Improving patient access to the ambulatory enterprise is on the minds of every health system, hospital, and group practice executive. Whether it's accommodating patients with primary care or specialty physicians, focusing on the "keep-age" of internal referrals or growing external referrals, patient access is vital to the success of any healthcare organization. There may, however, be internal and external barriers embedded in the very core of our business that prevent us from moving forward effectively. We need to address six barriers against our goal to expand access to meet patients' needs.

Barrier # 1

Physician Compensation Plan. Let's start with perhaps the most surprising barrier: Most healthcare organizations incentivize physicians via work-relative value units (RVUs). The system has its merits—the scale, which is a consistent national measure, is payer-blind. As a result, it avoids the often-painful results of historical models that focused on collections.

Albeit payer-agnostic, the units are not access-ignorant, as Table 1 demonstrates. Using most any standard combination of the appointment duration of new versus established patients, the physician who sees established patients in lieu of new patients comes out ahead each and every time. Physicians are rational beings: the work RVU productivity model incentivizes avoiding new patients as the work RVU credit (and, therefore, compensation) increases the more established patients they see.

No Easy

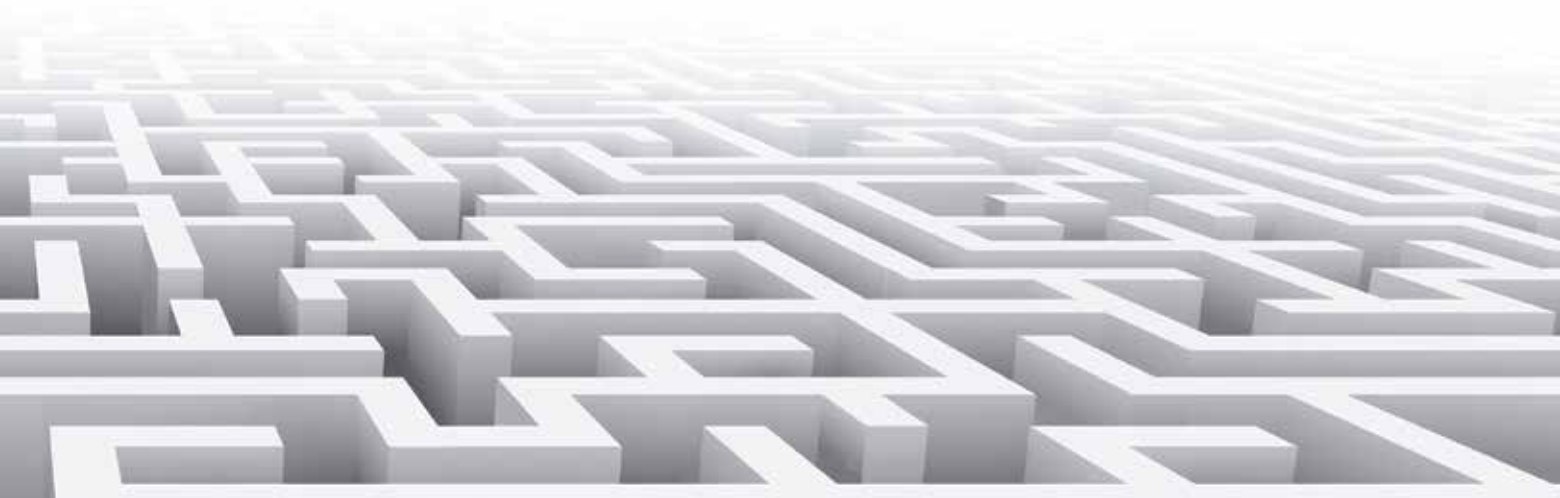
Is failure embedded in our current system?

Table 1

Appointment Durations for New/Established Patients

Per Hour Mixture of New and Established Patients	Work RVU
Duration: 60/30 Minutes	
1 New Patient per Hour	2.43
2 Established Patients @ 30 per Hour	3.00
Duration: 30/15 Minutes	
1 New Patient @ 30 + 2 Established Patients @ 15 per Hour	5.43
4 Established Patients @ 15 per Hour	6.00
Duration: 40/20 Minutes	
1 New Patient @ 40 + 1 Established Patient @ 20 per Hour	3.93
3 Established Patients @ 20 per Hour	4.50

Source: Centers for Medicare & Medicaid Services. 2018. Resource-based Relative Value Scale Work RVUs. Examples based on 1.50 work RVUs for 99214 (established patient office visit) and 2.43 work RVUs 99204 (new patient office visit). Accessed May 16 at cms.gov/apps/physician-fee-schedule/license-agreement.aspx.



