

Patient-Centered Medical Homes in New York, 2018 Update: Drivers of Growth and Challenges for the Future

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April 2019

Acknowledgments

The analysis in this report would not have been possible without the support of Kate Bliss and Dana Schiffman 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.

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Introduction

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 is especially valuable 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. Adopting the medical home model to achieve a higher-performing primary care system is a path toward a higher-performing health care system overall.

Since 2011 adoption by primary care practices across New York State of the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) model has grown steadily. Over that period the number of PCMH clinicians (providers working in practices that had achieved NCQA recognition as PCMHs) has increased from roughly 3,400 clinicians to over 9,000 at the end of May 2018 (see Figure 1).

The growth rate has varied from year to year, with notable increases in the number of PCMH clinicians stimulated by specific state policy changes and investments. After increasing at an average rate of roughly 15% per year between 2011 and 2017, the number of PCMH clinicians¹ in New York increased sharply between May 2017 and May 2018, a one-year increase of more than 35%. This report focuses on the drivers of that recent growth and considers what the future may bring for future PCMH adoption.

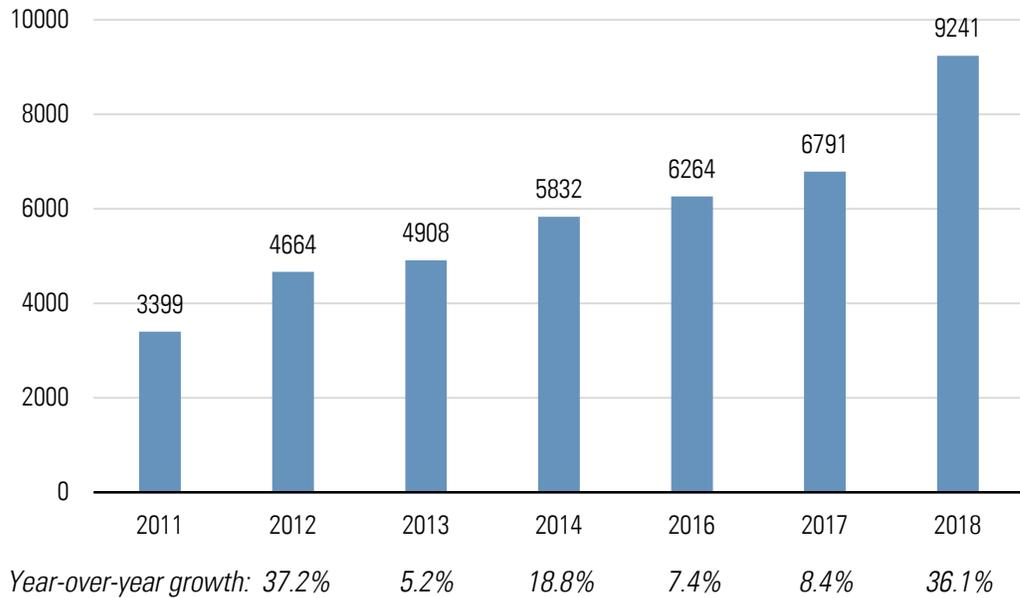
The remarkable recent growth in the number of PCMH clinicians in New York coincides with the implementation of the state's Delivery System Reform Incentive Payment (DSRIP) program. Health systems participating in that program (Performing Provider Systems, or PPSs) had an incentive to help their affiliated primary care practices achieve PCMH recognition by March 2018. It appears that the implementation of the DSRIP program accounts, in large part, for the increase in PCMH clinicians.

Taking the Long View on Patient-Centered Medical Homes

Since 2011, UHF has produced a series of annual reports tracking the increasing adoption of the Patient-Centered Medical Home model across New York State. These reports are available from the United Hospital Fund website, www.uhfny.org.

With generous, ongoing support from The Peter and Carmen Lucia Buck Foundation, we have been able to follow that growth trajectory over time, to analyze regional trends in the uptake of this care model, and to identify and articulate key issues facing providers in adopting and sustaining this innovative care model.

Figure 1. Growth in PCMH Clinicians in New York State, 2011-18



The continued growth of the PCMH model across New York State has helped primary care providers change the way they practice, moving from a visit-based to population-focused practice style, enabling those practices to improve care quality, and better manage the care of all patients they serve, particularly those with the greatest needs—patients with multiple, complex chronic illnesses, whom the health care system manages least well.

As this innovation has gained traction, however, the health care system and methods for paying providers have continued to change. The eventual impact of these changes on the trajectory of the PCMH model in the state is not yet clear. Some—like value-based payment and the emergence of large, integrated health systems focused on managing population health—have the potential to support and sustain the PCMH model, or to retard its growth. Others, particularly the emergence of convenient care, may erode its relevance and support.

