

Recent Trends and Future Directions for the Medical Home Model in New York



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Executive Summary

There is growing evidence that a higher-performing primary care system—one built on the medical home model—will be critical to achieving the central aims of health reform: better care, lower costs, and improved population health. A substantial departure from the way traditional primary care practices function, the medical home has shown great promise for improving access to and the quality of care, with particular value in managing the care of the complex, chronically ill patients who generate a disproportionate share of the health system's costs.

Since 2011, the United Hospital Fund has tracked the spread of the medical home model in New York State, using a particular formulation of it: the Patient-Centered Medical Home (PCMH) as defined by the National Commission on Quality Assurance (NCQA). New York State is now pursuing the design and implementation of a “next-generation” medical home model, Advanced Primary Care, which will challenge primary care practices to move beyond improving their structures and processes of care, as specified by the NCQA criteria, to show that they are truly improving outcomes, in terms of better health and reduced costs.

This report is the UHF's fourth “census” of PCMH providers in New York State. Over the past four years we have noted New York's continued national leadership in adoption of PCMHs, and seen the number of medical homes grow from a few demonstration projects in isolated regions to broad acceptance as a foundational element in the State's strategy for health care reform. Our analysis of growth from 2013 to 2014 identifies a number of trends in the spread of PCMHs:

- PCMH adoption continues to grow across New York. Essentially all regions showed increases in the number of providers working in practices that have been recognized by NCQA as PCMHs. Much of that growth occurred upstate; for the third year in a row, there was more growth in PCMH providers outside New York City than in it. Much of the statewide growth was a result of the Hospital Medical Home program, a State initiative that supported adoption of the PCMH model in hospital teaching clinics.
- Adoption of the PCMH model continues to be centered in larger practices (e.g., group practices, hospital clinics, and federally qualified health centers) that have the scale required to implement and sustain the added capacities and costs that the model demands. Adoption of the PCMH model in small practices remains low.
- There is some evidence of a correlation between payers who provide incentive payments for PCMHs and higher numbers of PCMH providers. For example, clinics that care for substantial numbers of Medicaid enrollees represent over half of the state's PCMH providers and over 70 percent of those in New York City. Providers in regions where major payers are participating in multipayer medical home demonstrations are also more likely to work in a PCMH.

Looking ahead, New York's experience to date with promoting adoption of the PCMH model should provide both a strong foundation of increasingly high-performing primary care practices on which to build Advanced Primary Care, and some important lessons.

Acknowledgments

This analysis 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.

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Introduction

There is growing evidence^{1,2} that a higher-performing primary care system—one built on the medical home model—will help achieve the goals of health reform articulated as the “triple aims”: better care, lower costs, and improved population health.

A medical home is quite different from a traditional primary care practice. As medical homes, practices actively manage care by expanding access, interacting more with patients before and after visits, using dedicated care managers, and demonstrating a particular focus on high-risk, chronically ill patients, who are the health system’s most complex and costly. Supporting these efforts are evidence-based best practices, closer work with registries, and new processes for measuring and reporting outcomes.

Over the past four years, the United Hospital Fund has followed the growth of the medical home model in New York State, monitoring a particular formulation of the medical home: the patient-centered medical home (PCMH) as defined by the National Commission on Quality Assurance (NCQA). The growth in PCMHs has been substantial: between July 2011 and October 2014, the number of New York State providers working in PCMHs increased by over 70 percent, from 3,400 to over 5,800.

NCQA’s PCMH program is not the only medical home recognition process; other such programs are sponsored by the Joint Commission³ and URAC,⁴ and certainly some practices operate

like a medical home but have not sought formal recognition. However, it has been the most widely used method for defining and certifying practices as medical homes, and New York State has used the definition in its own efforts to encourage use of the medical home model. NCQA operates a national program granting practices PCMH recognition on the basis of their ability to document that their structures and processes of care meet or exceed specific standards. These criteria cover team-based care, expanded access, care coordination, the use of registries and care managers to help manage the care of patients with multiple chronic conditions, and systems incorporating evidence-based approaches.

During the years that UHF has been tracking the growing numbers of PCMHs in New York, NCQA’s standards for recognition as a PCMH have evolved: NCQA’s original standards (issued in 2008) were revised in 2011 to include new standards focusing on patient experience, relationships with subspecialists, use of electronic medical records, and measurement of cost and quality. NCQA’s 2014 standards include an increased emphasis on team-based care; care management focused on high-need patients; more focused, sustained Quality Improvement (QI) on patient experience, cost, clinical quality; alignment with CMS’s Electronic Health Records Incentive Programs (specifically, Stage 2 “meaningful use” criteria);⁵ and further integration of behavioral health.

¹ Patient-Centered Primary Care Collaborative. January 2015. *The Patient-Centered Medical Home’s Impact on Cost & Quality: An Annual Update of the Evidence, 2013-2014*. <https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality>

² Friedberg M, M Rosenthal, R Werner, KG Volpp, EC Schneider. June 1, 2015. Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care. *JAMA Internal Medicine*. <http://archinte.jamanetwork.com/article.aspx?articleid=2296117>

³ The Joint Commission, “The Primary Care Medical Home” (web page). www.jointcommission.org/accreditation/pchi.aspx

⁴ URAC, “Provider Care Integration and Coordination: The Patient Centered Medical Home” (web page). www.urac.org/accreditation-and-measurement/accreditation-programs/all-programs/patient-centered-medical-home/

⁵ CMS, EHR Incentive Programs, Stage 2 Criteria. http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html

Even as the PCMH model has been adopted more widely, and as evidence for its effectiveness accumulates, providers, payers, and regulators have expressed concern about variable performance of NCQA-recognized PCMHs on measures of clinical quality, utilization, and costs of care. There are concerns that NCQA recognition might be inadequate as a measure of true practice transformation, or as a predictor of improved outcomes in terms of improved health or reduced costs. As noted at the first meeting of the State's Integrated Care Work Group, "A practice meeting any 'standards' (NCQA or otherwise) is helpful, but not a sufficient guarantee of meaningful practice improvement."⁶ There is increasing support for a model that focuses on outcomes, a practice's performance on measures of quality and cost, which can help position the State's primary care practices to participate in various forms of value-based payment.

