Published in final edited form as:

J Ambul Care Manage. 2018 ; 41(2): 105–113. doi:10.1097/JAC.0000000000000224.

Off-setting PCMH Investment Costs through Per-Member-Per-Month or MIPS Incentive Payments

Briget da Graca, MS^{1,2}, Gerald O. Ogola, PhD, MPH¹, Cliff Fullerton, MD, MS^{3,4}, Russell McCorkle, MBA⁵, and Neil S. Fleming, PhD^{1,2}

¹Center for Clinical Effectiveness, Baylor Scott & White Health, Dallas, Texas

²Robbins Institute for Health Policy & Leadership, Baylor University, Waco, Texas

³Baylor Scott & White Quality Alliance, Dallas, Texas

⁴Baylor Scott & White Health, Dallas, Texas

⁵HealthTexas Provider Network, Dallas, Texas

Abstract

Primary care practices become patient-centered medical homes (PCMHs) to improve care. However, investment costs and opportunities to off-set those costs are critical to the decision. We examined potential off-sets through commercial-payer per-member-per-month (PMPM) payments and the Medicare Merit-based Incentive Payment System (MIPS) for a network that spent \$4,818,260 over 4 years obtaining and renewing PCMH recognition for 57 practices. With PMPM payments of \$3.37–\$8.98, “break-even” requires 2.4%–6.4% of the network’s 1645 commercially-insured patients/physician be covered, while applying MIPS incentive payments of half the maximum available each year to the network’s average 2016 Medicare reimbursement of \$196,812/physician showed they would exceed PCMH costs by 2022.

Introduction

Primary care physicians that transform their practices into patient-centered medical homes (PCMHs) are aiming for the improved quality of care and patient outcomes the model is believed to support (Flores, 2011). Nonetheless, questions about the costs associated with implementing and sustaining the PCMH model, and the reimbursement available for these activities, are critical to the efforts to transform the US health care system into one that, through increased focus on disease prevention and management, care coordination, patient engagement, and population health management, improves patients’ outcomes and decreases the overall costs of care. Even if the evidence gradually accumulating regarding the PCMH model’s impact on delivery of recommended care process and health care resource utilization (Edwards, Bitton, Hong, & Landon, 2014; Friedberg, Schneider, Rosenthal,

Corresponding Author: Briget da Graca, 8080 North Central Expressway, Suite 500, Dallas, TX 75206, Phone: 214-265-3610, Fax: 214-265-3640, briget.dagraca@baylorhealth.edu.

This work was presented at the AcademyHealth National Policy Conference in Washington, DC, in January 2017.

Conflicts of Interest: The authors have no conflicts of interest to declare.

Volpp, & Werner, 2014; Hebert et al., 2014; Homer & Baron, 2010; Jackson & Williams, 2015; Neal, Chawla, Colombo, Snyder, & Nigam, 2015; Nelson et al., 2014; Patel et al., 2013; Yoon, Chow, & Rubenstein, 2016) ultimately lands in its favor, this information will be of limited use if we have not simultaneously developed a reimbursement strategy that enables and incentivizes practices to adopt this model while sustaining their financial performance.

Currently, there is little real-world evidence available to guide practices' decisions about investing in PCMH transformation. Outside of a study conducted in the unique setting of the Veterans Health Administration (Hebert et al., 2014), reports of the costs of transformation have largely been limited to the experience of small numbers of independent practices (Halladay et al., 2016; Ho & Antonucci, 2015) or have focused on very specific aspects of supporting PCMH-related activities (such as staffing costs (Magill et al., 2015; Patel et al., 2013)), while studies looking at reimbursement models for PCMH activities have either excluded the up-front costs of transformation (Basu, Phillips, Song, Landon, & Bitton, 2016) or excluded the costs of necessary supporting resources (such as care coordination and information infrastructure) supplied by a centralized entity across a broader network of practices (Cuellar et al., 2016). We recently reported both the practice-level and centralized corporate costs for a large physician network implementing and sustaining the PCMH model across its 57 primary care practices. (Fleming et al., 2017) Here, we compare these costs to the "per member per month" (PMPM) case management/care coordination fees reported available from various payers to practices that maintain PCMH recognition, and to the incentive payments PCMH recognition will potentially assist physicians/practices under the Merit-based Incentive Payment System (MIPS) track as the reimbursement structures authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are implemented.

