



**Department
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Patient Centered Medical Home Initiatives In New York State Medicaid

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Executive Summary

The following report contains updates for the Patient Centered Medical Home programs operating in New York State. The previous reports were published in [April 2013](#) and [June 2014](#). This report includes updated, enrollment, quality, cost, and evaluation results for Medicaid enrollees in both the New York Statewide Patient Centered Medical Home Incentive Payment Program and the Adirondack (ADK) Medical Home Demonstration. All evaluations, performed by the New York State Department of Health Office of Quality and Patient Safety (OQPS), have generally shown improvements across the evaluation domains.

There are two chapters included in this report. Chapter 1 focuses on the New York Medicaid Statewide Patient Centered Medical Home Incentive Payment Program from 2013 through 2015. Trends, such as provider participation and enrollee exposure to a medical home physician, are included as well as expenditures since the program's inception. Quality of care, utilization, and patient satisfaction evaluations can also be found in the first chapter of this report. Chapter 2 focuses on the ADK demonstration and serves as a program update since the previous report. It includes trends and evaluations covering 2013 through 2015 as well. The net increase of providers joining the demonstration, the number of people insured by participating payers in the demonstration, expenditures, and a pay for performance program update are found in the first portion of this section. Adult and pediatric quality of care evaluation results are available for both Medicaid managed care cohorts and cohorts comprised of all members insured by payers participating in the Adirondack Medical Home Demonstration. An analyses conducted on Medicaid utilization, patient satisfaction, and the provider experience are also presented in this chapter.

The New York Medicaid Statewide PCMH Incentive Payment Program

From 2010 through 2015, the State invested approximately \$500 million in PCMH incentive payments. Findings in this report show that an increasing number of providers are becoming PCMH-recognized, availing more New Yorkers to this model of primary care. About 25 percent of primary care providers (PCPs) in the State are PCMH-recognized, providing care to nearly two million Medicaid enrollees.

Patients getting care in medical home settings generally perform better on quality measures. For example, Medicaid enrollees with a PCMH-recognized PCP have consistently higher rates for Adult BMI Assessment, Breast Cancer Screening, Comprehensive Diabetes Care, Dilated Eye Exams, and HbA1C Testing. Statewide pediatric quality measures show consistently higher rates for Adolescent HPV Immunization, Appropriate Testing for Pharyngitis, Counseling for Nutrition, Counseling for Physical Activity and Weight Assessment-BMI Percentile.

Utilization analyses reveal less consistent results. Adult Medicaid enrollees with a PCMH-recognized provider have statistically significantly fewer inpatient hospitalizations and outpatient primary care visits, but significantly more emergency department visits. Pediatric Medicaid enrollees that see a PCMH-recognized PCP have significantly more potentially preventable admissions and emergency department visits, but significantly fewer outpatient primary care visits.

Most measures of patient satisfaction displayed in this report reveal high levels of satisfaction in patients who get care in medical homes, but not statistically higher than those who do not.

The Adirondack Medical Home Demonstration

From 2010 through 2015 about \$45 million was invested by eight insurers in the Adirondacks (ADK); Medicaid alone contributed approximately \$11.2 million. All primary care practices participating in the demonstration have committed to maintaining PCMH recognition, therefore, exposing almost all New Yorkers in the Adirondacks to a higher standard of primary care. Investments are mainly allocated towards providing more abundant and improved care management services, improving salaries in order to retain a strong workforce, administrative services, demonstration governance, management, and evaluation, and a pay for performance program.

Enrollees getting care from ADK providers generally have better quality of care results according to the quality of care analysis presented in Chapter two of this report. For example, Medicaid adult quality measures show consistently higher rates for Annual Monitoring for Patients on Persistent Medications and Breast Cancer Screening. Pediatric quality measures show consistently higher rates for Adolescent Well-Care Visits, Appropriate testing for Pharyngitis, and Well Care Visits in the third, fourth, fifth, and sixth year of life for Medicaid enrollees with a PCMH-recognized PCP. All enrollees in the demonstration had statistically significant better results for Adolescent Well-Care Visits and Well Care Visits in the First 15 months of Life quality measures as well.

Utilization analyses for Medicaid enrollees in the demonstration are mixed as well. There was no difference, although directionally positive results, between groups for adult inpatient hospitalization and potentially preventable visits. Both the ADK adult and pediatric group performed significantly better than the comparison groups for the emergency department visits utilization measure. There was statistically significantly more outpatient utilization among the adult ADK group, which is normally expected, while there was statistically significantly less outpatient utilization for the ADK pediatric group.

Patient satisfaction in the ADK was higher compared to national benchmarks in all but one category where benchmarks were available, indicating high satisfaction of services among the response population in the ADK region.

A survey of practitioners in the ADK Demonstration showed provider satisfaction was not as high as desired, indicating job satisfaction should be a priority in the future in order to maintain a strong work force in the region.

Background

A Patient Centered Medical Home (PCMH) is a model of care in which each patient has an ongoing relationship with a primary care physician (PCP) who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for meeting the patient's primary care needs and coordinates appropriate care with other providers when needed. This may include roles for nurse practitioners, registered nurses, physician assistants, social workers, and care managers, who are collectively responsible for providing all of the patient's health care needs to arrange appropriate care with other qualified physicians and community resources when necessary. 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.

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 PCMH. NCQA's first set of PCMH standards were released in 2008 with a second, strengthened version published in 2011. A third, more rigorous, set of standards was released in 2014. Health Information Technology (HIT) implementation and behavioral health integration within primary care continue to remain areas of importance, as well as focusing on coordination with community resources and non-primary care specialists to ensure person-centered care. NCQA plans to release the next iteration of their PCMH standards in early 2017.

In an effort to increase the number of New York State (NYS) medical practices that are PCMHs, Governor Andrew Cuomo signed legislation that allow for the development of incentive programs in NYS' Medicaid program and, in one instance, a multipayer 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. 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 PCMH-recognized are eligible to receive additional payments for services provided to Medicaid FFS and managed care enrollees.

Continuing to support 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 position New York towards achieving the triple aim: improved health, high quality care, and decreased costs.

New York State Medicaid and Patient Centered Medical Homes

There are numerous initiatives throughout NYS that focus on improving the quality of primary care for New Yorkers and use PCMH concepts as a foundation. Each quarter the NYS DOH Office of Quality and Patient Safety (OQPS) posts reports to the [PCMH Medicaid Redesign Team \(MRT\) website](#) to illustrate how the NYS PCMH environment is changing over time. Additionally, the PCMH MRT website includes a link to the [Medicaid Update Articles](#) related to PCMH policies and program changes over time.

The New York Medicaid Statewide PCMH Incentive Payment Program

The New York Medicaid Statewide PCMH Incentive Payment Program is one of the largest initiatives focusing on investing in the primary care workforce that serves Medicaid patients. The statewide incentive program began in July 2010, where NYS Medicaid adopted NCQA's PCMH 2008 recognition program as the gold standard to determine practice's achievements in medical home transformation. Practices meeting NCQA's standards are provided additional incentives for their Medicaid Managed Care (MMC), Medicaid Fee for Service (FFS), HIV Special Needs Plan (SNP), and Family Health Plus (FHP) enrollees¹. In October 2011, the Child Health Plus (CHP) program was folded into this initiative and Health and Recovery Plans (HARPs) were also incorporated when they operationalized in October 2015.

The New York Medicaid Statewide PCMH Incentive Payment Program has served as the original and primary driver of the exponential growth of PCMH-recognized practices and providers statewide resulting in over 1,300 primary care practices and more than 6,200 PCPs designated as an NCQA PCMH by December 2015.

¹ The Family Health Plus program concluded December 31, 2014 and is no longer part of the PCMH incentive.

Incentives under this program are structured to provide office based practitioners and article 28 clinics, recognized as PCMHs by the NCQA, additional payments for primary care services in two ways: Enhanced payments are given to providers for MMC, CHP, HARP, and HIV SNP enrollees through the patient’s health plan via capitation payments, and ‘add-on’ payments to claims for certain qualifying visits are given to providers for Medicaid FFS enrollees. Around \$500 million was invested in the PCMH-recognized provider population and primary care service delivery system via increased capitation and FFS add-on payments from July 2010 through December 2015.

As the NCQA PCMH model continues to modernize and evolve, the incentives as part of this program have also evolved to encourage providers to strive towards achieving higher standards of care, continue practice transformation efforts, and modernize primary care delivery. The following table lists the payment structure for this program as of December 2015.

