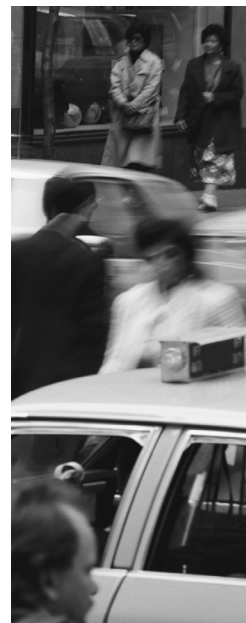
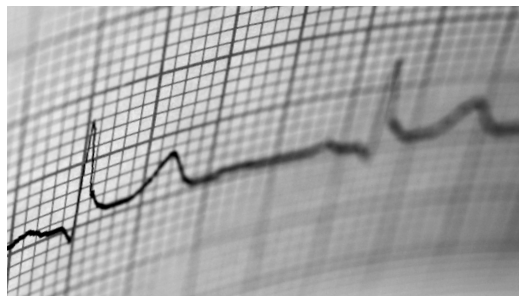


The Growth of Medical Homes in New York State, 2014 to 2016



Executive Summary	2
Acknowledgments.....	3
Introduction.....	4
Methods.....	5
Overall and Regional Trends in PCMH Recognition.....	6
Current Status	6
NCQA Recognition Status	8
PCMH Providers, and PCMH Penetration in New York State	12
Licensure	12
PCMH Penetration in New York State	13
PCMH Adoption by Different Practice Types.....	15
Current Status (April 2016) PCMH Providers by Practice Type	16
PCMH Providers by Practice Type: Changes Over Time	17
Regional and Borough Trends.....	18
The Role of Clinics in Driving PCMH Growth.....	18
Discussion.....	21
Looking Back	22
What Have We Learned?.....	23
Looking Ahead	24
Appendix. Changes in PCMH Providers by Practice Type, 2013–2016, by Region and Borough.....	27
Non-NYC Regions.....	27
New York City and Its Boroughs.....	31

Executive Summary

New York State has made a high-performing primary care system—one built on the medical home model—a central element in its strategy for reforming its health care delivery system. The state has made remarkable progress in its pursuit of this goal: New York currently accounts for one out of eight patient-centered medical home (PCMH) providers in the nation, as recognized by the National Committee for Quality Assurance (NCQA).

Over the last five years, UHF has tracked the spread of NCQA's PCMH model in New York State. In this paper, we analyze the status of PCMH adoption in New York as of April 2016.

Surveying PCMH Growth

Growth has not been uniform across the state. For the third year in a row, PCMH growth in New York City has lagged the growth in other regions. Additionally, the settings in which the PCMH providers work is changing. In 2013, New York's PCMH providers were equally split between clinic-based providers and private practices (groups, hospital/AMC practices, and small practices). Since then, PCMH growth in non-clinic settings has slowed, and growth in small practices appears to be stalled.

Since 2013, 80 percent of the growth in PCMH providers across the state has been in hospital clinics, most of them outside New York City. Two state initiatives appear to have driven that change: the continued provision, by Medicaid, of incentive payments to practices that are PCMHs; and the \$250 million Hospital-Medical Home program, which ran from 2011 to 2014 and provided resources to hospitals to help them achieve NCQA recognition as PCMHs.

Expanding the Model Further

NCQA's PCMH model is no longer the only model being pursued in New York State. Three other medical home models have recently emerged in New York State: the state's Advanced Primary Care (APC) program, and two additional models sponsored by the Center for Medicare and Medicaid Innovation (CMMI), the Comprehensive Primary Care, Plus program (CPC+) and the Transforming Clinical Practice Initiative (TCPI). A federally funded initiative (the Delivery System Reform Incentive Payment program, or DSRIP), which supports both the APC and PCMH models, is also under way.

These programs all emphasize the same basic competencies, and they focus on improving the way the state's primary care system cares for people with complex chronic diseases, whom the current system serves least well and at the highest cost.

As we consider New York's achievements to date, and consider where and why the PCMH model has taken root, and where it has not, it is increasingly clear that the state is facing four distinct challenges:

- With the proliferation of different medical home models, the centrality of the PCMH is eroding. There is a need to better align the competing programs, and to

give clearer signals to primary care practices that will allow the practices to determine which model payment incentives work best for them.

- Widespread adoption of the medical home model by the state's primary care practices will be difficult to achieve or sustain without the support of a critical mass of the payers whose members they serve.
- Traditional incentive payments are at risk of being supplanted by payment models that retrospectively calculate shared savings and shared risk. Such models do not offer primary care practices funds to cover their costs over their start-up period, which can last two to three years before the providers have savings to share.
- Achieving PCMH recognition, and participating in new value-based payment systems is a particular challenge for small practices. New York's small practices account for a sizeable share of the state's primary care workforce and play an important role in providing care to high-need populations in both urban and rural communities.

New York's progress to date in adopting the PCMH, together with the likely spread of this and similar models, has the potential to make a measurable difference in the way New York's health system performs and in the health of all New Yorkers. Achieving further progress, and reaching the state's goal—that 80 percent of New Yorkers have access to primary care in a medical home—will require attention to these four challenges.

Acknowledgments

The analysis in this report would not have been possible without the support of Kate Bliss from the Office of Quality and Patient Safety in the New York State Department of Health.

This report was supported in part by The Peter and Carmen Lucia Buck Foundation. The Innovation Strategies initiative is supported by the TD Charitable Foundation.

Introduction

It has been nearly 10 years since the nation's major primary care physician associations developed and endorsed the Joint Principles of the Patient-Centered Medical Home, a new model of primary care, with the potential to improve access, quality and coordination of care, to improve patient experience, and to reduce unnecessary and avoidable utilization. This landmark statement was shortly followed by the formulation by the National Commission on Quality Assurance (NCQA) of a recognition program for Patient-Centered Medical Homes (PCMHs).

Over the past decade, the medical home has been widely recognized as an important innovation for enhancing the performance of primary care practices and improving the health of the patients they serve. Based in a primary care setting, the medical home emphasizes the provision of comprehensive care focused on patient needs and preferences. Medical homes offer expanded access to care through extended hours of operation and a team approach to providing care, in order to make care more efficient and responsive to a wider range of patient needs. The medical home coordinates referrals and care transitions; connects patients and families to community-based resources and support; provides personalized care management for complex, chronically ill patients; and has a sharp focus on measuring, reporting, and improving quality of care.

The medical home model has been supported by the New York's Medicaid program since 2010, when Medicaid began to provide augmented payments to primary care providers who had achieved recognition by the National Commission on Quality Assurance (NCQA) as Patient-Centered Medical Homes (PCMH). Since then, providers and a number of other payers in New York State have made their own investments in a more effective primary care system, using NCQA's model or other similar ones.

As a result of these and other federally funded and state-funded initiatives, New York State continues to lead the nation in the adoption of the PCMH model by primary care practices. Today, over 25 percent of the state's primary care physicians work in practices designated by NCQA as PCMHs.

The intent of this report—the fifth in a series of reports produced by the UHF since 2011—is to describe the current status of adoption of the PCMH model across New York State; to review the trajectory of PCMH adoption over the past three years by primary care providers across the state; and to identify some trends (notably, where and by whom that model has been adopted). We close with some reflections on where we have been and lessons learned, and some challenges that require attention if the state's objective—to ensure that 80 percent of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral health care¹—is to be achieved.

¹ New York State Health Innovation Plan, December 2013, page 5; https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf; Also New York State Innovation Models Test grant application, page 4; https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_sim_project_narrative.pdf; Both accessed July 25, 2016

PCMH remains the most widely adopted model for the medical home, but it is no longer the only one. The medical home environment in New York has become substantially more complex over the past few years: three other competing models for higher-performing primary care (all sponsored and funded by the Centers for Medicare and Medicaid Innovation, CMMI) have emerged: the state's Advanced Primary Care (APC) program, and CMMI's Medicare's Comprehensive Primary Care, Plus (CPC+) and Transforming Clinical Practice Initiative (TCPI). All are now poised for implementation in New York State.

Over the next few years, the PCMH model will be competing with other models, even as the PCMH model itself will be updated by NCQA to better align with the value-based payment approach that focuses on rewarding practices that demonstrate improved outcomes and lower costs.

This report is likely to be the last UHF census of primary care medical homes that reports on a single model. To date, no practice in New York State has received certification under the APC or CPC+ initiatives or completed the TCPI program; but all three programs are now or will shortly be up and running. The growing attention to and investment in primary care is a positive development for New York; but the proliferation of slightly different models is creating some confusion among providers and systems interested in enhancing their primary care base, and it will make future reporting more complex.

Methods

This report is based on a provider-level database provided by NCQA to the New York State Department of Health (NYSDOH), formatted for our analysis by staff from the NYSDOH Office of Quality and Patient Safety. Although the NCQA gives PCMH recognition to practices rather than individual practitioners, we focus here on the number of "PCMH providers"—that is, the number of providers working in practices recognized as a PCMH—because the number of practitioners is a more reliable measure of the availability of medical home services than the number of practices.

Time Periods Covered: As in prior reports, we used the most recent available provider-level database from NCQA to identify all providers in New York State working in NCQA-recognized PCMHs (April 2016). We analyzed those data to depict the current spread of the PCMH model; and we used the data employed in two prior reports (PCMH providers in New York, as of July, 2013 and October, 2014) as comparators, to illustrate trends in the adoption of the PCMH model across the state, over the past three years.

Geography: We grouped practices and providers by the 11 regions used by the New York's Population Health Improvement Program (PHIP) initiative, shown in Figure 1. Within New York City, we analyzed data and trends by borough.

Figure 1. New York's Population Health Improvement Program (PHIP) Regions



Practice Type: We grouped providers according to the type of practice within which they worked. As there is no standard definition for practice type, we developed and used an approach that categorize the practices within which the providers worked: Hospital Clinic, New York City Health and Hospitals (NYC H+H), Hospital Practice, Health Center, Group, and Small Practice.

Overall and Regional Trends in PCMH Recognition

Current Status

As of April 2016, there were 6,264 providers (physicians and mid-level practitioners) working in practices with PCMH recognition. As shown in Figure 2, New York State continues to lead the nation in PCMHs, accounting for one out of eight PCMH providers in the country, and substantially more PCMH providers than any other state.

Figure 2. State NCQA-Recognized PCMHs Practices and Providers²

State	NCQA-Recognized PCMH Practices and Providers	% of NCQA Total PCMH Practices and Providers
NY	8,447	12.4%
CA	6,408	9.4%
PA	4,134	6.1%
NC	3,414	5.0%
FL	3,348	4.9%
Other states	42,184	62.1%
Total NCQA	67,935	100.0%

² Source: NCQA's searchable PCMH database, accessed on June 15, 2016 at <http://recognition.ncqa.org/>

Note: These figures are not the same as the data analyzed elsewhere in this report, because NCQA's methodology counts both PCMH providers (providers working in sites that have been recognized by NCQA as PCMHs) and the number of practices that have achieved recognition as PCMHs. The figures included in this table for New York and other states are all from that website, using the same methodology, and are comparable. Figures in the remainder of this report count only PCMH providers.

As shown in Figure 3, the number of PCMH providers—those working in NCQA-recognized PCMHs—grew by a total of 28 percent between 2013 and 2016. After increasing by 19 percent between 2013 and 2014, the number of providers in PCMHs grew more slowly (rising 7 percent between 2014 and 2016). As has been true for the past two years, most of the state’s growth in PCMH providers between 2013 and 2016 was in regions outside New York City (NYC) (Figure 4).