Methods

Setting

HealthTexas Provider Network (HTPN) is the fee-for-service ambulatory care provider network affiliated with Baylor Scott & White Health, a not-for-profit healthcare system, in North Texas. As reported elsewhere, a common electronic health record was implemented across all (HTPN) primary care practices between 2006 and 2008 (Fleming, Culler, McCorkle, Becker, & Ballard, 2011), and, between June 2010 and 2012, all 57 HTPN primary care practices obtained recognition from the National Committee for Quality Assurance (NCQA) as Level III PCMHs under the 2008 criteria, renewing 3 years later under either the 2011 or 2014 criteria (Fleming et al., 2017).

Data Collection and Analysis

We previously combined data regarding the time and effort expended by individuals in both the HTPN corporate resources supporting PCMH transformation and maintenance activities, and in the individual practices, with payroll and expense data, to determine the overall, corporate, and practice-level incremental costs associated with the initial transformation of HTPN primary care practices to PCMHs, ongoing activities, and required renewals (Fleming

et al., 2017). These costs were assessed at the global HTPN corporate and practice levels as the time and resources devoted to these activities impact all HTPN primary care patients, not only those for whom PCMH-related PMPM payments are available or who will contribute to MIPS scores.

From HTPN administrative data, we determined the average size and payer distribution of an HTPN primary care physician's patient panel, as well as average annual Medicare reimbursement per physician.

From the literature, we identified the range (and median) of the per member per month (PMPM) payments assorted initiatives and payers have offered to support PCMH related activities to determine what percentage of the average physician patient panel would need to be covered by such a payment for HTPN to off-set the investment costs of PCMH transformation and maintenance in 4 years – a time period selected to capture the initial transformation costs, the first renewal (after 3 years), and the ongoing activity costs (eg, care coordination).

Because PCMH recognition can assist primary care physicians earn performance awards under the MIPS track within MACRA, we also compared cumulative total and practice-level costs to the awards a single hypothetical average 5-physician HTPN practice could earn and that the network of 57 PCMHs could earn. To provide a picture useful to physician networks currently debating whether to initiate PCMH transformation, we “moved” HTPN's initial transformation to 2016. For these comparisons, we applied both a “best case scenario” in which all 57 practices would earn the maximum award under MIPS (4% of Medicare Part B payments in 2019, 5% in 2020, 7% in 2021, and 9% from 2022 onwards (Centers for Medicare and Medicaid Services, 2017)) and a more realistic scenario under which the awards would average out at half available maximum reward (eg, 2% in 2019; 4.5% from 2022 onwards). For simplicity, we converted all HTPN dollar amounts to 2016 US dollars using the Consumer Price Index (CPI) annual percent changes for medical care reported for Dallas-Fort Worth by the US Bureau of Labor Statistics; the range of PMPM payments obtained from the literature was converted using the US City Average CPI annual percentage changes for medical care, as they were based on a national survey (Bureau of Labor Statistics).

Results

In fiscal year 2016, the average HTPN primary care physician had a patient panel of 2,137 (20% Medicare [n=426], 77% Commercial insurance [n=1645], and 3% Other [n= 64; Medicaid, self-pay, etc]) and received annual Medicare reimbursement of \$462 per patient (\$196,812 total per physician).

We have previously estimated HTPN's incremental costs associated with its 57 primary care practices obtaining and maintaining Level III NCQA PCMH recognition, in 2012 US dollars (Fleming et al., 2017). Table 1 summarizes these costs, and converts them to 2016 US dollars. By Year 4, HTPN's cumulative PCMH costs (in 2016 US dollars) amounted to:

$$\$1,686,798_{Corporate\ Initial\ Transformation} + (57 \times \$11,930_{Practice\ Initial\ Transformation}) +$$

$$\$387,585_{\text{Corporate Renewal}} + (57 \times \$5,543_{\text{Practice Renewal}}) + (4 \times \$436,979_{\text{Annual Care Coordination}}) = \underline{\$4,818,260}$$

A national survey of PCMH initiatives conducted in 2013 reported a median (interquartile range) of the PMPM payments available at \$4.90 (\$3.00, \$8.00) (Edwards et al., 2014). In 2016 US dollars, these were equivalent to PMPM payments of \$5.50 (\$3.37, \$8.98). Table 2 shows the percentage of patients that would need to be covered by a PMPM payment for HTPN to “break even” by Year 4 under a low (\$3.37), median (\$5.50), and high (\$8.98) payment scenario.

