



Planned Evolution of PPC-PCMH Requirements

This paper provides a brief review of the National Committee for Quality Assurance's Physician Practice Connections[®]-Patient-Centered Medical Home standards (PPC[®]-PCMH[™]) and presents a framework for considering how to evolve the standards in a deliberate, but timely manner. The proposed framework takes into account opportunities offered by health reform to promote delivery system and payment reform. Appended are details of the process NCQA plans to follow, opportunities for input and details of the timeline.

Background--Current Version

Guided by input from advisory groups, pilot tests and public comment, NCQA developed the current version of the Physician Practice Connections[®]-Patient-Centered Medical Home standards (PPC[®]-PCMH[™]) to provide a standardized tool for qualifying practices for demonstration projects evaluating the patient-centered medical home model (PCMH). The Joint Principles for the Patient-Centered Medical Home, endorsed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), the American Osteopathic Association (AOA) and now many others, provided high-level guidance for the content. NCQA's experience with the predecessor standards, Physician Practice Connections, also provided a foundation for development of the standards. The four primary care specialty societies (AAFP, AAP, ACP and AOA) endorsed the PPC-PCMH standards for use in demonstration projects. The standards also are endorsed by the National Quality Forum.

The standards were ground-breaking both in content as well as in the process required of physician practices. The vast majority of physician practices have never participated in such an endeavor, which often requires practice redesign as well as documenting practice activities for external review. The PPC-PCMH provides the first means of operationalizing the concept of the PCMH. Those involved recognized that there are aspects of the PCMH that were not addressed in the standards for a variety of reasons. We addressed some of these areas in the attestation to the Joint Principles required of all PPC-PCMH applicants. NCQA and others recognized that initial experience with the standards, and other knowledge being generated in demonstration projects, would provide important material for the creation and testing of additional standards that might strengthen the concordance of the standards with the concepts of the patient-centered medical home. We are all especially interested in understanding better how to assess patient-centeredness and experience as well as quality and cost outcomes.

NCQA designed the current version of PPC-PCMH to be feasible for all practices and for use in demonstration projects intended to understand better the relationships between the standards and clinical quality, resource use and patient experience performance results. Current demonstrations are providing additional payment to PPC-PCMH Recognized practices. The usual mechanism is to offer a per patient per month fee, in addition to normal fee-for-service payments. Sometimes, pay for performance rewards are also available to practices that demonstrate desired outcomes (using a variety of clinical, patient experience and resource use measures).

As of April 2009, NCQA has Recognized 416 practices with 4,358 physicians. Approximately one-third of Recognized practices have achieved Level 3, the highest level, and sixty percent are at Level 1.

Demonstration projects across the country, including those in Colorado, Louisiana, the mid-Hudson Valley of New York, New York City, New York State (Medicaid) and Pennsylvania, are using the current version. The Medicare Medical Home demonstration project will be using a related version of the standards to qualify 400 practices.

As the standards have gained exposure and use, we have received many, sometimes conflicting, suggestions on how to improve them. NCQA welcomes this input from all stakeholders including physician users, quality experts and health services researchers and consumers. NCQA has continued to solicit input from experts and field test ideas for new requirements. This paper shares NCQA's reflections on knowledge gained and input we have received thus far; specifies processes for obtaining additional input and provides a timeline for the further evolution of the standards.

Evolution of the Standards

We would like the next version of the standards to continue to be feasible for individual practices but also to have standards designed to realize quality and cost gains achieved through better coordination and integration *across* settings. Recognizing that the current payment system does not properly reimburse for some medical home services and recognizing that reducing overuse and inappropriate care is imperative, we want the standards to assess and designate organizations capable of assuming clinical responsibility for sets of bundled services. This hopefully would be coupled with similar financial responsibility.

As we think about the immediate future, it is important to keep in mind that many physician practices have yet to function at a level that would meet the current PPC-PCMH standards. As cited above, the majority of currently Recognized practices achieved Level 1. At the same time some practices, including some affiliated with multi-specialty groups and some with larger provider systems, achieved Recognition and are in a position to demonstrate that they meet additional expectations. These might be the practices that have achieved Level 3.

Changes relevant to all practices, including individual practices providing primary care. Following are some specific areas to consider for improving the current standards. As always our standards development will be guided by empiric evidence and the ability to collect reliable and valid data efficiently.

- Based on new empiric evidence, including preliminary findings from demonstration projects, what areas are critical to improving the value of care provided by practices that implement the PCMH model?
- How can we further assess whether practices are patient-centered? How can we further incorporate patient experience into our evaluation? This is a particularly important area to us and others. We are exploring ways to move towards collecting a cores set of standardized patient experience results.
- Are there key components of the PCMH model that we should assess but are not capturing through our current program? Relationships to various types of community organizations is one component of the chronic care model that the standards do not yet address and which community health centers, advocates for children with special needs and others believe should be assessed.
- How do we align the standards with requirements for meaningful use of electronic health record technologies in the Recovery Act?
- What requirements can be eliminated?
- How can we maximize use of documentation that supports office work flow and care management and that is easily generated by electronic systems and documentation?

Program structure

- Might it be appropriate to have a basic set of standards and an “advanced” set for previously-recognized practices? Will it be time for an “advanced” program to incorporate performance results (clinical, resource use, patient experience) as well as structure and process standards?
- How should the program recognize the role of providers other than physicians?
- How can we best recognize the comprehensive approach of community health centers?

