THE PATIENT-CENTERED MEDICAL HOME INITIATIVE IN NEW YORK STATE MEDICAID

Report to the Legislature

April 2013

NEW YORK state department of HEALTH

EXECUTIVE SUMMARY

The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), have jointly defined the medical home as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team, which also may include roles for nurse practitioners or physician assistants, is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with all of the qualified physicians.

The National Committee for Quality Assurance (NCQA) designed a recognition program to objectively measure the degree to which a primary care practice meets the operational principles of a Patient-Centered Medical Home (PCMH). NCQA's Physician Practice Connections® - Patient-Centered Medical Home Program (PPC-PCMH™) and PCMH 2011 programs assess whether practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC®-PCMH™ and PCMH 2011 standards emphasize the use of systematic, patient-centered, coordinated care management processes.

There are over five million enrollees and over 13,000 primary care physicians who participate in the New York State (NYS) Medicaid program. Given the large number of enrollees and participating physicians, Medicaid has the ability to make a significant contribution to an agenda that will expand primary care capacity and improve care for all New Yorkers. In an effort to increase the number of NYS medical practices that are recognized as PCMHs, Governor Cuomo signed three laws that allow for the development of incentive programs in New York's Medicaid program and, in one instance, a multi-payer approach. These initiatives are also expected to result in long-term savings by promoting primary care services that help patients stay healthy, reduce the complications associated with chronic diseases, and avoid potentially preventable admissions.

NYS Medicaid chose to use NCQA's PCMH recognition program as the basis for providing enhanced payments for PCMH providers. The Adirondack Medical Home Multi-payer Demonstration, which includes Medicaid, Medicare and seven other regional payers in the Adirondack region of northern NYS was implemented in January 2010. The Statewide Medicaid and Child Health Plus (CHPlus) PCMH incentive programs were implemented in July 2010 and October 2011 respectively.

Per member per month (PMPM) payments are based on the provider's level of recognition or participation in the Adirondack Medical Home Demonstration (ADK) as follows:

- *Statewide Level 1: $2 PMPM*
- *Statewide Level 2: $4 PMPM*
- *Statewide Level 3: $6 PMPM*
- *Adirondack Medical Home Demonstration: (ADK) $7 PMPM*

Since 2010, the number of PCMH providers in NYS has increased from 633 to 4,461. As of mid-2012, over 1.4 million Medicaid managed care (MMC) and CHPlus enrollees are assigned to PCMH providers. In 2011, about 75,000 Medicaid fee-for-service (FFS) members had a visit with a PCMH provider. For the first six months of 2012, this number increased to 84,000. As this number represents unique recipients and not visits, there is no expectation that the number for the full year will double or increase substantially. Since January 2010, NYS Medicaid has provided over $148 million in enhanced reimbursement to providers.

An evaluation of quality of care, as defined by nationally recognized measures of care, indicates that PCMH providers have outperformed non-PCMH providers in several domains of care, in particular, management of chronic disease which is essential to improving outcomes, quality of life and lowering costs. For example, the management of cholesterol for those treated in PCMHs is twelve percentage points higher than those who are not in PCMHs (59% vs. 47%). PCMHs also provided superior care to diabetics with a higher rate of preventive care and testing, as well as, better outcomes such as control of blood sugar and cholesterol. PCMH practices also provided better preventive care and counseling such as measurement of BMI and nutrition counseling. Children in PCMHs are less likely to have an inpatient hospitalization.

BACKGROUND

History of Patient-Centered Medical Home

The PCMH has its origins in the "Medical Home" concept first described and practiced by pediatricians applied to a care model for children with special needs.[1] That concept sought to establish a physician practice environment such that the patient's history was well known, routine preventive care was delivered, and care from specialty or inpatient providers was coordinated with primary care. The care would be comprehensive, including all dimensions of health, including developmental and psychosocial issues.

The model envisioned using a team approach led by a primary care physician the family and patient knows and trusts. For example, a child with asthma needs frequent follow-up for assessment of asthma control and lung function both provided by a primary care physician and possibly an allergist, coordinated by the primary care office. Patient and family education is also required to reduce triggers, respond to exacerbations, understand when and how to contact the pediatrician, and avoid the need for emergency room visits. Coordination with the school is even required, to be sure there is an Asthma Action Plan and onsite rescue medications. Chronic disease-specific coordination and management must also include comprehensive preventive and acute primary care to ensure routine screenings and immunizations take place. In today's healthcare system, both adults and children, with or without chronic disease, can suffer the consequences of fragmented and episodic healthcare, particularly for individuals with multiple complex chronic diseases. It is an ever more complicated healthcare system in which uncoordinated care can have dramatic effects on preventable diseases related to lifestyle or those that could be prevented with early detection/treatment. A PCMH is now widely believed to be a promising new strategy to address these, and other challenges related to access, patient and family engagement and care coordination.

Patient-Centered Medical Home

The American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), have jointly defined the medical home as a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team, which also may include roles for nurse practitioners or physician assistants, is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians.

A PCMH also emphasizes enhanced care through open scheduling, expanded hours, and communication between patients, providers and staff. Care is also facilitated by disease registries, information technology, health information exchange among providers and other means to ensure that patients obtain the proper care in a culturally and linguistically appropriate manner.

[1]American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf. Published March 2007. Accessed November 5, 2012.

The NCQA designed a recognition program to objectively measure the degree to which a primary care practice meets the operational principles of a PCMH. NCQA's PPC-PCMH™ and PCMH 2011 programs assess whether practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC®-PCMH™ and PCMH 2011 standards emphasize the use of systematic, patient-centered, coordinated care management processes.

PPC-PCMH™ and PCMH 2011 feature three tiers of medical home recognition. Achievement of a given tier is dependent upon a point-scoring system whereby points are awarded if the practice has achieved competency in a given business/practice management process.