Figure 3. Growth in PCMH Providers, 2013–2016

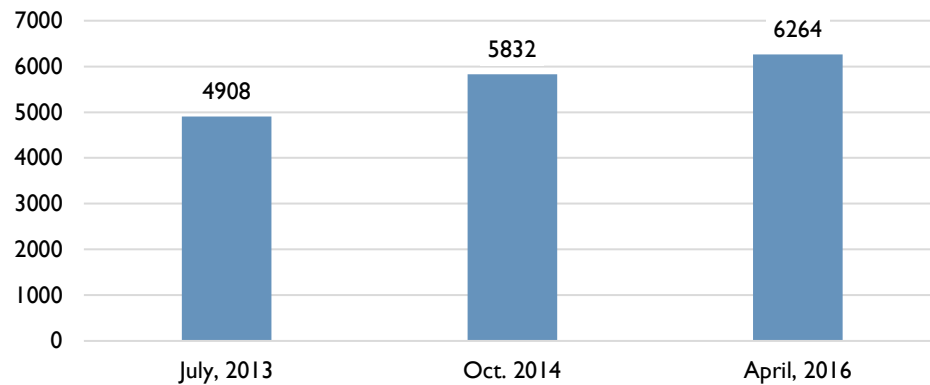
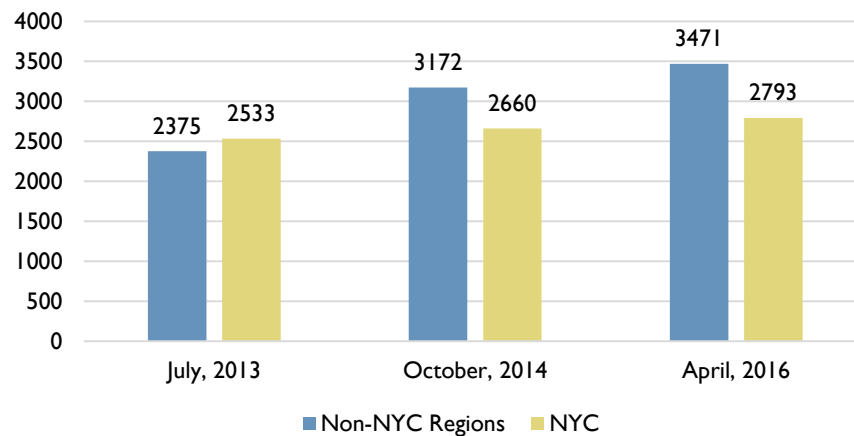


Figure 4. Recent Growth in PCMH Providers Has Occurred Outside New York City



The overall growth outside New York City was not uniform across regions. We analyzed the state’s three-year growth trends using the state’s PHIP regions, noting most of that growth was driven by increased PCMH adoption in four regions: Finger Lakes, Long Island, Mid-Hudson and Western New York; there were smaller increases in most other regions and decreases in the Capital Region and Tug Hill (Figure 5). Within New York City, the largest increase was in the Bronx, which grew by over 28 percent between 2013 and 2016. The other boroughs grew more slowly, and in one borough (Manhattan), the number of PCMH providers decreased slightly (by 3 percent) between 2013 and 2016.

Figure 5. Growth in PCMH Providers in Regions Outside New York City

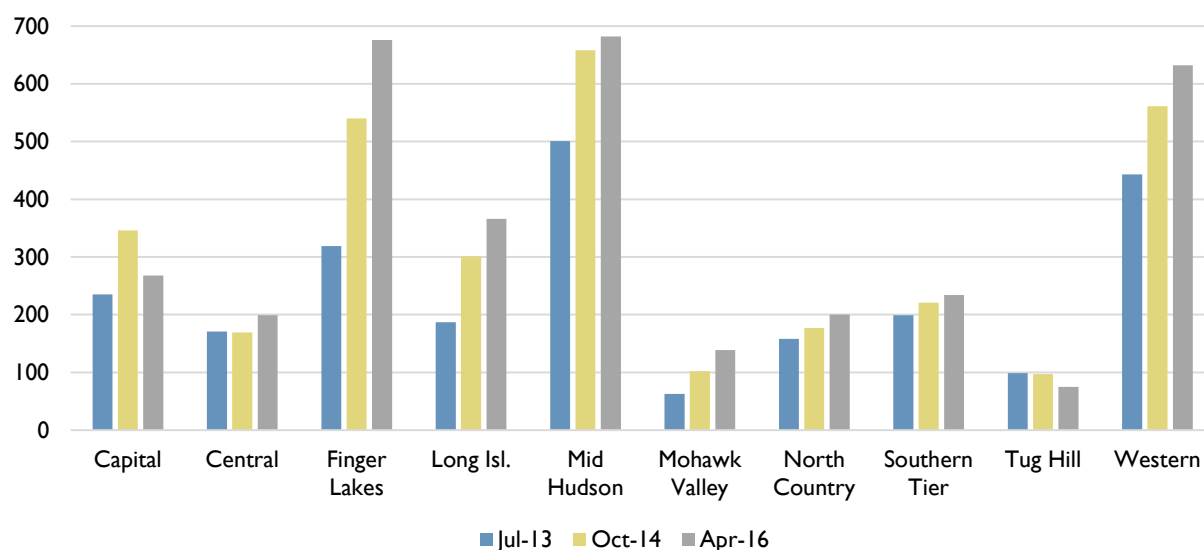
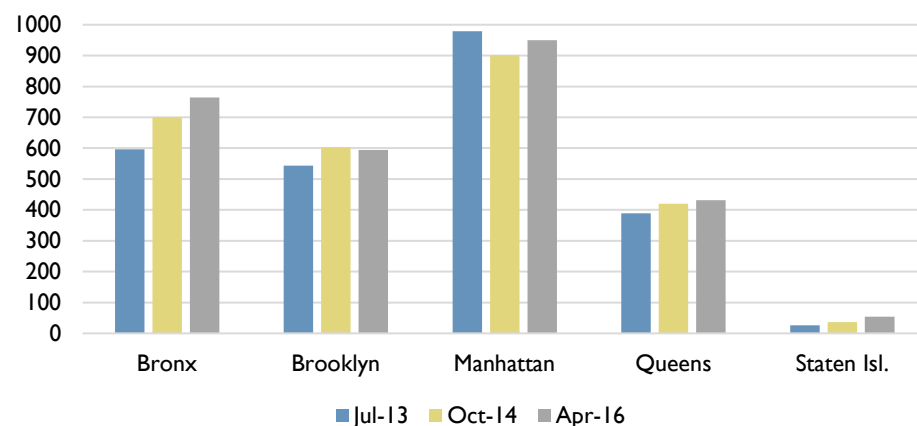


Figure 6. Growth in PCMH Providers in New York City, by Borough



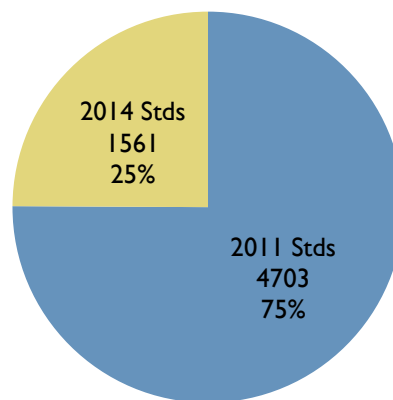
NCQA Recognition Status

Since it first issued PCMH Standards in 2008, NCQA has updated them every three years with increasingly rigorous criteria. A practice can apply for recognition at any time under the then-prevailing Standards; recognition lasts for three years. This rhythm means that, depending on when a given practice applies for and achieves recognition, it may be subject to a different set of NCQA Standards than other practices and that practices receiving recognition under one set of standards have had to meet more demanding criteria when applying for a second (or third) three-year renewal.

The PCMH program’s early adopters were recognized under NCQA’s 2008 Standards, perhaps its least rigorous. Since 2008, NCQA has required more from practices in each subsequent iteration of its standards. (The 2014 standards, for example, include an increased emphasis on support for behavioral health, care management of high-need populations, and team-based care.)

2016 will be a pivotal year for the state’s NCQA-recognized practices. As shown in Figure 7, three-quarters of the state’s PCMH providers work in practices recognized under the 2011 Standards. Over the next year, these practices will face a decision: whether to make the investments and changes required and reapply for PCMH recognition under the tougher 2014 Standards or let their participation in the PCMH program lapse.

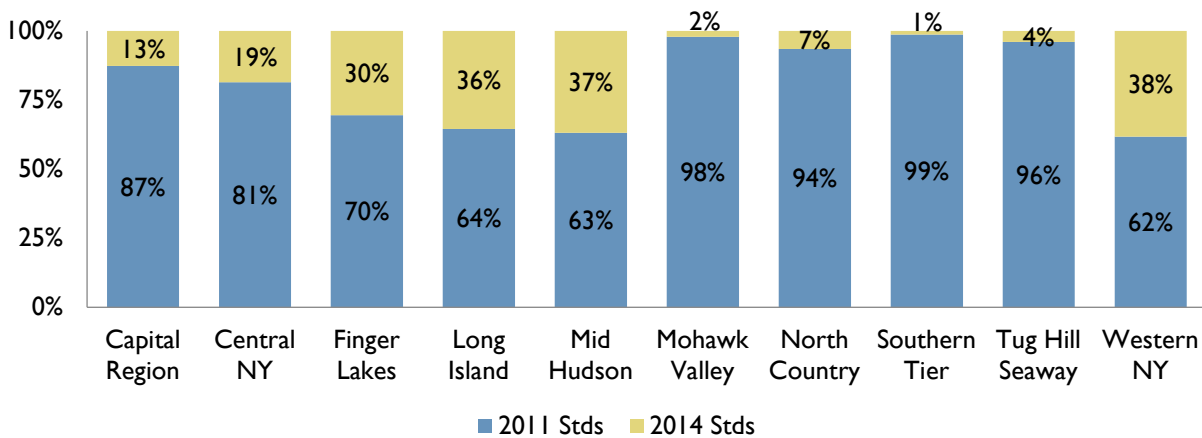
Figure 7. PCMH Providers in New York State, April, 2016, by Version of NCQA Standards



Regions of the state differ in terms of the number and proportion of practices recognized under NCQA’s 2011 and 2014 Standards. In some regions (notably where there were a substantial number of early adopters—e.g., New York City, the North Country, Mohawk Valley, Southern Tier and Tug Hill) the proportion recognized under the 2011 Standards is higher. In regions where more practices entered the PCMH program later, the proportion recognized under the 2014 Standards is higher.

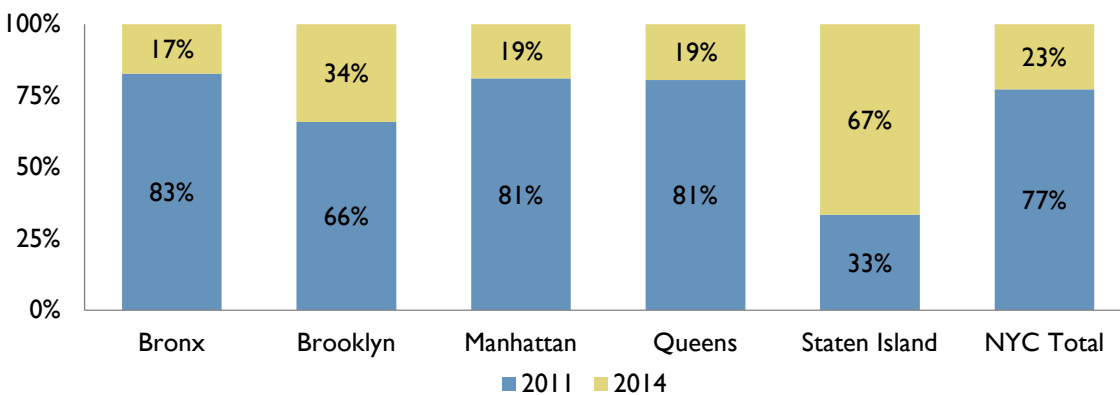
This phenomenon can be seen in Figure 8, for regions outside New York City. Those regions with more recent growth (Finger Lakes, Long Island, Mid-Hudson and Western New York) all show proportionately more providers working in practices recognized under the 2014 Standards.