PCMH Incentive Payment Structure as of December 2015			
Payment Type	Level 1, 2, or 3 2008 Standards	Level 2 2011 or 2014 Standards	Level 3 2011 or 2014 Standards
MMC-PMPM	\$0.00 PMPM	\$4.00 PMPM	\$6.00 PMPM
FFS Per Visit			
Institutional	\$0.00	\$11.25	\$16.75
Professional	\$0.00	\$14.25	\$21.25

NCQA Level 1 payments for all standard years were discontinued on January 1, 2013.
 NCQA Level 2 payments for 2008-recognized providers were discontinued on July 1, 2013.
 NCQA Level 3 payments for 2008-recognized providers were discontinued on April 1, 2015.

In April 2013, the Office of Quality and Patient Safety (OQPS), Division of Performance Improvement and Patient Safety produced an initial report on the PCMH Initiative in New York State utilizing 2010-2012 data. To view a copy of this report, click [here](#).

The Adirondack Medical Home Demonstration

With an already small base of PCPs, the Adirondack region of NYS continued to observe a shrinking primary care workforce in the early 2000s. In just one year, from 2006 to 2007, 25 PCPs left the region due to finding jobs with higher salaries elsewhere, retirement, or other personal reasons. The community viewed this as a crisis and reform began to retain physicians and revitalize the primary care workforce in the Adirondacks, using the PCMH model.

Under the supervision of the NYS DOH, on January 1, 2010, NYS Medicaid, Excellus, The Empire Plan (UHC), Fidelis, Empire Blue Cross Blue Shield of Northeastern New York (BCBS), the Mohawk Valley Plan (MVP), and Capital District Physicians’ Health Plan (CDPHP) agreed to provide additional financial support to a group of practices and providers in Hamilton, Franklin, Clinton, Essex, Warren and northern Saratoga counties. This was known as the Adirondack Medical Home Demonstration (ADK). As a condition of the demonstration, participating practices and providers committed to achieve NCQA PCMH recognition. In 2011 CMS implemented the Multipayer Advanced Primary Care Demonstration Program (MAPCP), a national project that allowed Medicare to join with other multipayer demonstrations to support the transformation of care in already-existing state multipayer arrangements.

The ADK demonstration was originally anticipated to sunset December 31, 2014. All payers and providers in the collaborative decided to extend participation through 2019, except for Medicare. Medicare’s participation was only extended through December 31, 2016.

Medicaid incentives under the ADK demonstration are distributed in a similar fashion to the New York Medicaid Statewide PCMH Incentive Payment Program, where MMC, CHP, HIV SNP, and HARP payments are passed through the managed care plans and FFS payments are provided as ‘add ons’ for eligible services. Almost \$13 million was distributed via increased capitation and FFS add-on payments from January 2010 through December 2015. Participants of this program are not permitted to simultaneously participate in the New York Medicaid Statewide PCMH Incentive Payment Program. The following table lists the payment structure for this program as of December 2015.

PCMH Incentive Payment Structure as of December 2015	
Payment Type	Amount
MMC-PMPM	\$7.00
FFS Per Visit (Professional and Institutional Claims)	\$35.00

In June 2014, the NYS DOH OQPS released a report on the history and evaluations through 2013 on the ADK since the beginning of the pilot which can be found on the [PCMH MRT Website](#). Most evaluations in Chapter 2 of this report are continuations of evaluations included in the original ADK report.

The Delivery System Reform Incentive Payment Program

In April 2014, NYS finalized terms and conditions with CMS for the Delivery System Reform Incentive Payment Program (DSRIP) waiver which allows the State to reinvest eight billion in federal savings that was generated by the many MRT reforms implemented over the last decade. This statewide program focuses on system reform, including a goal to achieve a 25% reduction in avoidable hospital use over five years. As a program requirement, participating primary care practices must achieve Advanced Primary Care (APC) certification or 2014 level 3 NCQA PCMH recognition by March 31, 2018. This requirement of DSRIP is expected to have a large impact on both the Statewide and ADK PCMH programs. For more information about this program please see: http://www.health.ny.gov/health_care/medicaid/redesign/dsrif/.

Chapter 1: The Statewide Patient Centered Medical Home Initiative in New York State

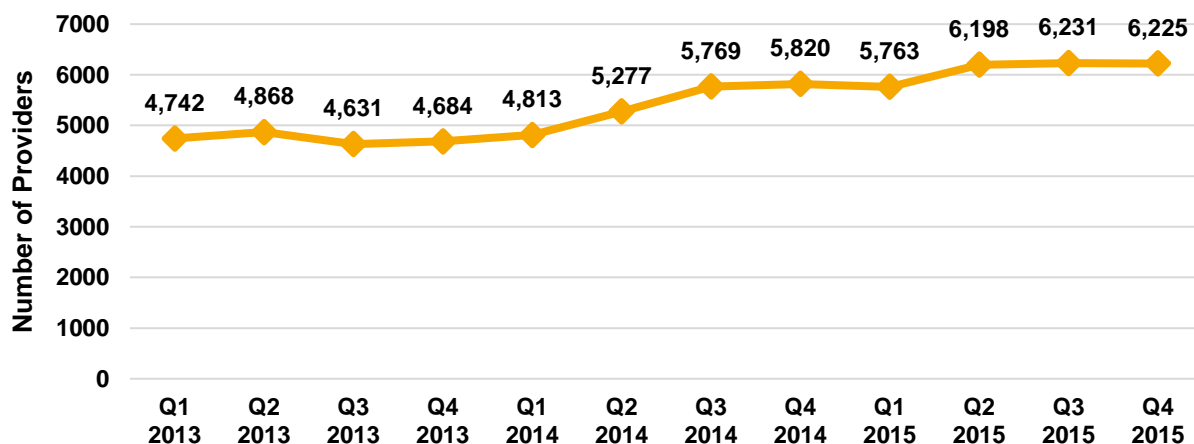
Chapter one covers the statewide growth and expenditures of the PCMH program since 2010. This section also contains updated quality, utilization, and satisfaction evaluation results since the previous statewide report to the legislature.

Participation

Trends in Provider Participation

Since the inception of the New York Medicaid Statewide PCMH Incentive Payment Program in 2010, the number of PCMH-recognized PCPs in NYS has increased. As of December 2015, there were 6,225 providers in NYS recognized under NCQA's 2011 or 2014 standards. Of the 6,225 PCMH-recognized providers, 5,399 were participating in MMC at that time. There are 826 PCMH-recognized providers not participating with MMC, but could participate with FFS Medicaid. During the same timeframe, there were around 20,000 physicians participating in MMC. A little more than a fourth of MMC PCPs were PCMH-recognized by NCQA by the end of 2015. Figure 1.1 shows the number of NCQA PCMH-recognized providers in NYS over time.

**Figure 1.1: Provider Participation Over Time
2013 to 2015**



It is anticipated that this number will continue to grow over time given the DSRIP program requirement for all participating practices to become recognized as a 2014 Level 3 PCMH or APC-recognized by March 31, 2018. It is anticipated that the APC program will begin in 2017. Since there are around 14,000 PCPs participating in DSRIP, the number of PCMH recognized providers in NYS could double by early 2018.

Trends in Enrollee Participation Using Assignment

When a Medicaid member joins a health plan, they are required to select a PCP. If they do not select a PCP, the member is automatically assigned a PCP. Panel data, or lists of health plan's enrollees and their selected or auto-assigned PCPs, is collected quarterly from MMC and HIV SNP plans. The number of MMC enrollees assigned to PCMH-recognized PCPs continues to grow as more practices and their providers achieve PCMH recognition.

Using the quarterly panel data submitted by health plans and a roster of recognized PCMH providers from NCQA, the NYS DOH can identify which enrollees are assigned to a PCMH-recognized provider each quarter. The percentage of members in MMC and HIV SNPs who are assigned to PCMH PCPs has grown from 10% in December 2010 to 47% at the end of December 2015. Table 1.2 shows the number of MMC enrollees assigned to PCMH recognized providers from December 2010 to December 2015.