Other

- What type support systems do small practices need to build or engage with externally to achieve the objectives of the PCMH model?
- How can we make the name resonate more positively with consumers?

Relationship to payment reform: Primary care practices need additional payment to cover medical home services, such as patient outreach, education and care coordination, that are not reimbursed through fee-for-service. Are individual primary care practices meeting the next version of standards qualified and in a position to manage a global fee for primary care?

For primary care-sub-specialty networks. Primary care practices are critical, but it is difficult for them to achieve the reforms expected of medical homes without having established common expectations with sub-specialists. NCQA would like the standards to articulate expectations that lead to improved coordination of care and judicious use of services across primary and sub-specialty care. We would like to strengthen our current requirements for referral tracking, test tracking and continuity of care and, where appropriate, to move beyond evaluating primary care practices to evaluating multispecialty arrangements, be they physician organizations or other more virtual arrangements.

- How should non-electronic communication be structured? What can be expected without electronic exchange of information? What should expectations be in environments where electronic exchange of information is possible? Should we expect electronic exchange of information?
- What type of measurement of multispecialty communication and use of services is appropriate?

Relationship to payment reform: Multispecialty arrangements meeting a designated set of standards could be clinically qualified to be paid based on a global fee for nonacute care.

For networks that include hospitals. For networks that include hospitals, such as fully integrated delivery systems, we would like the standards to address the important need for communication between physicians and hospitals and assess the judicious use of hospital services. These might be organizations or virtual arrangements that assume accountability, for quality and for cost, for bundles of services.

- How should we evaluate and seek to improve coordination of care between physicians (primary care and sub-specialty) and hospitals?
- Should we expect such arrangements to be able to exchange electronic information?
- What additional requirements are important for organizations interested in assuming accountability for both ambulatory and inpatient services?

Relationship to payment reform: Integrated delivery systems meeting a designated set of our standards could be clinically qualified to be paid based on a comprehensive global fee for patients.

Conclusion

It is our vision that the next set of PPC-PCMH standards will continue to provide guidance to small practices that want to become medical homes and raise expectations for more complex delivery systems that can be accountable for a greater share of health care services. The standards for different types of delivery systems—primary care practices; multispecialty networks; networks that include hospitals—can designate delivery arrangements clinically capable of assuming responsibility for bundled payments of increasing comprehensiveness. All of the standards might be packaged together so that all organizations can see the complete set and chose the designated subset most appropriate for them. We look forward to working with stakeholders and policy experts on the details necessary to accomplish this vision.

Timeline and Process for Evolving PPC-PCMH

As many continue to gain experience with the current PPC-PCMH standards, NCQA welcomes suggestions for improvement from practices using the standards; from payers and demonstration project sponsors; and from quality experts, health services researchers and other interested parties. Below we provide a timeline and offer a variety of communication channels.

In light of the amount of current activity using the PPC-PCMH and the need to give practices and NCQA the opportunity to gain experience with the current version, NCQA felt that it was important to use the remainder of 2009 to seek broad input into the process, to gain as much experience as possible with the current standards and to analyze that experience and input provided as the foundation for a deliberative process to develop the next version of the standards. The current version will thus remain the same through 2010, with anticipated revisions to be released to practices by January 2011.

NCQA will proceed as follows over the course of 2009 and 2010:

- NCQA will continue to seek, examine and catalog informal input from all interested parties.
- Spring 2009 – Disseminate concept paper describing the planned evolution of the PPC-PCMH program requirements
- November 2009 – Announce membership for a multi-stakeholder advisory committee to consider the various inputs and empiric evidence related to the evolution of the PPC-PCMH standards. This committee will include representatives of physicians, payers, consumers, policymakers and quality experts. This group will recommend a complete set of changes.
- November 2009 – Request input representing the interests of key stakeholder groups including the Commonwealth Fund and its group of evaluators, the PCPCC, ACP, AAFP, AAP, AOA and others
- December 2009 – Engage Advisory Committee in an orientation/informational call to review input and research completed to date.
- 1st Quarter 2010 – Engage key stakeholder groups through calls and meetings with key NCQA staff.
- 1st Quarter 2010 – Meet with Advisory Committee to develop draft changes.
- March/April 2010 – Review draft changes to PPC-PCMH with NCQA’s Committee on Physician Programs (CPP). The CPP is a multi-stakeholder committee that, in accordance with NCQA’s governance, recommends changes in requirements for recognition programs to our Board of Directors. The Advisory Committee recommendations will be considered by the CPP and a final draft set of changes will be prepared based on input received.
- April/May 2010 - NCQA will solicit public comments on the proposed changes during a public comment period of at least 30 days. NCQA will broadly disseminate an announcement of the opening of the public comment period. All materials will be publicly available from our Web site.
- 3rd Quarter 2010 - Analyze comments and present them to the advisory committee.

- 4th Quarter 2010 - Bring final recommendations to the Committee on Physician Programs incorporating final input from the Advisory Committee. The Committee on Physician Programs approves all changes.
- December 2010, changes approved by the Committee on Physician Programs will go to the NCQA Board for final approval for anticipated release by January 2011.
- We anticipate asking NQF to endorse the revised standards following NCQA Board approval.

Ideas welcomed

NCQA offers several channels to communicate with us including:

- Our website – www.NCQA.org.
- Email: EvolvePCMH@ncqa.org.
- As always, questions of interpretation about the current standards should be directed to: ppc-pcmh@ncqa.org or NCQA customer support: 1-888-275-7585.