Access

By Elizabeth W. Woodcock, M.B.A., FACMPE, CPC

Barrier # 2

ED vs. Ambulatory Site Reimbursement. A second barrier to ambulatory patient access is the nation's financial reimbursement model that rewards emergency departments (EDs) over the ambulatory care setting, even for low-acuity patients. For some healthcare organizations, this external force challenges access improvement in the ambulatory enterprise. The professional reimbursement for an ED visit by Medicare—$119.52 for code 99284—is higher than its "companion" Current Procedural Terminology (CPT) code 99214 in an outpatient setting.[1] That office visit code pays only $109.44. The variance of approximately $15 in reimbursement, however, pales in comparison to the significant facility fees and testing that accompany the vast majority of ED visits. Although services vary widely, studies find ED charges average $1,200.[2,3] Thus, the reimbursement model directly favors the high-cost ED setting.

A recent conversation with the director of performance improvement at a large health system brought this point home. After building a low-cost urgent care center last year, ED volumes decreased, and it was no longer sustaining volumes at capacity. Her director told her that the health system would not be opening any new urgent care centers and that she needed to turn her attention back to the ED—since additional volume was of utmost necessity. EDs are loaded with costs, so margins aren't huge. With volume, however, they can be much more profitable than a primary care office living on a $109 reimbursement with no facility fees and minimal testing.

Of course, beyond the reimbursement discrepancy between the ED and primary care practice setting, patient behavior plays a role in the decision to seek care at an ED versus a primary care practice. Emergency departments are vital for the national healthcare system; absent utilization controls, however, patients embrace this entry point as convenient, timely and—for many—free. It's no wonder, then, that ED visits per 100 persons sit at 42, fairly close to 49.1, which is the ratio of primary care visits per 100 people.[4] ED visits for non-emergent services, according to Blue Cross Blue Shield of North Carolina, consumed 65% of all ED encounters, although most studies find that at least 30% of all ED visits are non-urgent.[5,6]

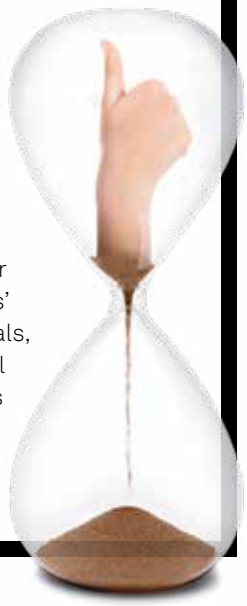
Unless and until the convenience of ED patient access is replicated by primary care offices and/or the reimbursement rules change, the ED is likely to continue to be a primary patient access point, with the potential to negatively impact the expansion of ambulatory access.

Barrier # 3

Advanced Practice Providers. Another reimbursement trend that may surprise observers is that advanced practice providers (APPs)—employed by many organizations to meet access goals by expanding provider capacity—are often not recognized by payers as "independent" providers. In fact, some payers do not credential advanced practice providers at all, instead requiring billing to be reported under a supervising physician's name. Although a Medicare term, this practice is often referred to as billing "incident to." In addition to insurance payers differing in their opinions of reimbursement for these clinicians, each state varies in its scope of practice. Thus, creating an effective APP strategy to enhance patient access to care is arduous at best for healthcare organizations, particularly those that operate in different geographic markets that cross state boundaries. Many find themselves unable to effectively deploy those providers in addressing the access challenge.

Barrier # 4

Payer Authorization. Payers exert demanding rules regarding authorizations for medical services. These serve as a fourth barrier to ambulatory patient access. Despite the fact that visits in a non-facility setting are the lowest cost, these authorization requirements are nonetheless on the rise. While same-day appointments could provide access to meet patients' needs for access without resorting to the ED, many organizations do not have the infrastructure to conduct "real-time" authorizations with payers—and many payers cannot accommodate instantaneous authorizations. Therefore, seeing patients on a same-day, as-needed basis is not possible—unless the healthcare organization is willing to render services for free. Indeed, the payers' imposition of authorizations, referrals, notifications—or whatever approval process the payer requires—makes immediate access impossible even with the best intentions.