Understanding Variation in PCMH Adoption

There is increasing evidence² that becoming a patient-centered medical home improves quality and positions primary care practices to better manage care of the populations they serve. New York State’s Department of Health (NYSDOH) recognized that value early on and has over the past decade pursued a series of policies aimed at increasing the number of PCMH clinicians serving New Yorkers.

To better understand the trajectory and drivers of PCMH adoption in New York State, UHF has been analyzing and reporting on data from NYSDOH’s Office of Quality and Patient Safety. These include detailed information on all practices in the state that have achieved NCQA recognition as a PCMH and on the clinical staff working there. UHF has used these data to analyze the adoption of the PCMH model by region and by type of practice.

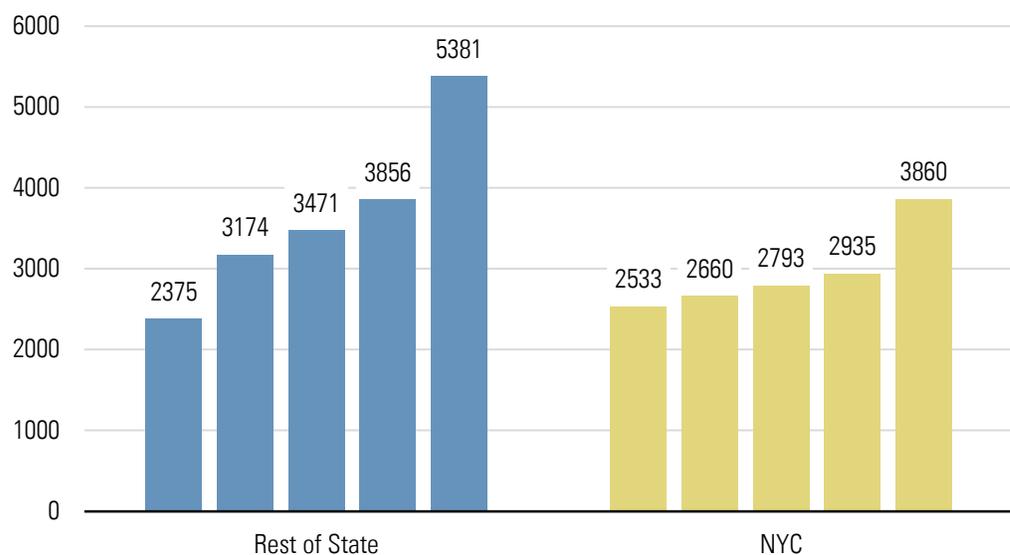
Like previous reports in this series,³ this report notes the uneven uptake of the PCMH model across the state. Providers in certain regions and different provider types have adopted the PCMH model much more rapidly and completely than others. This means that residents of some regions, or those cared for in different types of practices, may not have this care model available to them. Understanding this disparity is key to responding to it, focusing attention and resources on helping those that have lagged behind.

Regional Variation

Beneath the state’s aggregate growth in the number of PCMH clinicians is a great deal of regional diversity. Over the past five years, (see Figure 2), the number of PCMH clinicians in New York City and other regions of the state have grown at different rates. Since 2013, the growth in PCMH clinicians in the rest of the state has consistently outstripped that in New York City.