Table 3 compares the PCMH costs vs potential MIPS payments for 2017 to 2022 had PCMH transformation taken place in 2016. Under either scenario examined (earning the maximum MIPS incentive available, or earning on average half the maximum MIPS incentive available) a hypothetical 5-physician practice’s MIPS incentive payments would exceed its spending on obtaining and maintaining NCQA PCMH recognition from the first year MIPS payments will be available (2019) onward. In terms of total HTPN spending (corporate plus practice costs), under the scenario in which all physicians at all practices earn the maximum MIPS incentive every year it is available, the cumulative incentive payments received would exceed the cumulative spending on obtaining and maintaining NCQA recognition from 2021 on. Under the scenario in which physicians earned, on average, half the maximum MIPS incentive available, this would take until 2022.

Discussion

Our results show that, while transforming primary care practices into recognized PCMHs involves significant upfront investment, in the context of a large physician network such as HTPN that is able to provide centralized support both for the process, as well as for ongoing PCMH-related activities such as care coordination, off-setting these costs can realistically be achieved through such PMPM payments as payers have reportedly offered to date. Even at the low end of the reported PMPM range for practices achieving Level III NCQA recognition (\$3.37 PMPM), our results show that only 6.4% of HTPN’s commercially insured primary care patients would need to be covered by plans offering such payments for HTPN to off-set its full expenditure (including initial PCMH recognition, one renewal, and ongoing PCMH-related activities such as care coordination) within 4 years. We also estimate that, for a network like HTPN that chose to initiate PCMH transformation of its primary care practices in 2016 to help those practices qualify for higher performance scores and awards under the MIPS track in MACRA, it would be possible off-set the cumulative expenditures by 2022 if the physicians in that network earned, on average, half of the maximum MIPS performance award available from 2019 on. Having based our evaluation on a hypothetical “average” practice, our results do assume a degree of cross-subsidization, in which some physicians and practices earn greater MIPS incentive payments or have larger numbers of patients with PMPM payments related to PCMH recognition than others. Cross-subsidization could be direct, for example, requiring practices with higher MIPS or PMPM earnings to contribute more of those specific earnings towards the centralized support for the PCMH initiative. Alternatively, it could be unrelated to PMPM or MIPS incentive payments, with practices contributing funds towards central resources (supporting various network-

level initiatives, including the PCMH initiative) based on non-performance based factors, such as number of physicians in the practice.

Our results regarding the ability to off-set PCMH transformation and maintenance costs through PMPM payments with <10% of commercial patients covered stand in contrast to the experience reported an early PCMH adopter, who found the \$3–\$7 PMPM payments insufficient to maintain care coordinators on his payroll and cover the costs for the required data reporting – particularly since the attribution of patients for which he received these PCMH payments “always seemed to be less than half of the actual patients [he] was seeing with other payers” (Bender, 2015). An important part of this difference may well be the centralized support HTPN was able to offer – both for the process of applying for and renewing PCMH recognition, and for ongoing services such as care coordination and automated reporting of the necessary quality measures. As we have previously reported, this centralized support reduced the time spent by physicians and practice staff on obtaining PCMH recognition from the 500 hours reported by solo practices (Ho & Antonucci, 2015) to an estimated 240 hours (Fleming et al., 2017). Our results are also worth considering in light of the recent microsimulation model that found practices could add substantial additional net revenue through PMPM payments (with or without pay-for-performance awards) related to PCMH recognition, provided the practices implement only the minimum requirements to qualify for the payments (Basu et al., 2016). Our estimates are consistent with the simulation results to the extent that they suggest that revenue gains could be fairly readily achieved (assuming that at least 10% of commercially insured patients were covered by a plan offering a PMPM payment) – but may show that, in the context of a large network that provides centralized support for PCMH transformation and activities, these gains need not be lost by exceeding the minimum requirements to qualify for the PMPM payments. While we did not specifically examine the extent to which the HTPN practices have implemented the PCMH model, HTPN policy required them to achieve the highest level (III) of NCQA recognition – whereas, the microsimulation took into account that payers responding to a national survey regarding PCMH initiatives frequently accepted more basic PCMH standards (eg, NCQA Level I) (Basu et al., 2016; Edwards et al., 2014). Furthermore, the microsimulation did not include up-front costs of PCMH transformation (due to these being highly variable between settings) (Basu et al., 2016), whereas these represent a large portion of the costs that would need to be off-set in our results. As such, our results provide hope that the current PMPM-based PCMH payment structure need not disincentivize implementation of more than the minimum required PCMH standards.

