Whether it’s to fix old cracks in the care continuum or prepare for value-based care, organizations are pursuing new models to better manage and improve the health of the population. As organizations begin to investigate the ROI potential in these models, the patient-centered medical home (PCMH) in particular is piquing interest.

The PCMH is an innovative model of care that emphasizes comprehensive, coordinated, and integrated patient-centered care that aims to improve health outcomes and quality while reducing costs. The hallmarks of the PCMH model include:

- Patient- and family-centered care
- Comprehensive care
- Coordinated care
- Access to care
- Care management
- Health information technology
- Quality and performance improvement
- Aligned payment models

Establishing a PCMH can be costly in terms of the initial investments and the ongoing workforce necessary to maintain the model. This type of care producing an ROI with a PCMH

Patient-centered medical homes can deliver high-quality care and produce a healthy ROI for organizations that are willing to invest the time and effort required to plan for the transition and maintain the model.

AT A GLANCE

Although the expense of establishing a patient-centered medical home can be high, an organization can improve its ROI from adopting such a care delivery model by following four basic guidelines:

- Align care with payment.
- Develop a realistic timeline.
- Define expenses.
- Identify new revenue streams.
delivery transformation also requires patience, because it often takes a few years before organizations can generate a tangible ROI from such an endeavor. Organizations that accept the long-term commitment stand to reap considerable rewards.

In fact, recent reports directly link PCMHs to improved care coordination and quality (e.g., lower readmission rates, improved health outcomes, and greater patient satisfaction), as well as financial benefits (e.g., lower costs and additional revenue through innovative payment models) over time.a By addressing time frame and expense expectations relative to PCMH investments, organizations can develop more accurate ROI calculations.

**Facing the Challenge**

Organizations can ease the complexity of managing a PCMH by aligning care and payment delivery models at the outset. All too often, organizations focus solely on the clinical and operational transformation and leave their payment delivery model unattended. A focus on payment delivery will support care delivery as well as the organization’s strategy and viability. By aligning care and payment delivery mechanisms, organizations will be able to keep their financial and clinical priorities in sync.

For care delivery transformation efforts to be successful and sustainable, they must be supported by the requisite level of funding. Financial projections for PCMHs need to reflect both revenues and expenses for calculation of a realistic ROI. The resultant projections and calculation will guide organizations in their decision-making processes and financial planning, further facilitating changes in care delivery.

**Determining an Appropriate ROI Time Frame**

Timing is central to effectively implementing a new care model and realizing an ROI. The transition to a PCMH is a continuous journey that evolves as patient care needs change and best practices are defined and redefined. Along the way, payer, state, and federal payment negotiations may take time, and the receipt of payment may require the demonstration of certain criteria (e.g., three months of reporting metrics, PCMH care model components).

Similar to a business or home, a PCMH is an investment that will not result in immediate payout; organizations should not expect to see a tangible ROI from a PCMH for at least three years after the initial investment. A PCMH relies on new operational processes that require careful planning and a flexible implementation strategy. Incremental improvements, such as focusing on one patient population initially, may have a higher chance of success in the long term if the practice is allowed time to adapt to unplanned circumstances in the short term, such as barriers to a desired facility improvement or unexpected employee turnover. Although this approach lengthens the investment period, it also provides a PCMH with flexibility as it adapts the model across its scope of practice.

Organizations that focus on a shorter time frame in their ROI calculation may undervalue the model’s impact and potentially forgo what could have been a valuable transformation. Although there are some opportunities for clinical and financial improvements in the short term, for any significant accumulation of ROI, organizations must set realistic expectations. One way to do this and potentially reduce the time it takes to realize a substantial ROI is to ensure the following steps are part of the PCMH process.

**Adopt a phased approach.** By phasing implementation and transition, an organization can make critical adjustments without repeating costly work. A phased approach can help organizations avoid pitfalls such as hiring additional staff.
without clearly defining and piloting roles/ responsibilities and overspending on data analytic tools without fully understanding internal capabilities and patient population needs first.

**Revisit priorities.** Priorities could change as the organization, delivery model, and/or patient population evolves. Organizations shouldn’t hesitate to redeploy assets to meet new priorities related to issues such as chronic care or Medicaid expansion. For example, an organization might shift resources to chronic care based on total-cost-of-care analyses, seek additional community resources for Medicaid expansion beneficiaries, or shift workflows in response to changing state and federal regulatory requirements.