The New York State Department of Health (DOH), long a proponent of the NCQA's PCMH model, recognized and responded to this concern. In its State Health Innovation Plan (SHIP) the DOH proposed adopting a more robust model, Advanced Primary Care (APC)—which "will go beyond [PCMH's] new structures and capabilities to specify and measure processes and outcomes associated with more integrated care, including prevention, effective management of chronic disease, integration with behavioral health, and coordination among the

full range of providers working together to meet consumer needs."⁷

The APC model is a central element in New York's innovation efforts. One of the SHIP's stated goals was that within five years, 80 percent of the state's population would receive primary care in an APC setting. APC also has the potential to figure prominently in other New York State strategies for health care reform, including the State's recent Medicaid waiver, the Delivery System Reform Incentive Payment Program (DSRIP),⁸ and the state's recent proposal to CMS to move toward value-based payment in the Medicaid program.⁹

The new APC model is also the central focus of the State Innovation Models (SIM) grant New York was recently awarded by the Centers for Medicare & Medicaid. Noting in its SIM application that "the APC model is consistent with principles of NCQA Patient Centered Medical Home (PCMH) criteria, but seeks to move beyond structural criteria to achieve durable, meaningful changes in processes and outcomes," New York proposed to allocate \$67 million of the \$100 million grant to support a statewide program of APC practice transformation, providing regionally organized technical assistance to help primary care providers implement the APC model.¹⁰

Over the past six months, the State has begun implementing the SHIP, establishing a number

⁶ New York State Department of Health. Presentation at first meeting of the Integrated Care Work Group, January 16, 2015. Slide 20. www.health.ny.gov/technology/innovation_plan_initiative/docs/2015-01-16_integrated_care_presentation.pdf

⁷ New York State Department of Health. December 2013. New York State Health Innovation Plan. Pages 13–14. www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf

⁸ New York State Department of Health. DSRIP Project Toolkit. www.health.ny.gov/health_care/medicaid/redesign/docs/dsrrip_project_toolkit.pdf

⁹ New York State Department of Health, Medicaid Redesign Team. April 2015. *A Path toward Value-Based Payment: New York State Roadmap for Medicaid Payment Reform*. Page 7. www.health.ny.gov/health_care/medicaid/redesign/dsrrip/docs/revise_draft_vbp_roadmap.pdf

¹⁰ CMS CMMI. July 21, 2014. Model Test Application: New York State. Pages 4–6. http://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_sim_project_narrative.pdf

of multi-stakeholder workgroups, including the Integrated Care Workgroup. This body is responsible for advising the State in defining the proposed APC model, developing a method for allocating the funds available under the SIM for practice transformation to help primary care practices across the state adopt and implement the APC model, and working with payers to develop payment methods that recognize and support primary care provided by a practice that has achieved APC status.

As of this writing, the detailed definition of the APC model proposed in the SHIP remains a work in progress. It appears likely that the model that emerges will combine elements of NCQA's 2014 PCMH Standards with a set of clearly defined measures of clinical quality and performance. This will then become the model that is disseminated via New York's SIM-funded consulting and technical assistance. If APC is to become a sustainable model, it must also be a model that the payers are willing to support.

Methods and Definitions

NCQA Recognition: In this report, we track the adoption and use of the medical home model by primary care practices across New York State based on NCQA recognition as a PCMH. As noted above, NCQA's standards for recognition as a PCMH have been evolving: NCQA's 2008 standards were replaced by a more rigorous set of standards in 2011, and those have been further refined in its 2014 to include requirements for ongoing quality improvement and reporting.¹¹

Though APC is expected to become the main yardstick for measuring the spread of medical

homes, for now NCQA data remain the most consistent and comprehensive means of measuring statewide progress. They are also comparable across prior years, enabling analysis of changes over time.

Even as the working definitions and standards of medical homes are changing, it remains important and useful to track the growth of the NCQA's PCMH model in New York State. Whatever the eventual definition of APC, PCMH recognition by NCQA is a good marker for primary care practice transformation and performance improvement. Providers that have set up the structures, processes, and competencies required for NCQA recognition as a PCMH will be positioned well to succeed under a measures-based payment system such as APC.

In this quantitative report, we analyze the spread of the PCMH model in New York several ways: looking at PCMH adoption statewide, by region, by specific NCQA program and recognition level, and by practice type. In the appendix at the end of this report, we also present more detailed region- and borough-specific profiles of the changes in the number of PCMH providers between 2013 and 2014, by provider type.

PCMH Providers: Rather than tracking the number of practices recognized as PCMHs (which vary greatly in size, obscuring the relative availability of PCMH services), we have used the number of providers reported by NCQA as working in practices so recognized, a better measure of the impact and reach of the medical home model.

¹¹ Under NCQA's PCMH recognition process, a practice can receive recognition as a PCMH at one of three levels (Level 1, 2, or 3, with Level 3 being the highest), depending on their total points and performance on the "must-pass" elements. The vast majority (85 percent) of the state's PCMH providers have received recognition under NCQA's 2011 Standards, and most of those (90 percent) have been recognized at Level 3. For the purposes of this report, we are treating NCQA recognition as a single measure, not differentiating providers in terms of the year of the NCQA Standards under which they received recognition (2008 vs. 2011), nor according their level of recognition.

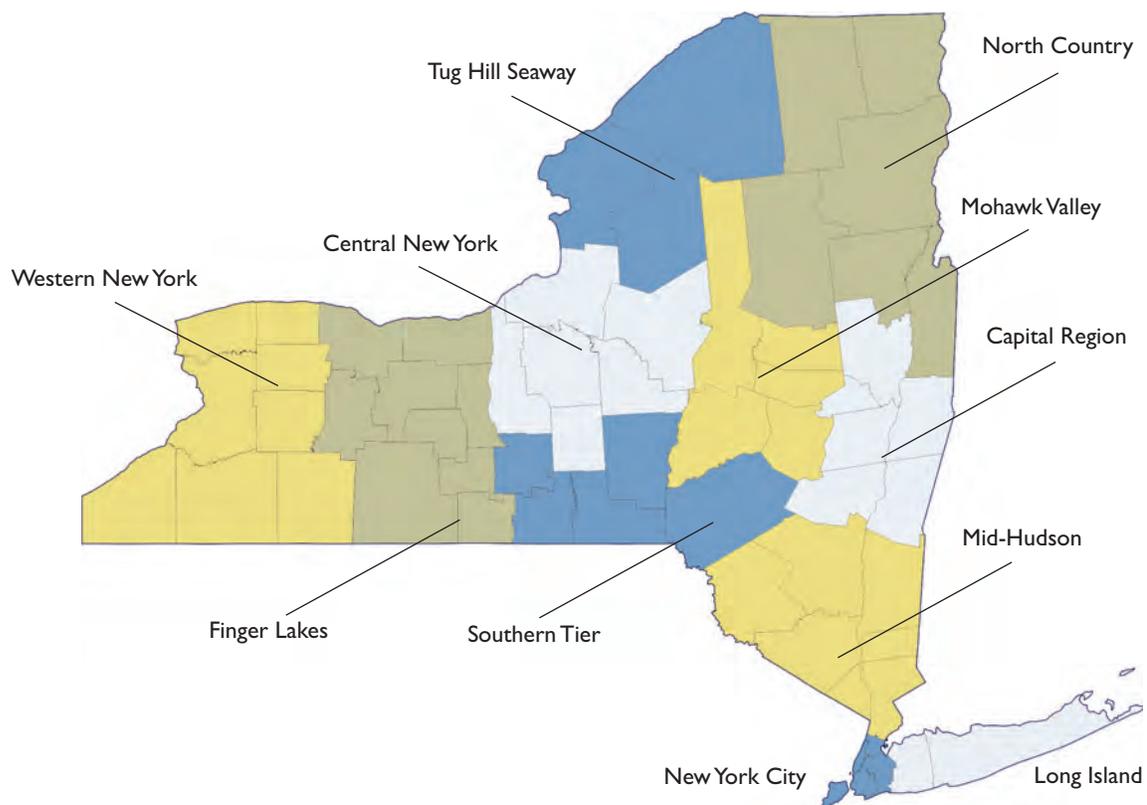
Geography: To provide a sense of the geographic spread and variation in adoption of the PCMH model, we grouped practices and providers by the 11 regions used by the New York’s Population Health Improvement Program (PHIP) initiative, shown in Figure 1. Within New York City, we analyzed data and trends by borough.