Figure 8. PCMH Providers Outside NYC, by Standards Year



Within New York City, the pattern is not as clear. Although New York City had many early adopters, many were hospital clinics participating in the state's Hospital-Medical Home Demonstration Program, under which they were required to pursue and achieve NCQA recognition under the 2014 Standards. This may account for the slightly higher-than-expected proportion of New York City's PCMH providers recognized under the 2104 Standards.

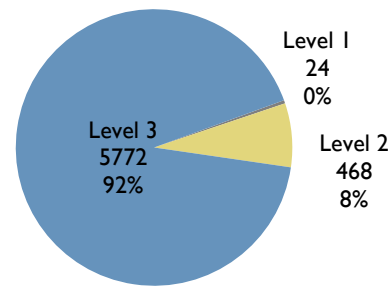
Figure 9. PCMH Providers in NYC, by NCQA Standards-Year



In addition to the year in which a practice received recognition, another major differentiator among NCQA-recognized practices is their level of recognition. NCQA recognizes PCMH practices at three different levels (Level 1, Level 2, and Level 3, with Level 3 being the highest) based on their demonstrated capacities and scores on NCQA's review and rating system. Practices that score well and meet certain "must-pass" elements receive Level 2 or Level 3 recognition.

As is shown in Figure 10, most providers statewide (over 90 percent, consistent for those recognized under 2011 and 2014 Standards) currently work in practices with Level 3 PCMH recognition.

Figure 10. PCMH Providers by Recognition Level as of April 2016.



The predominance of Level 3 recognition is relatively constant across the regions and boroughs (Figures 11 and 12).

Figure 11. PCMH Providers by Recognition Level—Regions Outside NYC

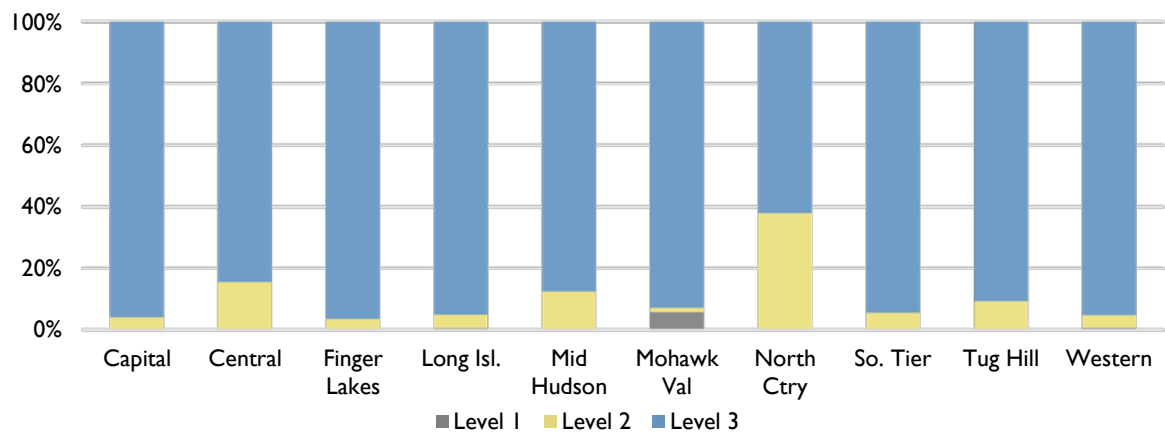
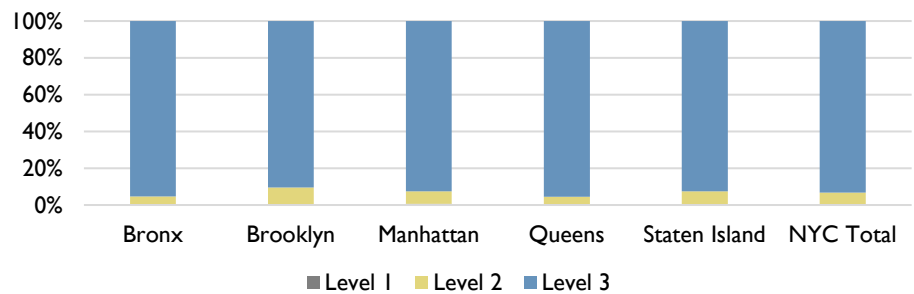


Figure 12. PCMH Providers by Recognition Level —NYC by Borough



PCMH Providers, and PCMH Penetration in New York State

Licensure

The term “PCMH provider” aggregates a number of different types of professionals and licensures: doctors of medicine and osteopathy (MDs and DOs, grouped together here as “physicians”), nurse practitioners, advanced practice nurses, and physician’s assistants (NPs, APNs, and PAs). Overall, physicians constitute most of the professionals in that category, but NPs, APNs, and PAs represent over 17 percent of the PCMH providers in the state (Figure 13).

As with many other aspects of PCMH adoption across the state, the role and importance of NPs, APNs, and PAs varies substantially by region. Figure 14 displays the proportions of the various licensure categories among the regions of New York State, in 2016.

Figure 13. Professional Licensure of New York’s PCMH Providers

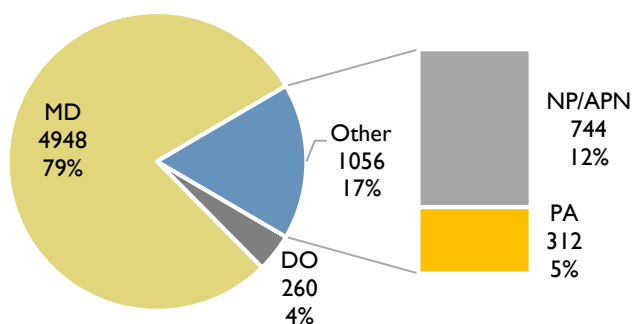
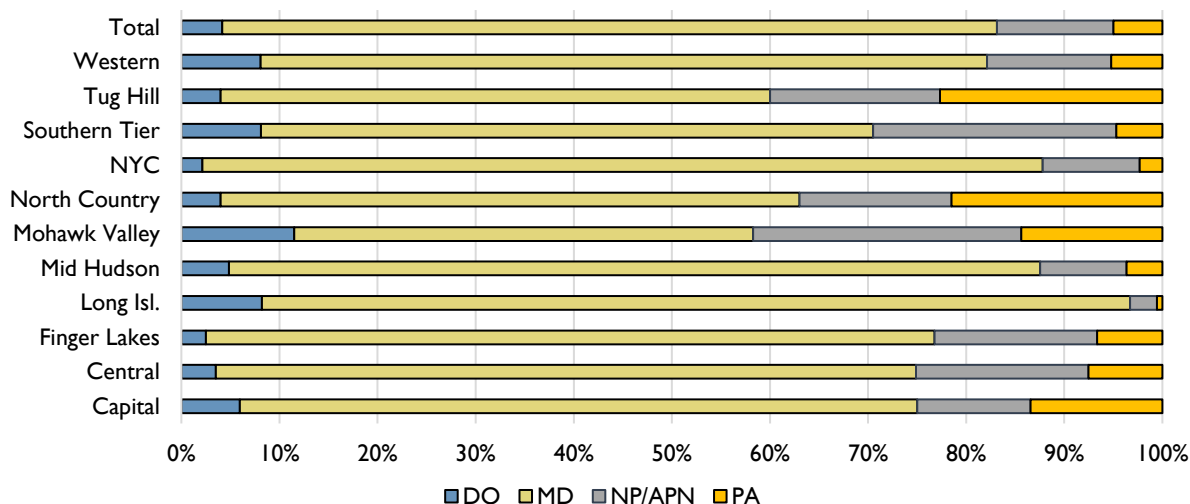


Figure 14. Professional Licensure of New York’s PCMH Providers, by Region



PCMH Penetration in New York State

We were able to develop a rough profile of the penetration of the PCMH model in New York State as a whole, and in the various regions, using the number of physicians practicing in NCQA-recognized sites as the numerator, and county-level estimates of the primary care physician supply (provided by the Center for Health Workforce Studies)³ as the denominator.

We used these data to calculate estimated penetration rates for the state's 62 counties, aggregating them into the state's 11 PHIP regions, and for the boroughs of New York City (Figures 15 and 16).

Figure 15. Percent of New York State Primary Care Physicians practicing in PCMHs, by Region

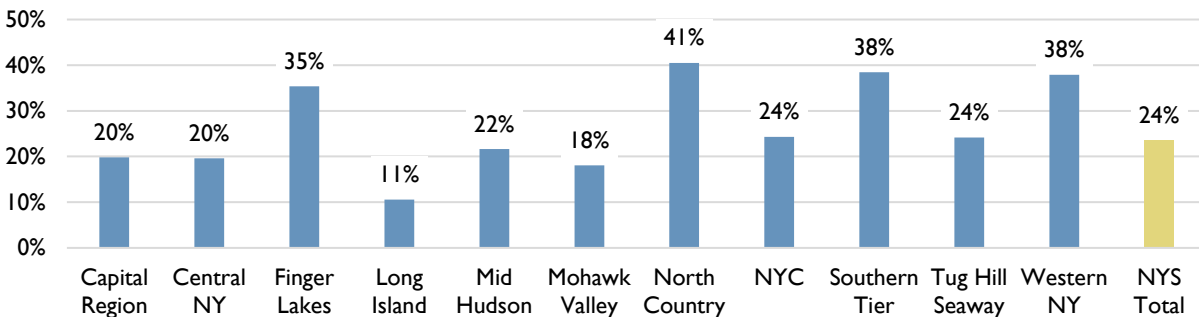
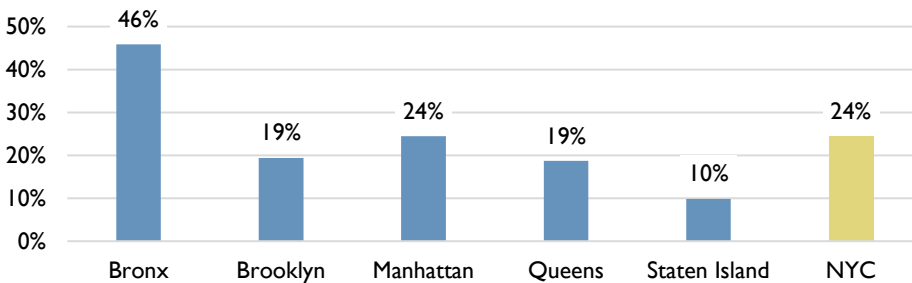


