

# Patient-Centered Medical Homes in New York, 2017 Update: Continued Growth in a Time of Change

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## **Acknowledgments**

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## Introduction

Achieving a higher-performing primary care system—adopting a model of care referred to, generically, as the medical home—is viewed by many observers as the foundation of a higher-performing health care delivery system. The medical home model has been shown to measurably improve the quality of care delivered by primary care practices, and to improve the health of the populations they serve. Evidence suggests it has particular value for people with multiple chronic diseases (who generate a disproportionate share of the nation’s health care costs) and for those with chronic diseases who are at risk of becoming the next generation of high-cost patients.

Since 2011, United Hospital Fund has tracked statewide adoption of the medical home model across New York State, with regular reports on the one model for which consistent, statewide data is available at a provider level: the National Committee for Quality Assurance’s (NCQA’s) Patient-Centered Medical Home (PCMH). This issue brief updates those reports, covering changes that have occurred over the past year in the adoption of the PCMH model by primary care providers across the state. As we have monitored the spread of the PCMH model, several trends have emerged, and from 2016 to 2017 many of those trends have continued their trajectory.

- New York State has led the nation in adoption of the PCMH model since the program’s inception, but over the past five years, PCMH adoption in other states has been growing rapidly as well. In terms of number of PCMH providers, California and New York are now essentially tied for first.<sup>1</sup>
- The number of PCMH providers<sup>2</sup> in New York has continued to grow, but over the past two years that growth has averaged 8% per year, slower than the state’s average growth since 2011.
- Since 2013, when New York City had more PCMH providers than the rest of the state combined, growth upstate and on Long Island has continued to outpace that in the city. The number of PCMH providers outside the city is now greater than the number in it (3,856 vs. 2,935 in 2017).
- PCMH growth has been mainly in organizations with the scale and infrastructure to support the model, and adoption among small independent primary care practices continues to be much slower.

1. NCQA Report Cards: Clinicians (web page). <https://reportcards.ncqa.org/#/clinicians/list>

2. Unless otherwise noted, in this report “PCMH providers” includes primary care physicians and mid-level practitioners working in practices that have achieved NCQA recognition as PCMHs.

- As noted in UHF's 2016 update<sup>3</sup>, much of the recent growth has been in hospital clinics, supported in large part by Medicaid's PCMH incentive payments.
- Most PCMH providers are currently working in primary care settings that achieved recognition as a Level 3 PCMH, NCQA's highest level of recognition under its 2011 and 2014 standards. Going forward, those providers will have to decide whether to continue to participate in the PCMH program under NCQA's recently released 2017 standards.

## 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 practitioners (e.g., individual physicians, nurse practitioners, and physician assistants) working in practices recognized as a Patient-Centered Medical Home—because the number of practitioners is a more reliable measure of the availability of medical home services than the number of practices.

## Time Period

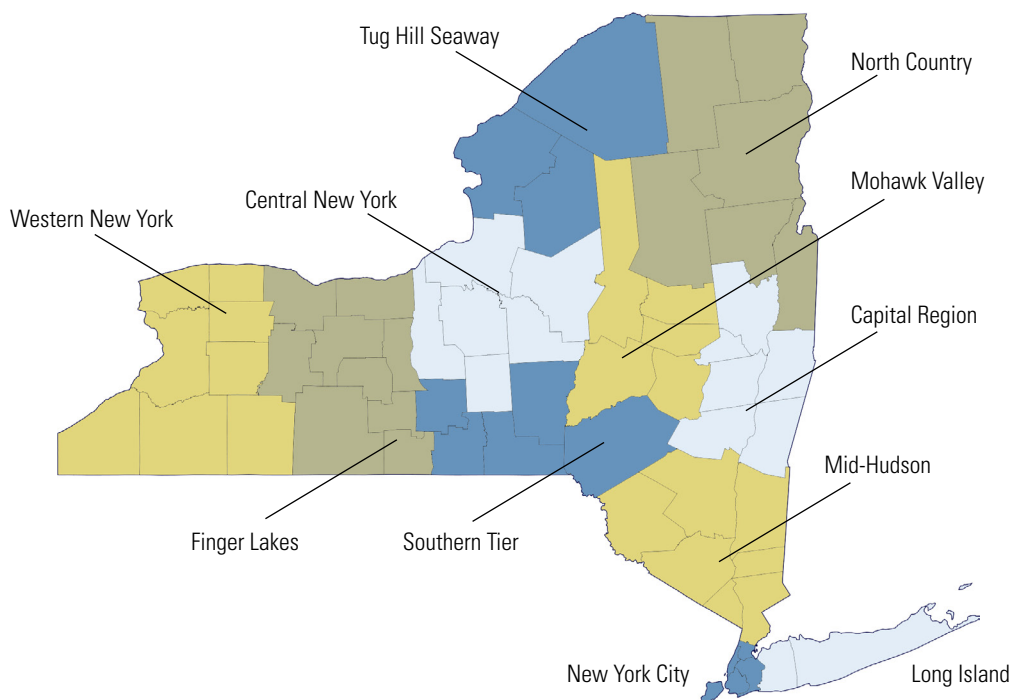
To identify all providers in New York State working in NCQA-recognized PCMHs, we used the clinician-level database (New York clinicians in NCQA-recognized PCMHs as of May 2017) that was provided by NCQA to the NYSDOH. We analyzed those data to depict the current status of PCMH model adoption; and, using data employed in prior UHF reports as comparators, to illustrate trends in the adoption of the PCMH model across the state over the past few years. The one exception is our comparison of the number of clinicians working in PCMHs across states, which used the most recently available data from NCQA's website (accessed September 19, 2017).