Practice Type: As in prior reports, we used a provider-level database from NCQA to identify all providers in New York State working in NCQA-recognized PCMHs (in this case, so recognized as of October 2014), and 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 the following methodology to categorize the practices within which the providers worked:

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 Corporation (HHC).
2. *HHC:* Hospital clinics, extension clinics, and community-based Diagnostic and Treatment Centers (DTCs) operated by HHC; here broken out as a separate category because of the scale of their participation in the NCQA PCMH program.

Figure 1. Regions Used in New York State’s Population Health Improvement Program



3. *Hospital Practice*: Private practices owned by a hospital or medical school (not licensed under Article 28, but operating as a “faculty practice”).
4. *Health Center*: Clinics licensed under Article 28 as a 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, but that are not listed as 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.

Current Status of PCMH Adoption in New York State

New York has been a national leader in the adoption of the medical home model. NCQA data show that New York continues to have by far the largest number of practices and practitioners working in NCQA-recognized PCMHs—over 14 percent of all PCMH practices and practitioners in the country (Table 1).

Geography

As of October 2014, there were 5,832 New York State primary care providers working in practices

recognized by NCQA as PCMHs (Figure 2). These providers were roughly evenly split between New York City and the rest of the state (45 and 55 percent of the state total, respectively).

Practice Type

The PCMH model is not evenly distributed across different types of practices. As is shown in Figure 3, NCQA recognition in New York tends to be concentrated in practices with “scale”—group practices, health centers, and

Table 1. PCMH Practices and Providers in New York and Other States, January 2015

	Total in State	% of U.S. Total
New York	7,608	14%
California	3,483	7%
Pennsylvania	3,300	6%
North Carolina	2,765	5%
Texas	2,470	5%
Florida	2,391	5%
Massachusetts	2,090	4%
Other States	28,802	54%
U.S. Total	52,909	100%

Source: NCQA Physician Directory (<http://recognition.ncqa.org/index.aspx>), accessed January 13, 2015.

Note: The NCQA data presented in this table combines the number of practices recognized as PCMHs with the number of providers working in those practices. All other tables and charts report unduplicated numbers of providers working in PCMH practices.

institution-based providers. PCMH adoption by smaller practices which lack the scale to put in place the required infrastructure, is far lower.

There are substantial differences by region (and by borough, in New York City) in the number of PCMH providers working in practices that have achieved PCMH designation, and the provider type of those practices (Figures 4 and 5). This

variation may reflect underlying regional differences in composition of their primary care providers. For instance, in some areas (e.g., Western New York, Mid-Hudson, and the Capital Region), physician group practices are more prevalent, while in others (e.g., Manhattan and Rochester) more of the hospital-affiliated primary care physicians are organized as faculty practice plans.

Figure 2. PCMH Providers in New York State, by Region, October 2014

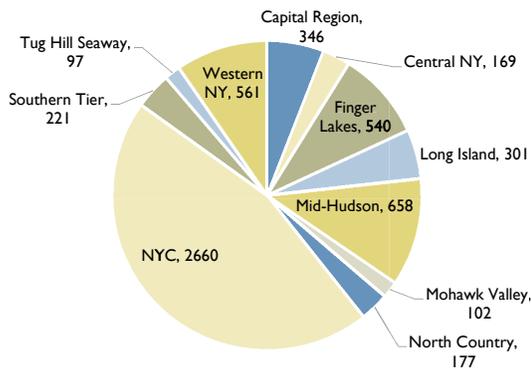


Figure 3. PCMH Providers in New York State, by Practice Type, October 2014

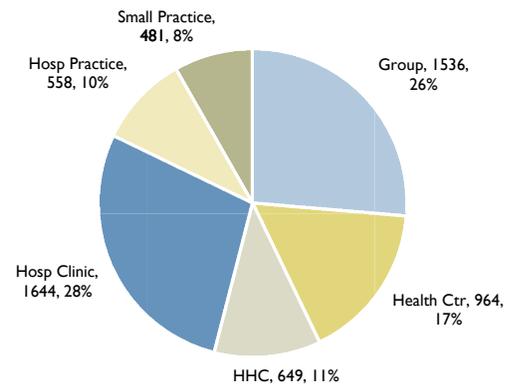


Figure 4. PCMH Providers Outside New York City, by Region and Practice Type, October 2014

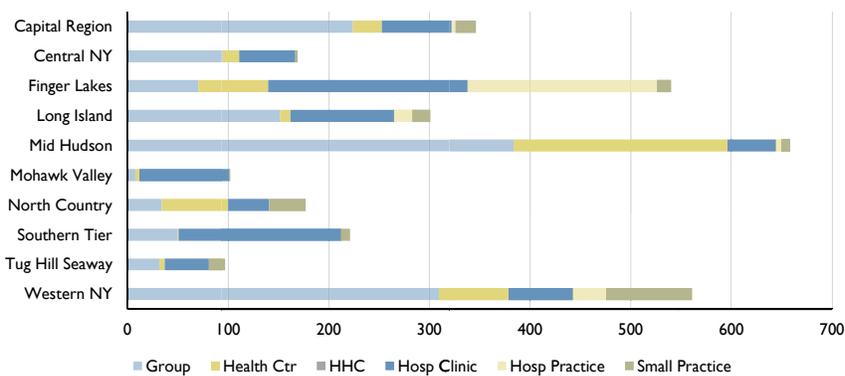
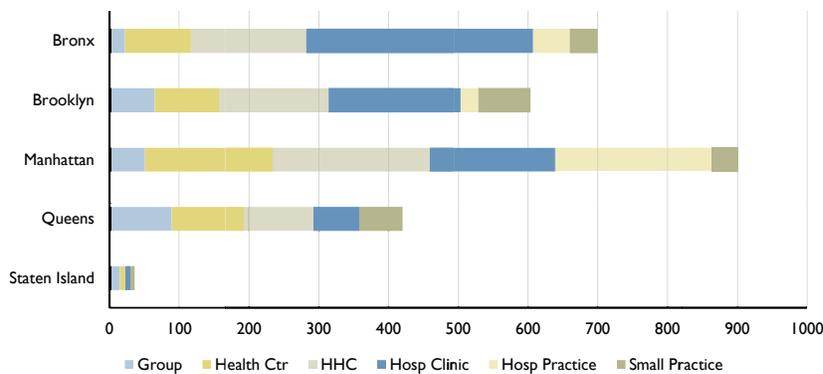


Figure 5. PCMH Providers in New York City, by Borough and Practice Type, October 2014



Growth

After growing by 37 percent between 2011 and 2012, the number of providers working in PCMHs in New York grew by only 5 percent between 2012 and 2013. Between 2013 and 2014, however, the state experienced another period of substantial growth, with a year-over-year increase of nearly 20 percent (Figure 6).