1. *Level 1 is the basic tier and can be achieved without deploying electronic health records (EHR).*
2. *Level 2 requires some EHR.*
3. *Level 3 requires a fully functional EHR.*

The program includes ten standards that medical practices must meet, including use of patient self-management support, care coordination, evidence-based guidelines for chronic conditions and performance reporting and improvement. To be recognized as a patient-centered medical home, practices need to demonstrate the ability to meet the criteria of these standards (i.e. achieve a minimum of 25 points out of 100 to attain the first of three levels of recognition) and specifically pass at least five of the following ten elements:

1. *Written standards for patient access and patient communication;*
2. *Use of data to show standards for patient access and communication are met;*
3. *Use of paper or electronic charting tools to organize clinical information;*
4. *Use of data to identify important diagnoses and conditions in practice;*
5. *Adoption and implementation of evidence-based guidelines for three chronic conditions;*
6. *Active patient self-management support;*
7. *Systematic tracking of test results and identification of abnormal results;*
8. *Referral tracking, using a paper or electronic system;*
9. *Clinical and/or service performance measurement, by physician or across the practice; and,*
10. *Performance reporting, by physician or across the practice.*

NCQA's PPC-PCMH's™ medical home standards were first released in 2008 with the second and most recent updated (and strengthened) version published in 2011 ("PCMH 2011"). New York Medicaid initially chose to provide financial incentives to all levels of recognition to facilitate the expansion of medical homes in NYS as a model of care that seeks to strengthen the physician-patient relationship and improve health care services and outcomes. NCQA recognition is 'site or practice' specific – it recognizes practice sites, as well as the physicians (and nurse practitioners) practicing at those sites.

However, a physician's recognition is attached to a particular site of care – it does not 'automatically' travel to any other sites or practices, unless those sites are also recognized. Recognition is valid for up to three years, at which time it needs to be renewed through NCQA.

The 2011 PMCH standards consolidate the ten requirements into six and strengthen the requirements to enhance patient-centeredness, the use of clinical performance measures, and the coordination of care. The standards are also aligned with the Centers for Medicare and Medicaid Services (CMS) Meaningful Use requirements and processes to improve quality of care and increase the applicability of these standards of care to pediatric practices. The goals of the 2011 standards concentrate on better care management by targeting high risk, complex patients, language barriers, and encouraging integration of behavioral health care with primary care and relationships with specialists. The changes in the standards place a stronger emphasis on the importance of system cost savings, continuous quality improvement, team-based care, and understanding the patient experience.[2]

Additional information about NCQA's PCMH program is available at:
http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx

National Demonstrations

The CMS is sponsoring a number of projects to transform primary care. The goals are to increase care that is comprehensive, coordinated, evidence-based, and meets the Triple Aim of better healthcare for individuals and better health for populations, while also lowering costs. Examples of these projects include: 1) the Comprehensive Primary Care Initiative (CPCI), which is a multi-payer demonstration supporting 500 primary care practices across the country including in NYS to develop within practices the capacity to provide advanced primary care; 2) the Federally Qualified Health Center (FQHC) Advanced Primary Care Demonstration Program, which is supporting 500 FQHCs across the country to become patient-centered medical homes; 3) The Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) in which Medicare has joined 8 other payers, including Medicaid, in the Adirondack region of New York to support the transformation of the care across over 30 practices. Private health insurance plans have also widely promoted and supported the PCMH model of primary care. WellPoint has invested in 10 separate patient-centered medical home pilots in Colorado, New Hampshire, and New York covering 100,000 patients.[3] These pilot programs have demonstrated promise in improving quality and patient satisfaction while reducing costs.

PCMH programs run by member organizations of the national BlueCross BlueShield Association provide care to four million patients in 39 states, the District of Columbia and Puerto Rico, while Humana offers medical home services in 10 states for 70,000 Medicare Advantage members and 35,000 commercial members. Capital District Physicians Health Plan (CDPHP), Aetna, and United Healthcare have also begun and/or are expanding pilots that pay an enhanced fee for physicians that offer primary care in NCQA recognized PCMHs.[4]

[2] National Committee on Quality Assurance (NCQA). Comparison: PPC-PCMH 2008 with PCMH 2011. National Committee on Quality Assurance Website. http://www.ncqa.org/Portals/0/Programs/Recognition/PPC-CMH%202008%20vs%20PCMH%202011Crosswalk%20FINAL.pdf. Published 2011. Accessed January 28, 2013.
[3] Raskas RS, Latts LM, Hummel JR, Wenners D, Levine H, Nussbaum SR. Early Results Show Wellpoint's Patient-Centered Medical Home Pilots Have Met Some Goals for Costs, Utilization, And Quality. *Health Affairs.* 2012;31(9):2002-2009.
[4] Stagg V. Insurers Latest to Champion Medical Homes. *American Medical* News. October 8, 2012.

Incorporating the medical home model in undergraduate and graduate medical education programs is another strategy being used to promote PCMH. In Ohio, Wright State University is one of four medical schools working on a statewide PCMH project with 44 primary care practices. The National Center for Medical Home Implementation, an initiative by the American Academy of Pediatrics and the federal Health Resources and Service's Administration's Maternal and Child Health Bureau, are developing a model curriculum for residency programs on the medical home model. In NYS, the Department of Health (NYSDOH) has begun work on a $250 million Hospital Medical Home Demonstration Project, supported by the Medicaid 1115 Partnership Plan Waiver (approved in 2011) aimed at primary care residency programs that will improve care in 165 primary care sites, including supporting the transformation of those sites into high-level PCMHs using 2011 NCQA standards.

New York State Medicaid and Patient-Centered Medical Homes

Disabled and disadvantaged New Yorkers who rely on Medicaid have been particularly subject to the problems created by fragmented, episodic, and uncoordinated health care. They are historically less likely to access preventive health care and are more likely to end up in the emergency room for non-urgent or potentially preventable conditions, such as complications from poorly-managed diabetes or asthma. Supporting NYS primary care practices to become PCMHs has the potential to significantly improve the quality of healthcare for all New Yorkers and is also expected to result in long term savings by promoting primary care services that help patients stay healthy and out of institutional care settings.

In addition, because there are over five million Medicaid enrollees and over 13,000 primary care physicians who treat them, the program has the ability to make a significant contribution to an agenda that will improve care for all New Yorkers. In an effort to increase the number of NYS medical practices that are PCMHs, Governor Cuomo signed three laws that allow for the development of incentive programs in New York's Medicaid program and, in one instance, a multi-payer approach.

Statewide Patient-Centered Medical Home

Article 5, Title 11 of the New York State Social Services Law, Section 364-m gives the Commissioner of Health the authority to establish a Statewide PCMH program whereby providers who are recognized by the NCQA are eligible to receive additional payments for services provided to Medicaid FFS and managed care enrollees. The law was implemented in July 2010.

Adirondack Medical Home Demonstration

Article 29, Title 2, Section 2959 of NYS Public Health Law provides the Commissioner of Health with the authority to establish a multi-payer medical home demonstration in the Adirondack region of NYS. Under the supervision of the NYSDOH, on January 1, 2010, NYS Medicaid along with seven other payers agreed to provide financial support to the majority of providers in six counties in the Adirondacks (Hamilton, Franklin, Clinton, Essex, Warren and northern Saratoga) to become recognized by NCQA as PCMHs and transform their practices, including introducing EHR and health information exchange. Providers participating in the ADK Demonstration are excluded from the statewide initiative with respect to incentive payments.

Medicaid Redesign Team

In 2011, Governor Cuomo established the Medicaid Redesign Team (MRT) to lower the costs and improve the care provided to New Yorkers and Medicaid enrollees. The MRT consisted of many health care stakeholders and evaluated thousands of proposals from the public to improve care, increase access and reduce costs. Eventually, approximately 70 proposals were implemented, one of which was an expansion of PCMH to the State's Child Health Insurance Program (SCHIP) known in New York as Child Health Plus (CHPlus). Enhanced reimbursement to providers began in October 2011 (Article 29-AA, Section 2959-a).

Payment

As mentioned, the NYSDOH chose to adopt NCQA's recognition program as criteria for enhanced payments for services provided to enrollees in both managed care and FFS. Per member per month (PMPM) payments are based on the provider's level of recognition or participation in the ADK as follows:

- *Statewide Level 1: $2 PMPM*
- *Statewide Level 2: $4 PMPM*
- *Statewide Level 3: $6 PMPM*
- *Adirondack Medical Home Demonstration: (ADK) $7 PMPM*

Providers are reimbursed directly through the managed care plans for care provided to the plans' enrollees. For services provided to enrollees in Medicaid FFS, Medicaid provides an enhanced per visit payment for selected primary care Evaluation and Management (E&M) codes. These amounts provide, on average, an annual reimbursement to providers which is equivalent to the PMPM determined amounts with managed care plans. The table below shows the amounts paid by FFS Medicaid for the different levels in the statewide program and the ADK Demonstration. Because the calculation of the per-visit add-on is based on the enrollees' average number of visits per year and this differs by type of provider, the add-on amounts differ between community-based providers and office-based practitioners.

Setting	Level I	Level II	Level III	ADK
Article 28 clinics	$5.50	$11.25	$16.75	$28.00
Office-based practitioners	$7.00	$14.25	$21.25	$28.00

Hospital Demonstration

One of the special terms and conditions of NYS Medicaid's 1115 waiver with the CMS is to implement a PCMH demonstration with New York's hospital outpatient departments (OPDs) and residency programs. Up to $250 million is being allocated to 63 hospitals to transform their 165 primary care residency training clinics into Level 3 PCMHs with 2011 standards. The hospitals are also required to submit work plans and performance measures throughout the demonstration period. This demonstration began with an award notice in late fall of 2012 and will continue through 2014.

IMPLEMENTATION

State Plan Amendment

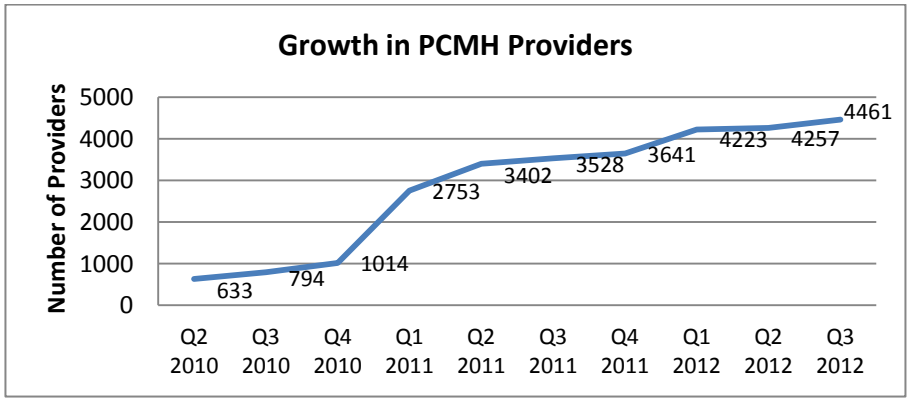
In 2009, NYSDOH submitted two State Plan Amendments (SPAs) for approval: one for the statewide medical home initiative and one for the ADK demonstration seeking approval to provide enhanced payments to PCMH providers for providing primary care services to MMC and FFS enrollees. CMS approved both SPAs in 2010. The statewide medical home program was effective in July 2010 while the ADK Demonstration was retroactively effective to January 1, 2010, in order to maintain consistency with the other payers in the Demonstration. (Due to CMS concerns about enhanced payments to hospital outpatient departments (OPDs) as they related to Upper Payment Limit requirements, the implementation for OPDs for FFS recipients in the statewide program did not occur until October 2011, when those issues were successfully resolved.) OPD payments were made retroactive to January 2010 for the ADK Demonstration. In addition, MMC plans were approved to provide enhanced payments to their OPD networks beginning in July 2010. This delayed implementation is evident and noted in several data tables below.

Child Health Plus

As mentioned previously, an MRT initiative (MRT #70) allowed for the expansion of the medical home initiative to the CHPlus program. Following approval by CMS, on October 1, 2011, the NYSDOH incorporated the CHPlus program into the ADK Demonstration and statewide programs by enhancing managed care capitation payments amounts equal to Medicaid payments. No FFS enhancement was necessary since all children in CHPlus are in managed care plans.