Barrier # 5

Scheduling Limitations. In addition to the reimbursement environment steering patients away from the ambulatory setting, external forces impact basic scheduling operations. Many healthcare organizations rely on scheduling protocols housed in a database outside of the scheduling system, typically accessible to schedulers via a dual monitor (or, even worse, a paper notebook version of the same). Schedulers bounce back and forth to locate the "right" provider for the patient. Organizations are prioritizing the automation of provider matching strategies (see "Slow but Sure Progress").

Appointment scheduling represents the framework for access; it's not surprising that patients, referring physicians, and even organizations themselves are challenged to create an effective infrastructure for access, having to rely on a fundamentally inefficient operation.

These encumbered scheduling processes are being enhanced by technology, leveraged to improve scheduling optimization. Patient self-scheduling is business-critical to meet patient needs, with a corollary benefit of significantly increasing the organization's show rate. The Patient Access Symposium reports 37% of its academic health system members offer self-scheduling for new patients, with another 10% in progress. Self-scheduling is extended to established patients by 69%, with another 8% in progress. Members have provided evidence that no-show rates drop by 25% to 50% for self-scheduled appointments, as compared to the general patient population.

Slow but Sure Progress

The Patient Access Symposium®, a collaboration of 61 academic health systems, reports that 63% of members have integrated automated provider matching solutions through their management information system or a bolt-on third party, with the remaining organizations having protocols on dynamic files. These strategies are slowly but surely facilitating scheduling *within* an organization, such as permitting a primary care office to directly schedule a specialty care visit. Outside of large, sophisticated health systems, however, the current state reveals that manual systems continue to punctuate today's scheduling processes.

Barrier # 6

Physician Supply. On a strategic level, there may simply not be an adequate supply of physicians to meet the access needs of the country even if these internal and external barriers are addressed. A study commissioned by the American Association of Medical Colleges in 2017 revealed that the United States will face a shortage of between 40,800 and 104,900 physicians by 2030; the numbers of new primary care physicians and other medical specialists are not keeping pace with the demands of a growing and aging population.[7] If traditional delivery systems and reimbursement models that favor patient-facing visits persist, the velocity to treatment will continue to lag. Innovative delivery and reimbursement models that extend provider reach and permit provider collaboration are required.

Creative Strategies

Healthcare leaders must create strategies to proactively address barriers that prevent inroads to patient access. This internal work, combined with engaging insurance payers to determine alternatives to current reimbursement policies, must be at the heart of the nation's healthcare dialogue. Without taking a thorough "history and physical," we cannot create an effective plan of care for our nation's diagnosis of poor, costly, and ineffective access. GPJ

***Elizabeth W. Woodcock, M.B.A., FACMPE, CPC**, is founder and executive director, Patient Access Symposium®.*

References

1. Rates cited are 2018 national Medicare rates. For 99214, the rate reflects the non-facility reimbursement schedule. The American Medical Association publishes the CPT©.
2. N. Caldwell, T. Srebotnjak, T. Wang, and R. Hsia. 2013. How Much Will I Get Charged for This? Patient Charges for Top Ten Diagnoses in the Emergency Department. PLoS ONE 8(2): e55491. Accessed May 16 at doi.org/10.1371/journal.pone.0055491.
3. Agency for Healthcare Research and Quality. 2013. *Medical Panel Expenditure Survey,* January 23, 2013. Accessed May 16 at meps.ahrq.gov/data_stats/quick_tables.jsp.
4. National Center for Health Statistics. 2017. *Health, United States, 2016: With Chartbook on Long-term Trends in Health.* Table 76. Visits to physician offices, hospital outpatient departments, and hospital emergency departments, by age, sex, and race: United States, selected years 2000–2013. 286–288. Accessed May 16 at cdc.gov/nchs/data/hus/hus16.pdf.
5. Blue Cross Blue Shield of North Carolina. 2012. Non-Emergency Emergency: Reducing Avoidable ER Visits. Blue Cross Blue Shield of North Carolina, Provider News (undated). Accessed May 16 at bluecrossnc.com/provider-news/non-emergency-emergency-reducing-avoidable-er-visits.
6. L. Uscher-Pines, J. Pines, A. Kellermann, et al. 2013. Deciding to Visit the Emergency Department for Non-Urgent Conditions: A Systematic Review of the Literature. *American Journal of Managed Care,* 19(1): 47–59. Accessed May 16 at ncbi.nlm.nih.gov/pmc/articles/PMC4156292.
7. S. Mann. 2017. Research Shows Shortage of More than 100,000 Doctors by 2030. *AAMCNEWS,* March 14, 2017. Accessed May 16 at news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor.