 40% of the practice’s patient panel

Stefanek has used the additional funds to hire a care coordinator and other staff, and upgrade the practice’s EHR system. But the biggest change, he says, is “now I really work with my patients to make them more responsible for their healthcare. I hold orientation sessions for all my new patients where I tell them, ‘it’s not our job to take care of you. It’s your job to take care of you. It’s our job to guide and support you, but we can’t make you healthier. I don’t expect you to do it perfectly, but I do expect you to try to improve your habits.’ I always say a medical home is a verb, not a noun. It’s where we give patients permission and empower them to take care of themselves, and we put systems in place to back them.”

Adapting to the new approach was difficult for some practice employees, Stefanek acknowledges. “Some left, and some we let go, because one of the basic tenets of being a PCMH is just being nice to people, and some of them couldn’t do that,” he says. “We tell our staff they have the chance to make or break a patient’s day by how they treat them. When the patient feels cared about, that’s when you can influence their behavior.”

NEXT: Creating a patient-centerted ACO

A patient-centered ACO

Whereas a primary care practice can decide on its own whether to adopt the PCMH model, an ACO requires a network of providers, thereby creating additional levels of complexity and investment. For United Physicians of San Antonio, Texas, a 45-provider ACO formed late in 2013, that investment has been about $1 million so far, says Lloyd Van Winkle. MD, FAAFP, the chief executive officer of United Physicians.

That expenditure includes hiring four nurses and social workers to serve as case managers, standardizing the EHR systems used by the ACO’s providers, developing protocols for coordinating care among the providers and educating providers on the principles of evidence-based care, and establishing ties with two local hospital systems. “The sweat equity is massive as well,” Van Winkle says.

“I would strongly encourage development of a PCMH core group within the organization, because the standards of care in those have a superior track record for reducing costs while providing better care,” he adds.

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At the end of 2014, United Physicians hadn’t gotten its results for its first full year of operation, but Van Winkle says “the numbers I’ve been seeing early on (for reducing hospitalizations and medication costs) are showing significant improvement. We’re approaching our threshold for

getting into shared savings in those areas." Moreover, he says as United Physicians establishes a track record, it creates a virtuous cycle whereby it can attract additional, high-performing practices and weed out practitioners not meeting its cost and quality standards.

Van Winkle believes ACOs, or models like it, will spread as the nation's population ages and the demand for health services grows. "If we want to provide good care to everyone, we can't continue providing episodic care, we have to have care that's preventive and global," he says. "It's not rocket science. If we keep doing what we're doing now, we'll get what we've always gotten, and the ship is going to sink."

NEXT: The five vital features of a patient-centered medical home

The five vital features of a patient-centered medical home (PCMH) are:

Comprehensive care

The PCMH is designed to meet the majority of a patient's physical and mental healthcare needs through a team-based approach to care.

Patient-centered care

Delivering primary care that is oriented towards the whole person. This can be achieved by partnering with patients and families through an understanding of and respect for culture, unique needs, preferences, and values.

Coordinated care

The PCMH coordinates patient care across all elements of the healthcare system, such as specialty care, hospitals, home healthcare, and community services, with an emphasis on efficient care transitions.

Accessible services

The PCMH seeks to make primary care accessible through minimizing wait times, enhanced office hours, and after-hours access to providers through alternative methods such as telephone or email.

Quality and safety

The PCMH model is committed to providing safe, high-quality care through clinical decision-support tools, evidence-based care, shared decision-making, performance measurement, and population health management. Sharing quality data and improvement activities also contribute to a systems-level commitment to quality.

Achieving the goals of the PCMH model requires aligning three vital components:

Health information technology

Health information technology (IT) can support the PCMH model by collecting, storing, and managing personal health information, as well as aggregate data that can be used to improve processes and outcomes. Health IT can also support communication, clinical decision making, and patient self-management.

Workforce

A strong primary care workforce including physicians, physician assistants, nurses, medical assistants, nutritionists, social workers, and care managers is a critical element of the PCMH model. Amid a primary care workforce shortage, it is imperative to develop a workforce trained to provide care based on the elements of the PCMH.

Finance

Current fee for service payment policies are inadequate to fully achieve PCMH goals. Providers are not routinely compensated for care coordination or enhanced access, contributions of the full team are often not reimbursed, and there is no incentive to reduce duplication of services across the care continuum. Payment reform is needed to achieve the potential.

NEXT: The main features of an ACO

The main features of an ACO

The website accountablecarefacts.org defines an accountable care organization as "a set of healthcare providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients."

The primary characteristics of the ACO model are:

1. An ACO should have the capability to manage both the cost and quality of health care services under a range of payment systems, including fee-for-service, episode payments, and full and partial population-based prepayment (capitation).
2. Possession of sufficient infrastructure and management acumen to support comprehensive, valid, and reliable performance measurements; to make internal system improvements in care quality; and to externally report on its performance with regard to cost and quality of care.
3. A clear organizational mission and commitment to achieve quality and cost efficiencies; a physician management structure that is supportive of all of the requirements listed above; and a culture that supports and rewards continuous quality improvement.
4. The use of health information technology to manage patients across the continuum of care and across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post-acute care.

Want to join an ACO? Ask these 10 questions first:

- What are the ACO's by-laws, and do they protect my interests?
- What representation will I have on the ACO's governing body?
- What are the administrative and organizational requirements to participate (for instance, pertaining to data submission, committee participation, etc.)?
- What practice transformation changes will be required to participate (for instance, use of an electronic health record system, 24/7 access or triage, provision of case management)?
- What financial or "in kind" assistance can I expect from the ACO to implement and maintain any required practice transformation?
- What are reasonable estimates of shared savings or extra payments that the ACO can earn?
- How will any earned shared savings or extra payments be distributed?
- Is there any potential for accrued loses and participation in a "pay back" to the payer?
- Is the ACO adequately protected from relevant federal and state penalties (related to anti-trust

and anti-kickback statutes)
- What are the advantages and disadvantages of ACO participation versus establishing an independent service contract with the ACO, particularly for subspecialty physicians?

Source: American College of Physicians