Trends in Provider Enrollment

The graph below illustrates the number of NCQA-recognized PCMH providers from the Quarter 2 of 2010 through the Quarter 3 of 2012. During Quarter 2 of 2010, the number of NCQA recognized-PCMH providers in NYS was 633. A year later, in Quarter 2 of 2011, the number was 3,402, marking a growth of 437%. In Quarter 2 of 2012, the number of providers was 4,257 (a growth of 25% from the previous year or 573% from Quarter 2 2010). While the number of recognized providers continues to grow, the rate of growth has been slowing slightly in recent quarters. The recent rate of growth from quarter to quarter has been between 2 and 5%. It is likely that the rate of growth will increase in 2013 as the above-noted hospital outpatient medical home demonstration is implemented, moderated by the increased difficulty of meeting the newer, 2011 standards.



At the time of this report, 82% of the recognized providers had achieved NQCA level 3 recognition; 4% had achieved level 2 recognition; and 14% had achieved level 1 recognition. Almost all providers (95%) were recognized under NCQA's 2008 standards.

TRENDS IN RECIPIENT ENROLLMENT

Managed Care

The number of MMC enrollees choosing (or assigned to) primary care providers (PCPs) that are NCQA recognized as PCMHs continues to grow as more providers become medical homes and more Medicaid Members enroll in managed care plans. Based on quarterly data reported from the plans which links each member to his/her assigned PCP, the percentage of members in managed care who are patients of PCMH recognized PCPs (the penetration rate) has grown from 5% to 38% in two years (Quarter 2 2010 to Quarter 2 2012). The table below details the growth in enrollees in medical homes since the beginning of the program.

MMC Enrollees Assigned to PCMH PCPs			
Quarter	**MMC Enrollees**	**Assigned to PCMH PCPs**	**Penetration Rate**
Q2 2010	3,059,887	145,195	5%
Q3 2010	3,098,286	202,685	7%
Q4 2010	3,159,745	317,787	10%
Q1 2011	3,209,828	827,027	26%
Q2 2011	3,245,228	991,205	31%
Q3 2011	3,112,470	952,197	31%
Q4 2011	3,325,365	1,097,208	33%
Q1 2012	3,388,110	1,289,804	38%
Q2 2012	3,460,600	1,329,053	38%

Similarly, the number of CHPlus beneficiaries assigned to PCMH providers has grown. The penetration rate has grown from 20% in Quarter 1 of 2011 to 36% in Quarter 2 of 2012, as seen in the table below.

CHP Enrollees Assigned to PCMH PCPs*			
Quarter	**CHP Enrollees**	**CHP Enrollees Assigned to PCMH PCPs**	**Penetration Rate**
Q1 2011	399,199	79,831	20%
Q2 2011	394,532	96,453	24%
Q4 2011	305,788	104,046	34%
Q1 2012	308,651	113,225	37%
Q2 2012	271,576	97,876	36%

*CHP penetration rates were derived using data reported by the plans on an aggregate level rather than on a member-level as the MMC data was reported.

Medicaid FFS

While Medicaid members enrolled in FFS are not assigned to a PCP, the number of FFS recipients who have qualifying primary care visits (members with visits that result in an incentive payment) with a PCMH provider in a set time period continues to grow. The table below shows the number of Medicaid enrollees that saw a PCMH provider for a primary care visit in a twelve-month period in both the statewide and ADK programs. As noted above, the start date of July 2010 for the statewide program and October 2011 for the OPDs incentive payments means that the number of unique enrollees with a visit resulting in an incentive payment is lower in the 2010 and 2011 calendar years than actual visits to a PCMH.

FFS Members with a PCMH Visit*	
Jan-Dec 2010	22,564
Jan-Dec 2011	74,822
Jan-June 2012	82,588

*Visits include those with ADK and Statewide PCMH providers.

Medicaid Expenditures

As discussed above, there are two ways in which NYS Medicaid provides incentive payments to PCMH providers: 1) through increased capitation payments to the MMC plans (plans are required to reimburse their PCMH recognized network providers the PMPM amounts delineated previously on page 5 for each members 'assigned' to that PCP), and 2) per visit add-on payments for FFS visits.

Medicaid Managed Care

The PCMH incentive amount included in the capitation payments to MMC plans is based on spending projections related to the number of PCMH providers in the plans' networks and the number of MMC enrollees assigned to these providers including any adjustments for the plans' prior years' spending. The table below shows the amount paid by plans to providers by calendar year. The "Paid to Providers" amount is based on Medicaid Managed Care Operating Report (MMCOR) data. MMCOR is a financial reporting tool completed by the plans and submitted to NYS Medicaid quarterly. For 2012, the amounts are extrapolated to 12 months based on payments made from January 1, – June 30, 2012.

PCMH Spending for MMC by Calendar Year			
	Statewide Paid to Providers	ADK Paid to Providers	Total Paid to Providers
CY 2010	$8,376,459	$231,252	$8,607,711
CY 2011	$51,732,429	$893,740	$52,626,169
CY 2012*	$76,014,915	$1,192,610	$77,207,525

*CY 2012 figures are projected amounts based on actual spending in the first two quarters of the calendar year.

Medicaid FFS

The table below shows FFS expenditures for PCMH by calendar year. In the statewide program, the majority of money spent on the medical home 'add-on' is spent on providers that have achieved level 3 NCQA recognition as a medical home. With the exception of one practice that is at Level 2, all providers in the ADK Demonstration are Level 3. Spending has increased as more providers have become recognized since the inception of the program with estimated spending in CY 2012 over four times greater than spending in CY 2010. As previously noted, there has been an increase in the number of PCMH providers since 2010 which contributes to the increased spending. Additional factors contributing to the increase in spending include: 1) the statewide program did not become operational until July 2010; and, 2) FFS add-on payments to hospital outpatient departments did not start until October 2011 (as described previously). Note also that 2012 spending is based on an extrapolation of expenditures from January 1 – June 30, 2012 and is therefore an estimate.

PCMH Spending for FFS Medicaid by Calendar Year					
	Statewide (excluding ADK)			ADK	
	Level 1	Level 2	Level 3	All ADK Levels	Total
CY 2010	$ 74,269	$ 16,969	$ 145,432	$ 997,528	$ 1,234,197
CY 2011	$ 388,976	$ 302,794	$ 1,676,882	$ 977,648	$ 3,346,299
CY 2012*	$ 330,906	$ 582,218	$ 4,249,624	$ 763,336	$ 5,926,083

*CY 2012 figures are projected amounts based on actual spending in the first two quarters of the calendar year.