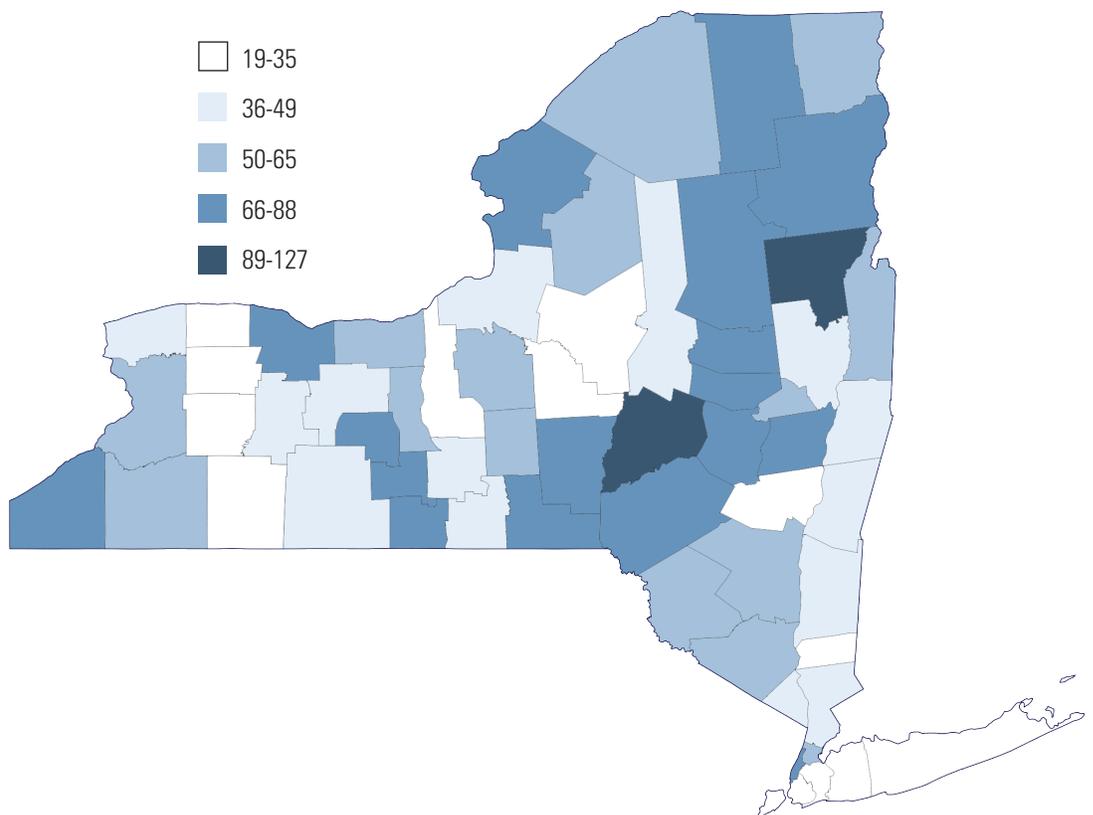
The adoption of the PCMH model varies widely across New York State. To better understand that phenomenon, we developed a population-based measure (PCMH clinicians per 100,000 residents) and used it to compare availability of PCMH

Figure 2. PCMH Growth, 2013-18, NYC vs. Rest of State



services across New York’s 62 counties (see Figure 3). This measure attempts to show the patient’s perspective: the relative availability, within any one region, of how many PCMH providers there are and how busy they are likely to be. It is important to note that this measure does not account for the fact that there is wide variation in the total number of physicians and other primary care providers in any given region—not just those in PCMH practices. Relatedly, prior adoption of the PCMH model by practices in a region—its existing “PCMH penetration”—can hamper its potential for further growth. In regions like the North Country, where a high proportion of the primary care practices have already achieved NCQA recognition, fewer practices are available to contribute to additional growth. (For more discussion and regional detail, see the accompanying chartbook.)

**Figure 3. Availability of PCMH Services by County, May 2018
(PCMH Clinicians per 100,000 Population)**



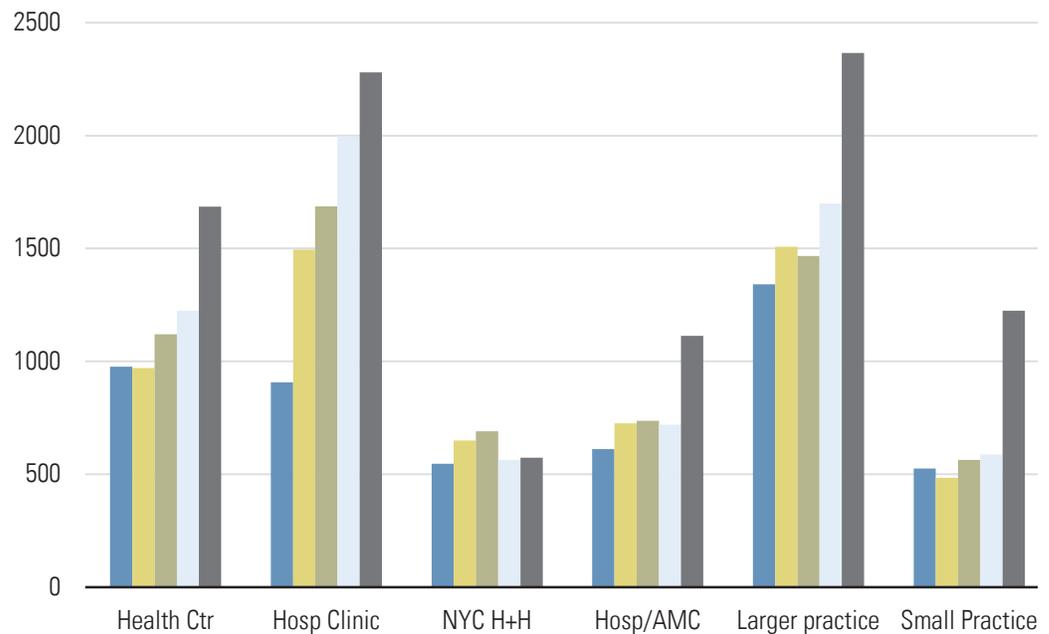
Variation by Practice Type

PCMH adoption and growth has also varied substantially by practice type over the years. Six broad categories of PCMH providers capture the different practice types: Article 28-licensed Health Centers/Diagnostic and Treatment Centers, hospital clinics (NYC Health + Hospitals is reported separately, due to its size), hospital/

academic medical center (AMC) practices, larger practices and groups (practices with five or more clinicians in the NCQA database), and small practices (with four or fewer clinicians).⁴

It is easy to see the growth across all practice types (except NYC H+H, which converted essentially all its primary care practices to the PCMH model by 2013), and notable increases in the adoption of the PCMH model in health centers, hospital/AMC practices, and private practices (see Figure 4). For further exploration of this issue and regional variation, see the 2018 PCMH chartbook that accompanies this report.