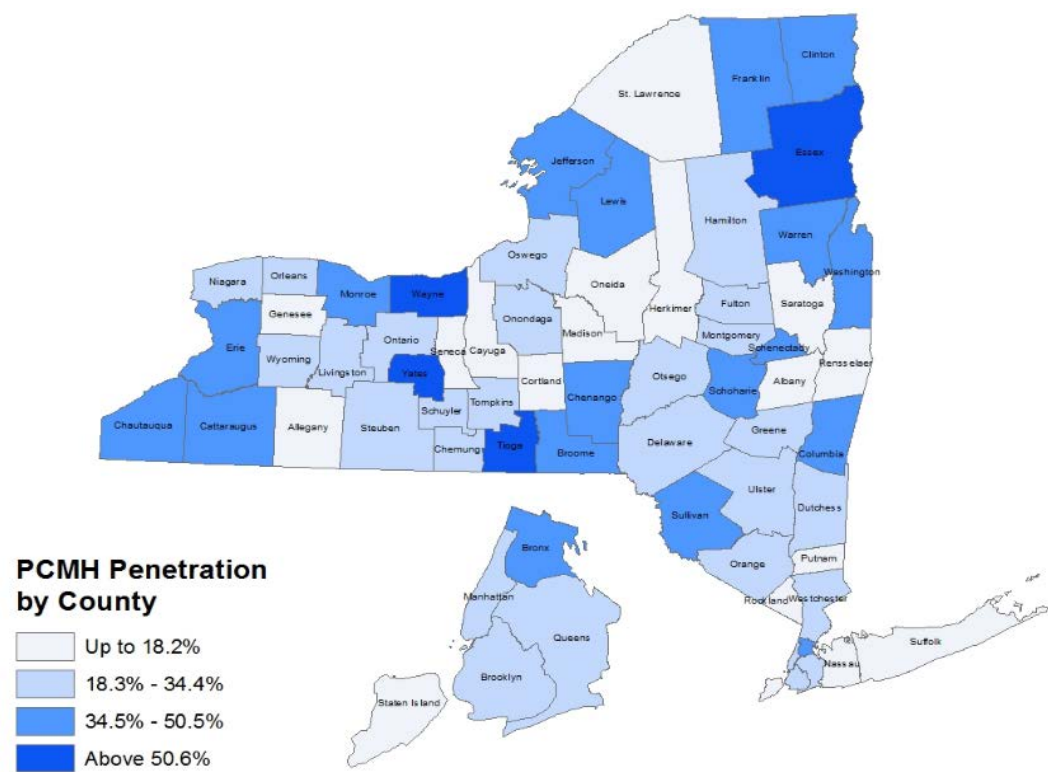
Figure 16. Percent of NYC Primary Care Physicians Practicing in PCMHs



³ Special analysis conducted by the Center for Health Workforce Studies, a research center in the School of Public Health at the University at Albany, State University of New York

Having county-level data on both PCMH-based physicians and the estimated number of primary care physicians enabled us to generate (Figure 17) a county-level map of New York State, depicting the PCMH penetration rate by county.

Figure 17. County-Level Estimates of PCMH Penetration, April 2016



PCMH Adoption by Different Practice Types

As we have observed in previous analyses, the adoption of the PCMH model is not uniform across different types of practices.

To conduct this analysis, we grouped practices (and their providers) into six discrete practice types:

- 1. Hospital Clinic:** Clinics licensed under Article 28 as a hospital outpatient clinic or as an off-site clinic (“extension clinic”), excluding those operated by the New York City Health and Hospitals.
- 2. New York City Health and Hospitals (NYC H+H):** Hospital clinics, extension clinics, and community-based Diagnostic and Treatment Centers (DTCs)⁴ operated by HHC; here broken out as a separate category because of the scale of their participation in the NCQA PCMH program.
- 3. Hospital Practice:** Private practices owned or controlled by, or closely affiliated with a hospital or medical school (these physician groups—whose names generally reference their sponsoring institution—are not licensed under Article 28, but they operate as faculty practices).
- 4. Health Center:** Clinics licensed under Article 28 as a Diagnostic and Treatment Center (DTC) and extension clinics sponsored by a DTC. This group includes federally qualified health centers (FQHCs), FQHC look-alikes, and other health centers licensed under Article 28 as DTCs.
- 5. Group:** Practices that have five or more providers included in the NCQA’s PCMH provider database (in one site, or multiple practice sites), but that are not hospital clinics, health centers, or hospital practices.
- 6. Small Practice:** Practices that have four or fewer providers included in the NCQA’s PCMH provider database, but that are not listed as hospital clinics, health centers, or hospital practices.

⁴ In 2014, NYC H+H received approval from the federal Health Resources and Services Administration (HRSA) to convert its freestanding Diagnostic and Treatment Centers (DTCs) to FQHC look-alikes. The centers in question, however, remain part of the NYC H+H system, thus are included in the totals for NYC H+H

Current Status (April 2016) PCMH Providers by Practice Type

The proportion of PCMH providers working in the six practice types varies widely across the state, at least in part reflecting the underlying organization of primary care services in New York City and the rest of the state (Figures 18, 19, and 20) .

Figure 18. PCMH Providers by Practice Type: New York State

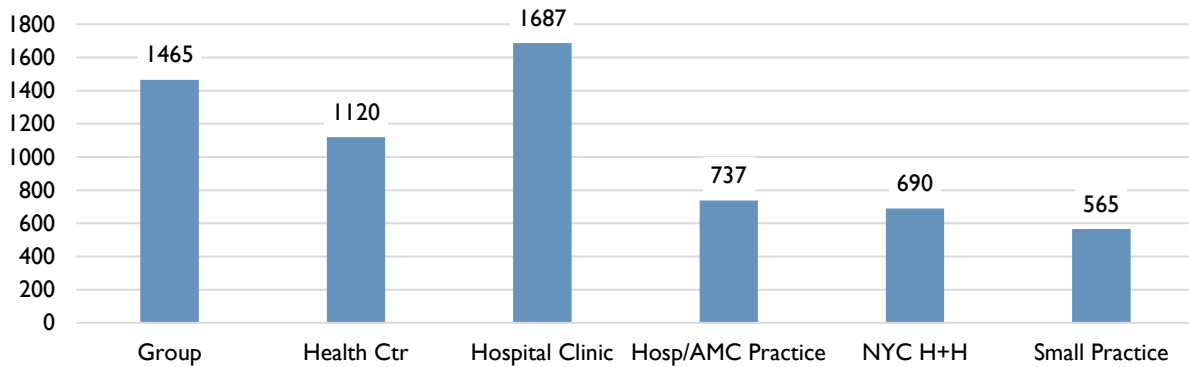


Figure 19. PCMH Providers by Practice Type: Non-NYC Regions

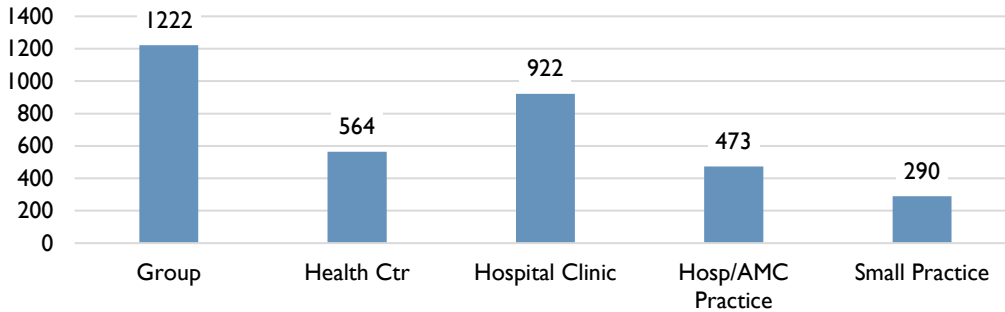
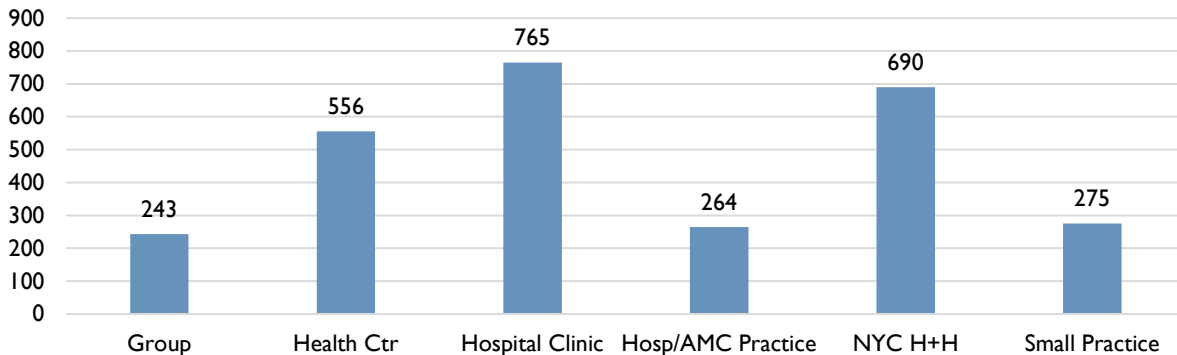


Figure 20. PCMH Providers by Practice Type: NYC



PCMH Providers by Practice Type: Changes Over Time

The distribution of PCMH providers by practice type in the state, upstate, and in New York City has changed substantially over the past few years, driven by a number of statewide and regional initiatives (Figures 21, 22, and 23).

Figure 21. Changes in the Composition of PCMH Providers in New York State, 2013 vs. 2016

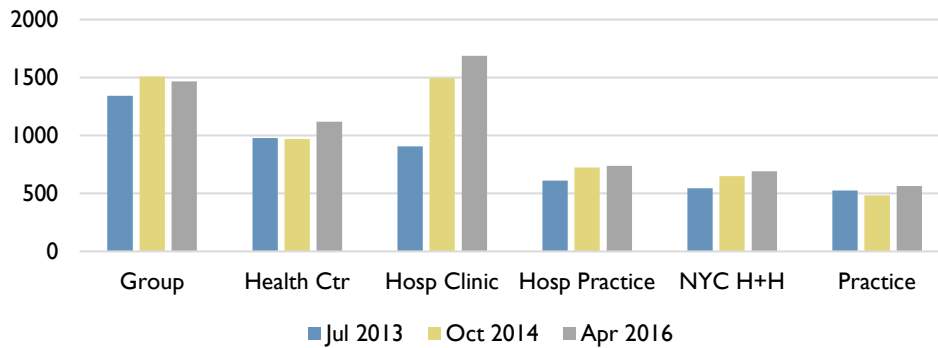


Figure 22. Changes in the Composition of PCMH Providers in Non-NYC Regions, 2013–2016

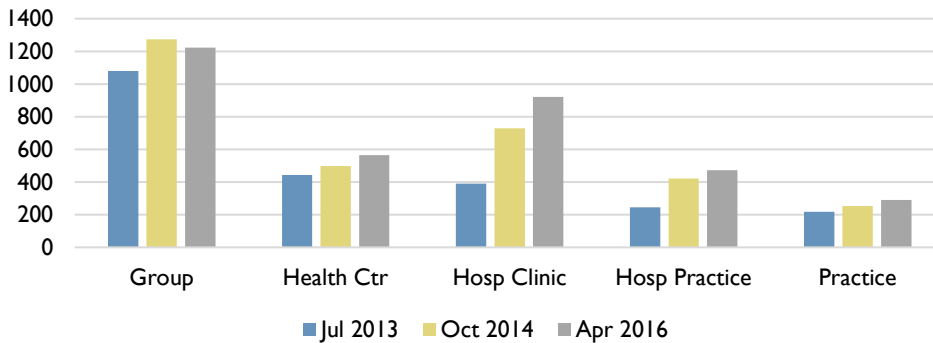
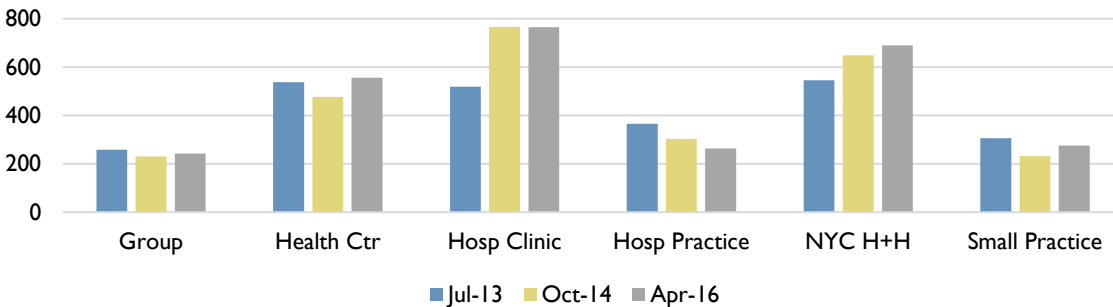


Figure 23. Changes in the Composition of PCMH Providers in NYC, 2013–2016



Regional and Borough Trends

The proportion of PCMH providers working in each of the six practice types also varies widely among the eleven regions. Appendix A (Regional and Borough detail) includes profiles of the changes in the composition of PCMH providers, by practice type, of the eleven PHIP regions and New York City's five boroughs.