As is shown in Table 2, the rate of growth in PCMH providers between 2013 and 2014 varied

substantially between New York City and the rest of the state.

To better understand the characteristics and drivers of that growth, we compared the number of PCMH providers reported as of July 2013 to the corresponding counts as of October 2014. As is shown in Figures 7 and 8, different regions across the state increased the number of PCMH providers at different rates, between 2013 and 2014.

Figure 6. Growth in PCMH Providers in New York State, 2011–2014

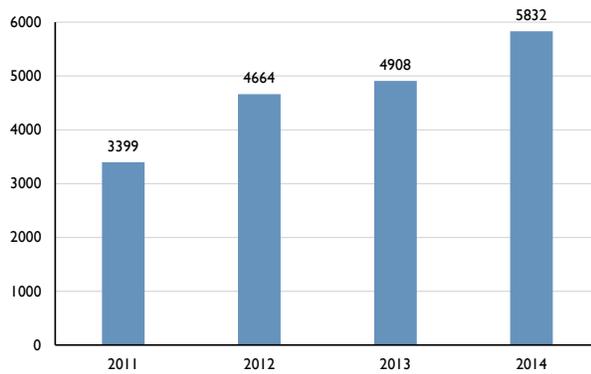


Table 2. PCMH Providers and Growth, New York City vs. Rest of State, 2013–2014

	2013		2014		Year-Over-Year Change
	PCMH Providers	% of NYS Total	PCMH Providers	% of NYS Total	
NYC	2,533	51.6%	2,660	45.6%	5.0%
Rest of State	2,375	48.4%	3,172	54.4%	33.6%
New York State Total	4,908		5,832		18.8%

Figure 7. Changes in PCMH Providers Outside New York City, by Region, 2013–2014

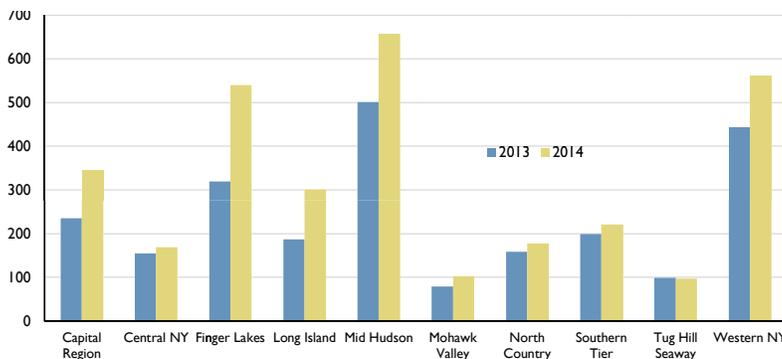
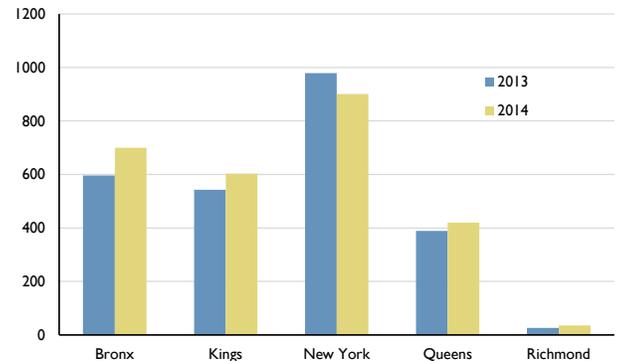


Figure 8. Changes in PCMH Providers in New York City, by Borough, 2013–2014



Changes by Provider Type

One of the major factors that appears to have contributed to the growth in PCMH providers between 2013 and 2014 was the implementation of the Hospital Medical Home program,¹² a two-year, \$250-million quality demonstration program funded under a CMS 1115 waiver.

This program focused on increasing the number of hospital teaching clinics (a major source of primary care for Medicaid enrollees, and training sites for hundreds of medical residents statewide) that are recognized as PCMHs under NCQA's 2011 Standards. It supported practice transformation efforts at 62 of the state's teaching hospitals (32 in New York City, and 30 elsewhere in the state), which enabled their primary care teaching clinics to be recognized as PCMHs. As is shown in Figure 9, statewide

growth in the number of PCMH providers between 2013 and 2014 was largely driven by increases in hospital teaching clinics and hospital-owned practices. Over 70 percent of the year-to-year growth was due to an increase in the number of such providers.

Growth in PCMH providers in settings other than hospital clinics was modest: Statewide, the number PCMH providers in all other practice types grew by only 7 percent between 2013 and 2014, from 3,326 to 3,547. However, as is shown in Figures 10 and 11, this measurement differed between New York City and the rest of the state. Outside New York City, the number of non-clinic PCMH providers increased by 19 percent; in New York City, the number of non-clinic PCMH providers actually decreased by 10 percent over the same period.

¹² www.health.ny.gov/health_care/medicaid/redesign/hospital_medical_home_demonstration_project.htm

Figure 9. Changes in PCMH Providers in New York State, by Practice Type, 2013–2014

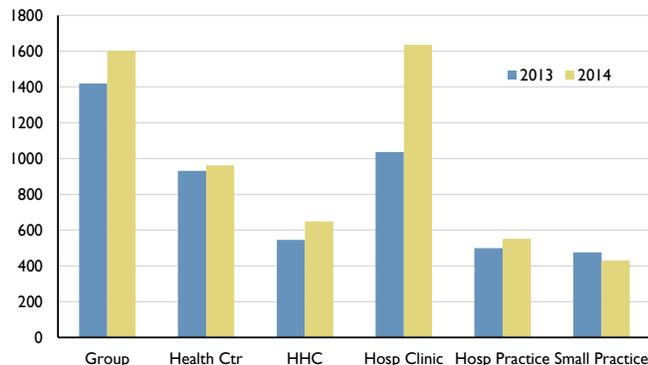


Figure 10. Changes in PCMH Providers Outside New York City, by Practice Type, 2013–2014