Figure 4. Change in PCMH Clinicians by Practice Type



The DSRIP Effect

While it is not possible to directly attribute the 2017-2018 increase in PCMH adoption to one specific cause, it is reasonable to assume that much of that growth was related to the state’s Medicaid DSRIP program. As part of that program, many of the state’s PPSs took on delivery system transformation projects with the specific goal of helping primary care practices achieve NCQA recognition as medical homes by March 2018.

Over the past two years, many of the state’s PPSs invested DSRIP funds to support practice transformation for their affiliated primary care practices, helping them to

achieve recognition under NCQA's 2014 PCMH standards. Since the recent sharp increase in the number of PCMH clinicians in New York State coincided with the timeframes included in the state's DSRIP program, at least some of that increase seems related.

To test this hypothesis, in July 2018 UHF surveyed a sample of PPSs in New York City and three high-growth regions (the Capital region, Mid-Hudson, and Long Island), to assess the number of providers they had supported in achieving NCQA

recognition as PCMHs. To ensure an accurate assessment, PPSs were also asked about the number of providers transformed who were new to NCQA's PCMH program as opposed to providers who were upgraded from NCQA's 2011 standards to the 2014 standards.

The responding PPSs⁵ reported helping substantial numbers of practices and providers achieve PCMH recognition, and stimulated major growth among those new to the PCMH program. Based on this survey (see call-out box) it is clear that DSRIP has driven most of the overall increase in PCMH clinicians in the three highest-growth regions, and among small practices in New York City. While the surveyed sample does not provide a complete picture of the PPS-sponsored efforts to increase participation in the PCMH program, it does indicate that in these high-growth areas, PPSs were major contributors to the sharp increase in

PCMH clinicians observed between May 2017 and May 2018. A fuller and more precise accounting of the PPSs' contribution to the growth in PCMH clinicians in New York State is currently under way, led by the Office of Health Insurance Programs and its DSRIP Independent Assessor.

Quantifying the DSRIP Effect

- Five of nine PPSs operating in **New York City** reported providing or supporting practice transformation for 1,300 clinicians in total (new to the PCMH program and renewals). Over two-thirds of the NYC clinicians were new to the PCMH program; most (over 90%) of the increase of new PCMH clinicians was in small practices, in Brooklyn, Queens, and the Bronx
- The two PPSs operating in the **Hudson Valley** supported practice transformation for 560 clinicians in total (new and renewals), and most of those were new to the PCMH program
- One **Long Island** PPS reported supporting practice transformation for 123 clinicians new to the PCMH program, 43% of the total regional growth
- A **Capital Region** PPS reported supporting practice transformation for 132 clinicians new to the PCMH program, 53% of the total regional growth

Additional Changes in the Landscape That Likely Enhanced PCMH Growth

UHF's PCMH reports over the past few years have noted two forces with the potential to retard the growth of the medical home model in New York State.

- **Model Overload.** Providers in New York State have had to choose among four different and competing medical home models,⁶ including New York State's

Advanced Primary Care (APC) model, the centerpiece of the New York's \$100 million State Innovation Models (SIM) initiative. Each of those programs has its own set of standards and its own approach to practice transformation. This diversity has had the effect of confusing primary care practices as to which one to pursue.

- **Payment Indifference.** While Medicaid has long supported PCMH with an add-on payment, there has been little if any consensus to date among other payers on how to pay providers to cover the increased operating costs associated with practice transformation and operating as a medical home. As a result, the broad base of multipayer support necessary to sustain the medical home model has remained elusive.

Over the past year, there has been progress on both fronts.