EVALUATION

MMC plans have been required to submit quality measurement data to the NYSDOH since 1994. The recent requirement for plans to submit enrollee-specific data has allowed for the evaluation of quality for specific members, which therefore permits evaluation of quality for members seeing a PCMH provider vs. those in non-PCMH practices. The following analyses use this member-level Quality Assurance Reporting Requirements (QARR) data to evaluate the quality of care by providers at the PCMH-recognized versus non-recognized sites. This study is not applicable to the FFS population because there are no quality-reporting requirements for individual providers in FFS Medicaid. The NYSDOH began collecting member-level CHPlus data in 2010 through QARR and once health plans begin submitting PCP assignment files a similar analysis will be conducted in this population. The utilization data are based on MMC encounters. These data are submitted monthly.

Methodology

A matched comparison study of two subsets of MMC members (PCMH group and non-PCMH group) was used to assess differences in clinical quality measures and utilization between the PCMH and non-PCMH groups. Because certain enrollee factors, such as health status, may impact measured quality of care and health care utilization, matched comparison studies allow for the selection of a comparison group that is similar in terms of patient demographics and clinical characteristics, in order to reduce selection bias and determine the true effect of the intervention, in this case the PCMH. (Selection bias would occur if there is something inherently different about enrollees who choose, or are assigned, to a PCMH PCP versus those who are not.)

Using the PCP assignment files of assigned MMC members submitted by each health plan, members assigned to a PCMH provider were matched to those assigned to a non-PCMH provider by various socio-demographic characteristics such as: gender, age, race/ethnicity, Medicaid Aid Category, eligibility for cash assistance, length of enrollment in MMC in months, region, and the member's health status as defined by 3M's Clinical Risk Groups which provides 'disease severity adjustment' based on claims data (CRGs).

A PCP-member combination was not considered to be in the PCMH group unless the PCP was NCQA-recognized for at least 12 months and was not newly recognized in the measurement years (2010 and 2011). This allows time for PCMH changes to have been implemented in the practices. In addition, those providers that became PCMH recognized during the measurement year were excluded from the non-PCMH group.

To evaluate differences in clinical quality of care between the two groups, measures were chosen from each of the following areas of health care services: preventive care, chronic disease management, acute care, utilization and potentially preventable hospital admissions. To evaluate differences in healthcare utilization patterns, inpatient admissions, emergency department visits (ED), and outpatient primary care visit were calculated for each group. Total inpatient admissions were measured as well as Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs), which identify hospitalizations that most likely could potentially have been avoided through high-quality outpatient care. See Appendices 1 and 2 for a complete description of all measures included. Because even a very small difference between the two groups may result in statistical significance at the p=0.5 level, meaning the differences between the two groups have only a 5% probability of occurring by chance alone, a relative difference between the PCMH and non-PCMH group of greater than or equal to 5% was used to indicate clinical significance.

RESULTS

Study Population

For the 2010 measurement year, there were 333,847 MMC members in the final matched study population of which 41% were less than 18 years old (pediatric), 59% female, 49% Hispanic, 48% resided in NYC, 77% were TANF, 66% continuously enrolled in MMC for 12 months or more, and 57% would be considered 'healthy' using CRGs. This means that through analysis of claims data there was no evidence of any significant acute or chronic conditions for those members.

For 2011, there were 653,194 MMC members in the final matched study population. Of those in the final matched population, 43% were less than 18 years old (pediatric), 58% female, 40% Hispanic, 60% resided in NYC, 78% were TANF, 73% were enrolled in MMC for 12 or more months, and 60% of the population had a CRG of 'healthy.'

Quality of Care

Adult members assigned to a PCMH were more likely to have received preventive care (as defined by standardized measures of preventive care), most notably a BMI assessment and breast cancer screening, than adult members assigned to non-PCMH providers. Adult members assigned to a PCMH also performed better on several chronic disease control measures, such as cholesterol management after a cardiovascular event, and care for their diabetes leading to improved control (hemoglobin A1c/ HbA1c). While there were some exceptions – a measure of antibiotic overuse in adults for 2010 showed better performance in non-PCMH practices, this gap disappeared in 2011. There were no differences between PCMH and non-PCMH adult members in either use of imaging studies for low back pain or annual monitoring for patients on persistent medications (see Table 1).

Table 1. *Comparison of Patient-Centered Medical Home vs. Non-Patient-Centered Medical Home Rates for Adult Health Quality Measures for 2010 and 2011.*

Measure	2010			2011		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adult BMI Assessment	80	64	16*	NA	NA	-
Annual Monitoring for Patients on Persistent Medications- Combined Rate	88	89	-1	90	89	1
Antidepressant Medication Management-Effective Acute Phase Treatment	55	52	3	52	48	4
Antidepressant Medication Management-Effective Continuation Phase Treatment	36	34	2	35	32	3
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	18	28	-10*	27	26	1
Breast Cancer Screening	71	66	5*	70	65	5*
Cervical Cancer Screening	72	71	1	73	70	3
Chlamydia Screening (Ages 21-24)	70	67	3	72	71	1
Cholesterol Level Controlled (<100mg/dL)	NA	NA	-	59	47	12*
Cholesterol Screening Test	NA	NA	-	91	88	3
Comprehensive Diabetes Care						
HbA1c Testing	NA	NA	-	90	86	4
Lipid Profile	NA	NA	-	84	83	1
Dilated Eye Exam	NA	NA	-	65	60	5
Nephropathy Monitoring	NA	NA	-	84	80	4
Received All Tests	NA	NA	-	52	45	7*
Poor HbA1c Control †	NA	NA	-	32	38	6*
HbA1C Control (<8.0%)	NA	NA	-	58	55	3
HbA1C Control (<7.0%)	NA	NA	-	42	40	2
Lipids Controlled (<100 mg/dL)	NA	NA	-	45	46	-1
Blood Pressure Controlled (<140/90)	NA	NA	-	71	63	8*
HbA1c and Lipids Controlled	NA	NA	-	37	35	2
Controlling High Blood Pressure	70	66	4	NA	NA	-
Medical Management for People with Asthma 50% Covered(Ages 19-50)	NA	NA	-	68	67	1
Use of Imaging Studies for Low Back Pain	79	78	1	78	78	0