Our estimates of how PCMH implementation and maintenance costs compare to the rewards that PCMH recognition can help primary care physicians/practices earn through MIPS incentive payments also provide useful information for physician networks currently considering initiating PCMH transformation - or maintaining the PCMH recognitions they have already obtained.

MIPS enables practices participating in Medicare to earn payment adjustments based on evidence-based and practice-specific quality data (Centers for Medicare and Medicaid Services). The MIPS Composite Performance Score will factor in four weighted categories: quality, improvement activities, advancing care information, and cost - although the weight

of this last category will be 0% for the transition year of 2017 (Centers for Medicare and Medicaid Services, 2016). Figure 1 shows examples of how obtaining NCQA PCMH recognition can help primary care practices earn Composite Performance Scores that will qualify them for positive payment adjustments in multiple ways. Our results suggest that, if physicians/practices earn on average half the maximum MIPS incentive payment available (not including the additional award available to those achieving “exceptional” performance under MIPS (Centers for Medicare and Medicaid Services, 2017), a network like HTPN would be able to off-set the investment cost of initially obtaining and maintaining NCQA PCMH recognition from the MIPS incentive payments by 2022.

Our results need to be considered in the context we investigated: a large physician network that committed to providing centralized support for PCMH transformation, including some ongoing activities such as care coordination and tracking and reporting quality of care measures. As we have previously reported, this substantially reduced the time and cost burden on the individual practices (Fleming et al., 2017). Furthermore, we examined incremental costs associated with the practices obtaining and maintaining NCQA Level III recognition – since the practices already routinely engaged in many of the activities required to meet the NCQA criteria, the incremental costs do not represent the full cost of PCMH-related activities. Solo practices, or smaller groups of practices, that do not have access to centralized resources similar to those HTPN offers, and practices in which the routine daily activities do not already incorporate many of the NCQA PCMH criteria might therefore have very different costs, which may not be offset by the available PMPM payments or MIPS incentive payments to the same extent. Similar cautions apply to practices that have not already implemented an EHR capable of supporting the data-drive aspects of the PCMH model – although the rising adoption of EHRs in primary care should lessen this concern (Xierali et al., 2013) – and practices in which a more clinically and/or socially complex patient mix requires greater care coordination support (thus potentially increasing that category of cost, although, as we previously noted, care coordination activities that focus on bringing patients into the office for overdue preventive or disease management services reimbursable under fee-for-service mechanisms can help offset the care coordination personnel costs (Fleming et al., 2017)). Finally, because the HTPN practices obtained their initial PCMH recognition in 2010–2012, they did so under the 2008 NCQA criteria, which differed from the current criteria and it is not known to what extent those differences impact the time and resources required for initial transformation and recognition. Additionally, the time estimates from which we calculated costs were based on information obtained through interviews and surveys, and so may be subject to recall and response bias.

As primary care practices increasingly operate in network contexts similar to HTPN (Bishop, Shortell, Ramsay, Copeland, & Casalino, 2016; Kirchhoff, 2013), our results should prove useful to many of those still considering engaging in PCMH transformation or trying to accommodate the upfront investment in their budgets. We show that, when the network provides centralized support for the PMCH initiative, costs can be off-set within 4 to 6 years at both the practice and network levels with relatively small numbers of commercially insured patients covered by PMPM payments, or Medicare MIPS incentive payments averaging at half the maximum available. For practices with patient panels that provide access to both types of payments, investment costs can be off-set even more rapidly.

Acknowledgments

Project Funding: This project was funded by AHRQ, grant number R03 HS022621-01 (Principal Investigator: Neil Fleming).