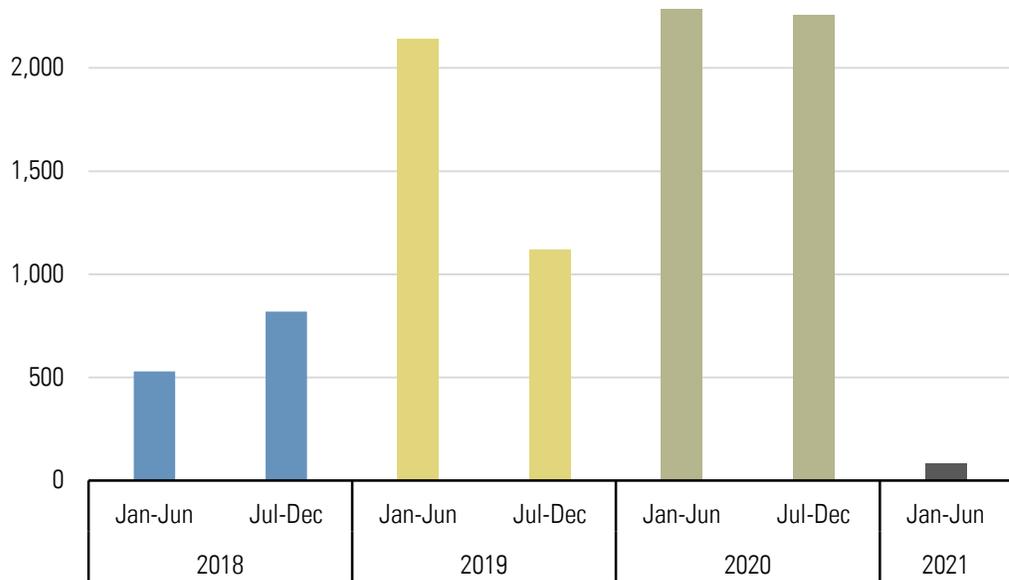
Clarifying the Model, Building On-Ramps

In June 2017, NCQA released revised standards⁷ for its updated model, PCMH-17. Staff from NYSDOH analyzed the new standards, comparing them with those developed for the state's APC model, and found a great deal of alignment between the two. The SIM program's advisory councils subsequently recommended that NYSDOH pursue a hybrid model consolidating the best elements of both programs to create a single, unified medical home model, the New York State Patient-Centered Medical Home (NYS-PCMH). This combined model adds requirements in a few areas that were required in the APC program but optional in NCQA's model. Since April 2018, NYS-PCMH is now the only model that NCQA offers to new entrants or to those with the PCMH-14 recognition looking to renew. This latter group is a large and important cohort: over 95% of the state's PCMH clinicians work in practices that have received a three-year Level 3 recognition under NCQA's 2014 Standards, and nearly half have an NCQA recognition that does not expire until 2020 (see Figure 5).

These consolidating changes—and clear NYSDOH and NCQA processes for practices with different types of certification and different renewal dates—represent a major step toward a long-pursued goal: a single model for medical homes in New York State. New York plans to develop a similar on-ramp for practices currently involved in the state's next-largest medical home initiative (the CMMI-sponsored Transforming Clinical Practice Initiative, or TCPI), which includes another 1,500 primary care providers.⁸

Once it settled on NYS-PCMH as its unified medical home model, New York began its SIM-funded practice transformation in earnest in 2018. Hundreds of primary care practices across the state are currently receiving practice transformation

Figure 5. Expiration Dates of PCMH Practices' Current NCQA Recognition



technical assistance but the SIM's full impact on the number of PCMH clinicians has yet to be felt, as practice transformation can take 6 to 12 months—or longer. Since May 2018, the overall number of PCMH clinicians (PCMH plus NYS-PCMH) has increased by roughly 700, to a total of 9,977; and the distribution by program has begun to shift. As of April 2019, NCQA reported a total of 7,236 clinicians in practices with PCMH-14 or PCMH-17 recognition, and another 2,741 in practices with NYS-PCMH recognition.⁹

Paying for Medical Homes

Operating as a medical home entails new functions and staff that increase operating costs but are not covered in the primary care setting by traditional fee-for-service payments. Covering these increased costs is a challenge for any primary care practice; but it is particularly onerous for small practices, which lack the infrastructure to support those new functions.

Since 2010, the state's Medicaid program has offered practices achieving recognition under NCQA PCMH program an incentive payment for each Medicaid member they served. Beginning as an add-on to established fee-for-service visit rates, it was converted in 2013 to a payment per Medicaid member, per month (PMPM), for providers participating in Medicaid's managed care program. That PMPM payment has varied over the last four years between \$6.00 and \$8.00 PMPM.¹⁰ It has offered primary care practices serving substantial numbers of Medicaid enrollees a

source of funds to help defray a portion of those increased operating costs, which helps explain the penetration of the PCMH model in hospital clinics and federally qualified health centers, both of which serve large Medicaid populations.