## Geography

We grouped practices and providers by the 11 New York's Population Health Improvement Program (PHIP) regions, shown in Figure 1.

3. Burke G. 2016. *The Growth of Medical Homes in New York State, 2014 to 2016*. United Hospital Fund. <https://www.uhfnyc.org/publications/881155>

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



## Practice Type

As in prior years, we grouped providers by the type of practice within which they work. As there is no standard definition for practice type, we have developed and used a step-wise approach to categorize practices in one of six categories, using the following logic:

First, we selected practice sites listed on the NYSDOH licensure website<sup>4</sup> as hospital clinics and extension clinics (**Hospital Clinics**). From that roster, we then selected a subset of clinics and community-based health centers operated by the New York City Health and Hospitals Corporation (**NYC H+H**). Next, we selected Article 28 licensed freestanding Federally Qualified Health Centers (FQHCs) and non-hospital Diagnostic and Treatment Centers licensed under Article 28 (**Health Centers**). We then selected private practice sites owned by hospitals and medical schools that are operated as faculty practices and sponsored or operated by a medical school or hospital (**Hospital Practices**). We then divided the remaining private practice sites into those with five or more providers listed on the NCQA database (**Groups**); and those with four or fewer listed in the NCQA database and not part of a larger group (**Small Practices**).

A chartbook of additional detail by region and practice type is included in an [appendix](#), also available at [www.uhfnyc.org](http://www.uhfnyc.org).

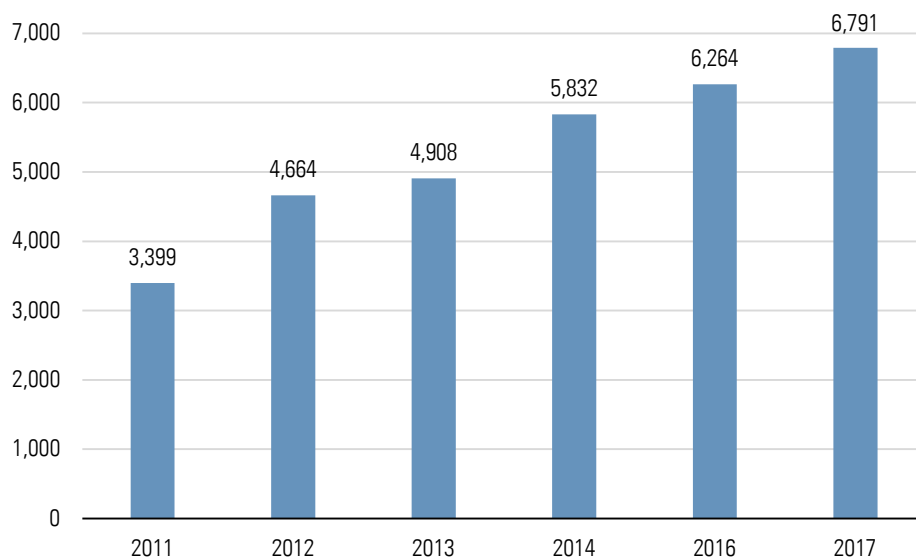
4. New York State Department of Health. Health Facility General Information (online dataset). <https://health.data.ny.gov/Health/Health-Facility-General-Information/vn5v-hh5r/data>

## 2017 PCMH Trends in New York

### New York's Year-Over-Year Growth in PCMH Continues

While the number of PCMH providers in the state increased between 2011 and 2017 by an average of roughly 12.5% per year, that rate of growth has varied from year to year. Between 2011 and 2014, the number of PCMH providers in the state grew by an average of 20% per year, but in the two most recent measurement periods (2014–2016 and 2016–2017), that growth rate dropped, averaging 8% per year. There have been occasional sharp increases, due to a specific investment or initiative (the 19% increase between 2013 and 2014, for example, largely attributable to the implementation of the state's Hospital-Medical Home program), and other years when growth was slower.