NA= Not available. Measure was not collected that year.
†For Poor HbA1c Control, a low rate is desirable.
* Relative differences between groups were ≥5% and statistically significantly different (p<0.05)

Pediatric members assigned to a PCMH also had higher rates or performed better than non-PCMH members for several preventive care measures, especially weight assessment and counseling for nutrition and physical activity, and childhood and adolescent immunizations. In 2010 pediatric members in a PCMH performed less favorably than non-PCMH for all well-child and preventive care measures (0-15 months, 3-6 years, and 12-21 years). However, by 2011 all differences had diminished and well-child and preventive care among children 0 to 15 months was trending higher among PCMH than non-PCMH. Among children newly prescribed medication for attention deficit hyperactivity disorder, PCMH members performed less favorably than non-PCMH members in both 2010 and 2011. There were no differences between PCMH and non-PCMH members in acute care as measured by appropriate care for pharyngitis (see Table 2).

Table 2. *Comparison of Patient-Centered Medical Home vs. Non-Patient-Centered Medical Home Rates for Pediatric Health Quality Measures for 2010 and 2011.*

Measure	2010			2011		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adolescent Immunization-Combo	NA	NA	-	76	65	11*
Adolescent Well-Care Visits	50	56	-6	58	58	0
Appropriate Testing for Pharyngitis	83	84	-1	84	84	0
Childhood Immunization Status	NA	NA	-	84	76	8*
Chlamydia Screening (Ages 16-20)	70	67	3	72	71	1
Counseling for Nutrition	72	68	4*	84	74	10*
Counseling for Physical Activity	63	54	9*	72	64	8*
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	60	65	-5	65	67	-2
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	58	59	-1	55	61	-6*
Medical Management for People with Asthma 50% Covered (Ages 5 -18)	NA	NA	-	49	49	0
Weight Assessment- BMI Percentile	76	60	16*	81	68	13*
Well-Child & Preventive Care Visits in First 15 Months of Life (5+ Visits)	78	77	1	87	83	4
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	79	80	-1	82	82	0

NA= Not available. Measure was not collected that year.
* Relative differences between groups were ≥5% and statistically significantly different ($p<0.05$)

Healthcare Utilization

Baseline data comparing adult PCMH members with non-PCMH members in 2010 showed slightly higher rates for adult inpatient admissions and no differences among potentially preventable inpatient admissions or PQIs. (Developed by the Agency for Healthcare Research and Quality, PQIs are a set of admissions that, after adjusting for risk factors, should be avoidable if the conditions were managed in an ambulatory care setting.) For pediatric PCMH members compared with non-PCMH members there was little difference in pediatric inpatient admission rates both overall and among potentially preventable inpatient admissions. In 2010 there were slightly higher rates of Emergency Department (ED) visits and very similar rates of outpatient primary care visits in adult PCMH members compared to adult non-PCMH members. There was very little difference in ED visit rates and slightly lower rates of outpatient primary care visits in pediatric PCMH members compared to pediatric non-PCMH members.

In 2011 there were slightly higher rates of overall inpatient admissions and potentially preventable admissions for adult PCMH members compared to adult non-PCMH members. Among adult members there were also higher rates of ED visits and lower rates of primary care visits in the PCMH group compared to the non-PCMH group. In 2011, among the pediatric population there were slightly lower rates of overall inpatient admissions but no differences among potentially preventable admissions when comparing PCMH member to non-PCMH members. There were higher rates of ED visits and lower rates of primary care visits among pediatric PCMH members compared with the non-PCMH member (see Table 3).

Table 3. *Comparison of Patient-Centered Medical Home vs. Non Patient-Centered Medical Home Healthcare Utilization Measures for 2010 and 2011.*

Measure	2010			2011		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adults						
Inpatient Hospitalization	0.140	0.135	0.005	0.118	0.110	0.008
Prevention Quality Indicators	0.010	0.011	-0.001	0.010	0.009	0.001
ED Visits	0.685	0.641	0.044	0.619	0.597	0.022
Outpatient Primary Care Visits	4.31	4.33	-.020	4.23	4.34	-0.11
Pediatric						
Inpatient Hospitalization	0.044	0.044	0	0.037	0.039	-0.002
Pediatric Quality Indicators	0.004	0.004	0	0.004	0.004	0
ED Visits	0.510	0.518	-0.008	0.556	0.518	0.038
Outpatient Primary Care Visits	4.29	4.74	-0.45	4.43	4.80	-0.37

DISCUSSION

These analyses show that PCMH practices have higher rates of quality performance, as defined by national standardized measures, than non-PCMH practices for a majority of measures after controlling for differences in enrollee case mix. The utilizations results however, while preliminary, do not at this time show changes in the expected, or desired direction of reductions in ER visits or inpatient stays.

There is one limitation in these analyses that should be noted. Because the location of services provided is unavailable in the data sources we have available, we have not performed an attribution of MMC enrollees to a provider and site by virtue of where they received most of their care. Therefore, all utilization is attributed to a PCMH provider if that enrollee is assigned to the PCMH provider by the managed care plan regardless of where that enrollee received care. In addition, it is possible that increased detection and/or management of previously undetected diseases associated with an increased focus of PCMH providers on assessment and prevention could be driving increased inpatient utilization as is sometimes seen with individuals who are newly insured and have previous unmet need. Nevertheless, we would expect that most services could be delivered in the outpatient setting.

In an effort to further understand the utilization results, additional analyses not shown here, evaluated: 1) PCMH vs. non-PCMH after removing enrollees without chronic conditions ("non-chronic") by the CRG methodology, 2) comparing Level 3 providers to non-PMCH providers given the higher standards for Level 3, and 3) comparing PMCH providers to non-PCMH providers within a New York City demonstration of practices who have EHRs and are focused on care management. The removal of "non-chronic" enrollees did not change results nor were the results for Level 3 providers noticeably different. However, PCMH providers within the New York City demonstration had lower rates of inpatient admissions and ED visits, particularly for pediatric PCMH enrollees. Children with PCMH providers also had a higher rate of outpatient visits than children assigned to non-PCMH providers.