Most primary care practices serve patients covered by many different payers, including Medicaid, Medicare, and commercial insurance. Few payers beyond Medicaid offer meaningful, predictable support for medical homes, leaving many practices with a substantial gap between operating costs and operating revenues attributable to medical home transformation. The prospect of this shortfall discourages practices from adopting the medical home model and threatens the longer-term viability of practices already operating as medical homes. Two initiatives currently under way may help address this problem:

Value-Based Payment. Across the nation, payers are pursuing value-based payment (VBP) contracts, which give providers incentives to reduce costs and improve quality. Most VBP contracts offer participating providers the opportunity to share in cost savings generated against a benchmark, for specific cohorts of attributed patients covered by a given payer. Medical homes have been shown to improve quality and to reduce costs (particularly for patients with multiple chronic conditions, who generate high levels of utilization and costs). VBP contracts would appear to be a promising source of revenues to help primary care practices cover the added costs of operating as medical homes.

Regional Multipayer Initiatives. New York State has continued to pursue the goal of generating broad and consistent multi-payer support for the medical home model. In 2017, the New York State Department of Health and Department of Financial Services (DFS) organized a regionally-based effort¹¹ to generate consensus among payers and primary care providers about ways to increase the spread of the medical home model; how best to target practice transformation efforts; and how best to pay for primary care in practices recognized as medical homes.

One outcome of this effort has been a sharper focus on small, independent primary care practices that are not already part of existing VBP contracts. Payers participating in the regional initiatives are identifying rosters of small practices that would benefit from the SIM program's practice transformation efforts. Payers are currently considering how they could provide those practices with the additional resources necessary to operate as medical homes under the new NYS-PCMH model.

While these two interventions have some potential to provide primary care practices with added revenues, the long-term systemic challenge remains: how to provide the resources primary care practices need to achieve and sustain the capacities of a medical home.

Looking Ahead: Challenges and Opportunities

New York State has been a leader in the adoption of the medical home model; today it accounts for 14.5% of the nation's NCQA-recognized PCMH clinicians.¹² Over the longer term, however, the state's ability to sustain the medical home model faces some challenges.

New York State Has Driven Change, But Revisions Loom

The importance of the New York State Department of Health and its Office of Health Insurance Programs (OHIP, New York's Medicaid agency) to the growth of the PCMH growth model cannot be overemphasized.

- OHIP provided early leadership, offering PMPM care management payments to providers who had achieved NCQA recognition.
- NYSDOH was the force behind the \$250 million HHS-funded Hospital-Medical Home program, which sharply increased participation of hospital primary care teaching clinics in the PCMH program.
- NYSDOH, along with the Department of Financial Services, led the successful effort to procure a State Innovation Models award, a \$100 million program focused mainly on increasing medical home participation, and organizing statewide multi-payer support for medical homes.
- OHIP organized and led the state's successful 1115 Medicaid waiver request, which included the DSRIP program's incentives for PPSs to help transform primary care practices to PCMH, which in turn led to the recent spike in PCMH growth.

These state efforts have clearly been in the public's interest, improving the performance of the state's primary care practices. They have also been in the state's own interest, helping practices serving Medicaid enrollees to better manage the care of high-cost patients who account for a disproportionate share of Medicaid's expenditures. The investments have had at least some of the desired effect, with many more Medicaid enrollees receiving their care from the primary care providers who have achieved PCMH recognition. While a state-specific evaluation has not been conducted, past evidence would suggest that those practices are better equipped to manage patients' care, improve access and quality for Medicaid patients, and reduce avoidable emergency department visits, hospital admissions, and readmissions—and potentially the total cost of care for at least some Medicaid members.

That success, however, has come at a cost. As the number of Medicaid patients receiving their care in medical homes has grown, so too have Medicaid program expenditures for the PCMH incentive payment, placing increasing financial

pressure on the state's budget. There are signs that the state may modify its direct financial support for medical homes in future years.

- In the FY 2019 budget, OHIP reduced the PCMH incentive payment from \$7.50 to \$6.00 PMPM for providers serving Medicaid managed care members. If PCMH growth continues in New York's capped Medicaid global budget environment, future decreases may continue to be on the table.
- The current mechanism for delivering a large portion of the PCMH incentive through Medicaid managed care plans may have to change because of new federal managed care guidelines.
- As New York transitions to the NYS-PCMH model, it could also adjust what counts as PCMH for the Medicaid incentive payment (reducing or eliminating payments for PCMH-14), raising valid questions from providers that only recently achieved PCMH-14 recognition.

Achieving further spread of the medical home model will require sustained, predictable support from Medicaid managed care plans, and broader support from Medicare and commercial payers.

Uncertain Multipayer Support

Some payers are offering different payment methods that align the timing of added payments with the added operating costs of the medical home. These models (monthly care management payments, or risk-adjusted primary care capitation, with quality and cost incentives) may prove to be more appropriate ways to cover the increased operating costs of medical homes. Unfortunately, not all payers are providing augmented payments to medical homes. The lack of participation by and alignment among payers adds complexity to operating a medical home that serves patients covered by many different payers.