Table 1.2: MMC Enrollees Assigned to PCMH-Recognized PCPs 2010 to 2015			
Year	MMC Enrollees assigned to PCMHs	MMC Enrollees	PCMH Penetration Rate
December 2010	317,787	3,159,745	10%
December 2011	1,097,208	3,325,365	33%
December 2012	1,710,775	3,612,457	47%
December 2013	1,511,875	3,446,820	44%
December 2014	1,969,641	4,320,321	46%
December 2015	1,937,839	4,097,395	47%

Trends in Enrollee Participation Using Attribution

Attribution is a process whereby a member is designated to a provider. This attribution process may link a member with the provider they had the most visits with, or attribution may associate a member to a provider based on particular types of visits. This differs from member "assignment" to a provider, which is usually done upon enrollment and is not based on visit history. Attribution is sometimes preferred because it represents a specific relationship between patients and providers they actually received services from.

The number of MMC, FFS Medicaid, and CHP enrollees attributed to PCMH-recognized PCPs has grown drastically since 2010, as more providers become PCMH-recognized. The number of enrollees in MMC who are attributed to a PCMH-recognized PCP has grown from 287,857 in 2010 to 1,128,115 by the end of December 2015. The number of FFS Medicaid enrollees attributed to a PCMH-recognized provider has grown from 41,360 in 2010 to 132,309 in December 2015. Similarly, the number of CHP enrollees attributed to PCMH-recognized provider grew from 23,410 in 2010 to 77,890 by the end of 2015.

Table 1.3 shows the growth of PCMH-recognized PCP attribution in MMC, FFS Medicaid, and CHP over time. In 2010, about 11% of primary care utilizers were attributed to a PCMH-recognized PCP. By the end of 2015, 41% of primary healthcare utilizers were receiving care from a PCMH-recognized PCP.

It should be noted that in 2015, the number of attributed enrollees decreased across products. This is due to a decrease in the utilization of primary care services across these populations.

Table 1.3: Medicaid and CHP Enrollees Attributed to PCMH Recognized Providers from 2010 to 2015

Year		MMC	FFS Medicaid	CHP	Total
2010	PCMH-Attributed	287,857	41,360	23,410	352,627
	Total Attributed	2,423,526	502,366	364,838	3,290,730
	Percent	12%	8%	6%	11%
2011	PCMH-Attributed	662,195	98,883	70,196	831,274
	Total Attributed	2,641,066	486,695	382,587	3,510,348
	Percent	25%	20%	10%	24%
2012	PCMH-Attributed	924,044	125,459	90,204	1,139,707
	Total Attributed	2,819,753	408,906	345,906	3,574,565
	Percent	33%	31%	26%	32%
2013	PCMH-Attributed	937,470	123,382	81,393	1,142,245
	Total Attributed	2,783,821	346,749	294,594	3,425,164
	Percent	34%	36%	28%	33%
2014	PCMH-Attributed	1,133,148	168,694	94,562	1,396,404
	Total Attributed	2,946,893	358,480	285,005	3,590,378
	Percent	38%	47%	33%	39%
2015	PCMH-Attributed	1,128,115	132,309	77,890	1,338,314
	Total Attributed	2,664,067	352,505	224,614	3,241,186
	Percent	43%	38%	35%	41%

Providers were considered to be a PCMH if they were recognized under any standard year at any level, regardless of their incentive eligibility
The MMC group contains MMC, HARP, and HIV SNP enrollees

The New York Medicaid Statewide PCMH Incentive Payment Program

The New York Statewide Medicaid PCMH Incentive Payment Program provides additional funds to practices and their providers based on the practice’s recognition level and standard year. In 2015, NCQA released the 2014 standards, which places greater emphasis on care management, team-based care, and integrating behavioral and physical health care services, as well as setting additional standards for improving overall quality of care to patients.

Table 1.4 summarizes the MMC per member per month (PMPM) capitation amount and the FFS Medicaid ‘add-on’ reimbursement by provider type and recognition status as of December 2015.

Table 1.4: PCMH Statewide Incentive Payment Program PMPM and FFS ‘Add-on’ Reimbursement

Payer Type	NCQA Level 2, 2011/2014 Standard	NCQA Level 3, 2011/2014 Standard
MMC-PMPM	\$4.00	\$6.00
FFS Institutional	\$11.25	\$16.75
FFS Professional	\$14.25	\$21.25

Note: These rates are effective through December 31, 2015.
 NCQA Level 1 payments for all standard years were discontinued on January 1, 2013
 NCQA Level 2 payments for 2008-recognized providers were discontinued on July 1, 2013
 NCQA Level 3 payments for 2008-recognized providers were discontinued on April 1, 2015

Table 1.5 shows the amount spent per calendar year from July 2010 to December 2015 on PCMH incentives and is broken out by the following programs and product types: MMC, Medicaid FFS, FHP, HIV SNPs, CHP, and HARPs.

Table 1.5: PCMH Expenditures July 2010 - December 2015

Year	MMC	Medicaid FFS	FHP	HIV SNPs	CHP	HARPs	Total
2010	\$6,958,604	\$309,514	\$1,411,214	\$6,641	-	-	\$8,687,984
2011	\$46,030,958	\$2,153,314	\$5,461,605	\$239,866	\$1,206,586	-	\$55,094,373
2012	\$73,293,027	\$4,869,487	\$8,209,511	\$479,507	5,577,933	-	\$92,429,537
2013	\$75,493,105	\$4,885,453	\$7,985,187	\$567,292	\$4,879,022	-	\$93,810,792
2014	\$93,016,568	\$4,981,725	\$4,477,346	\$777,804	\$5,009,235	-	\$108,258,711
2015	\$122,152,588	\$5,119,517	-	\$493,283	\$6,333,023	\$126,089	\$134,142,355
Total	\$416,944,850	\$22,319,010	\$27,544,863	\$2,564,393	\$23,005,799	\$126,089	\$492,423,753

MMC, FFS Medicaid, HIV SNP, and FHP spend began on July 1, 2010.
 CHP was incorporated into the program October 1, 2011.
 FHP ended December 31, 2014 and was no longer included in the incentive program.
 HARPs were fully operationalized by October 1, 2015 and were included in the incentive program when they began.

The number of enrollees in Medicaid seeing a PCMH-recognized provider has increased as a result of the change in provider participation; therefore, growth in expenditures has also occurred since the incentive is given PMPM.

Evaluation of Quality and Utilization Measures

The NYS DOH performed a clinical quality measure analysis and utilization analysis, using the most recently available data, on the MMC enrollees that were attributed to PCMH-recognized providers. MMC plans are required to submit aggregate and enrollee-specific quality

measurement data to the NYS DOH annually, known as the Quality Assurance Reporting Requirements (QARR). QARR measures include select Health Effectiveness Data and Information Set (HEDIS) measures and additional select measures created by the NYS DOH. Plans are required to report on a specific set of common measures annually. This allows the evaluation of quality health measures for enrollees seeing a PCMH-recognized provider versus those seeing non-PCMH providers. There are also rotated measures that are only required to be submitted every other year; therefore, some of the rates are not available for a year-to-year comparison. A list of adult and pediatric quality measures can be found in Appendices A and B of this report. These quality analyses use this enrollee-level QARR data to evaluate the quality of care provided by PCMH-recognized practices versus non-PCMH-recognized practices in NYS.

Study Population

Table 1.6 displays how many enrollees were included in this analysis by year. For all years half of the enrollees in the study population were attributed to a PCMH-recognized provider and the other half were attributed to a non-PCMH-recognized provider. The matched cohorts for all years looked relatively similar across years: almost half were age 18 or younger, slightly more than half were female, more than half resided in New York City compared to the rest of the state, a large proportion were considered to be ‘healthy’ as defined by 3M’s Clinical Risk Groups (CRG), and most were continuously enrolled in Medicaid for at least 12 months.

Year	Number of enrollees	Proportion of PCMH-attributed Enrollees vs. Non-PCMH attributed Enrollees	Age 18 or Younger	Female	New York City	Healthy CRG	Twelve Months Continuous Enrollment
2012	1,522,676	50%	48%	57%	69%	44%	78%
2013	1,469,288	50%	47%	57%	59%	43%	79%
2014	1,623,100	50%	47%	56%	52%	42%	75%
2015	1,366,438	50%	47%	56%	54%	54%	69%

Methods

For each calendar year, enrollees are attributed to a provider based on the number of evaluation and management (E&M) or preventive care visits. PCPs were identified as a PCMH using NCQA recognition lists.