The Role of Clinics in Driving PCMH Growth

Over the last three years, a number of forces have provided incentives for clinics (organized primary care programs, licensed under the state's Article 28 regulations, including hospital clinics, health centers and NYC H+H) to transform their outpatient primary care services to PCMHs. Two factors have been particularly important:

- The implementation of the Hospital-Medical Home⁵ Demonstration Program between 2011 and 2014; and
- The ongoing support of the PCMH model by the state's Medicaid program, through the provision of incentive payments to providers serving Medicaid members who have achieved NCQA recognition as PCMHs. This incentive is particularly important for providers (notably, clinics and FQHCs⁶) that tend to rely on Medicaid as their major payer.

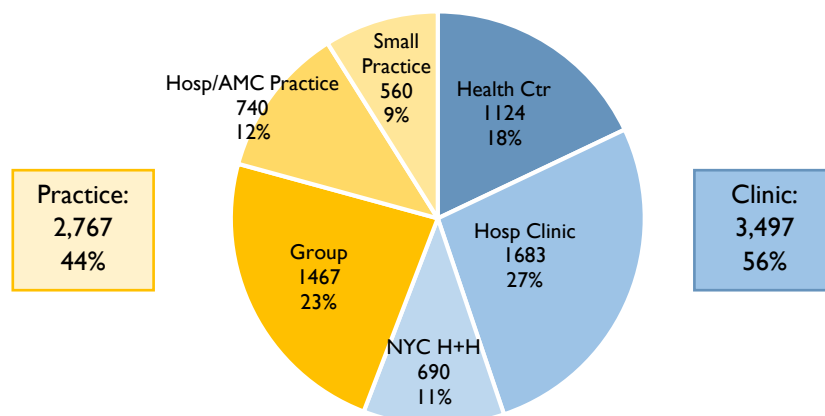
Together, these two initiatives are largely responsible for a substantial increase in the number of PCMH providers working in hospital clinics, between 2013 and 2016.

As is shown in Figure 24, as of April 2016, over half (56 percent) of New York State's PCMH providers currently work in clinic settings (hospital clinics, NYC H+H, health centers), while roughly 44 percent work in private practice settings (hospital practices, groups, and small practices).

⁵ The Hospital-Medical Home (H-MH) Demonstration Program was a 2010 CMS 1115 Waiver Quality Demonstration Program, in which up to \$250 million in funding was awarded to 65 hospitals in New York State to transform their primary care training sites to PCMHs. https://www.health.ny.gov/health_care/medicaid/redesign/docs/2015-oct_final_rpt.pdf

⁶ Like hospital clinics, federally qualified health centers receive incentive payments from New York State's Medicaid program. In addition, HRSA has funded a number of initiatives to increase adoption of the PCMH model.

Figure 24. PCMH Providers in New York State, by Practice Type



The proportion of PCMH providers working in clinics varies dramatically between New York City and other regions. Outside New York City, clinics account for 43 percent of all PCMH providers; but in the city, clinic-based providers account for 72 percent of all PCMH providers (Figures 25 and 26).

Between 2013 and 2016, the growth in the number of PCMH providers working in clinic settings has been substantially stronger than the growth of PCMH providers in practice settings (hospital practices, groups, and small practices). In 2013, clinics and practices had roughly equal numbers of PCMH providers; but over the next two years, their trajectories diverged (Figure 27). Between 2013 and 2016, the number of PCMH providers practicing in clinic settings grew by 44 percent; over the same time period, the number of PCMH providers in practice settings grew by only 12 percent.

This disparity—growth in PCMH providers in clinic settings exceeding that in practice settings—was generally consistent across the state. However, while the number of PCMH providers practicing in clinic settings grew by 79 percent outside New York City, it grew by only 26 percent in the city. And while the number of PCMH providers in practice settings in grew by 29 percent outside New York City, it actually decreased by 16 percent in the city (Figure 28).

The differential growth of PCMH providers in clinic settings was clearly the major driver of PCMH growth in New York between 2013 and 2016. Over that period, clinics accounted for more than three-quarters of the state’s overall increase in PCMH providers.

Figure 25. Proportion of PCMH Providers in Clinic Settings—Non-NYC Regions

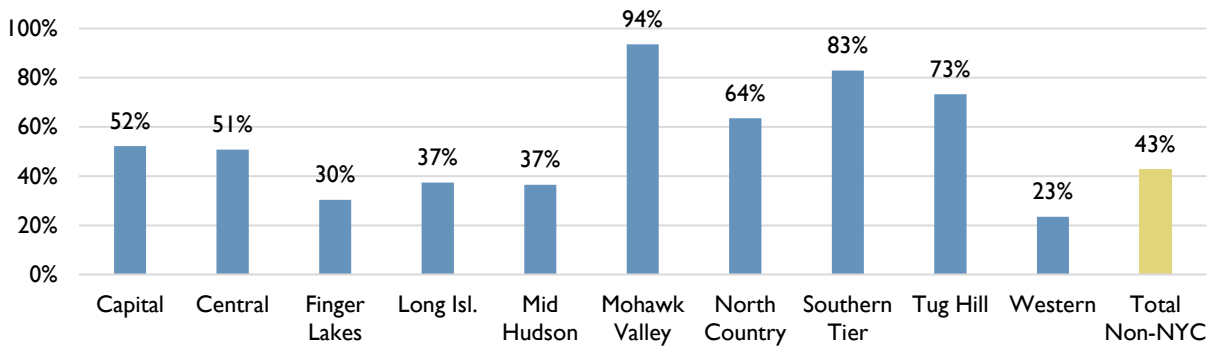


Figure 26. Proportion of PCMH Providers in Clinic Settings —NYC Boroughs

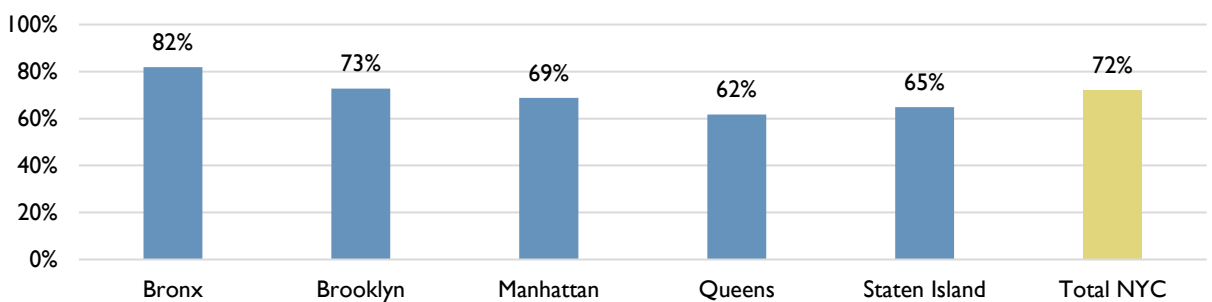


Figure 27. Growth of PCMH Providers in Clinic and Practice Settings, 2013–2016

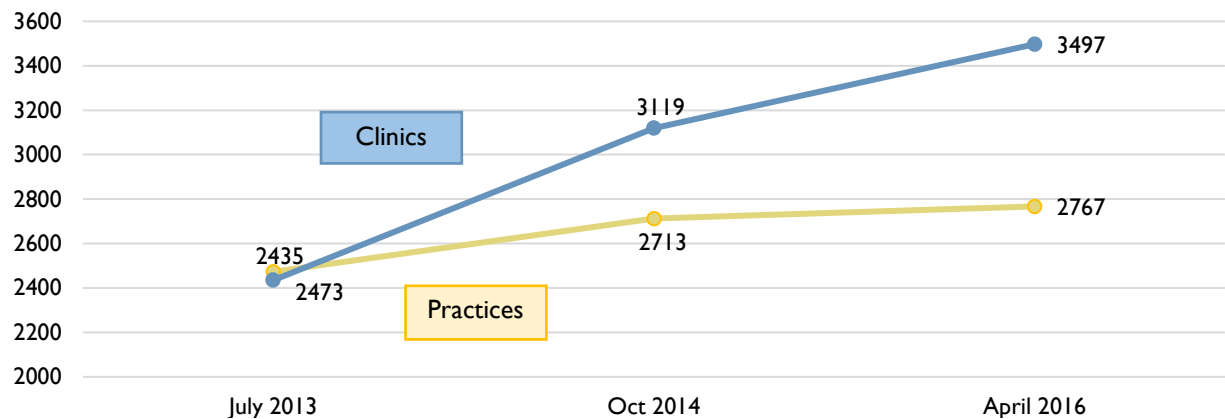


Figure 28. PCMH Providers in Clinic Settings, 2013–2016

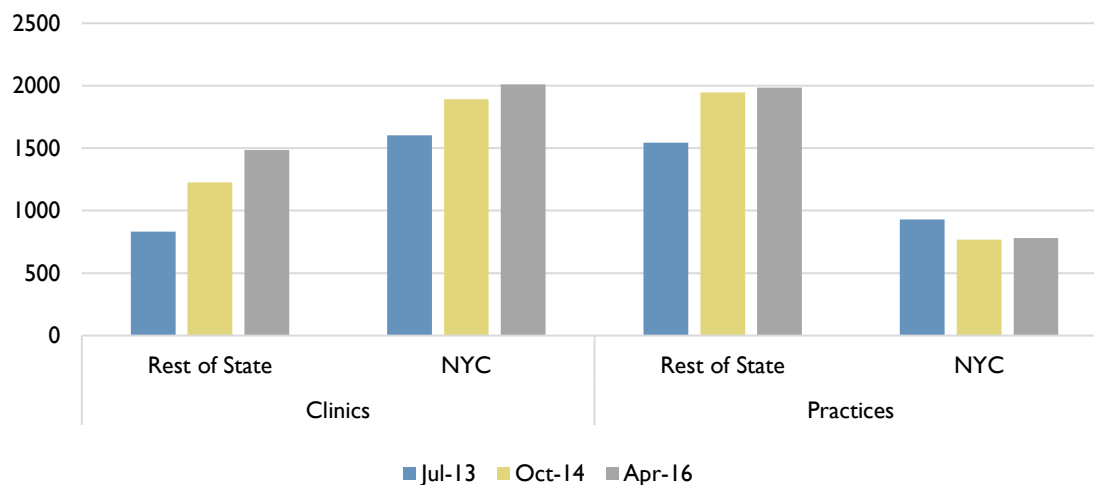
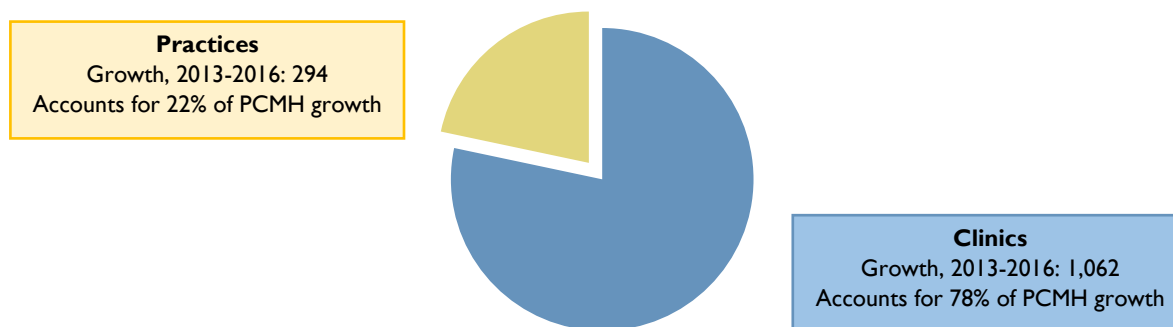


Figure 29. Contribution of Clinics and Practices to Statewide Growth in PCMH Providers



Discussion

Over the five years that UHF has been tracking the adoption of the medical home model in New York State, we have seen continued increases in the number of providers working in practices that have been recognized by NCQA as PCMHs. That growth, however, has been uneven; some parts of the state have seen substantial growth while others seem to be lagging; and some types of practices have seen far greater rates of adoption than others. In recent years, growth in PCMH adoption has been driven by organized clinics (hospital clinics and health centers), which have the scale to implement the necessary infrastructure, and a dominant payer (Medicaid) that has long supported this model of primary care with ongoing incentive payments to providers.