A second problem lies in the real or perceived variability in the actual value of the medical home model for payers across different lines of business—Medicare, Medicaid and commercial insurance. Most studies of medical home cost-effectiveness have found that near-term reductions in avoidable health care costs are driven by improved management of high-risk patients with complex chronic conditions. These patients are over-represented in the Medicaid and Medicare populations and drive much of the cost in those programs.

The utility of the PCMH model in serving populations covered by commercial insurance (generally employment-based) has not been demonstrated as well. The medical home model may turn out to be less effective in dealing with commercial payers' high-cost patients, whose higher costs are driven more by unpredictable acute-care events (like cancer, trauma, and neonatal intensive care) than by poorly

managed chronic diseases.¹³ Similarly, medical homes may also be less well suited to directly affect commercial payers' financial pain points, which tend to be related to higher prices and overuse of specialty care, tests, and procedures—rather than avoidable hospital admissions.

Value-Based Payment and Accountable Care

A high-performing primary care network with the capacities of a medical home can be a strong foundation for population health management, particularly for the management of patients with multiple chronic illnesses. It is a core competency for any provider group considering VBP or accepting accountable care contracts,¹⁴ providing a locus of responsibility for the management of attributed patients.

As initial taps of VBP and accountable care have grown into a strong drumbeat, payers are under increasing pressure (internal and external) to meet specific targets for the percent of provider contracts or total spending facilitated through VBP arrangements. These agreements generally take the form of shared-savings, shared-risk, or capitation arrangements that consider both total cost of care and performance on quality measures.

Many payers already have VBP contracts with primary care practices, either directly or through contracts with larger groups like IPAs or hospital systems. Those VBP arrangements vary, but most are built on the mechanics of Medicare's largest accountable care program, the Medicare Shared Savings Program (MSSP) program, in which providers receive shared savings retrospectively, six or more months after the close of a given performance year. Payers are hesitant to modify these contracts in order to do something different for primary care.

The fundamental problem with these existing VBP models is cash flow and timing. Most shared-savings and shared-risk models are built on a fee-for-service chassis, paying primary care practices using historical fee-for-service methods, which do not reflect the added costs or value of the medical home. Unless payers take explicit action to pay more for medical homes within the context of VBP arrangements, primary care practices are likely to receive no additional upfront funding to cover their increased operating costs.

A second VBP-related challenge relates to the type of contract the primary care practice has with the payer. If a primary care provider negotiates a VBP contract directly with a payer, it may be possible to negotiate increased upfront payments that enable the practice to cover the operating costs of the medical home. If a primary care practice is part of a VBP contract with a larger health system, however, it may be more difficult to arrange up-front payments for primary care. Most health system contracts resemble the Medicare ACO program, in which the savings are generated at the system level, with most or all incentive payments coming after 12 to 18 months of performance. A forward-thinking health system may invest its own

resources in primary care to support the added costs involved in enabling its primary care practices to operate as medical homes, but examples of such thinking are not yet the norm.

Changing Models and the Role of Primary Care

Since the introduction of the Patient-Centered Medical Home model in 2008, the health care landscape has changed. New models (e.g., direct primary care, concierge medicine, telemedicine, and technology-based solutions like Teladoc, MDLIVE, Doctor on Demand, MeMD) have emerged, each with its own appeal to consumers seeking more convenient care. These innovations have the potential to alter the role of the traditional primary care office. Perhaps most disruptive is the emergence of retail clinics and urgent care centers, offering patients accessible and convenient alternatives to traditional primary care offices for their immediate needs.

These innovations are challenging traditional primary care practices, eroding some of their patient base, serving otherwise healthy patients with minor health problems who were historically part of those practices' core economics. It is impossible to turn back the clock; patients will seek-out and use services that most efficiently meet their needs at an affordable price. The question is, in this changing ecology, what will be the role of the traditional primary care practice, and within that context, of the medical home?

One answer could be for primary care medical homes to improve access (e.g., expanded hours), and build on their core competencies, things that a medical home can do better than the convenient but largely episodic alternatives:

- Focusing on prevention and health education, and effectively engaging patients in their own care.
- Helping patients and families to negotiate the health system during and after acute care events, coordinating care around specialty referrals and follow-up care after emergency department visits or hospitalizations.
- Perhaps most important, working with patients who have multiple chronic diseases (including patients with mild-to-moderate behavioral health issues and those at risk for chronic diseases) to better manage those conditions, and help avoid complications and preventable events and utilization.

Each of these roles plays well with the historical strength of good primary care: the development and maintenance of solid, longitudinal relationships between providers and patients, based on trust and an understanding of who patients are and what they want.

Conclusion

The continued growth of the PCMH model across New York State has been a remarkable success story in health care innovation. It has helped primary care providers to change the way they practice, moving from a visit-based to population-focused practice style, enabling those practices to improve care quality and to better manage the care of all patients they serve, particularly those with multiple, complex chronic illnesses.