Additional studies to explore the superior performance of PCMH practices within the New York City demonstration are needed. Evaluation efforts should also recognize that the health and economic benefits of the conversion to a PCMH may not be evident for up to 5 to 10 years.[5] These studies and additional evaluations are described in the Next Steps section.

[5] Stange KC, Nutting PA, Miller WL, et al. Defining and Measuring the Patient-Centered Medical Home. *J Gen Intern Med.* 2010;25(6):601–612. doi: 10.1007/s11606-010-1291-3

MAJOR ACCOMPLISHMENTS

As previously discussed, nearly 4,500 providers in NYS are recognized by NCQA as PCMHs – the largest number of any state. Almost 80 percent are recognized as Level 3. Medicaid's incentive program and its support of the ADK Demonstration have contributed to this growth resulting in over 1.3 million Medicaid enrollees assigned to and/or receiving care within a PCMH. An MRT proposal also allowed for the participation of CHPlus in the program whereby approximately 100,000 children and adolescents are receiving care from PCMH practices and providers.

Preliminary analyses conducted by the NYSDOH indicate that MMC enrollees assigned to a provider within a PCMH have higher quality of care and outcomes as defined by standardized measures of quality. In addition, clinical areas where PCMH providers were initially underperforming such as appropriate antibiotic prescribing, have improved from 2010 to 2011.

The goals of PCMH are to increase the accessibility of primary care and potentially reduce utilization in more expensive sites of care. To date, healthcare utilization patterns among PCMH members have not shown reductions in overall inpatient and ED visits as anticipated, however, these important metrics will continue to be monitored over time. In terms of looking at access and use of primary care, using Medicaid claims and encounters to capture primary care visits may or may not capture the enhanced primary care that is offered at a PCMH practice such as telephonic visits, and e-mail communication with providers. Patient/family surveys, to be used for future evaluation, may help clarify by including the patient experience of access to care in a PCMH practice.

An additional goal of PCMH is to improve the management of chronic illness, which should increase ambulatory care and pharmacy services, and decrease inpatient and emergency department care for preventable complications. The high-quality outpatient care seen in PCMH practices is promising and continued investment in these practices should result in fewer preventable complications. The data presented in this report on potentially preventable admissions for both adults and pediatric members show little differences between PCMH and non-PCMH members to date but will continue to be monitored over time as the program expands and evolves. We are particularly interested to see if the more challenging 2011 standards are more likely to lead to positive changes in quality and utilization and explore the characteristics of those practices that have been able to both improve quality and reduce costs.

NEXT STEPS

PROGRAM ADMINISTRATION

As the NYSDOH's goals and expectations for the program continue to evolve, the following changes and advancements in the administration of the program will be implemented.

Legislative Authority

The Commissioner of Health has the authority to continue the ADK program until March 31, 2014. A recent budget request will extend the statewide program until March 31, 2016.

Quarterly Reports

The NYSDOH has developed quarterly reports that will be made available on the MRT page of the public web site. The reports will provide a snapshot of descriptive statistics such as counts of PCMH providers and provider payments.

Incentive Payments

The NYSDOH seeks to develop and implement payment policies that provide incentives for providers to improve efficiency and outcomes. Our incentive program is designed to promote recognition at higher and more intense levels of practice transformation, including the meaningful use of EHRs and health information exchange. For dates of service as of January 1, 2013, the NYSDOH is no longer providing incentive payments to providers recognized as Level 1 PCMH by NCQA. The NYSDOH has advised providers and health plans of this policy change. Providers who wish to continue to receive payments will need to upgrade to levels 2 or 3.

Measurement and Pay for Performance

The NYSDOH has begun to evaluate the practicality of collecting practice-level performance measures from PCMH practices to evaluate performance to develop a pay-for-performance (P4P) component to the incentive program with some of the payments 'at risk' depending on quality measures. NYSDOH executive staff met with numerous stakeholders in November 2012 to obtain feedback on this potential initiative. We will continue to engage providers in advancing the PCMH program to include P4P as a means to reward improved outcomes and efficiency and ways to align our PCMH program with other initiatives including Meaningful Use, Health Homes, and Accountable Care Organizations.

EVALUATION

While the evaluation of the PCMH program presented in this report has provided a great deal of insight into the quality of care provided to members receiving care from PCMH practices, additional and evolving analyses are necessary as described below.

Costs

The NYSDOH has begun the process of evaluating costs as well. A similar comparison of two groups, as described above, will provide some insight. However, a longitudinal study following the PCMH and the non-PCMH cohorts over time may be necessary as cost savings are unlikely to be realized 12 months after a practice converts to PCMH per this evaluation's criteria.

Practice Attributes

As was noted earlier, 95% of PCMH providers are recognized by NCQA's 2008 standards. The 2011 standards are more robust and over time, practices will need to convert to 2011. In addition, the hospital outpatient demonstration requires 2011 standards. During this conversion period, a comparison of outcomes between the two standards should be considered. The NYSDOH is also pursuing means to evaluate the impact of additional practice attributes such as NCQA's Diabetes Recognition program. Also, as mentioned in the Discussion section of this report, further research will be performed to improve the risk adjustment as applicable and investigate why PCMH providers have lower ED visits and inpatient utilization than non-PCMH providers within the New York City demonstration.

Consumer Satisfaction

The NYSDOH surveys a sample of MMC enrollees every other year. While it has been possible to evaluate satisfaction for PCMH enrollees, because the surveys are based on a sample of enrollees, 65% of whom do not respond, there is often not enough data to draw meaningful conclusions. Future surveys may be administered to allow for more robust evaluation of enrollees' experience of care with PCMH, including the use of a PCMH Consumer Assessment of Health Provider (CAHPS) survey instrument.

Child Health Plus

As mentioned previously, when provider-enrollee assignment files are available, a comparison of PCMH to non-PCMH can be initiated.