To evaluate differences in healthcare quality, PCMH attributed enrollees were compared to a similar group of enrollees attributed to non-PCMH-recognized providers. To control for confounding factors, the two groups were refined through a one-to-one match of socio-demographic characteristics including gender, age, race, aid category, county, length of time enrolled in MMC, and health status as defined by 3Ms clinical risk group (CRG) scores using a logistic regression model. For each quality measure, a rate was calculated for each group and the difference between the two rates was tested for statistical significance using a z-test to observe the difference in proportions. A p value of <0.05 was used to determine statistical significance.

The same matched cohort groups were used to evaluate differences in healthcare utilization patterns in the clinical quality analysis. The total number of inpatient admissions were

measured, as well as Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs), which identify potentially avoidable hospitalizations resulting from high-quality ambulatory care. Emergency department (ED) usage as well as outpatient primary care utilization were also evaluated.

Clinical Quality Measure Results

Table 1.7a displays all rates for QARR measures reported from 2013 and 2015 for the PCMH-attributed and non-PCMH-attributed adult Medicaid population. In 2015, a PCMH cohort showed statistically significant better results for 12 of 18 adult quality measures. These measures included: Adult BMI Assessment, Antidepressant Medication Management – Effective Acute Phase Treatment, Antidepressant Medicaid Management – Continuation Phase Treatment, Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis, Blood Pressure Controlled (<140/90), Breast Cancer Screening, Comprehensive Diabetes Care, Dilated Eye Exams, HbA1c Testing, Medication Management for People with Asthma 50 Percent Covered (age 19-64), Nephropathy Monitoring, Poor HbA1c Control (lower rate is desirable for this measure).

In 2015, there was no statistically significant difference between the two cohorts for six of 18 clinical quality measure results. These measures include: Annual Monitoring for Patients on Persistent Medications Combined Rate, Cervical Cancer Screening, Chlamydia Screening (age 21-24), HbA1c Control <7%, HbA1c Control <8%, and Use of Imaging Studies for Low Back Pain. Most of these measures showed higher rates for the PCMH-attributed cohort compared to the non-PCMH-attributed cohort, but did not show statistical significance. There were no measures where the non-PCMH-attributed cohort had significantly better results than the PCMH-attributed cohort.

The PCMH-attributed cohort showed statistically significant better results for the breast cancer screening measure for all three years presented in this report.

Table 1.7a: Comparison of PCMH and Non-PCMH rates for Adult Quality Measures 2013 to 2015									
Measure	2013			2014			2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adult BMI Assessment	95%	82%	13*	NA	NA	-	93%	83%	10*
Annual Monitoring for Patients on Persistent Medications-Combined Rate	91%	92%	-1*	NA	NA	-	93%	93%	0
Antidepressant Medication Management - Effective Acute Phase Treatment	57%	57%	0	50	53	-3	54%	52%	2*

Table 1.7a: Comparison of PCMH and Non-PCMH rates for Adult Quality Measures 2013 to 2015 cont.

Measure	2013			2014			2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Antidepressant Medication Management - Effective Continuation Phase Treatment	54%	55%	-1	61%	58%	3	39%	37%	2*
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	23%	26%	-3*	27%	26%	1	30%	28%	2*
Blood Pressure Controlled (<140/90)	72%	71%	1	NA	NA	-	72%	67%	5*
Breast Cancer Screening	78%	73%	5*	76%	71%	5*	78%	74%	4*
Cervical Cancer Screening	77%	77%	0	77%	73%	4*	74%	72%	2
Chlamydia Screening (Age 21-24)	76%	74%	2*	75%	74%	1	76%	76%	0
Cholesterol Level Controlled (<100mg/dL)	43%	40%	3*	NA	NA	-	NA	NA	-
Cholesterol Screening	88%	84%	4*	NA	NA	-	NA	NA	-
Comprehensive Diabetes Care	53%	46%	7*	NA	NA	-	61%	55%	6*
Dilated Eye Exam	65%	61%	4*	NA	NA	-	66%	63%	3*
HbA1c and Lipids Controlled	34%	32%	2	NA	NA	-	NA	NA	-
HbA1C Control (<7.0%)	33%	31%	2	NA	NA	-	29%	28%	1
HbA1C Control (<8.0%)	59%	55%	4*	NA	NA	-	58%	55%	3
HbA1c Testing	92%	88%	4*	NA	NA	-	93%	91%	2*
Lipids Controlled (<100 mg/dL)	44%	40%	4*	NA	NA	-	NA	NA	-

Table 1.7a: Comparison of PCMH and Non-PCMH rates for Adult Quality Measures 2013 to 2015 cont.

Measure	2013			2014			2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Medication Management for People with Asthma 50% Covered (Age 19-64)	67%	67%	0	23%	25%	-2*	68%	66%	2*
Nephropathy Monitoring	87%	80%	7*	NA	NA	-	94%	92%	2*
Poor HbA1c Control † (lower rate is desirable)	31%	35%	-4*	NA	NA	-	31%	34%	-3*
Use of Imaging Studies for Low Back Pain	77%	78%	-1	75%	77%	-2*	77%	76%	1
NA= Not available. Measure was not collected that year.									
* Relative differences between group is statistically significantly different (p<0.05)									

Table 1.7b displays all rates for QARR pediatric measures reported from 2013 and 2015 for the PCMH-attributed and non-PCMH-attributed pediatric Medicaid population. In 2015, the PCMH cohort of pediatric enrollees showed better results with statistical significance for eight of 15 clinical quality measures. These measures included: Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life, Adolescent HPV Immunization, Weight Assessment – BMI Percentile, Counseling for Nutrition, Counseling for Physical Activity, Adolescent Well Care Visits, Chlamydia Screening, and Appropriate Testing for Pharyngitis.

In 2015, there was no statistically significant difference between the two cohorts for four of 15 clinical quality measure results. These measures include: Adolescent Immunization Combination, Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Use of Multiple Concurrent Antipsychotics in Children and Adolescents, and Medical Management for People with Asthma 50 Percent Covered. Although not statistically significant, the Adolescent Immunization Combination and Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics measures showed higher rates for the PCMH-attributed cohort. Three of 15 clinical quality measure results showed the non-PCMH-attributed cohort had better results. These measures include: Well Child Visits in the First 15 Months of Life (five or more visits), Follow Up Care for Children Prescribed ADHD Medication - Initiation Phase, and Follow Up Care for Children Prescribed ADHD Medication – Continuation Phase.

The PCMH-attributed cohort showed statistically significantly better results for the Adolescent HPV Immunization measure for all three years presented in this report.

Table 1.7b: Comparison of PCMH and Non-PCMH rates for Pediatrics Quality Measures 2013 to 2015

Measure	2013			2014			2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adolescent HPV Immunization	56%	49%	7*	57%	50%	7*	60%	52%	8*
Adolescent Immunization-Combo	76%	71%	5*	NA	NA	-	79%	75%	4
Adolescent Well-Care Visits	78%	77%	1	78%	78%	0	79%	78%	1*
Appropriate Testing for Pharyngitis	86%	87%	-1	91%	82%	9*	92%	89%	3*
Chlamydia Screening (Age 16-20)	73%	71%	2*	72%	71%	1	73%	72%	1*
Counseling for Nutrition	79%	74%	5*	NA	NA	-	81%	75%	6*
Counseling for Physical Activity	70%	66%	4*	NA	NA	-	74%	67%	7*
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	54%	55%	-1	NA	NA	-	64%	70%	-6*
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	57%	57%	0	NA	NA	-	50%	53%	-3*
Medical Management for People with Asthma 50% Covered (Age 5-18)	52%	52%	0	48%	51%	-3*	53%	53%	0

Table 1.7b: Comparison of PCMH and Non-PCMH rates for Pediatrics Quality Measures 2013 to 2015 cont.

Measure	2013	2014	2015			2013	2014	2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NA	NA	-	37%	41%	-4*	38%	43%	-5*	
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NA	NA	-	65%	69%	-4	67%	66%	1	
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NA	NA	-	3%	3%	0	2%	3%	-1	
Weight Assessment-BMI Percentile	79%	71%	8*	NA	NA	-	83%	71%	12*	
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	88%	88%	0	88%	88%	0	89%	88%	1*	
Well-Child Visits in First 15 Months of Life (5+ Visits)	84%	84%	0	82%	84%	-2*	79%	84%	-5*	
NA= Not available. Measure was not collected that year.										
* Relative differences between groups were statistically significantly different (p<0.05)										

Utilization Results

Tables 1.8a and Table 1.8b show utilization results per member per year (PMPY) from 2012 through 2015 for the PCMH and non-PCMH cohorts, by adult and pediatric utilization metrics. Utilization rates from 2010 and 2011 were presented in the [previous statewide report](#).