However, the health care system and methods for paying providers have continued to change. Sustaining this model may require new responses—reacting to emerging trends in delivery and payment—as well as continued attention to the obstacles this model has faced from the start: securing payer alignment and helping smaller practices pay for the changes necessary to operate in this broad, proactive fashion.

Endnotes

1. The data provide two possible ways of measuring medical home model adoption: the number of practices that have been recognized by NCQA as PCMHs; or the number of clinicians working in those practices. The main drawback in using practices as the unit of measure is that they vary substantially in size. UHF tracks PCMH adoption using the number of PCMH clinicians—providers working in practices that have achieved NCQA PCMHs recognition—because it provides a more accurate estimate of the actual availability of medical home care.
2. The Patient-Centered Primary Care Collaborative (PCPCC) publishes annual reports on the evidence of PCMH effectiveness in improving quality and reducing care costs. For a recent report, see <https://www.pcpcc.org/sites/default/files/resources/PCPCC%202018%20Evidence%20Report.pdf>
3. See the UHF website for prior reports: www.uhfnyc.org
4. In New York State, primary care services are offered by different types and sizes of practices, and there is substantial variation in PCMH adoption for different practices. UHF analyzes the number of PCMH Clinicians according to the type of practice in which they worked, using a 6-step process to categorize PCMH Practices and Clinicians into six different practice types:
 - Health Center: Federally-Qualified Health Center (FQHC) and/or Article 28-licensed Diagnostic and Treatment Center (DTC) of extension clinic of a DTC, as listed on NYSDOH website: <https://www.healthdata.gov/dataset/health-facility-general-information> as of 6/21/18
 - Hospital Clinic: Article 28-licensed clinic or extension clinic included in the NYS Dept of Health website, <https://profiles.health.ny.gov/> as of 6/21/18
 - NYC H+H: Licensed clinic operated by NYC Health + Hospitals
 - Hospital / AMC Practice: Practice name includes the name of a hospital or academic medical center (AMC) and/or website refers to hospital/medical school ownership, but the practice site is not listed as an Article 28 clinic

- Larger Practice or Group: Five or more PCMH clinicians included in the NCQA database for a given private practice name
 - Small Practice: Four or fewer PCMH clinicians included in NCQA database for a particular private practice
5. PPSs responding to UHF's survey included NYU Langone Health, New York-Presbyterian/Queens, OneCity Health, Montefiore Hudson Valley Collaborative, Suffolk Care Collaborative, Community Care of Brooklyn, Better Health for Northeast New York, WMC Health, SOMOS Community Care, Bronx Partners for Healthy Communities, New York Presbyterian, and Mount Sinai PPS, LLC.
 6. The four competing models were NCQA's PCMH model; New York State's Advanced Primary Care model, supported by the state's SIM initiative; and two other CMMI-funded initiatives, Transforming Clinical Practice Initiative (TCPI) and Comprehensive Primary Care Plus (CPC+).
 7. <http://www.ncqa.org/programs/recognition/practices/patient-centered-medical-home-pcmh>
 8. Two New York-based organizations are participating in the CMMI-sponsored Transforming Clinical Practice Initiative. The New York State Practice Transformation Network (NYSPTN), sponsored by the New York e-Health Collaborative, has provided practice transformation to 1,005 primary care providers; the New York Regional Practice Transformation Network, sponsored by New York University School of Medicine, has provided practice transformation to another 529 primary care providers.
 9. <https://reportcards.ncqa.org/#/clinicians/list?state=New%20York&recognition=Patient-Centered%20Medical%20Home&recognition=New%20York%20State%20Patient-Centered%20Medical%20Home>
 10. In May 2018, OHIP reduced the incentive payment available to providers recognized under NCQA's PCMH program to \$5.75 PMPM; as of July 2018, that payment has been increased to \$6.00 PMPM. https://www.health.ny.gov/health_care/medicaid/program/update/2018/2018-04.htm#pcmh
 11. New York State has organized five Regional Oversight and Management Councils, across the state: New York City Metropolitan Area; Capital Region/Hudson Valley; the Eastern Adirondacks; Finger Lakes / Central New York; and Western New York (in progress).
 12. <https://reportcards.ncqa.org/#/clinicians/list?state=New%20York&recognition=Patient-Centered%20Medical%20Home>
 13. Powers BW and Chaguturu SK. January 2016. ACOs and High-Cost Patients. *New England Journal of Medicine* 374(3): 203-5.
 14. The Patient-Centered Primary Care Collaborative (PCPCC) recently released a report focusing on the value of PCMHs in ACOs. <https://www.pcpcc.org/resource/impact-primary-care-practice-transformation-cost-quality-and-utilization>