APPENDIX 1 – ADULT QUALITY MEASURES

Measure	Area	Description
Adult BMI Assessment	Prevention	The percentage of members, 18 to 74 years of age with an outpatient visit, who had their body mass index (BMI) documented during the measurement year or the year prior the measurement year.
Annual Monitoring for Patients on Persistent Medications- Combined Rate	Safety	The percentage of members 18 years and older who were taking certain medications for a minimum of six months and who received specific monitoring tests. The following rates specify categories of medications that are of interest: ACE Inhibitors or ARBs, Digoxin, Diuretics or Anticonvulsants.
Antidepressant Medication Management-Effective Acute Phase Treatment	Chronic Disease	The percentage of members ages 18 years and older who were diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication during the entire 12-week acute treatment phase.
Antidepressant Medication Management-Effective Continuation Phase Treatment	Chronic Disease	The percentage of members ages 18 years and older who were diagnosed with depression and treated with an antidepressant medication who remained on antidepressant medication for at least six months.
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	Acute Care	The percentage of adults, ages 18 to 64, with acute bronchitis who did NOT receive a prescription for antibiotics.
Breast Cancer Screening	Prevention	The percentage of women between the ages of 40 and 69 who had a mammogram during the measurement year or the year prior.
Cervical Cancer Screening	Prevention	The percentage of women between the ages of 24 and 64 who had a Pap test, within the measurement year.
Chlamydia Screening (Ages 21-24)	Prevention	The percentage of sexually active young women between the ages of 21 and 24 who had at least one test for Chlamydia during the measurement year.
Cholesterol Screening Test Cholesterol Level Controllec (<100mg/dL)	Chronic Disease	The percentage of members, ages 18 to 75 years, with a cardiovascular condition, who had at least one cholesterol screening test and whose cholesterol level was below the recommended level (100 mg/dL) during the measurement year.
Comprehensive Diabetes Care	Chronic Disease	This measure reports components of care for members, ages 18 to 75, with diabetes and the rate at which they received necessary components of diabetes care.
Lipid Profile	Chronic Disease	The percentage of members with diabetes who had at least one cholesterol screening test done during the past year.
Dilated Eye Exam	Chronic Disease	The percentage of members with diabetes who had a retinal eye screening exam during the last year or who had a negative retinal exam in the year prior.
Nephropathy Monitoring	Chronic Disease	The percentage of members with diabetes who had at least one nephropathy screening test or had evidence of nephropathy during the last year.
Received All Tests	Chronic Disease	The percentage of members with diabetes who had at least one of each of the following: HcA1c test, cholesterol screening test, dilated eye exam, and medical attention for nephropathy.
Poor HbA1c Control	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level indicated poor control (>9.0 percent).
HbA1C Control (<8.0%)	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level indicated poor control (>8.0 percent).
HbA1C Control (<7.0%)	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level indicated poor control (>7.0 percent).

(continued)
APPENDIX 1 – ADULT QUALITY MEASURES

Measure	Area	Description
Lipids Controlled (<100 mg/dL)	Chronic Disease	The percentage of members with diabetes whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL).
Blood Pressure Controlled (<140/90)	Chronic Disease	The percentage of members with diabetes whose most recent blood pressure reading was below 140/90.
HbA1c and Lipids Controlled	Chronic Disease	The percentage of members with diabetes whose most recent HbA1c level was at or less than 9.0 percent and whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL).
Controlling High Blood Pressure	Chronic Disease	The percentage of members, ages 18 to 85 years, who have hypertension and whose blood pressure was adequately controlled (below 140/90).
Medical Management for People with Asthma 50% Covered (Ages 19-50)	Chronic Disease	The percentage of members between 19 and 64 years of age, who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 50% of their treatment period.
Use of Imaging Studies for Low Back Pain	Overuse	The percentage of adults, ages 18 to 64, with acute bronchitis who did NOT receive a prescription for antibiotics.

APPENDIX 2 – PEDIATRIC QUALITY MEASURES

Measure	Area	Description
Adolescent Immunization-Combo	Prevention	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.
Adolescent Well-Care Visits	Prevention	The percentage of adolescents (ages 12-21) who had at least one comprehensive well-care visit with a primary care provider during the measurement year.
Appropriate Testing for Pharyngitis	Acute Care	The percentage of children, ages two to 18 years, who were diagnosed with pharyngitis, were prescribed an antibiotic, and who were given a group A streptococcus test.
Childhood Immunization Status (Combo 3: 4-3-1-3-3-1-4)	Prevention	The percentage of two-year olds who were fully immunized. The HEDIS specifications for fully immunized consist of the following vaccines: 4 Diptheria/Tetanus/Pertussis, 3 Polio, 1 Measles/Mumps/Rubella, 3 H Influenza type B, 3 Hepatitis B, 1 Varicella, and 4 pneumococcal.
Chlamydia Screening (Ages 16-20)	Prevention	The percentage of sexually active young women between the ages of 21 and 24 who had at least one test for Chlamydia during the measurement year.
Counseling for Nutrition	Prevention	The percentage of children and adolescents ages 3-17 who had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, had counseling for nutrition.
Counseling for Physical Activity	Prevention	The percentage of children and adolescents ages 3-17 that had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, which had counseling for physical activity.
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	Chronic Disease	The percentage of children, ages 6 to 12 years, who remained on the medication for 7 months and who, in addition to the visit in the Initiation Phase, had at least 2 follow-up visits in the 9-month period after the initiation phase ended.
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	Chronic Disease	The percentage of children, ages 6 to 12 years, who were newly prescribed ADHD medication and had one follow-up visit with a practitioner within the 30 days after starting the medication.
Medical Management for People with Asthma 50% Covered (Ages 5-18)	Chronic Disease	The percentage of members between 5 and 18 years of age, who were identified as having persistent asthma and were dispensed appropriate medications and remained on an asthma controller medication for at least 50% of their treatment period.
Weight Assessment - BMI Percentile	Prevention	The percentage of children and adolescents ages 3-17 who had an outpatient visit with a PCP or OB/GYN practitioner during the measurement year, who had their body mass index (BMI) calculated.
Well-Child & Preventive Care Visits in 3rd, 4th, 5th & 6th Year of Life	Prevention	The percentage of children between the ages of three and six years who had one or more well-child visits with a primary care provider during the measurement year.
Well-Child & Preventive Care Visits in First 15 Months of Life (5+Visits)	Prevention	The percentage of children who had five or more well-child visits with a primary care provider in their first 15 months of life.