**Figure 2. Growth in PCMH Providers, 2011 to 2017**



### Broader Adoption of the Model Outside New York State

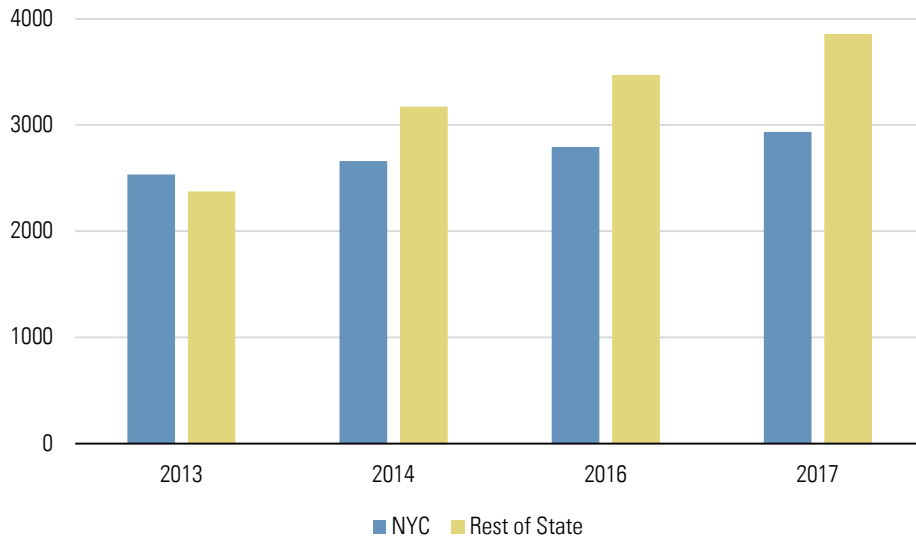
New York has led the nation in the adoption of the PCMH model since the program's inception, and it seems that other states are now catching up in the raw number of PCMH clinicians. According to NCQA data from September 2017,<sup>5</sup> California now has nearly the same number as New York; each accounts for roughly 12% of the NCQA-recognized PCMH clinicians in the United States.

5. NCQA Report Cards: Clinicians (web page). <https://reportcards.ncqa.org/#/clinicians/list>

## Adoption of PCMH Varies by Region and Has Changed Over Time

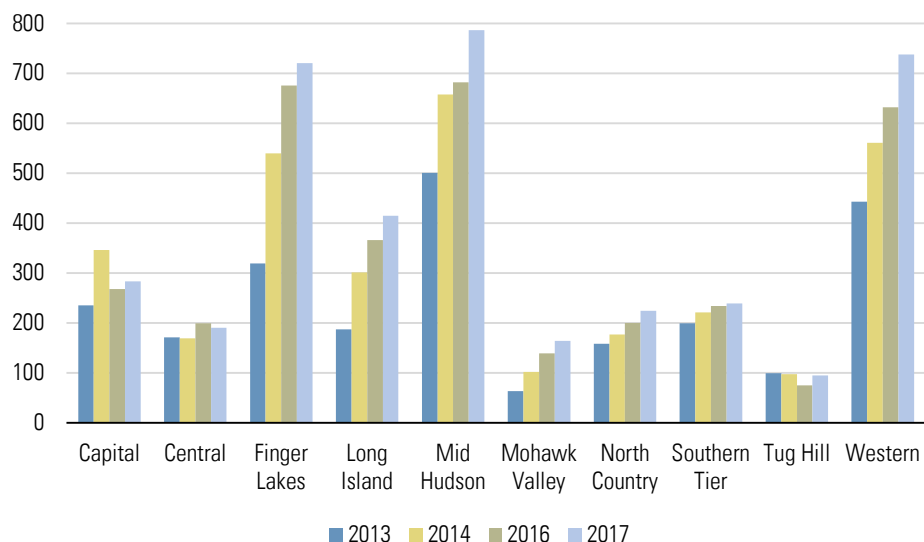
Since 2013, when New York City led the state in the adoption of the PCMH model, other regions have been adopting the PCMH model faster than New York City.

**Figure 3. Non-NYC Regions Outpace NYC in PCMH Growth, 2013 to 2017**



Outside New York City, PCMH growth continues to be uneven across the state’s PHIP regions, with most of the growth occurring in four regions: Finger Lakes, Mid-Hudson, Long Island, and Western New York.