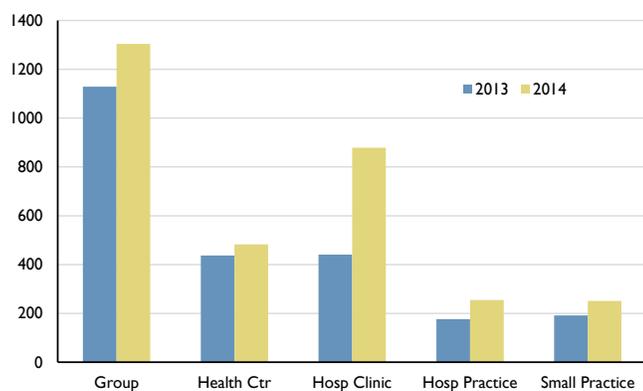
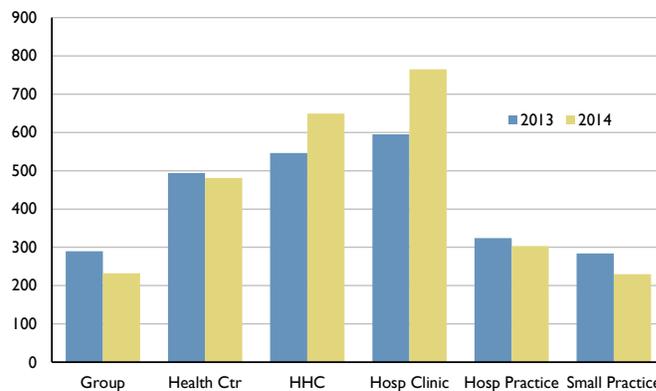


Figure 11. Changes in PCMH Providers in New York City, by Practice Type, 2013–2014



Another trend identified in our 2013 report on PCMHs continued: slow growth (and in recent years, even erosion) in the number of PCMH providers in small practices. Between 2013 and 2014, the number of providers at small practices decreased by 10 percent, from 476 to 430. Many small practices face big challenges in achieving NCQA recognition, and in the absence of broad payer support for medical homes many find it difficult to meet the PCMH's added costs and choose not to reapply to the NCQA when their current recognition lapses.

Regional Variation in Growth of PCMHs by Practice Type

As noted above, the different regions of the state (and, within New York City, the boroughs) exhibit substantial differences in their number and proportion of PCMH providers by practice type. Between 2013 and 2014, the regions also showed quite different patterns of distribution

and growth in PCMH providers, by provider type. Charts depicting those region and borough-specific trends are included at the end of this report.

Staffing the Medical Home: The Role of Mid-Level Practitioners

NCQA data includes both physicians and mid-level providers (nurse practitioners and physician assistants). Using licensure as reported in the NCQA database, we analyzed the role played by mid-level providers in PCMHs statewide and by region. As shown in Figure 12, 16 percent of PCMH providers in the state were mid-level practitioners, while roughly 84 percent were physicians (MDs and DOs).

As is shown in Figures 13 and 14, the number and proportion of PCMH providers who are NPs and PAs varies substantially by region and borough.

Figure 12. Physicians and Mid-Level Practitioners Working in New York PCMHs

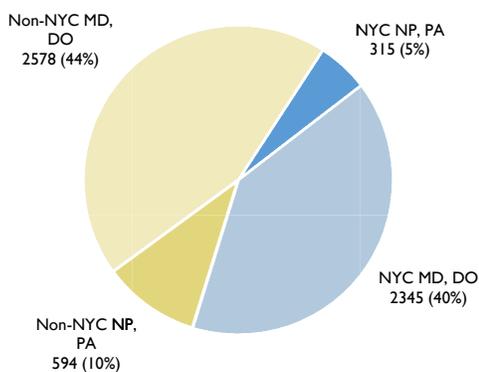


Figure 13. Mid-Level Practitioners Outside New York City, by Region, 2013–2014

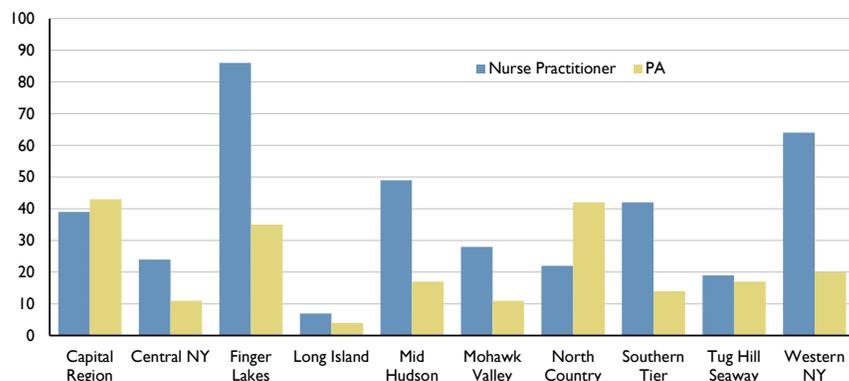
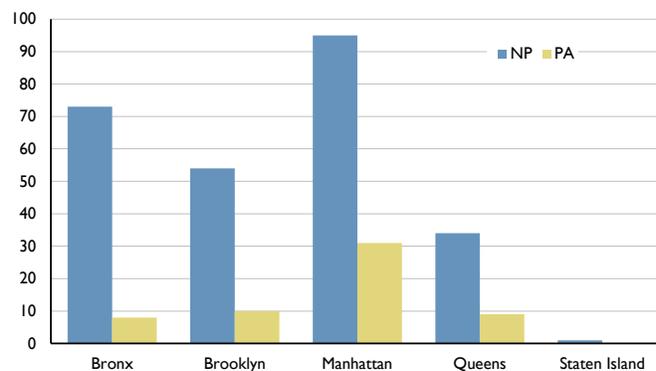


Figure 14. Mid-Level Practitioners in New York City, by Borough, 2013–2014



PCMH Penetration Rate

In order to assess the penetration of the PCMH model across regions in the state, we used the number of physicians (MD and DO) working in a region's PCMHs as the numerator, and an estimate of the total number of primary care physicians in that region as of 2010 as the denominator.¹³ Overall, the 4,923 physicians working in PCMHs represents roughly 25 percent of all primary care physicians; but, as is shown in Figures 15 and 16, that proportion varies widely by region, ranging from 44 percent in the North Country to 10 percent in Long Island.

A similar variation occurs across the boroughs of New York City. While the city's overall PCMH penetration rate (24 percent) is the same as the state's overall rate, the borough-specific PCMH penetration rate ranges from 44 percent in the Bronx to 8 percent in Staten Island.

Drivers of PCMH Adoption: Organizational Capacity and Financial Incentives

Two factors appear to correlate with PCMH adoption by practices of different types.

The first is practice size and available infrastructure, the capacity of a practice to mount and sustain a medical home model. A PCMH focuses on organizing care teams, on meaningful use of electronic medical records, on using registries to identify complex patients who are at risk for poor outcomes and potentially avoidable high-cost care, and using dedicated staff to help manage their care. These are capacities that require organizational scale and expertise, easier to achieve in organized systems and larger practices than in smaller, independent practices. The smaller uptake of the PCMH model among the state's small practices appears to attest to that difficulty.