Among adult and pediatric enrollees attributed to a PCMH-recognized provider, there were lower rates of primary care visits and higher rates of emergency department visits compared to the non-PCMH group for all four years presented in this report.

Table 1.8a: Comparison of PCMH and non-PCMH PMPY Rates of Utilization 2012 to 2013

Measure	2012			2013		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adults						
Inpatient Hospitalization	0.15500	0.15400	0.00100	0.15500	0.15300	0.00200
Prevention Quality Indicators	0.01810	0.01660	0.00150*	0.01800	0.01700	0.00100
ED Visits	0.72200	0.70000	0.02200*	0.76400	0.72700	0.04300*
Outpatient Primary Care Visits	4.77500	5.22600	-0.45100*	5.12600	5.74600	-0.62000*
Pediatric						
Inpatient Hospitalization	0.09100	0.09200	-0.00100*	0.08100	0.08000	0.00100
Pediatric Quality Indicators	0.00555	0.00590	-0.00031*	0.00444	0.00413	0.00031
ED Visits	0.56700	0.53300	0.03400*	0.52600	0.50200	0.02400*
Outpatient Primary Care Visits	4.16500	4.64100	-0.47600*	4.14400	4.65400	-0.51000*
*Relative difference between groups were Statistically Significantly different (p<0.05)						
Note: lower rates are desirable for all measures except the outpatient primary care visit measure						

In 2015, the adult PCMH attributed cohort had statistically significantly fewer inpatient admissions, an improvement from all previous years. Although the rate was better for the PCMH group for the prevention quality indicators measure (potentially avoidable hospitalizations), there was no statistically significant difference between adult groups in 2015. However, the rates for adult prevention quality indicators have shown drastic improvement since 2012, where the non-PCMH group was originally, significantly outperforming the PCMH group.

Although the non-PCMH group rate had lower rates there was no statistically significant difference between the inpatient hospitalization rates among the pediatrics groups. Additionally, the difference between the two cohorts for the pediatric quality indicator rates was statistically significant, showing a better rate for the non-PCMH group.

Table 1.8b: Comparison of PCMH and Non-PCMH PMPY rates of Utilization 2014 to 2015

Measure	2014			2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
Adults						
Inpatient Hospitalization	0.15000	0.14800	0.00200	0.14632	0.14950	-0.00318*
Prevention Quality Indicators	0.01800	0.01700	0.00100	0.01634	0.01669	-0.00035
ED Visits	0.77400	0.73000	0.04400*	0.71258	0.69927	0.01331*
Outpatient Primary Care Visits	5.23400	5.85000	-0.61600*	5.65807	6.01970	-0.36163*

Table 1.8b: Comparison of PCMH and Non-PCMH PMPY rates of Utilization 2014 to 2015 cont.

Measure	2014			2015		
	PCMH	Non-PCMH	Difference	PCMH	Non-PCMH	Difference
<i>Pediatric</i>						
Inpatient Hospitalization	0.07910	0.07620	0.00300*	0.03063	0.02985	0.00077
Pediatric Quality Indicators	0.00500	0.00400	0.00100	0.00431	0.00383	0.00048*
ED Visits	0.50300	0.46000	0.04300*	0.45952	0.43072	0.02880*
Outpatient Primary Care Visits	4.26800	4.79600	-0.52800*	4.39822	4.64691	-0.24869*
*Relative difference between groups were Statistically Significantly different (p<0.05)						
Note: lower rates are desirable for all measures except the outpatient primary care visit measure						

Patient Satisfaction

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey is a comprehensive tool designed to assess consumers' experience with receiving health care. The NYS DOH sponsored a CAHPS PCMH survey for the MMC population to explore the variation in patient satisfaction among patients receiving care from PCMH-recognized and non-PCMH-recognized practices. DataStat, Inc. conducted the survey on behalf of the NYS DOH in the fall of 2013. The survey included 1,500 adults and 1,500 children enrollees who visited a PCMH-recognized practice and 1,500 adults and 1,500 children who visited a non-PCMH recognized site. A total of 1,010 adult and 1,064 child responses were received resulting in a 33.7% and 35.5% response rate, respectively. Achievement scores were risk adjusted by age, self-reported health status, and education to control for differences in the enrollee population across PCMH and non-PCMH populations.

Figure 1.9a shows the composite scores for each of the six domains included in the adult patient experience survey: Access, Communication, Discussion of Self-Management Support (DSMS), Satisfaction with Office Staff (SOS), Shared Decision Making (SDM), and Comprehensiveness of Care for Behavioral Health (CCBH). Results for PCMH, non-PCMH within NYC and Rest of State (ROS) are presented. The NYC and ROS PCMH and non-PCMH cohorts are compared to the NYC and ROS averages for statistical significance. More detailed analyses and a copy of the survey can be found in the [Adult Medicaid CAHPS PCMH/non-PCMH Survey Summary Report](#).

Across cohorts surveyed, responses related to questions about patient's general satisfaction with communication with their providers were positive. Responses also indicated patients were mostly satisfied with office staff at their practices. Access was rated more highly in non-PCMH practices but CCBH was better for the PCMH practices.

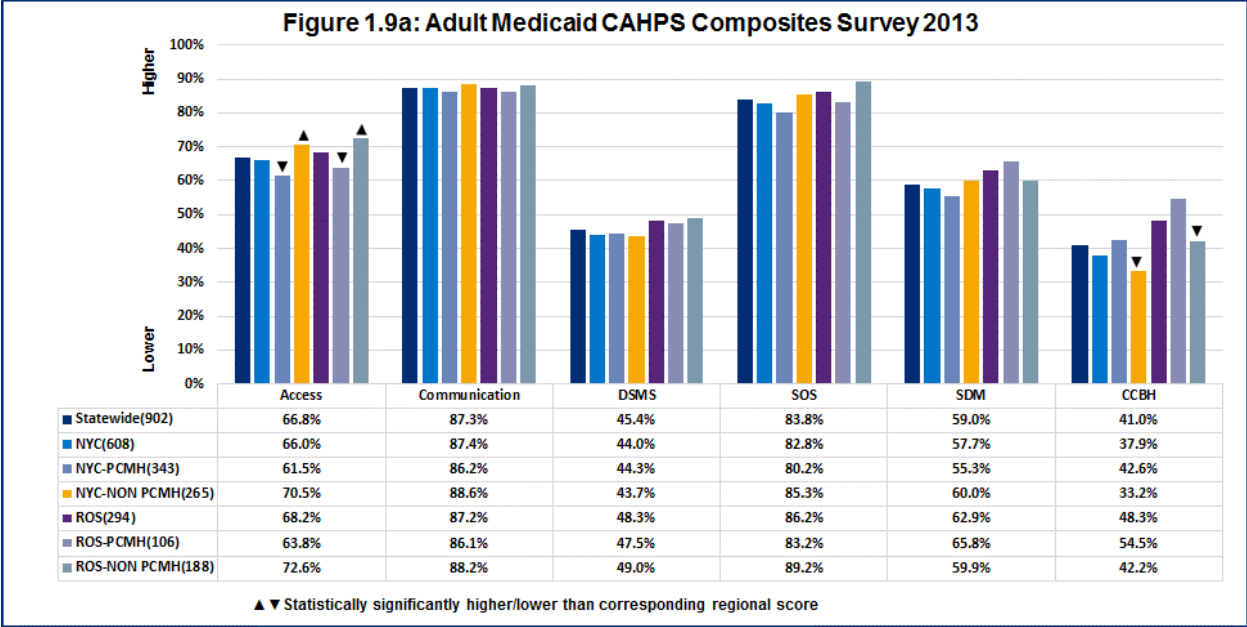
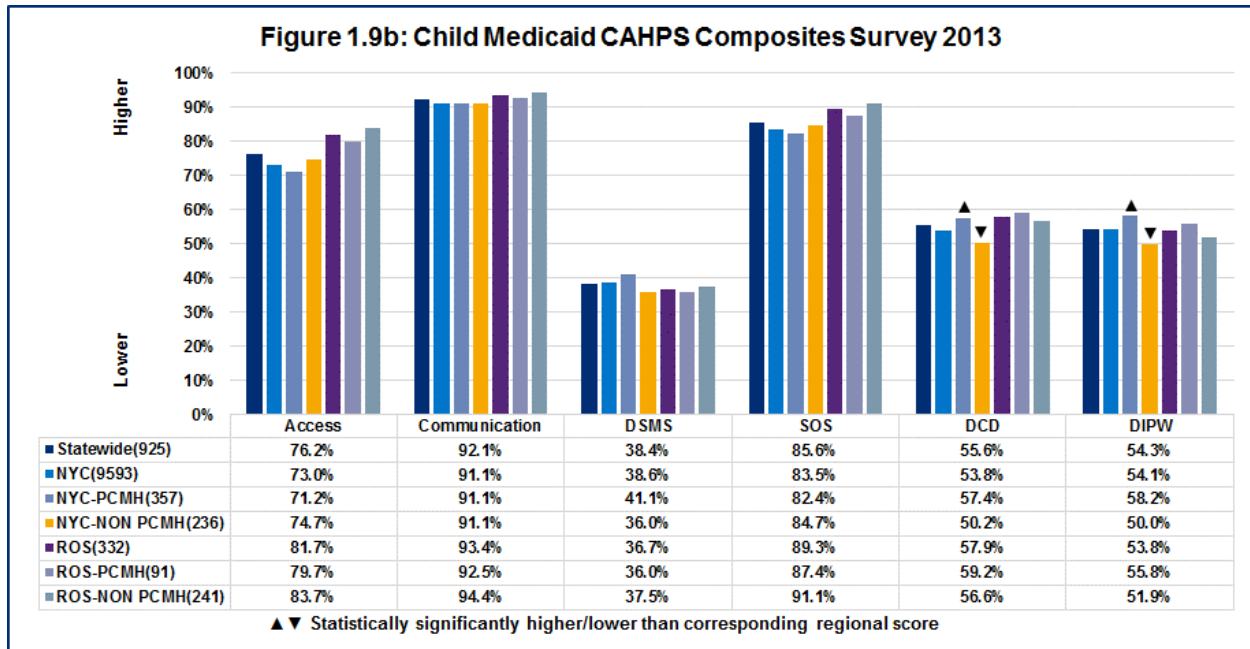