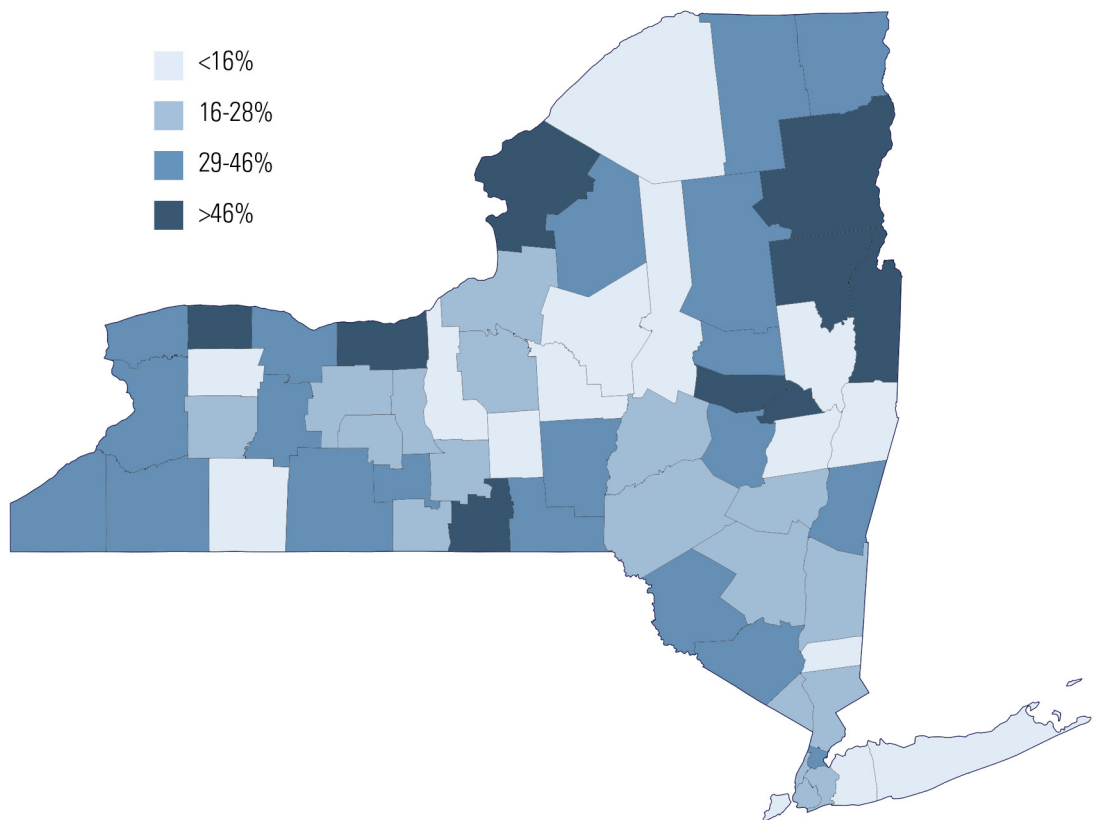
**Figure 4. PCMH Penetration in New York, by Region, May 2017**



Roughly 15% of all PCMH providers are non-physician, mid-level providers, including advanced practice nurses and physician assistants. Unfortunately, there are no good county-level estimates of the supply of non-physician providers, so in order to develop a county-level estimate of PCMH penetration, we focused specifically on physicians (MD and DO) for which there are reasonably reliable county-based estimates.

The number of physician PCMH providers by county divided by the total physicians in each county (provided by the Center for Health Workforce Studies) results in the county-level estimates of physician-only PCMH penetration presented in Figure 5. While overall PCMH penetration (as measured by the number and proportion of physicians working in PCMHs) is roughly 25%, statewide, the rate of adoption at the county level varies substantially.