¹³ For the total number of physicians in a region we used the most recent data available from the New York State Center for Health Workforce Studies. chws.albany.edu_archive/uploads_2012_07_nyphysprofile2010

Figure 15. PCMH Penetration Outside New York City, by Region, 2013–2014

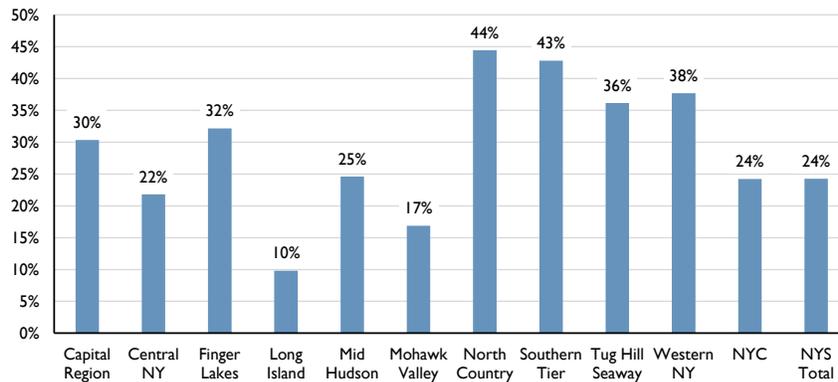
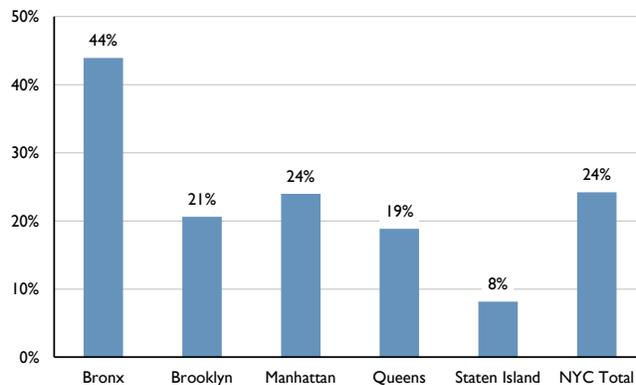


Figure 16. PCMH Penetration in New York City, by Borough, 2013–2014



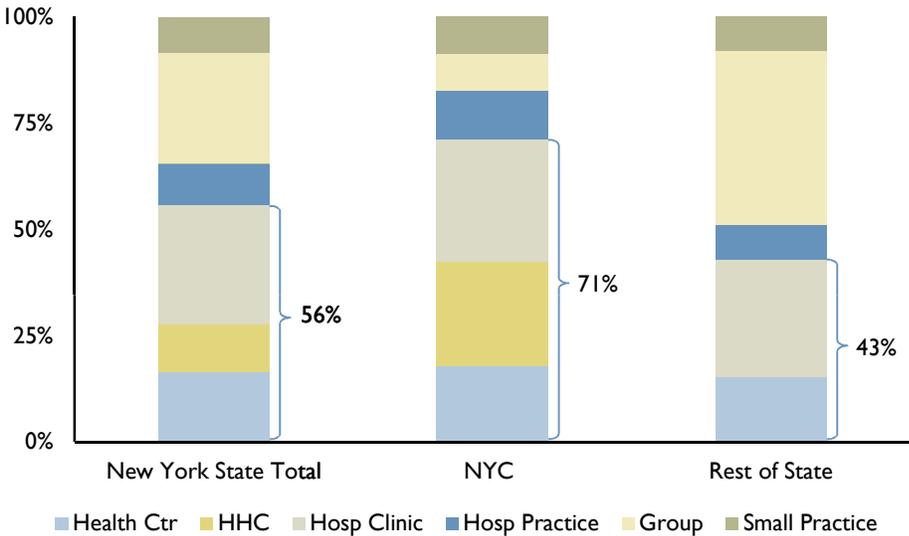
The second major factor likely affecting the composition of the state’s PCMH adopters is the extent to which financial incentives are available to providers who achieve NCQA recognition. Such incentives fall into two broad (and, to a degree, overlapping) categories: whether specific payers are making additional or increased payments to providers who have adopted the PCMH model or whether they are participating in a medical home demonstration project.

The single largest driver of PCMH adoption in New York State has been the existence of specific payments (e.g., care management payments) to primary care providers that have achieved NCQA recognition as a PCMH. Medicaid is by far the largest payer routinely providing enhanced payments based on PCMH status; providers primarily serving Medicaid enrollees are extraordinarily well-represented within the state’s overall roster of PCMH providers. As is shown in Figure 17, over half of all PCMH providers statewide (and over 70 percent in New York City) practice in hospital clinics, including HHC, and in health centers.

Another characteristic that appears to be associated with PCMH uptake is participation in a regional medical home demonstration project. The Adirondacks and the Hudson Valley (which spans the Mid-Hudson and Capital regions) are each home to a multipayer medical home demonstration; and the Finger Lakes is the site of a multiyear grant from the CMS Innovation Center (CMMI) working to increase the penetration of the medical home model, partly by direct financial support to the participating practices.

For practices that are neither large Medicaid providers, nor participating in regional medical home demonstrations or shared savings arrangements, there are fewer financial incentives to adopt and maintain a more costly medical home model. These factors may partly explain why the PCMH model has been adopted less in other parts of the state and by primary care providers that do not serve a substantial Medicaid population.

Figure 17. Percentage of New York PCMH Providers in Hospital Clinics and Health Centers



Looking Ahead

The current level of adoption of the PCMH model in New York is, by national standards, remarkable, and the number of PCMH providers in the state continues to grow. The distribution of PCMH providers varies substantially across the state, and among the different practice types. Not surprisingly, the trends on uptake of the model appear to be related to two simple factors: whether given practices have the scale and infrastructure to support a medical home, and whether enough of the payers in a given region provide them with financial incentives for adopting this more effective but more costly model.

To date, the main adopters of the PCMH model have been larger practices and those associated with hospitals and health centers—organizations with scale. Finding a way to adapt this model to the state’s small practices will be critical to achieving the hoped-for spread. Similarly, the main adopters of the PCMH model so far have been those whose major payers support the medical home model through augmented payments, either providers largely reliant on Medicaid or those participating in ongoing regional medical home demonstrations. Overall, certain practices—those with scale, and those

with substantial payer support for the model—appear to have been more willing to undergo the cost and disruption of practice transformation, and to maintain the medical home model over time.

New York State is in the process of designing a new medical home model—Advanced Primary Care—that builds on the PCMH model, but relies less on external certification of the structures and processes of care, and more on the ability of a practice to achieve, maintain, and be able to demonstrate improved outcomes—high levels of performance on measures of quality associated with better health outcomes and lower utilization and cost.

It remains to be seen precisely how the new APC model will relate to the NCQA’s evolving PCMH model; how the model will apply to the small practices that remain major providers of care to populations across New York State; and whether a new, more outcomes-based APC model will be broadly accepted and supported by payers beyond Medicaid. Those are among the challenges facing the State in its efforts to spread this new model, statewide.