Looking Back

The growth in adoption of the medical home model in New York State has occurred in two phases. In the first phase (2010–2013), PCMH recognition involved three broad cohorts of practices:

- Health centers and some hospital clinics (notably NYC H+H), providers heavily reliant on Medicaid as a payer, responded quickly to Medicaid’s medical home incentive payments. They sought PCMH recognition as a way to tap more resources for providing higher-quality care, particularly for patients with multiple chronic diseases.
- In a few areas of the state (the Adirondacks, Hudson Valley, and Finger Lakes), PCMH adoption was stimulated by large-scale medical home demonstration programs under which there were funds to support practice transformation, and (in the Adirondacks and Hudson Valley) multipayer support for the programs’ participants.
- A third cohort included practices—particularly large multi-specialty group practices interested in pursuing accountable care arrangements—that pursued PCMH recognition because they considered it an essential competency for managing population health; because they anticipated that PCMH recognition might bring added payment from payers beyond Medicaid; and because they hoped that such recognition would add value to their offerings in the market.

By July 2013 a broad swath of providers statewide had adopted the PCMH model; there were higher adoption rates in regions where there were ongoing demonstration programs, or group practices investing in the capacity of their primary care services. Most of that adoption took place among providers with scale, enough size to support the infrastructure required to meet NCQA’s standards. For small practices, the medical home has been and remains a challenge.

In the second phase (2013–2016) adoption of the medical home model has been largely driven by growth in clinic settings, both hospital clinics and FQHCs. Since 2013, much of the growth in PCMH providers has been due to the Hospital-Medical Home Demonstration program, which provided augmented resources to hospitals to transform their teaching clinics, support new personnel (e.g., care managers and behavioral health professionals), and support major changes in training programs for residents.

That program, coupled with Medicaid’s continuing incentive payments, has stimulated a substantial expansion of PCMH adoption across the state, but that growth has been largely confined to hospital clinics and—to a lesser extent—FQHCs. Adoption of the PCMH model by privately practicing physicians and groups serving substantial non-Medicaid-covered populations (i.e., commercial insurance and Medicare) has largely stalled, and adoption rates in small practices remain low.

What Have We Learned?

As has been noted elsewhere⁷, adoption of the PCMH model by a given practice is not easily achieved. Practice transformation is expensive and time-consuming; it disrupts established practice operations and routines; it changes the roles of existing staff, and it requires new personnel and new systems, like care managers and registries, and new processes for quality improvement. Furthermore, while the PCMH model positions a practice well for population health management and value-based payment, it is actually economically maladaptive (adding costs, but usually not increasing payments) in an environment dominated by fee-for-service payment.

National research⁸ and local experience⁹ have shown that the PCMH model can enable providers to improve quality and reduce costs due to preventable ED visits and admissions; but that achieving those savings takes time, a minimum of two to three years following practice transformation. This time-lag poses a serious challenge for the future of the medical home model in New York.

Many of those espousing VBP are proposing payment models that would shift payments away from defined incentive payments to practices meeting certain criteria (e.g., PCMH recognition), to a shared savings or shared risk model, in which the financial rewards to a practice are defined by their ability to generate shareable savings at year-end. Particularly in their start-up phase, PCMHs are not well-suited for models in which augmented payment is tied to near-term shared savings, which in turn are largely driven by attributable reductions in inpatient hospital or ED use.

Short-term shared savings approaches do not represent a compelling business case for primary care providers. Like other forms of medical homes, the PCMH model involves new expenses and activities not covered by CPT codes, and in their first years of operation as a PCMH, providers are unlikely to generate sufficient shareable savings to cover those costs.

Primary care providers pursuing the medical home model require defined and predictable payments during their first few years of operation. If there is no change in payment to help cover those costs for that period of time, providers pursuing the medical home model will face serious financial challenges.

Where it has been successful in New York, the PCMH model has been supported in two ways:

- participating primary care practices received direct support for practice transformation, and

⁷ Reference to prior UHF reports and other literature

⁸ In February 2016, the Patient-Centered Primary Care Collaborative summarized the peer-reviewed literature on cost, utilization and quality results from studies of PCMHs. <https://www.pcpcc.org/results-evidence>

⁹ The Patient-Centered Medical Home and Associations With Health Care Quality and Utilization: A 5-Year Cohort Study; Lisa M. Kern, MD, MPH; Alison Edwards, MStat; and Rainu Kaushal, MD, MPH; *Ann Intern Med.* 2016;164(6):395-405. doi:10.7326/M14-2633

- they were paid differently for their services from the outset, with adequate, predictable and either by their dominant payer (e.g., Medicaid) or by multipayer initiative that gave them the support needed to cover the added costs of functions and services of a medical home, capacities not recognized by prevailing fee-for-service payment methods.

These two investments—a time-limited investment in practice transformation, and multipayer support for the practices’ increased operating costs, in advance of their achieving a return on investment—appear to have been and will likely remain critical to the success and sustainability of the PCMH.

Looking Ahead

PCMH remains the most widely adopted model for primary care practice transformation, but today, it is no longer the only one. The medical home environment in New York has become substantially more complex over the past few years: three other competing models for higher-performing primary care have emerged (all three sponsored and funded by CMMI), all now poised for implementation in New York State; and a fourth federally funded initiative (the Delivery System Reform Incentive Payment program, or DSRIP), which supports the PCMH model, is now under way.

The first and largest initiative is spearheaded by the New York State Department of Health (NYSDOH). As part of its CMMI-funded State Innovation Models (SIM) award, NYSDOH is pursuing a model (Advanced Primary Care, or APC) that builds on the PCMH model, adding to it requirements for behavioral health integration, population health, quality improvement and the collection and reporting of a standard set of measures.

The APC model is considered to be more in keeping with an industry-wide movement toward value-based payment, and more responsive to payer concerns that, in order for primary care providers to receive additional payments for a medical home model, they need to be able to demonstrate improved outcomes in quality and cost savings. After spending more than a year designing this new model, the state is now poised to let \$67 million in contracts to practice transformation consultants to work with primary care practices statewide to adopt the APC model.

A second model, currently being implemented across the state, is CMMI’s Transforming Clinical Practice Initiative (TCPI), which is focused sharply on preparing providers to participate in VBP. Three different New York-based organizations¹⁰ have received over \$50 million from CMMI to spread this model. The three Practice Transformation Networks have already contracted with a variety of consultants to provide technical assistance to primary care and some specialty care providers across the state, and are now actively enrolling practices to participate in this program.

A third CMMI-funded model has recently emerged, the Comprehensive Primary Care, Plus (CPC+) program. This model builds on a prior CMMI effort, the Comprehensive Primary

¹⁰ The New York State Practice Transformation Network, National Council for Behavioral Health, Greater New York City Practice Transformation Network

Care Program Initiative, or CPCi. New York is home to one CPCi initiative, which has been operating in the Capital District / Hudson Valley region since 2013. CPC+ differs from the other three programs (PCMH, APC, and TCPI), in that it begins with an effort by CMS to assemble a coalition of payers in a given region of the state who are willing to commit to participating in a multipayer effort to support that program's model of a higher-performing primary care, through augmented payments.

Finally, and in parallel with these three initiatives, the state's Medicaid program is currently implementing a series of delivery system transformation initiatives, under the state's \$8 billion Section 1115 waiver, the Delivery System Reform Incentive Payments (DSRIP) program. Under DSRIP, the 25 Performing Provider Systems (PPSs) covering the state are required to bring their participating primary care practices (many of them safety-net providers) to one of two models: either PCMH, or NYSDOH's APC model. Currently, PPSs across New York are completing their planning, and beginning to engage practice transformation consultants to accomplish this task. Many of those PPSs are choosing to pursue the NCQA's PCMH model (the state's Medicaid continues to provide NCQA-recognized providers with augmented payments), which should—like the Hospital-Medical Home initiative before it—generate further growth in the number of providers and practices who achieve recognition as PCMHs.

Adoption of the PCMH model in New York has continued to grow through 2016, and—in light of DSRIP's requirements and action by the PPSs—further growth can be anticipated over the next few years. However, the PCMH model is facing competition from other models, even as NCQA updates its own methodology and Standards to respond to historical criticisms, and to adapt its own model to better align with VBP's focus on demonstrating improved outcomes and lower costs.

The different primary care practice transformation programs all emphasize the same basic competencies, and they focus on improving the performance of the state's primary care system, particularly in the way it cares for people with complex chronic diseases, whom the current system serves least well and at the highest cost.

Successfully spreading and sustaining a medical home model may depend less on which model is selected by providers and promoted by policymakers than on whether payers are willing to change the way they pay for primary care and participate in multipayer efforts. Participating practices must have enough of the payers whose members they serve providing adequate support to cover their added costs, payers that recognize and co-invest in the medical home's added value.

As the PCMH model is joined (or perhaps, over time, supplanted) by other models, it should be remembered that—for all its limitations—NCQA's model has led the way in improving the way primary care works for patients and providers.

As we consider New York's achievements to date, and consider where and why the PCMH model has taken root, it is increasingly clear that the state is facing four distinct questions:

- **Which model to pursue?** With the proliferation of different medical home models, the centrality of PCMH is eroding. There is a need for New York State and CMMI

to better align the four competing medical home models that they are simultaneously funding, and to provide clearer signals to primary care practices that will allow the practices to identify the medical home model—and the payment incentive model—that is best for them.

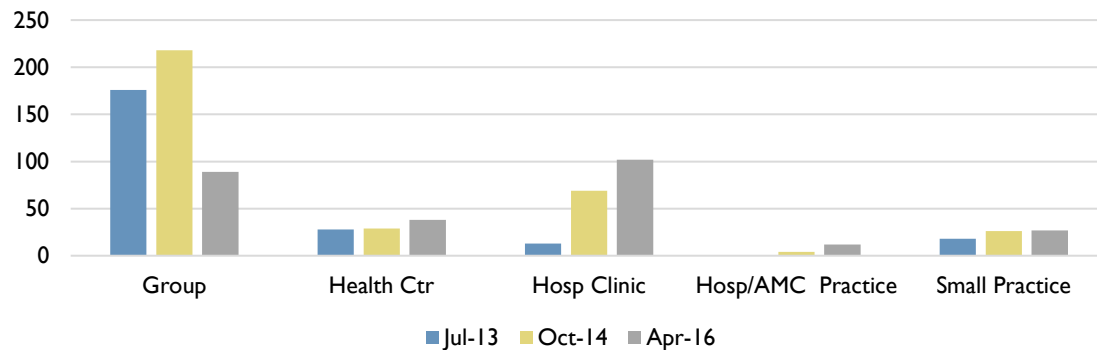
- **How to achieve aligned multipayer support for the medical home?** A primary care practice cannot afford to adopt the medical home model (which requires investment, and increases operating costs) without broad multipayer support.
- **How to pay for the medical home in the context of VBP?** With the increasing enthusiasm for value-based payment methods based on shared savings / shared risk models, the now-traditional payment approach (per-member, per-month incentive payments) is at risk of being supplanted by payment models that depend on shared savings. Such models do not offer primary care practices sufficient funds to cover their costs over their start-up, which can require 2-3 years before they can generate savings to share.
- **What about small practices?** Achieving PCMH recognition, and participating in new value-based payment systems is a particular challenge for small practices. There is a need to focus on how New York's small practices—which account for a sizeable share of the state's primary care workforce, and play an important role in providing care to high-need populations in both urban and rural communities—can achieve the increased capabilities represented by the medical home model, and continue to perform their important role, in this rapidly changing environment.