**Figure 5. PCMH Penetration in New York State, by County, 2017**

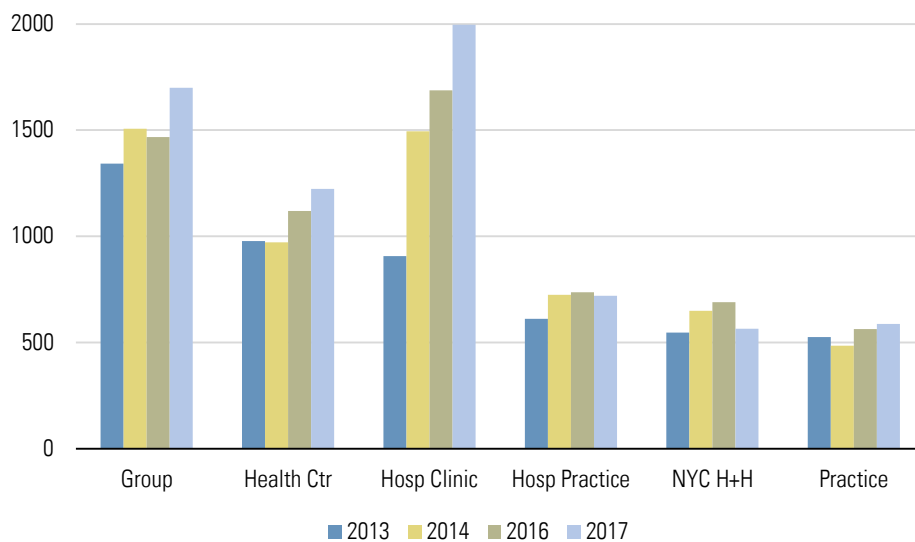




## PCMH Adoption Varies by Provider Type

Over the past six years, the adoption of the PCMH model has varied considerably across different practice types. Statewide, PCMH growth has historically been centered on specific types of practices—health centers, group practices, and hospital clinics—that have the scale and infrastructure to support the medical home model. The most recent reports continue those trends.

**Figure 6. Changes in PCMH Adoption, by Practice Type**



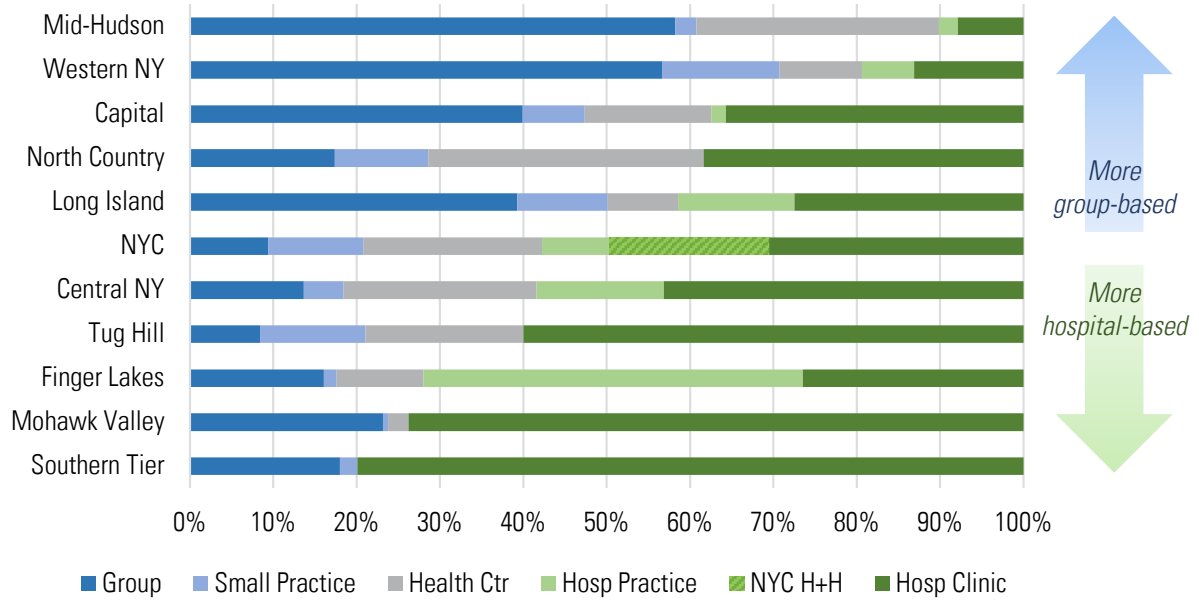
Another important theme across all regions has been the continued under-representation of small practices in the PCMH program. Practices with four or fewer providers represent over 40% of the state’s primary care workforce<sup>6</sup> but only 8% of the providers working in NCQA-recognized PCMHs. These small practices often lack the financial strength and infrastructure required to adopt and sustain the medical home model.

Beneath these aggregate trends, the PHIP regions vary considerably in their distribution of PCMH providers by practice type (see Figure 10). In part, this reflects the composition of their regional primary care systems. Some regions (e.g., Western New York, Mid-Hudson, and Capital regions) have a number of large multi-specialty group practices and physician-led independent practice associations. Others (e.g., Mohawk Valley and Southern Tier) rely more on hospital-based physicians.

See the [appendix](#) for additional regional detail on adoption by practice type.