**Define and implement metrics for success.** To be able to continuously make improvements and realize efficiencies, organizations must make sure that metrics are defined and implementable. Metrics also must be within the control of the provider and should align with other initiatives. Examples of potential key metrics include access to care, patient satisfaction, reduced emergency department (ED) utilization, and completion of screenings/tests for chronic conditions.

### Estimating the Initial and Ongoing Expenses

Once organizations recognize the time needed and plan accordingly, the next step is defining expenses and costs for the PCMH. Common categories include IT, clinical and administrative resources, facility improvements, and other expenses, as shown in the exhibit below.

**IT costs.** The IT costs likely will require an initial investment and ongoing operating expenses, both of which can be spread across multiple initiatives. If an organization is attempting to meet all of the standards for PCMHs established in 2014 by the National Committee for Quality Assurance (NCQA) related to capturing clinical data, reporting, and analytics, the initial investment for appropriate tools and capabilities is

---

**INVESTMENT REQUIREMENTS FOR A PATIENT-CENTERED MEDICAL HOME (PCMH)**

**Patient-Centered Medical Home Investment Categories**

| **Clinical and Administrative Resources** |
| Care coordinators, social workers, clinical/quality analysts, and project managers |

| **Facility Improvements** |
| Improvements to infrastructure or physical space, such as patient-specific design elements for more efficient patient flow |

| **Other Expenses** |
| Recognition or accreditation fees for NCQA, TJC, URAC, AAAHC, or other affirming entity costs, as well as consultant or vendor support, marketing efforts, phone system upgrades, and new patient education classes |

**IT**
Electronic health record, care management/coordination modules, health information exchange tools, disease registries, and reporting/tracking tools

---

Note: The above expense categories for PCMHs, focused on primary care delivery, are the same for patient-centered specialty practices (PCSPs), which are focused on specialty care.
approximately $40,000 per physician, depending on the current infrastructure’s level of sophistication.\textsuperscript{c}

Ongoing operating expenses are mainly related to staffing and electronic health record (EHR) or population health enterprise system maintenance. Recent research suggests that large multispecialty medical groups spend approximately $30,000 per physician FTE on ongoing IT operating expenses annually, which includes approximately $19,000 per physician FTE for IT staffing.\textsuperscript{d} Once again, this number may fluctuate depending on the size of the organization and its staffing needs.

New care models often require new roles and responsibilities as well. Nurse care managers, social workers, health coaches, and data analysts are integral to a PCMH’s care coordination and management efforts, but the individuals filling these roles have historically operated outside of the traditional practice setting and care team model. Depending on the number of providers in a practice, the FTEs and costs of these positions will vary.

The organization also should assess its current workforce to determine whether any positions could be augmented to align with the goals of a PCMH practice, ensuring all staff members are appropriately qualified for their positions and are making full use of their knowledge and expertise. The annual base compensation (based on current national figures) for 1.0 FTE extended care team member roles within a PCMH, excluding the value of benefits, is as follows:

\begin{itemize}
  \item Nurse care manager: $78,000
  \item Health coach and nutritionist: $53,000
  \item Social worker/behavioral health specialist: $62,000
  \item Patient navigator: $31,000
  \item Data analyst: $70,000
\end{itemize}

Facility improvements can be costly and are typically a longer-term investment that occurs later during the planning process. Organizations may decide to forgo this expense and instead design workarounds to operate within their current physical layout. However, space planning has the potential to increase a PCMH’s operational efficiency. For instance, locating nurse stations near physicians increases the team’s ability to communicate as often as is necessary, encouraging timely service and reduction of waste and errors.\textsuperscript{e}

A PCMH also may incur additional costs such as recognition/accreditation fees and other overhead expenses. Recognition/accreditation fees range roughly from $100 to $600 per physician.\textsuperscript{f} Other overhead expenses may include program administration, consultant or other vendor support, training and educational resources for patients and staff, and marketing efforts. Many of these potential expenses may be absorbed by current staff or within other initiatives.

An understanding of and careful planning for the time, resources, infrastructure, and financial capital required to transition to and maintain a PCMH will help organizations plan financially and realize a positive ROI.