Improving primary care has been and remains a foundational element in the New York's (and the nation's) strategies to reform the health care delivery system. New York's progress to date is worthy of note and celebration; and the likely spread of this and similar models has the potential—if properly supported by payers—to make a measurable difference in the way New York's health system performs, and in the health of all New Yorkers.

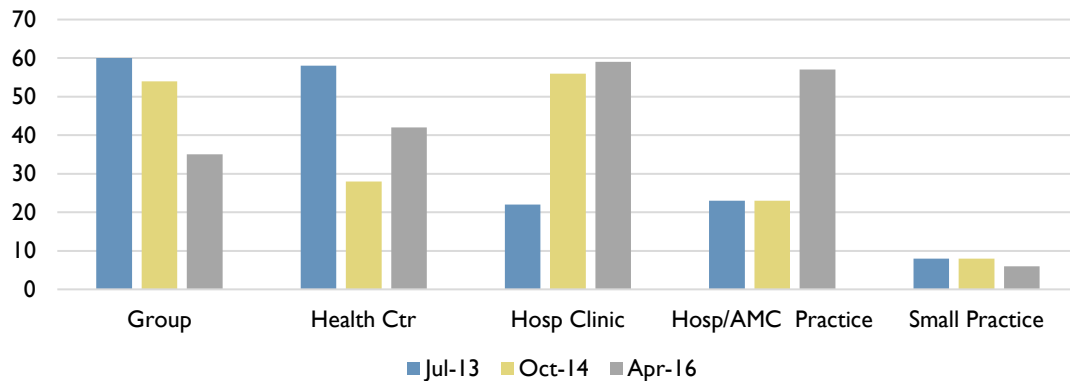
Appendix. Changes in PCMH Providers by Practice Type, 2013–2016, by Region and Borough

Non- NYC Regions

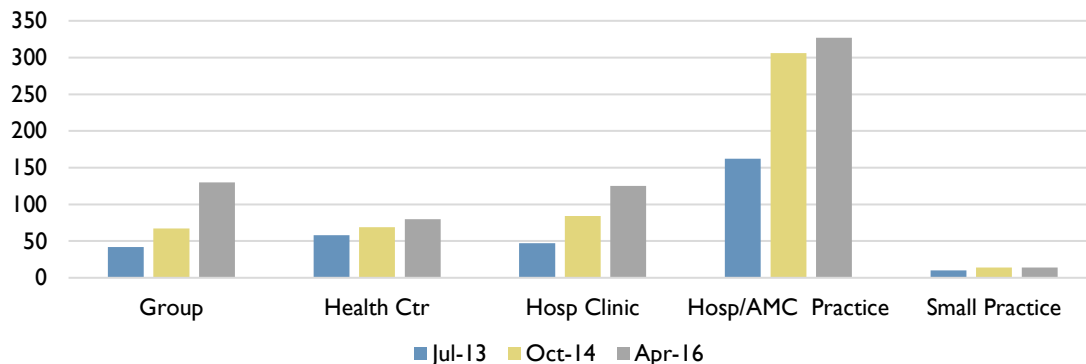
Capital Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016



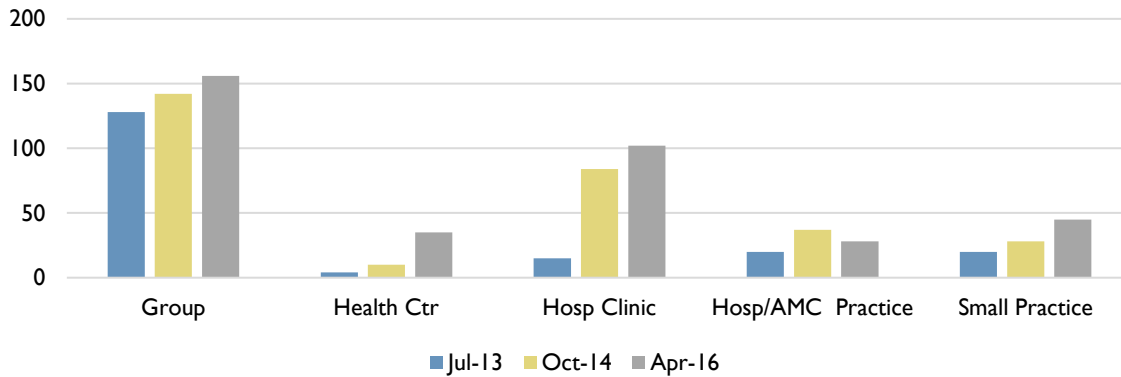
Central Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016



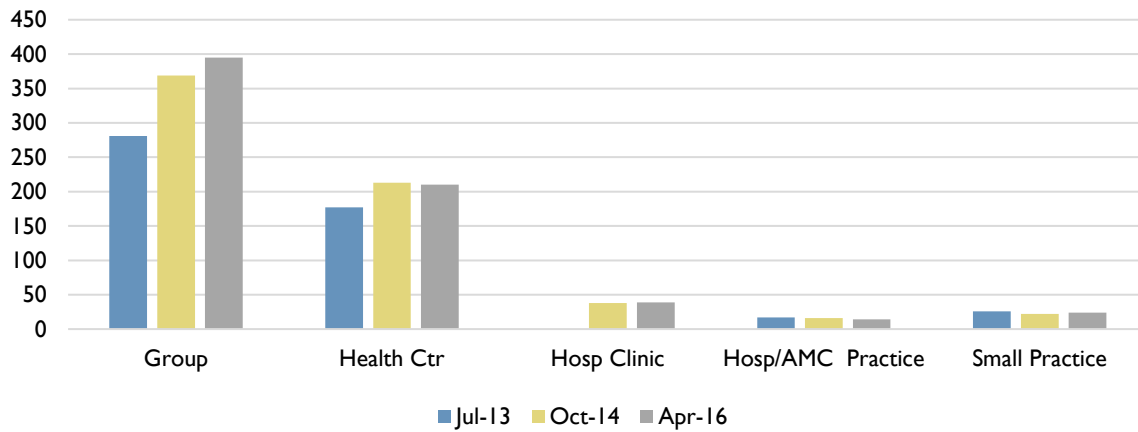
Finger Lakes Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016



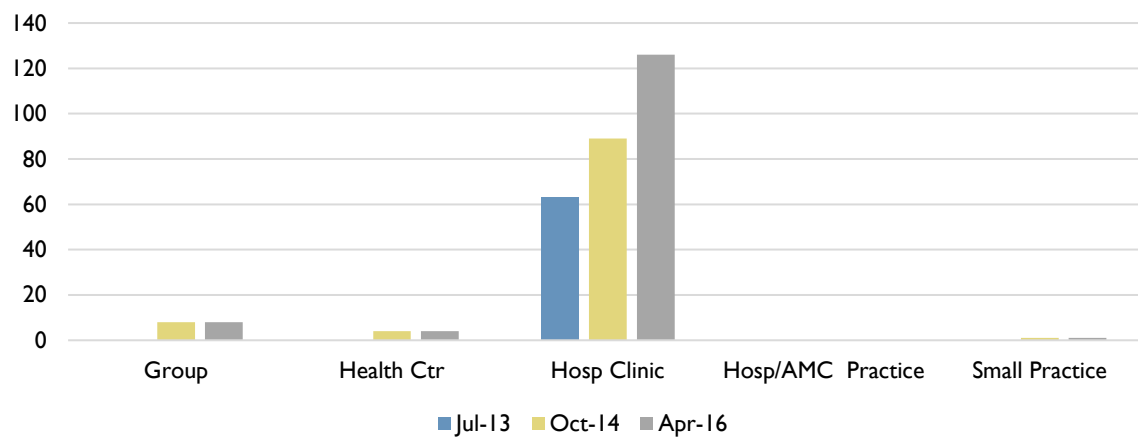
Long Island Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016



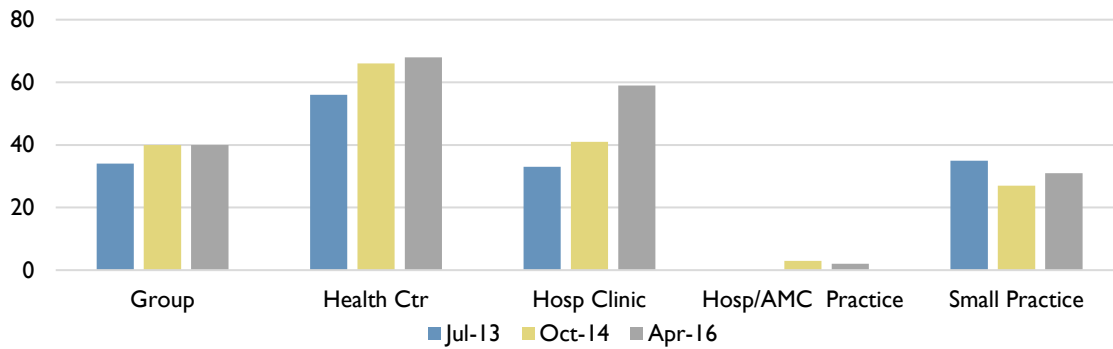
Mid-Hudson Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016



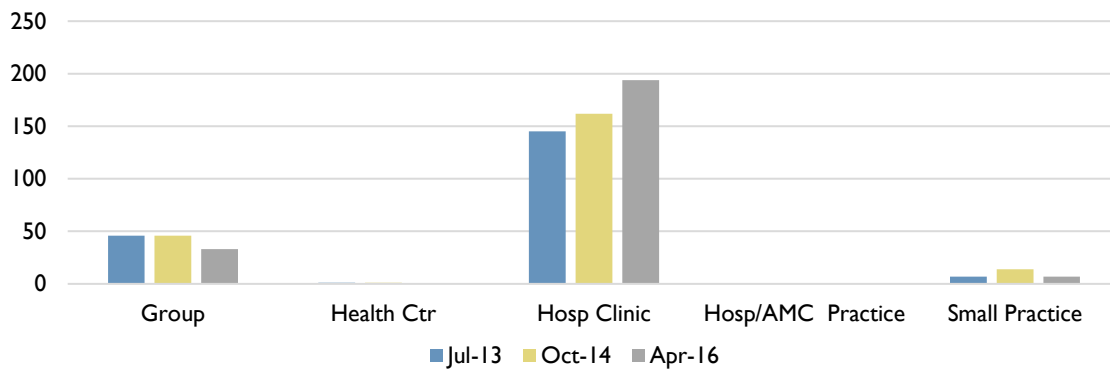
Mohawk Valley Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016