6. Special analysis conducted by NYSDOH Office of Quality and Patient Safety, October 2016.

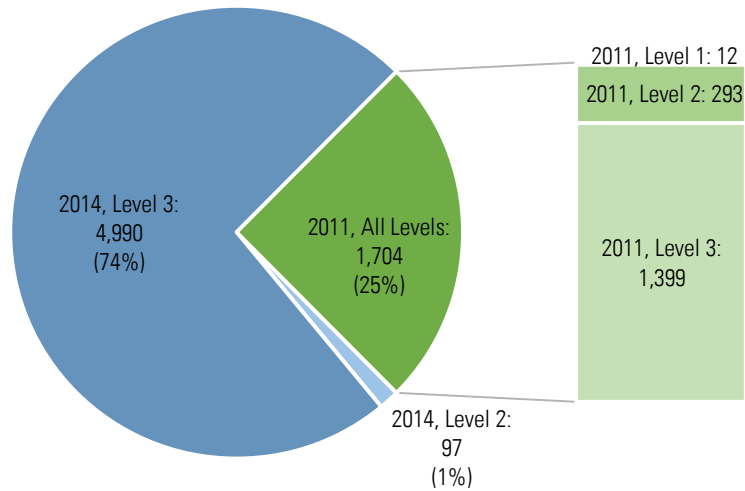
**Figure 7. PCMH Providers by Practice Type, May 2017**



**Variation by Year and Level of NCQA Standards; Upcoming Changes in Recognition Process**

The NCQA has updated its certification standards regularly to reflect evolving expectations for medical homes in a changing health care landscape. Providers’ PCMH recognition varies by the NCQA standards in effect in the year they were recognized (the 2011 or the 2014 standards) and by the level of recognition they achieved within them—Level 1, 2, or 3, with 3 being the most rigorous. As of May 2017, three-quarters of the PCMH providers had achieved NCQA recognition under the 2014 standards and one-quarter under 2011 standards; and 95% of those PCMH providers had achieved Level 3 recognition under the applicable standards.

**Figure 8. PMCH Providers in New York, by NCQA Standards Year and Level, May 2017**

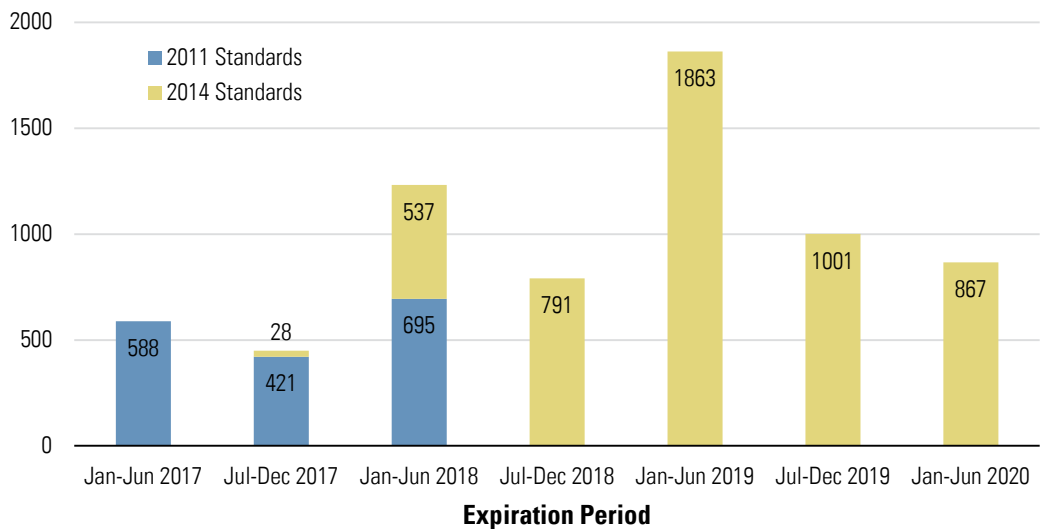


Under NCQA’s traditional process, providers could apply for PCMH recognition on a rolling basis, under the prevailing PCMH standards, and recognition lasted three years. At the end of this three-year period, providers would then need to reapply under the new set of standards.

This rolling-application process can produce some anomalous results. For example, providers could still apply for recognition under NCQA’s 2011 standards through the summer of 2014 (when the new 2014 standards officially took effect) with formal NCQA recognition date for these last PCMH 2011 providers as late as mid-2015. Given the three-year period of that recognition, they could remain NCQA-recognized as a PCMH under the 2011 standards until the spring of 2018. This helps explain how, as of May 2017, a quarter of New York’s PCMH providers worked in practices still recognized under NCQA’s 2011 standards.