\textbf{Identifying New Revenue Streams}

To offset the investment, organizations can cover their operating expenses by pursuing various new revenue sources and funding opportunities. For example, a review of current federal, state, and commercial payer arrangements can help organizations identify opportunities for value-based payment models. These models include transition support fees, pay-for-performance incentives, and per-member-per-month (PMPM) care management fees that may be directly or indirectly attributable to a PCMH (see

\begin{itemize}
\item This figure is based on ECG Management Consultants’ experience implementing PCMHs across multiple organizations.
\item “National Medical Group Cost and Staffing Survey,” ECG Management Consultants, 2015.
\item These figures are based on national PCMH program (e.g., NCOA, Joint Commission) pricing for application, license, and submission process. Costs per physician will vary depending on the size of the submitting practice.
\end{itemize}
Implementing such initiatives can greatly offset the initial investment and operating expenses associated with adopting a PCMH model. For example, a PCMH physician who receives payment from the Centers for Medicare & Medicaid Services (CMS) for providing care coordination for eligible Medicare patients could generate additional annual revenues for the organization amounting to as much as $180,000.\(^g\)

As new value-based payment models continue to proliferate across the nation, federal, state, and commercial payer programs supporting these models will likely also be introduced. Providers in national and local markets are shifting their focus toward value-based models that offer incentives for delivering more patient-centered, high-quality, high-value care. Organizations that are both clinically and financially aligned via a PCMH model and value-based payment arrangements are positioned to reap the greatest rewards.

### Making a Sound Investment

Care delivery transformation, whether through a PCMH or similar model, has become the new normal in health care as the payment requirements for patient and providers, both commercially and at the federal and state levels, have become increasingly complex. The PCMH model offers a structured approach to care delivery

---

**NEW REVENUE STREAMS TO SUPPORT A PCMH INVESTMENT**

<table>
<thead>
<tr>
<th>Type of Revenue Opportunity</th>
<th>Description</th>
<th>Examples of Financial Arrangements</th>
</tr>
</thead>
</table>
| Transition support fees     | Payments offered by states or payers that help to offset the initial investment required to transition to new models of care | > Provided through a lump sum up front upon agreement to meet certain criteria  
> Provided through per-member-per-month (PMPM) fees |
| Care coordination or care management fees | Payments offered by states or payers that support proactive management of a defined patient population, specifically regarding care management and coordination efforts | > CMS chronic care management PMPM payment of approximately $40  
> Anthem Blue Cross Enhanced Personal Health Care Program PMPM care management fees for participating in patient-centered care models  
> New York’s $6 to $8 PMPM fees for Medicaid managed care plans and $20 to $29 add-on per visit payments for its fee-for-service plans for PCMH participation* |
| Transitions of care management codes | Codes that provide higher relative-value-unit (RVU) values for ensuring efficient transition of care for patients discharged from an acute care facility | Varies by arrangement |
| Shared savings              | Payer (government and commercial) arrangements offering an opportunity to share in any savings generated from more efficient and effective operations and clinical care delivery | > Medicare Shared Savings Program  
> Medicaid managed care organizations  
> Major payer shared savings programs |
| Operational efficiencies    | The identification and execution of process and operations improvements, resulting in cost, quality, or clinical care efficiencies | Varies by organization |

\(^g\) This dollar amount assumes a 1,500-patient panel that is 50 percent Medicare, with 50 percent of patients having two or more chronic conditions (375 eligible patients). Data are based on the number of Medicare beneficiaries reported by The Henry J. Kaiser Family Foundation and the number of Medicare beneficiaries with two or more chronic conditions reported by CMS.

---

the exhibit above). Organizations also can uncover opportunities to reduce waste and unnecessary ongoing expenses, and realize additional cost savings, by conducting a thorough internal financial and operational assessment.

---

\(\text{hfma.org APRIL 2016 5}\)
transformation and is often used as the foundation for the evolution to value-based care.

Yet developing and implementing a PCMH requires time, capital, and human resource investments. As organizations transition to and engage in this model of care, it is imperative that they fully consider all the financial and temporal requirements that must be addressed to successfully develop and operate a PCMH. Organizations also should explore the full range of financial incentives and opportunities that exist nationally, locally, and internally—including payer reimbursement strategies, state and federal incentive programs, and expense savings—to potentially offset the care model investment, create financial sustainability, and support positive clinical outcomes.

With clear, defined objectives and a comprehensive strategy for managing the PCMH model, organizations can ensure their care delivery approach is focused on continuous improvements that generate a positive ROI, both clinically and financially.

### About the authors

**Emma Mandell Gray**

is senior manager, ECG Management Consultants, Boston (egray@ecgmc.com).

**Rachel Aronovich**

is project manager, Northwest Hospital & Medical Center, Seattle, and a member of HFMA’s Washington-Alaska Chapter (rachel.aronovich@nwhsea.org).