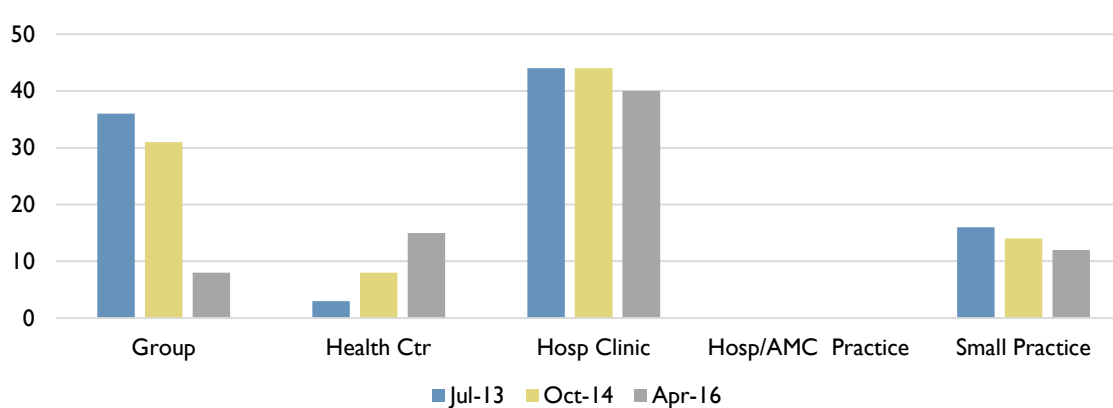
**North Country Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016**



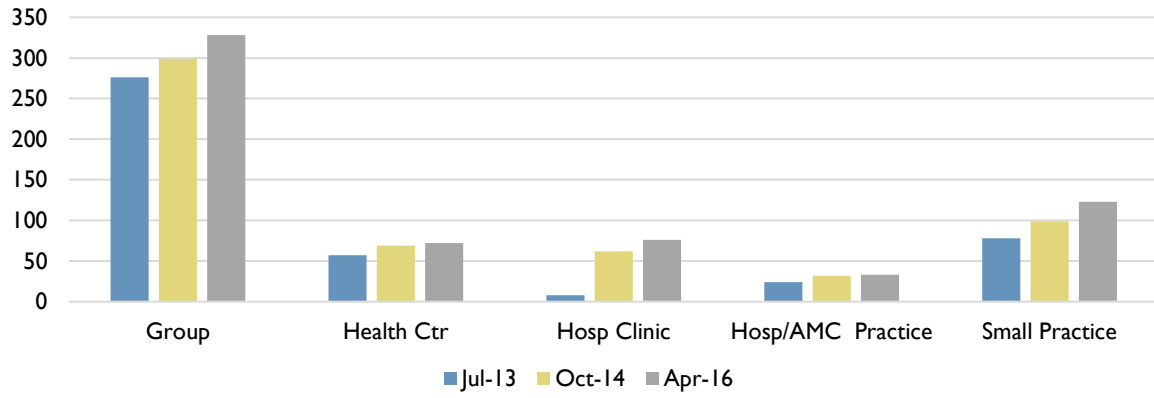
**Southern Tier Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016**



**Tug Hill Seaway Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016**

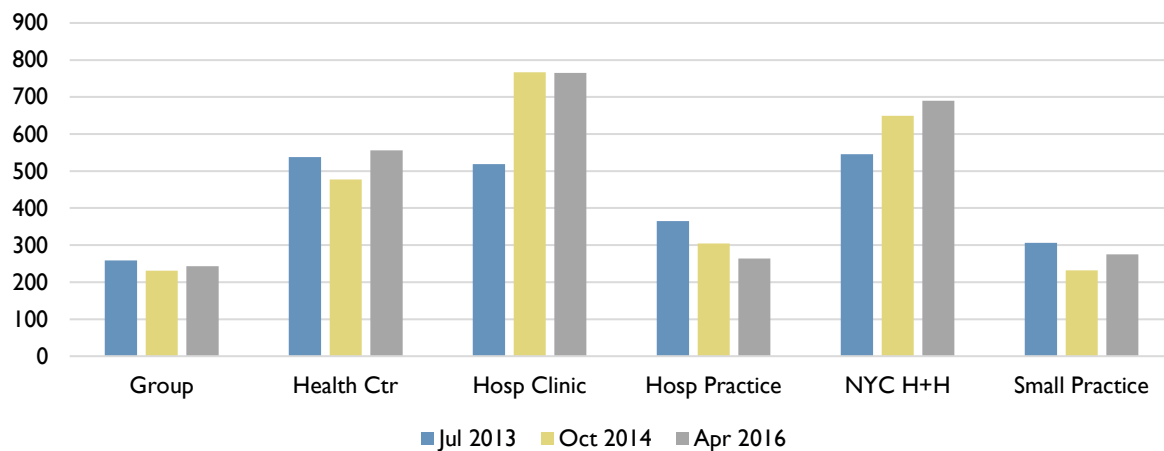


**Western NY Region PCMH Providers by Practice Type
Changes between July, 2013 and April, 2016**

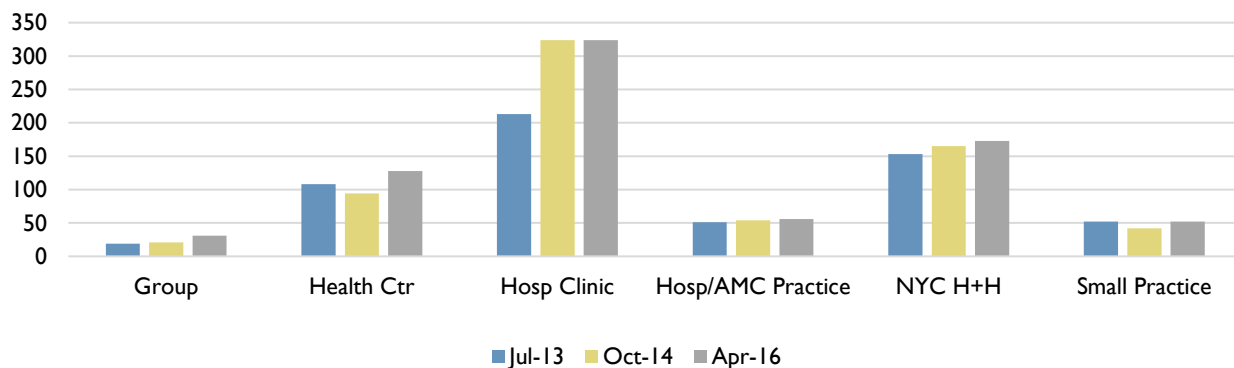


New York City and Its Boroughs

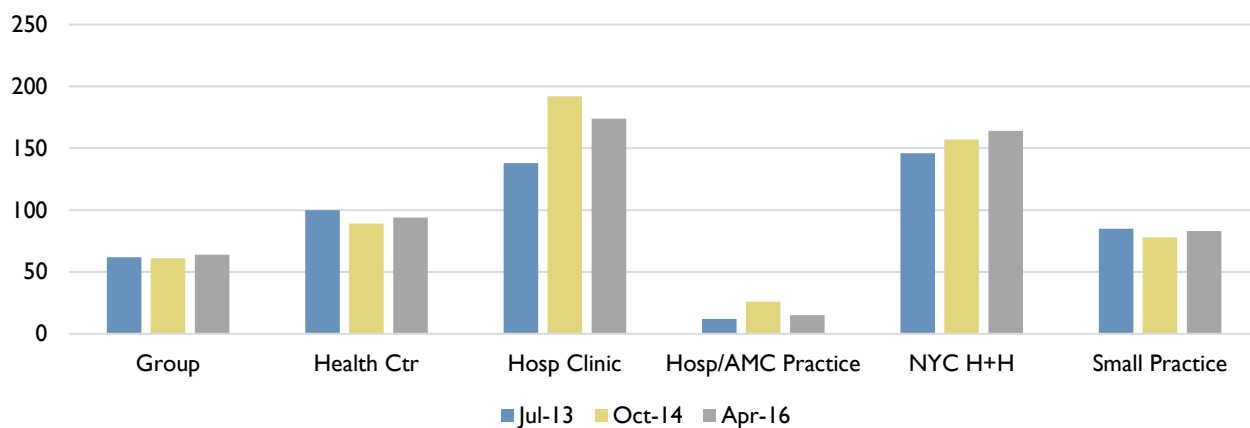
All PCMH Providers in NYC, by Practice Type
Changes between July, 2013 and April, 2016



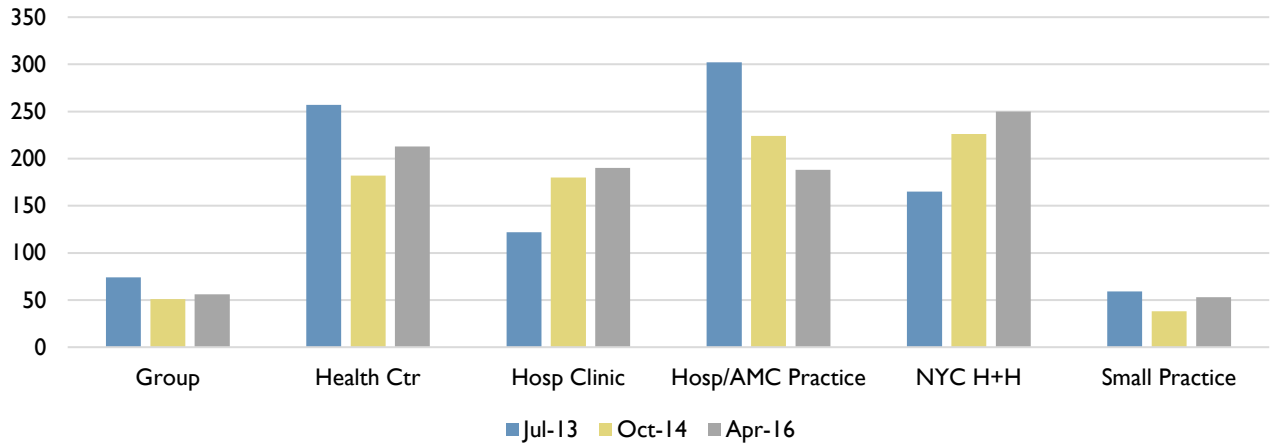
Change in PCMH Providers in The Bronx
2013-2016



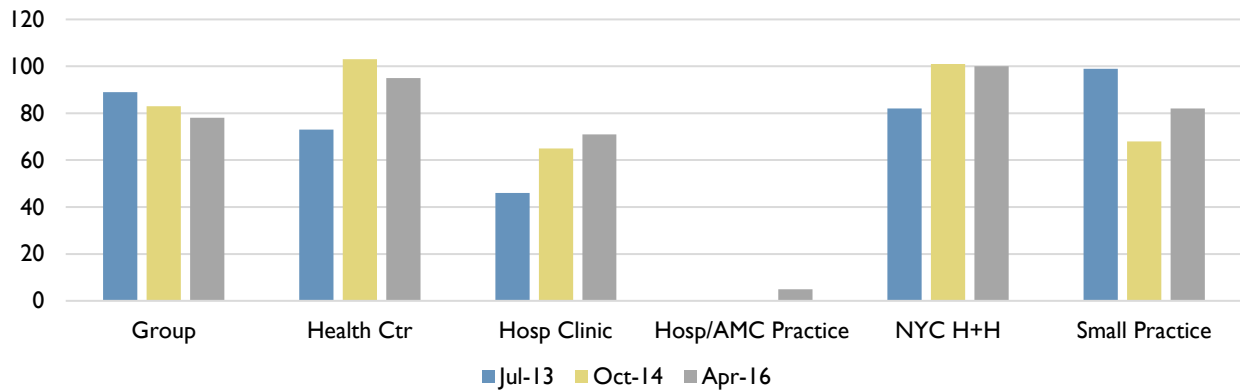
Change in PCMH Providers in Brooklyn
2013-2016



**Change in PCMH Providers in Manhattan
2013-2016**



**Change in PCMH Providers in Queens
2013-2016**



**Change in PCMH Providers in Staten Island
2013-2016**