Appendix: Changes in PCMH Providers by Practice Type, by Region and Borough, 2013–2014

Figure 18. Capital Region

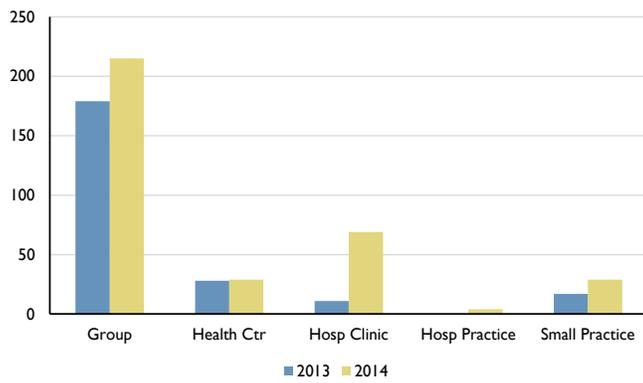


Figure 19. Central New York

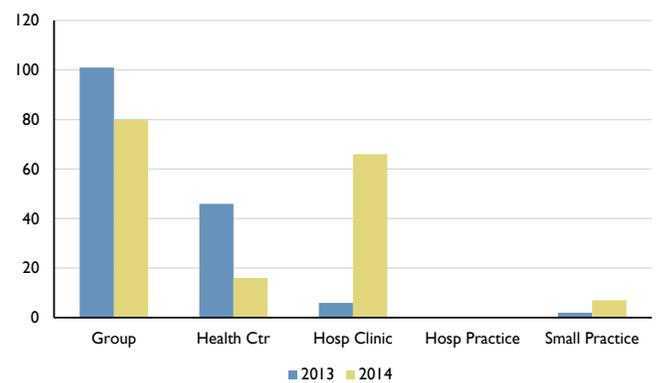


Figure 20. Finger Lakes

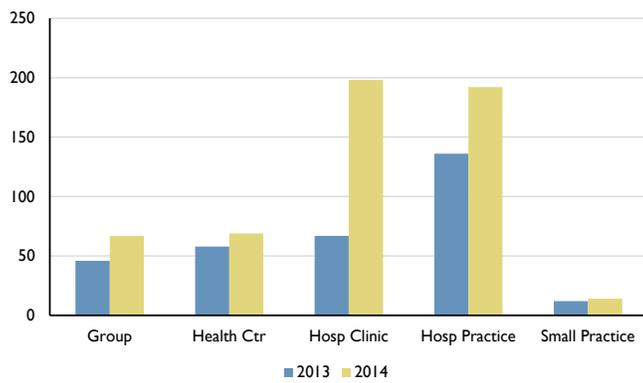
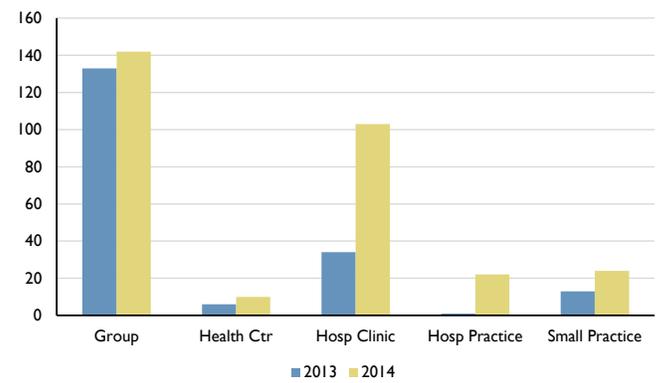


Figure 21. Long Island



Appendix: Changes in PCMH Providers by Practice Type, by Region and Borough, 2013–2014 (continued)