Figure 1.9b shows the composite scores for each of the six domains included in the child patient experience survey: Access, Communication, Discussion of Child Health Management Support (DCHMS), Satisfaction with Office Staff (SOS), Discussion with Child Development (DCD) and Discussion of Injury Prevention and Wellness (DIPW). Results for PCMH, non-PCMH within NYC and Rest of State (ROS) are presented. The PCMH and non-PCMH cohorts are compared to the NYC and ROS averages for statistical significance. More details on this analysis and a copy of the satisfaction survey is included in the [Child Medicaid CAHPS PCMH/non-PCMH Survey Summary Report](#).

Similar to the adult survey composite score results, responses from the child survey indicate patients are satisfied with communication practices as well as the office staff. The access to care composite also seemed to have higher responses than the adult survey. Results also indicate that there is room for improvement in areas related to discussion of child health management support.



Limitations

Evaluation results should be considered with the following caveats and limits for each analysis:

Although there are many differences between PCMH-recognized and non-PCMH-recognized practices, there are some elements of NCQA's PCMH model that all practices may incorporate in their daily operations, such as use of electronic health records, integration of behavioral health, enhanced care management and coordination, and expanded hours for patients to have better access to care. It is unknown which PCMH-like elements are implemented among non-PCMH-recognized practices, therefore the non-PCMH comparison groups created in all analyses included in this report may have PCMH like qualities that have not been accounted for.

Quality and Utilization

The cohorts examined in the MMC-specific quality and utilization were created from lists submitted by health plans with specific reporting criteria (for example, enrollees must be enrolled in MMC for 12 months). Therefore, while not all Medicaid enrollees are included in the submissions, there is no reason to believe that there was a disproportionate effect on either group examined in this analysis. Additionally, many enrollees are eliminated in the strict one-to-one match methodology used in this evaluation. Practice characteristics were not considered in the matching process and may impact the results such as size.

Patient Satisfaction

Lastly, the patient satisfaction survey response rate was only 35% (1,010 of 3,000) for adults and 37% (1,064 of 3,000) for children. Higher response rates may allow for more meaningful conclusions. Survey candidates were randomly selected but there is a possibility that there are inherent differences between responders and non-responders. Respondents answers on questions may have been impacted based on how they remembered the encounter, especially if the time between the visit and completing the survey was an extended period of time.

Discussion

Just under \$500 million was invested from 2010 through 2015 in the Statewide Medicaid PCMH program, and around 1,500 new providers joined the program since 2013. As the number of providers who become recognized continues to increase, more Medicaid enrollees will be exposed to the benefits of the PCMH primary care model. About half (47%) of MMC enrollees are currently assigned a PCMH-recognized provider and 43% are attributed to a PCMH-recognized provider.

The quality of care analyses showed that the PCMH cohorts have higher quality of care as defined by HEDIS standardized measures. Breast cancer screening and HPV immunization rates are statistically significantly higher for the PCMH populations for all years included in this analysis.

The utilization analysis revealed that PCMH could be positively affecting the number of inpatient admissions. The rates for the PCMH group in this analysis have improved over time and the NYS DOH will continue to monitor this trend. Directionally positive results across years for prevention quality indicators were also identified. Decreasing costly preventable inpatient admissions and increasing preventive care services has been, and continues to be, one of the highest priorities for the Medicaid program.

PCMH responders to the CAHPS survey seem to be generally satisfied with their care across several domains, but less so than non-PCMH responders based on the survey results. Although results did shed light on areas for improvement, it is positive that both adults and children groups, across the different surveyed populations, were satisfied with their care.

Next Steps

The NYS DOH will continue to monitor and compare trends and evaluation results of the statewide incentive payment program to ensure an adequate return on investment. Standards and incentive amounts will continue to be modified over time to ensure the PCMH practices and providers are delivering the highest quality of care to all of their enrollees. Additional cost, quality, and utilization analyses focusing on specific populations are also a priority.

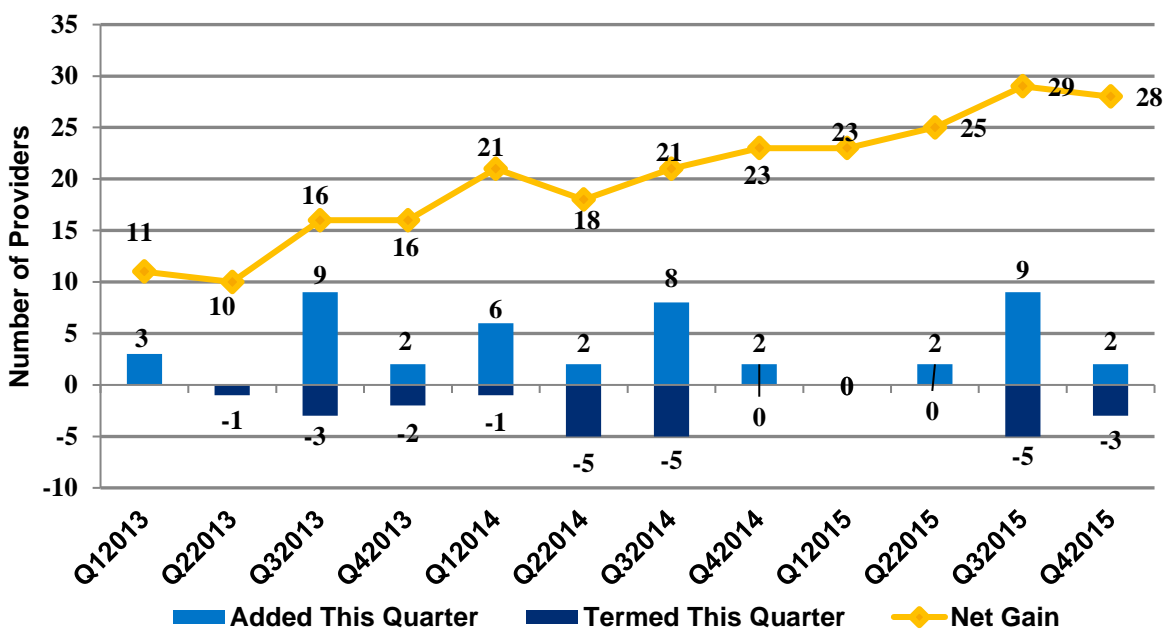
Chapter 2: The New York State Adirondack Multipayer Medical Home Demonstration

Chapter two focuses on the ADK demonstration program and includes program updates and changes. Evaluations that were updated from the previous report and new analyses are also included.