As is shown in Figure 9, as of May 2017 the NCQA recognition for nearly 600 providers working in practices recognized under NCQA’s 2011 standards was scheduled to expire by the end of June 2017—i.e., it has already expired; and *all* of the practices recognized under the 2011 standards will see their recognition expire by June 2018. As their expiration dates approach, those practices will need to decide whether or not to renew their NCQA recognition under the newest 2017 standards.

**Figure 9. PMCH Providers by Date When Current NCQA Recognition Expires**



Since the inception of the PCMH program, NCQA has continually updated its standards, to reflect learnings from the practices in implementing the PCMH model, and in response to changes in the health care environment. For example, NCQA's standards for the PCMH program changed between 2011 and 2014, to reflect a greater emphasis on team-based care and integration of behavioral health, expanding the focus of care management from managing patients with specific conditions to all patients the practice has identified as requiring care management, and expanding the use of evidence-based decision support tools.

In March 2017, NCQA announced a major revision of its existing PCMH standards and its process for recognition under them. Recognizing the emergence of accountable care organizations and clinically integrated networks, and the need to align the PCMH program with Medicare's Quality Payment Program and other outcomes-based payment systems, NCQA updated its standards for 2017 to include a greater emphasis on clinical quality improvement and reporting. The new standards make "Meaningful Use" standards for electronic medical records a core measure. The 2017 standards also stress the need for primary care practitioners to understand and respond to patients' behavioral health needs—as well as the impact of social factors on patients' health, and the ways in which improved connections with community resources can help address them.

At the same time, NCQA changed its PCMH recognition process, abolishing its prior three-tier level of certification and the three-year recognition period. Once a practice meets the new 2017 standards, its recognition will continue indefinitely unless it fails to submit required update information and data annually. The 2017

standards are effective for providers beginning the PCMH process after April 3, 2017, but providers who were already working on recognition under the 2014 standards as of that date will still be receiving three-year certifications over the next nine months.

NCQA's new process affects currently recognized practices differently.

- PCMH 2014 Level 3 practices can transition directly to the new annual reporting system when their current recognition period expires.
- PCMH 2014 Level 1 and 2 practices (of which there are very few in New York) will be able to transition to the new system using a two-step process, first meeting PCMH 2014 Level 3 requirements and then moving on.
- PCMH 2011 recognized practices can choose to renew recognition under the PCMH 2014 standards for the customary three-year period and then transition to PCMH 2017 at the end of that period—or, before their 2011 recognition ends, they can convert to PCMH 2014 status and then transition.
- Those PCMH 2011 practices choosing to renew under PCMH 2014 instead of the new PCMH 2017 process faced a September 30, 2017 deadline for submitting their application materials.

## **Looking Forward: Issues to Watch**

Over the past six years, we have seen remarkable growth of the medical home model across New York State. That growth has been driven by three forces: adoption of the PCMH model by providers and provider groups committed to improving the performance of their primary care programs; financial support offered by a number of private payers (like Empire Blue Cross and the Capital District Physicians Health Plan) to providers seeking and achieving PCMH recognition; and—perhaps most notable—by the early and ongoing support of the medical home model by the NYSDOH and the state's Medicaid program.

Three forces are likely to affect the future adoption of the PCMH model in New York over the coming years: New York's Delivery System Reform Incentive Payment program, competing models of primary care, and changes in payment systems. We have mentioned these forces in previous reports on PCMH adoption, and in other reports on health care innovation; here we examine their expected effects on PCMH, looking forward from 2017.

## **The DSRIP Effect**

New York's Delivery System Reform Incentive Payment (DSRIP) program is likely to increase PCMH adoption in New York over the coming months. Performing Provider Systems (PPSs) are currently helping their participating primary care practices achieve PCMH 2014 recognition or recognition under New York State's Advanced Primary Care model. While there is no systematic reporting of the number and types of practices PPSs are helping, the growth in PCMH providers between 2016 and 2017 likely reflects the early impact of investments by PPSs in PCMH practice transformation. Many more PPS-supported new entrants to the NCQA PCMH program are expected over the next nine months.

## **Competing Models**

In last year's report, we noted the issue of "model confusion": the fact that three major federally funded primary care practice transformation initiatives are now under way in New York State, each promoting a slightly different, arguably competing medical home program,<sup>7</sup> with the potential to confuse primary care providers and affect the growth of the PCMH program in the state.

With support from its State Innovation Models initiative,<sup>8</sup> the NYSDOH has worked with a multi-stakeholder group over the past three years to develop and spread a model for primary care (Advanced Primary Care, or APC) that was more robust than NCQA's 2011 standards, which was viewed by many providers and payers as insufficiently rigorous.