Figure 22. Mid-Hudson

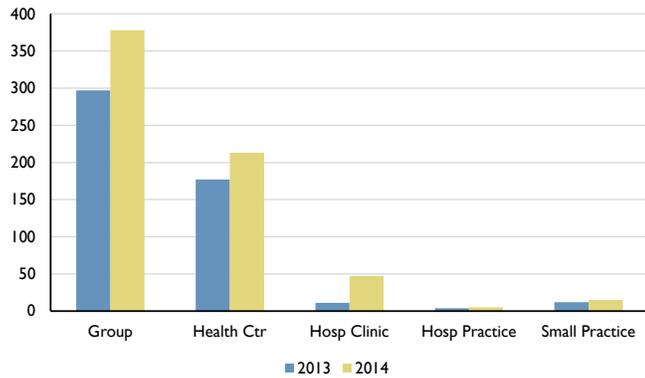


Figure 23. Mohawk Valley

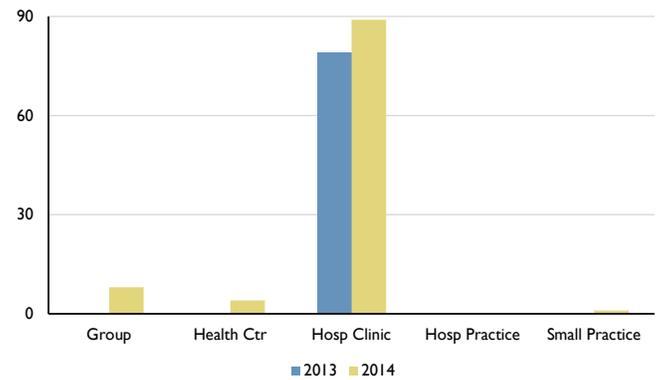


Figure 24. North Country

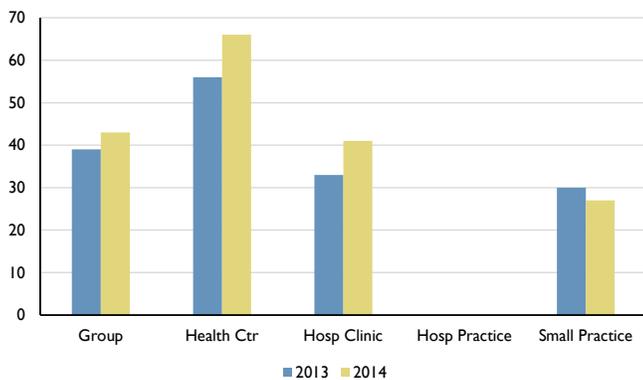


Figure 25. Southern Tier

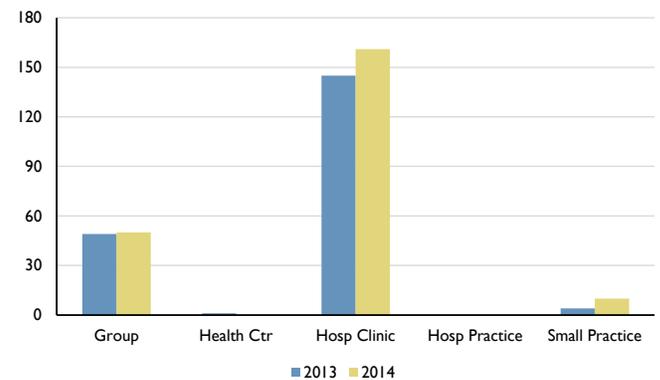


Figure 26. Tug Hill Seaway

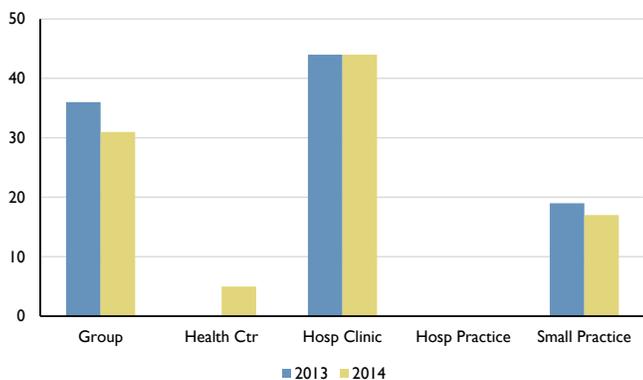
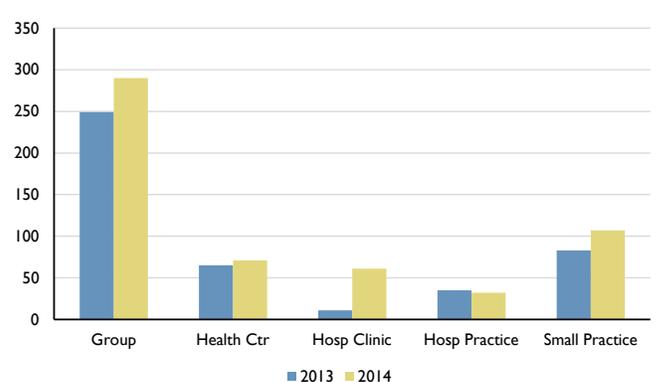


Figure 27. Western New York



Appendix: Changes in PCMH Providers by Practice Type, by Region and Borough, 2013–2014 *(continued)*

Figure 28. New York City (Total)

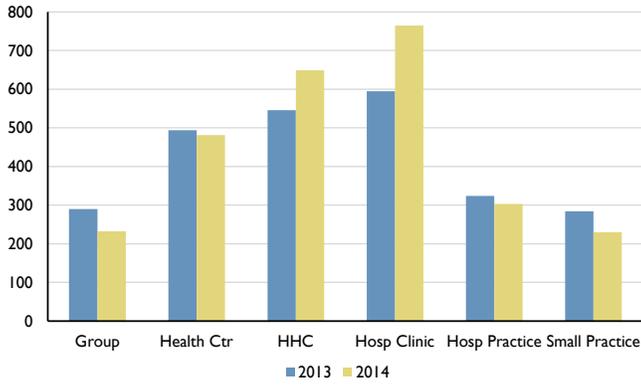


Figure 29. Bronx

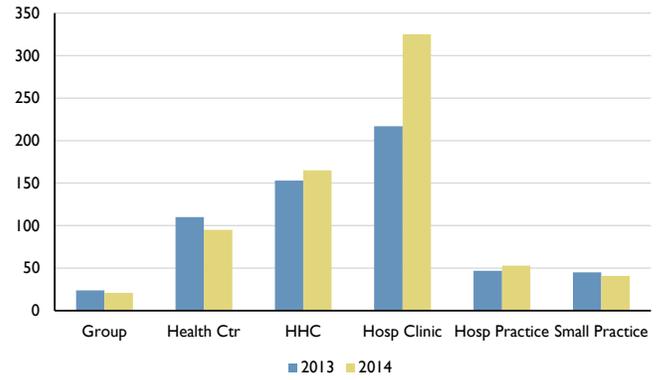


Figure 30. Brooklyn

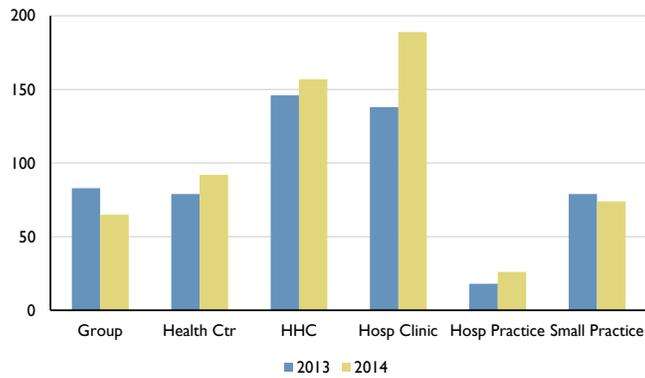


Figure 31. Manhattan

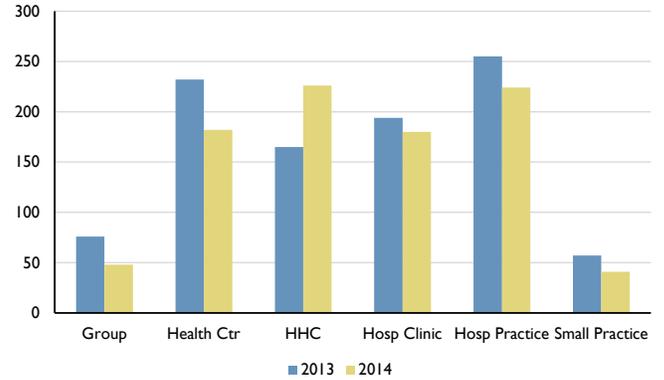


Figure 32. Queens

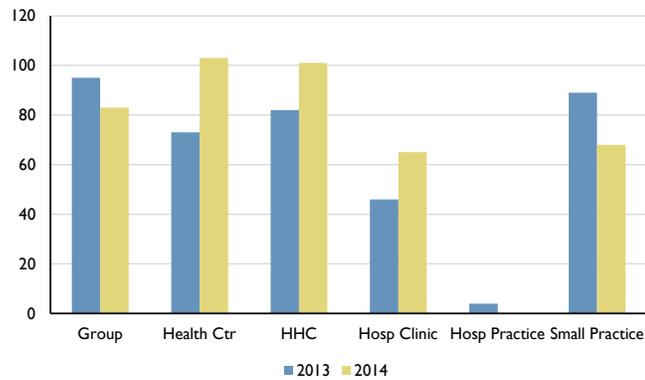
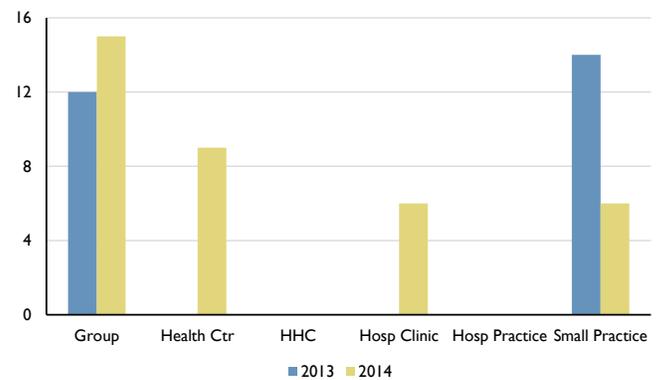


Figure 33. Staten Island





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