Workforce Stabilization

Figure 2.1 displays the trends of providers joining the demonstration, leaving the demonstration, and the net gain from January 2013 to December 2015. One of the driving factors for the creation of the ADK demonstration was to attract and retain a strong workforce. The number of PCPs in the region has slowly increased since the ADK demonstration was implemented (please see page eight of the previous [ADK report](#)). By January 2011, the region maintained a net gain of 11 new PCPs since the demonstration began in 2010 and by December 2015 the net gain was 28 providers. This increase of PCPs will contribute to improved access to care the residents in the region.

**Figure 2.1: Net Change in Providers Over Time
2013 to 2015**



Enrollees and Attribution

At the start of the demonstration, the majority of commercial payers agreed upon a common attribution methodology which assigns every plan enrollee to a PCP. This methodology has been continuously refined over the course of the demonstration and it incorporates the number and type of visits over a 24 month look-back period. Payers not using this common attribution method used their own methodology or provided additional 'add-on' payments for specific qualifying visits. Measuring the quality, satisfaction, and utilization of each physician's attributed patients is essential to evaluating performance based programs. The number of attributed enrollees is based on quarterly data reported by the payers. Although patients may see an ADK provider, if they regularly see a non-ADK provider for primary care services, they would not be

attributed to the demonstration. At the end of 2015, approximately 104,000 enrollees were insured by payers in the demonstration, as shown in figure 2.2.

Figure 2.2: Estimated Number of Enrollees Participating In The ADK Demonstration 2013 to 2015

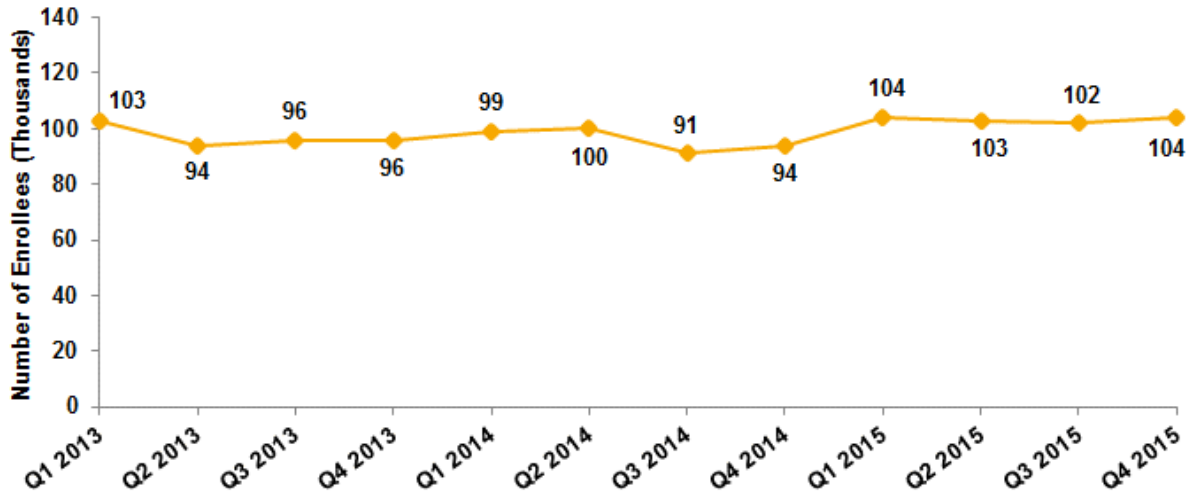
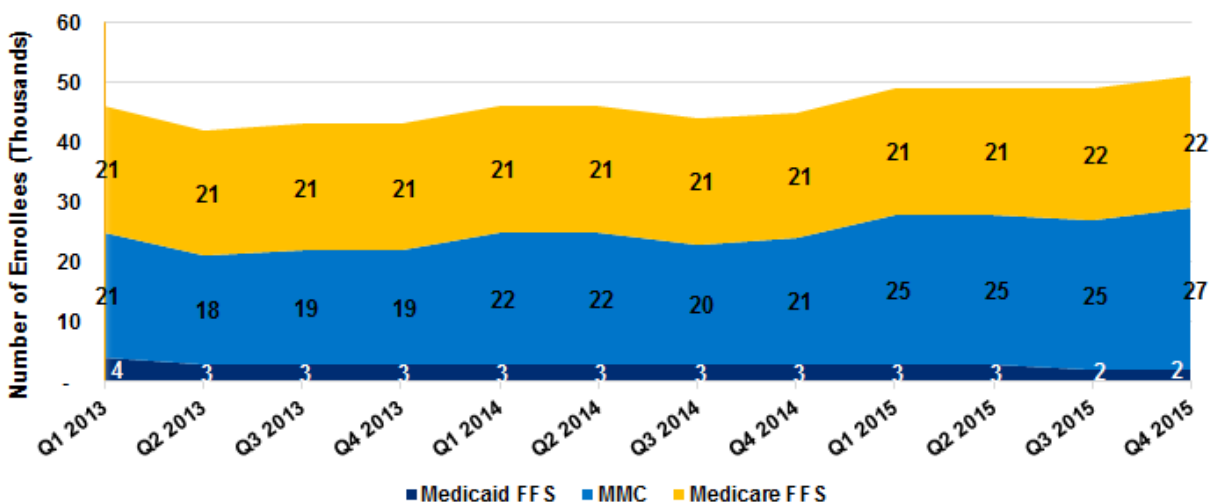


Figure 2.3 shows changes in the number of enrollees in public insurance programs that were attributed to an ADK provider. CHP enrollees participating in the demonstration are included in the MMC total. The decrease in the Medicaid FFS population and increase in MMC population is mostly due to the mandatory transition of most FFS populations into MMC in the ADK counties. As of December 2015, 50% (51,837) of the enrollees in the ADK demonstration were insured by one of the public payers: Medicaid FFS, MMC/CHP, and Medicare FFS (Medicare left the Demonstration on 12/31/16).

Figure 2.3: Number of Enrollees Attributed to Public Payers 2013 to 2015



Expenditures

All payers participating in the ADK demonstration provide an additional \$7 PMPM or \$84 PMPY, to participating providers within their networks for the providers' attributed enrollees. Medicaid FFS provides an add-on amount for eligible evaluation and management and preventive care claims to remain consistent with the MMC capitation rate. This is to ensure incentives for each enrollee is comparable, regardless of the enrollee's payer status.

Over time, the NYS DOH observed a downward trend in the average number of visits patients had with their PCPs in the ADK region and began adjusting the Medicaid FFS add-on amounts each year to ensure the incentive remained comparable to \$84 PMPM. On January 1, 2014, the FFS add-on payment amount was increased from \$28 per visit to \$32 per visit. On January 1, 2015 the FFS add-on amount was increased to \$35 per visit and to \$38.50 on January 1, 2016. Medicaid providers participating in the ADK demonstration are not eligible for MMC or Medicaid FFS incentives in the New York Statewide Medicaid PCMH Incentive Payment Program.

Figure 2.4a shows the estimated amount spent by payer for increased capitation payments and add-on amounts from 2010 to 2015. About 43 percent, or \$19.2 of \$45 million, of the incentive payments came from public programs (MMC, Medicaid FFS, and Medicare). Expenditures in capitated arrangements were calculated by multiplying the number of plan-reported enrollees attributed to that payer type for the given year by \$ 84 PMPY. CHP expenditures are included within the MMC total expenditures. Medicaid FFS expenditures were calculated by summing all add-on payments in the given year using Medicaid claims data.