New York's SIM award includes over \$60 million to support primary care practice transformation assistance, an effort which just began in mid-2017. As of mid-September,<sup>9</sup> 229 primary care practices have been enrolled and contracted to receive practice transformation assistance under the APC model, and another 900 practices are engaged in discussions with State-funded APC technical assistance providers. In parallel, NCQA continued to refine its PCMH model, resulting in the March 2017 release of its 2017 standards, which made significant changes both in the program requirements for recognition, and in the recognition process. That new, more rigorous model will, over the coming years, supplant the two models (PCMH

7. NCQA's Patient-Centered Medical Home (PCMH), New York State's Advanced Primary Care (APC), and another CMS-sponsored program, the Transforming Clinical Practice Initiative (TCPI), discussed further in this section.

8. December 2014, the New York State Department of Health was awarded a \$99.9 million Round Two Model Test Award State Innovation Models grant by the Centers for Medicare & Medicaid Innovation to implement the State Health Innovation Plan. New York State's official project period of the grant begins February 1, 2015, and will continue for four years.

9. New York State Department of Health, materials for the September 19, 2017, meeting of the Statewide APC Steering Committee.

2011 and PCMH 2014) under which all PCMH providers in New York currently operate.

NCQA's new standards for 2017 align quite well with those developed for New York's APC model. After conducting a detailed review of the new NCQA standards compared to those of the APC model, NYSDOH has resolved that it would be advantageous to work with NCQA to consolidate the two, creating a single hybrid NYS-PCMH model. As conceived, that new model would adopt—with some state-specific modifications—NCQA's 2017 standards, and it would use a recognition process that aligns with NCQA's (i.e., annual reviews and updates rather than a three-year recognition).

If successful, the consolidation of the two prevailing models should reduce the potential confusion among providers and payers. With SIM funding available to support practice transformation technical assistance over next few years, it should also stimulate increased adoption of the hybrid NYS-PCMH model.

The third primary care practice transformation program—the Transforming Clinical Practice Initiative (TCPI)—continues to operate as a distinct program, parallel to but slightly different from both NCQA's PCMH model and NY State's APC/ NYS-PCMH model. Unlike PCMH and APC, which focus on primary care, the TCPI program targets both primary care and specialty care providers. As of September 2017, TCPI Practice Transformation Networks have enrolled over 2,000 primary care providers statewide. These practices may or may not consider PCMH recognition in the future.

## **Changing Payment**

Over the past five years there has been a growing recognition of the need to change the way health care services are paid for, moving from fee-for-service to value-based payment (VBP) methods to reward providers for value, improve quality, and restrain costs. Today, all payers—Medicare, Medicaid, and commercial plans—are embracing VBP as the foundation for payment reform.

The core competencies of a medical home—coordinating and managing care, closing care gaps, improving quality, and focusing on the health of populations—align well with the skills required for a primary care practice to succeed under VBP. Two payment methods generally cited as examples of VBP—shared savings and shared risk—provide incentive payments retrospectively, at the end of a performance year, after comparing a provider group's performance to quality and cost benchmarks. These retrospective incentive payments do not offer a reliable

source of funds to help support a primary care practice's initial investments and added operating costs as they transition to and begin to operate as medical homes, and before they generate any shareable savings.

As part of its SIM initiative, New York is working to address that issue. The State has organized a series of multi-stakeholder Regional Oversight and Management Committees (ROMCs), bringing together providers, payers, purchasers, and patients to craft workable regional solutions to two key issues facing primary care practices as they consider adopting the medical home model:

- how best to measure (and reward) their performance in improving quality and reducing utilization and costs—what should be the measures, and how should they be applied; and
- how best to pay medical homes, helping to offset the practices' initial investments and added costs as they transition to the medical home model, and their ongoing operating costs, over the longer term.

In early 2016, the NYSDOH established ROMCs in three areas: the Finger Lakes, the Hudson Valley / Capital region, and the New York City metropolitan area. Each of these regional councils has convened multi-stakeholder groups charged with identifying practices that the regions' payers feel are priorities for practice transformation, and on better aligning payments and measures across the health plans to support the adoption of the new APC program. The ability of providers and payers to achieve consensus on these issues will strongly influence the future growth and sustainability of the medical home model in New York.

## **Conclusion**

Adoption of the PCMH model continues to increase across New York State, but many competing pressures could either intensify or hamstring future growth. Without multi-stakeholder agreement on a preferred model, how to measure its success, and a reliable, broad-based payment change, primary care practices—particularly smaller practices—may struggle to find a strong business case for adopting and implementing the medical home model.