New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program

Improve Patient Care.
Lower Costs.
Align with Payers.

NCQA
Measuring quality.
Improving health care.

About the New York State Patient-Centered Medical Home (NYS PCMH) Recognition Program

The National Committee for Quality Assurance (NCQA), the creator of the nation's leading patient-centered medical home (PCMH) program, collaborated with the New York State Department of Health (NYSDOH) to develop a customized PCMH Recognition Program that supports the state's initiative to improve primary care through the medical home model and promote the Triple Aim: better health, lower costs and better patient experience.

Why PCMH?

PCMH is a care delivery model where the primary care team, with the involvement of the patient (and family, when appropriate), is responsible for managing the full spectrum of health care needs, coordinating with clinicians in other settings when care cannot be provided in the primary care setting.

The PCMH model emphasizes care coordination, population health, evidence-based guidelines and effective use of Health Information Technology (HIT) to meet the patient's needs. New York State PCMH (NYS PCMH) Recognition helps practices put in place the structure, systems and processes to be effective in this model.

The NYS PCMH model helps practices

- Improve patient-centered access and patient experience.
- Perform comprehensive health assessments to identify patient needs.
- Deliver better preventive care such as immunizations and cancer screenings.
- Prioritize comprehensive care management to keep chronic conditions under control.
- Coordinate with other clinicians to improve continuity of patient care by closing the referral loop and gaps in services.

This all leads to **lower health care costs, improved patient experience** and **better health outcomes.**

Research shows NCQA PCMH Recognition **improves patient care and reduces costs.**

- One pilot program showed a 9.3% **reduction in emergency department utilization** (resulting in approx. $5 million in savings per year for the ~100,000 patients touched by the pilot) and a 10.3% **reduction in ambulatory-care-sensitive inpatient admissions** for patients with two or more comorbidities.[1]
- Another study found PCMH Recognition was associated with $265 **lower average annual total Medicare spend** per beneficiary (4.9%), lower hospital spending and **fewer emergency department visits** (55 fewer visits per 1000 beneficiaries for all causes).[2]
- Another study found patients with diabetes had **higher-quality treatment** than those not in an NCQA-Recognized PCMH.[3] Quality measurement showed:
    - 4.2 - 8.3% better on HbA1c testing.
    - 4.3 - 8.5% better on LDL-C testing.
    - 15.5 - 21.5% better on nephropathy monitoring.
    - 9.7 - 15.5% better on eye examinations.
- A Hartford Foundation study found that the PCMH model resulted in a **better experience for patients**, with 83% of patients saying being treated in a PCMH improved overall health.[4]

The PCMH model also **supports practice business goals.**

- A 2014 MGMA Cost Survey Report found that PCMH practices may spend more on general operating costs than non-PCMH practices, but they also **earn $65.54 more per patient in total medical revenue** (netting a margin of almost $23 more per patient after operating costs).[5]
- One analysis found implementation of NCQA PCMH Recognition to **increase staff's work satisfaction** while reported **staff burnout decreased** by more than 20%.[6]

Additional Benefits for Practices

To support the efforts required in transforming New York practices to this new, customized model of patient care, NYSDOH provides the following resources:

- **Recognition at no cost to practices.** NYSDOH covers the first year NYS PCMH Recognition fee or the first NYS PCMH Annual Reporting fee. The practice is responsible for paying their Annual Reporting fee each year after earning NYS PCMH Recognition.
- **Transformation assistance.** New York State has contracted with 15 organizations that specialize in NYS PCMH transformation and are available at no cost to participating practices. These entities provide step-by-step assistance in managing the transformation process and support the efforts of improving the patient experience. For more information, or to find a Transformation Assistance Contractor, visit ncqa.org/ta.
- **Enhanced reimbursement opportunities.** Practices that participate in NYS PCMH transformation may be eligible to receive supplemental payments through State programs such as the Medicaid PCMH Incentive Program. In addition, NYSDOH is engaged regionally with commercial payers to implement voluntary, multi-payer value-based payment (VBP) arrangements to support practices that have not had these opportunities through previous transformation efforts. Many of these models and eligibility to participate will depend on practices achieving NYS PCMH recognition.

PCMH: Better Quality. Lower Costs.

Research shows PCMH Recognition improves patient care and reduces costs. In addition, the PCMH model is associated with happier staff and patients, which is influential in patient satisfaction scores.

NYS PCMH Program Overview

The NYS PCMH Recognition Program features six concepts that make up a medical home. Underlying these concepts are criteria (activities for which a practice must demonstrate adequate performance to obtain NYS PCMH Recognition) developed from evidence-based guidelines and best practices.

To earn recognition through NYS PCMH, a practice must:

1. Meet all 40 core criteria and 12 NYS required criteria (with elective credit).
2. Earn a total of 25 credits in elective criteria across 5 of 6 concepts (16-19 credits are earned by the required NYS criteria, crossing all 6 concepts). Which of the remaining 6-9 credits of elective criteria you complete are up to you.

The **NYS PCMH Standards and Guidelines** document details program requirements.

How to Enroll in NYS PCMH

A practice downloads the NYS PCMH Standards and Guidelines document, which contains the requirements for the program, and works with a **Transformation Assistance Contractor** to begin applying the standards to the practice. The entire recognition process is managed through **Quality Performance Assessment Support System (Q-PASS)**, a user-friendly, online platform that allows for the upload of documentation, tracking of progress and management of practice sites and clinicians.

Learn More: ncqa.org/nyspcmh

1 Rosenthal MB, Alidina S, Friedberg MW, Singer SJ, Eastman D, Li Z, Schneider EC. (2015). A Difference-in-Difference Analysis of Changes in Quality, Utilization and Cost Following the Colorado Multi-Payer Patient-Centered Medical Home Pilot. Journal of General Internal Medicine.

2 Van Hasselt M, McCall N, Keyes V, Wensky SG & Smith KW (2014). Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes. Health Services Research.

3 Friedberg MW, Rosenthal MB, Werner RM, Volpp KG, Schneider EC. (2015). Effects of a Medical Home and Shared Savings Intervention on Quality and Utilization of Care. Journal for the American Medical Association Internal Medicine. http://archinte.jamanetwork.com/article.aspx?articleid=2296117

4 Langston C, Undem T, Dorr D. (2014). Transforming Primary Care What Medicare Beneficiaries Want and Need from Patient - Centered Medical Homes to Improve Health and Lower Costs. Hartford Foundation.

5 MGMA Cost Survey: 2014 Report Based on 2013 Data

6 Reid, Robert (2015). Transforming Primary Care: Evaluating the Spread of Group Health's Medical Home. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/tpc/tpc-profile-reid.pdf

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For more information on NYS PCMH, visit ncqa.org/nyspcmh or contact NCQA Customer Support at (888) 275-7585.

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