References

- Basu S, Phillips RS, Song Z, Landon BE, Bitton A. Effects of New Funding Models for Patient-Centered Medical Homes on Primary Care Practice Finances and Services: Results of a Microsimulation Model. *Ann Fam Med*. 2016; 14(5):404–414. DOI: 10.1370/afm.1960 [PubMed: 27621156]
- Bender JL. The Rise and Fall of the Patient-Centered Medical Home. Why a PCMH pioneer may abandon the model in his practice. *Med Econ*. 2015; 92(17):57.
- Bishop TF, Shortell SM, Ramsay PP, Copeland KR, Casalino LP. Trends in hospital ownership of physician practices and the effect on processes to improve quality. *Am J Manag Care*. 2016; 22(3): 172–176. [PubMed: 27023022]
- Centers for Medicare and Medicaid Services. [Retrieved March 16, 2017] What's the Merit-based Incentive Payment System (MIPS)?. from <https://qpp.cms.gov/learn/qpp>
- Centers for Medicare and Medicaid Services. [Retrieved March 16, 2017] Quality Payment Programs. Executive Summary. 2016. from https://qpp.cms.gov/docs/QPP_Executive_Summary_of_Final_Rule.pdf
- Centers for Medicare and Medicaid Services. Medicare program; merit-based incentive payment system and alternative payment model incentive under the physician fee schedule, and criteria for physician-focused payment models. *Fed. Reg*. 2017; 81(214):77008–77831.
- Cuellar A, Helmchen LA, Gimm G, Want J, Burla S, Kells BJ, Nichols LM. The CareFirst Patient-Centered Medical Home Program: Cost and Utilization Effects in Its First Three Years. *J Gen Intern Med*. 2016; 31(11):1382–1388. DOI: 10.1007/s11606-016-3814-z [PubMed: 27473005]
- Edwards ST, Bitton A, Hong J, Landon BE. Patient-centered medical home initiatives expanded in 2009–13: providers, patients, and payment incentives increased. [Research Support, Non-U.S. Gov't]. *Health Aff (Millwood)*. 2014; 33(10):1823–1831. DOI: 10.1377/hlthaff.2014.0351 [PubMed: 25288429]
- Fleming NS, Culler SD, McCorkle R, Becker ER, Ballard DJ. The financial and nonfinancial costs of implementing electronic health records in primary care practices. [Research Support, U.S. Gov't, P.H.S.]. *Health Aff (Millwood)*. 2011; 30(3):481–489. DOI: 10.1377/hlthaff.2010.0768 [PubMed: 21383367]
- Fleming NS, da Graca B, Ogola GO, Culler SD, Austin J, McConnell P, Fullerton C. Costs of Transforming Established Primary Care Practices to Patient-Centered Medical Homes (PCMHs). *J Am Board Fam Med*. 2017; 30(4):460–471. DOI: 10.3122/jabfm.2017.04.170039 [PubMed: 28720627]
- Flores L. Improving patient health drives PCMH interest. *MGMA Connex*. 2011; 11(6):35–37.
- Friedberg MW, Schneider EC, Rosenthal MB, Volpp KG, Werner RM. Association between participation in a multipayer medical home intervention and changes in quality, utilization, and costs of care. [Research Support, Non-U.S. Gov't]. *JAMA*. 2014; 311(8):815–825. DOI: 10.1001/jama.2014.353 [PubMed: 24570245]
- Halladay JR, Mottus K, Reiter K, Mitchell CM, Donahue KE, Gabbard WM, Gush K. The Cost to Successfully Apply for Level 3 Medical Home Recognition. *J Am Board Fam Med*. 2016; 29(1): 69–77. DOI: 10.3122/jabfm.2016.01.150211 [PubMed: 26769879]
- Hebert PL, Liu CF, Wong ES, Hernandez SE, Batten A, Lo S, Fihn SD. Patient-centered medical home initiative produced modest economic results for Veterans Health Administration, 2010–12. [Research Support, Non-U.S. Gov't]. *Health Aff (Millwood)*. 2014; 33(6):980–987. DOI: 10.1377/hlthaff.2013.0893 [PubMed: 24889947]
- Ho L, Antonucci J. The Dissenter's Viewpoint: There Has to Be a Better Way to Measure a Medical Home. *Ann Fam Med*. 2015; 13(3):269–272. DOI: 10.1370/afm.1783 [PubMed: 25964407]

- Homer CJ, Baron RJ. How to scale up primary care transformation: what we know and what we need to know? *J Gen Intern Med*. 2010; 25(6):625–629. DOI: 10.1007/s11606-010-1260-x [PubMed: 20467912]
- Jackson GL, Williams JW Jr. Does PCMH "Work"?--The Need to Use Implementation Science to Make Sense of Conflicting Results. [Comment]. *JAMA Intern Med*. 2015; 175(8):1369–1370. DOI: 10.1001/jamainternmed.2015.2067 [PubMed: 26030753]
- Kirchhoff, S. [Retrieved 16 May, 2016] Physician Practices: Background, Organization, and Market Consolidation. 2013. from <https://www.fas.org/sgp/crs/misc/R42880.pdf>
- Magill MK, Ehrenberger D, Scammon DL, Day J, Allen T, Reall AJ, Kim J. The cost of sustaining a patient-centered medical home: experience from 2 states. [Research Support, U.S. Gov't, P.H.S.]. *Ann Fam Med*. 2015; 13(5):429–435. DOI: 10.1370/afm.1851 [PubMed: 26371263]
- Neal J, Chawla R, Colombo CM, Snyder RL, Nigam S. Medical homes: cost effects of utilization by chronically ill patients. [Research Support, Non-U.S. Gov't]. *Am J Manag Care*. 2015; 21(1):e51–61. [PubMed: 25880268]
- Nelson KM, Helfrich C, Sun H, Hebert PL, Liu CF, Dolan E, Fihn SD. Implementation of the patient-centered medical home in the Veterans Health Administration: associations with patient satisfaction, quality of care, staff burnout, and hospital and emergency department use. [Research Support, U.S. Gov't, Non-P.H.S.]. *JAMA Intern Med*. 2014; 174(8):1350–1358. DOI: 10.1001/jamainternmed.2014.2488 [PubMed: 25055197]
- Patel MS, Arron MJ, Sinsky TA, Green EH, Baker DW, Bowen JL, Day S. Estimating the staffing infrastructure for a patient-centered medical home. *Am J Manag Care*. 2013; 19(6):509–516. [PubMed: 23844711]
- Xierali IM, Hsiao CJ, Puffer JC, Green LA, Rinaldo JC, Bazemore AW, Phillips RL Jr. The rise of electronic health record adoption among family physicians. *Ann Fam Med*. 2013; 11(1):14–19. DOI: 10.1370/afm.1461 [PubMed: 23319501]
- Yoon J, Chow A, Rubenstein LV. Impact of Medical Home Implementation Through Evidence-based Quality Improvement on Utilization and Costs. [Research Support, U.S. Gov't, Non-P.H.S.]. *Med Care*. 2016; 54(2):118–125. DOI: 10.1097/MLR.0000000000000478 [PubMed: 26761727]

Figure 1.

Examples of how meeting NCQA PCMH criteria can contribute to the MIPS Composite Performance Score

1. Nelson KM, Helfrich C, Sun H, Hebert PL, Liu CF, Dolan E, et al. Implementation of the patient-centered medical home in the Veterans Health Administration: associations with patient satisfaction, quality of care, staff burnout, and hospital and emergency department use. *JAMA Intern Med.* 2014;174(8):1350-8.
2. Hebert PL, Liu CF, Wong ES, Hernandez SE, Batten A, Lo S, et al. Patient-centered medical home initiative produced modest economic results for Veterans Health Administration, 2010-12. *Health Aff (Millwood).* 2014;33(6):980-7.
3. Yoon J, Chow A, Rubenstein LV. Impact of Medical Home Implementation Through Evidence-based Quality Improvement on Utilization and Costs. *Med Care.* 2016;54(2):118-25.
4. Reid RJ, Coleman K, Johnson EA, Fishman PA, Hsu C, Soman MP, et al. The Group Health medical home at year two: cost savings, higher patient satisfaction, and less burnout for providers. *Health Aff (Millwood).* 2010;29(5):835-43.
5. Xierali IM, Hsiao CJ, Puffer JC, Green LA, Rinaldo JC, Bazemore AW, et al. The rise of electronic health record adoption among family physicians. *Ann Fam Med.* 2013;11(1):14-9.
6. Centers for Medicare and Medicaid Services. MIPS Overview. [cited 2017 March 16]; Available from: <https://qpp.cms.gov/measures/performance>.
7. National Committee for Quality Assurance. Standards and Guidelines for NCQA Patient-Centered Medical Home 2014. Washington, DC: National Committee for Quality Assurance, 2016.
8. National Committee for Quality Assurance. Appendix 2 NCQA's Patient-Centered Medical Home 2011 and CMS Stage 1 Meaningful Use Requirements. Washington, DC: National Committee for Quality Assurance, 2013.
9. National Committee for Quality Assurance. Standards and Guidelines for NCQA Patient-Centered Medical Home 2014: Appendix 2 NCQA PCMH 2014 and CMS Modified Stage 2 Meaningful Use Requirements. Washington, DC: National Committee for Quality Assurance 2016.

10. Centers for Medicare and Medicaid Services. MIPS Advancing Care Information. [cited 2017 March 17]; Available from: <https://qpp.cms.gov/measures/aci>.
11. Raskas RS, Latts LM, Hummel JR, Wengers D, Levine H, Nussbaum SR. Early results show WellPoint's patient-centered medical home pilots have met some goals for costs, utilization, and quality. *Health Aff (Millwood)*. 2012;31(9):2002-9.
12. National Committee for Quality Assurance. Standards and Guidelines for NCQA's Patient-Centered Medical Home (PCMH) 2011. Washington, DC: National Committee for Quality Assurance, 2013.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

Table 1

Incremental costs associated with 57 HTPN primary care practices obtaining and maintaining NCQA Level III PCMH Recognition (in 2012 and 2016 US dollars)

	Initial NCQA recognition		Renewal of NCQA recognition		Care Coordination Resource	
	2012 USD	2016 USD	2012 USD	2016 USD	2012 USD	2016 USD
HTPN Corporate *	\$1,508,503	\$1,686,798	\$346,617	\$387,585	\$390,790/yr	\$436,979/yr
Hypothetical 5-physician practice †	\$10,669	\$11,930	\$4,957	\$5,543	-	-

HTPN = HealthTexas Provider Network; NCQA = National Committee for Quality Assurance; PCMH = Patient-Centered Medical Home; USD = United States Dollars

* covering time for clinical/executive leaders, data analysts, informaticists, PCMH specialists, and physician champions, as well as software/hardware purchases and application fees

† covering physician and staff time spent on incremental activities related to obtaining or maintaining NCQA recognition

Table 2

Proportion of HTPN primary care commercially-insured patients that would need to be covered by “per member per month (PMPM)” PCMH payments each year to reach a “breakeven” point on PCMH costs by Year 4 after transformation

PMPM Payment	“Breakeven” percentage of covered patients*	“Breakeven” number of covered patients
\$3.37 (low)	6.4%	105 per physician
\$5.50 (median)	3.9%	64 per physician
\$8.98 (high)	2.4%	39 per physician

* calculated as: HTPN cumulative cost (\$4,818,260) $\div 57 Practices \times 5 Physicians \times (\$PMPM \times 48 Months \times \% \text{ of } 1645 Commercial Pts)$

Table 3

Comparison of HTPN corporate, individual practice, and total spending on obtaining and maintaining NCQA Level III PCMH recognition to potential MIPS incentive payments, had the initial PCMH transformation occurred in 2016

	Cumulative Corporate Amount Spent on PCMH recognition *	Cumulative Amount Spent by hypothetical 5-physician HTPN practice on PCMH recognition	Total Cumulative Amount Spent (57 PCMHs)	Cumulative MIPS Incentive Payments [‡]			
				Hypothetical 5-Physician HTPN Practice		Across 57 PCMHs	
				Max.	1/2 Max.	Max.	1/2 Max.
2016	\$2,123,777	\$11,930	\$2,803,787.00	n/a	n/a	n/a	n/a
2017	\$2,560,756	\$11,930	\$3,240,766.00	\$0	\$0	\$0	\$0
2018	\$2,997,735	\$11,930	\$3,677,745.00	\$0	\$0	\$0	\$0
2019 [†]	\$3,822,299	\$17,473	\$4,818,260.00	\$39,362	\$19,681	\$2,243,657	\$1,121,828
2020	\$4,259,278	\$17,473	\$5,255,239.00	\$88,565	\$44,283	\$5,048,228	\$2,524,114
2021	\$4,696,257	\$17,473	\$5,692,218.00	\$157,450	\$78,725	\$8,974,627	\$4,487,314
2022 [‡]	\$5,520,821	\$23,016	\$6,832,733.00	\$246,015	\$123,008	\$14,022,855	\$7,011,428

* including an initial corporate cost of \$1,686,798 and an annual Care Coordination Cost of \$436,979;

[†] 3-year NCQA renewal, with Corporate Cost of \$387,585, and a cost per hypothetical 5-physician practice of \$5,543;

[‡] applied to the average HTPN 2016 Medicare payment of \$196,812 per primary care physician; the "Max." scenario assumes all physicians earned the maximum MIPS incentive available (4% in 2019, 5% in 2020, 7% in 2021, and 9% in 2022); the "1/2 Max." scenario assumes the average MIPS incentive earned across the network was half of the maximum (ie, 2% in 2019, 2.5% in 2020, etc)