Figure 2.4a: All Payer Expenditures 2010 to 2015
(In Millions) Total=\$45M

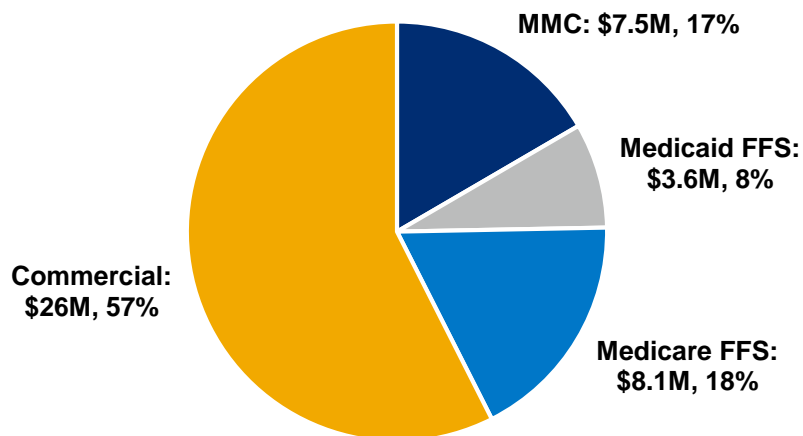


Figure 2.4b shows how much was distributed by MMC, Medicaid FFS, Medicare, and commercial payers each year since the program's inception through 2015. Among the public payers, Medicare expenditures were the highest: \$8.1 million from July 2011 through December 2015, due to their larger attributed population. Enhanced payments averaged approximately \$4.4 million for the commercially insured population each year. Medicaid has spent just over \$11.2 million on the ADK program from January 2010 through December 2015. As the FFS Medicaid population migrated into MMC during 2014, the add-on expenditure for FFS Medicaid

enrollees in ADK decreased substantially, resulting in less than \$200,000 spent on the FFS Medicaid population and over \$1.8 million spent on the MMC population in calendar year 2015.

Table 2.4b: All Payer Expenditures by Year					
Year	MMC	Medicaid FFS	Medicare	Commercial	Total
2010	\$ 231,252	\$ 1,141,420	\$ 0	\$ 4,206,468	\$ 5,579,140
2011	\$ 955,697	\$ 997,696	\$ 672,000	\$ 4,206,468	\$ 6,831,861
2012	\$ 1,143,072	\$ 667,940	\$ 1,740,879	\$ 4,520,040	\$ 8,071,931
2013	\$ 1,628,529	\$ 493,290	\$ 1,756,755	\$ 4,497,486	\$ 8,376,060
2014	\$ 1,783,656	\$ 190,449	\$ 1,799,679	\$ 4,275,474	\$ 8,049,258
2015	\$ 1,819,461	\$ 195,846	\$ 2,162,622	\$ 4,467,603	\$ 8,645,532
Total	\$ 7,561,667	\$ 3,686,641	\$ 8,131,935	\$ 26,173,539	\$ 45,553,782

*Medicare joined the demonstration in July 2011
 **The number of commercially insured enrollees was not reported in 2010 and therefore unavailable to calculate the 2010 spend. The 2011 reported number of enrollees was used for both 2010 and 2011.

Pay for Performance

In January 2013, a Pay for Performance (P4P) program was established for the ADK practices. The funds for this program were pooled by collecting \$0.50 of the \$7PMPM capitation from all of the payers. Funds were redistributed bi-annually based on practices' performance in quality, patient satisfaction, and utilization. Select quality metrics were collected from practices' electronic health records, and patient satisfaction measures were obtained through the Consumer Assessment of Healthcare Providers & Systems Clinician and Group surveys (CG-CAHPS). Lastly, inpatient, outpatient, emergency department (ED), and professional services utilization are available through the all payer data warehouse. P4P funds that were not earned by low performers were placed in a performance improvement pool (PIP) used to fund improvement initiatives across the ADK demonstration.

Table 2.5 shows the fund distribution for the first three cycles of the P4P initiative. A method for measuring quality of care was not implemented during the first two cycles, therefore practices were given the maximum funds allocated to this domain for the first year. Cycle four was the final cycle of the P4P initiative in the ADK, covering dates of service for the second half of calendar year 2014. Payout data for cycle four is not available at this time and will be included in the next report.

Table 2.5: Distribution of P4P Funds						
	Cycle 1 1/1/13-6/30/13		Cycle 2 7/1/13-12/31/13		Cycle 3 1/1/14-6/30/14	
	Funds Earned	PIP Funds	Funds Earned	PIP Funds	Funds Earned	PIP Funds
Quality (40%)	\$114,575	\$0	\$112,368	\$0	\$96,173	\$12,469
Utilization (40%)	\$76,378	\$38,197	\$52,482	\$59,886	\$25,051	\$83,591
Patient Experience (20%)	\$31,681	\$25,607	\$48,270	\$7,914	\$28,068	\$26,253
Total Distributed	\$222,634	\$63,804	\$213,120	\$67,800	\$149,292	\$122,313
Total Allocated to the P4P Program	\$286,438		\$280,920		\$271,605	

Evaluation of Quality Measures and Utilization

The methodology used in the QARR analysis described in [Chapter 1](#) was replicated to evaluate the same clinical quality measures in the ADK demonstration. A list of quality and utilization measures can be found in Appendix A and Appendix B of this report.

This analysis was limited to MMC enrollees attributed to participating providers in the ADK demonstration. Since the majority of the insured population in the ADK region are insured by payers participating in the demonstration, a comparison group of MMC enrollees that were not attributed to a PCMH-recognized provider, with similar demographic characteristics that reside in 16 non-ADK counties, was created. To control for confounding factors, the two groups were refined through a one-to-one match of socio-demographic characteristics including gender, age, race, aid category, length of time enrolled in Medicaid, and health status (as defined by 3M's CRGs) using a logistic regression model. A rate was calculated for each group and the difference between the two rates was tested for statistical significance using a z-test to observe the difference in proportions. A p-value of <0.05 was used to determine statistical significance.

Study Population

Table 2.6 displays how many enrollees were included in this analysis by year. For all years half of the enrollees in the study population were attributed to a PCMH-recognized provider and the other half were attributed to a non-PCMH-recognized provider. The matched cohorts for all years looked relatively similar across years: around half were age 18 or younger, slightly more than half were female, a large proportion were considered to be 'healthy' as defined by their CRG, and most were continuously enrolled in Medicaid.

Table 2.6: Study Population Composition						
Year	Number of enrollees	Proportion of Medicaid Enrollees in ADK vs. non-ADK regions	Age 18 or Younger	Female	Healthy CRG	Twelve Months Continuous Enrollment
2013	12,760	50%	44%	57%	44%	97%
2014	44,564	50%	56%	55%	48%	76%
2015	30,418	50%	48%	55%	48%	61%

Quality Measure Results

For measurement year 2015, the cohort of adult enrollees attributed to an ADK provider showed better results with statistical significance for two of 12 clinical quality measures. These measures included: Breast Cancer Screening and Annual Monitoring for Patients on Persistent Medications – combined rate.

In 2015, statistical significance could not be determined for Cervical Cancer Screening due to small sample size (a denominator less than 30). Although statistical significance could not be determined, the ADK rate for Cervical Cancer Screening was higher than the non-ADK group.

In 2015, there were no statistically significant differences between the two cohorts for nine of 12 measures. However, although not statistically significant, the ADK group had higher rates for seven measures: Chlamydia Screening (age 21-24), Antidepressant Medication Management – Effective Acute Phase Treatment, Antidepressant Medication Management – Effective Continuation Phase Treatment, Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis, Use of Image Studies for Low Back Pain, Follow-Up After Hospitalization for Mental Illness within seven days, and Follow-Up After Hospitalization for Mental Illness within 30 days. The two measures that the ADK group performed worse than the comparison group were: Medical Management for People with Asthma 50 Percent Covered (ages 19-64) and Metabolic Monitoring, although neither one was found to be statistically significant.

None of the rates calculated for the 2015 measurement year showed that the ADK cohort performed statistically significantly worse than the comparison group, indicating that the ADK cohort examined received at least the same quality of care or better than those in the comparison counties.

Across all years presented in this analysis, the ADK group rates were statistically significantly higher for Breast Cancer Screening and Annual Monitoring for Patients on Persistent Medications. Figure 2.7a contains a comparison of all results in this analysis.

Table 2.7a: Comparison of ADK and Non-ADK Non-PCMH Rates for Medicaid Adult Quality Measures for 2013 to 2015									
Measure	2013			2014			2015		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Annual Monitoring for Patients on Persistent Medications-Combined Rate	92%	86%	6*	93%	88%	5*	95%	90%	5*
Antidepressant Medication Management-Effective Acute Phase Treatment	57%	62%	-5	57%	56%	1	57%	55%	2

Table 2.7a: Comparison of ADK and Non-ADK Non-PCMH Rates for Medicaid Adult Quality Measures for 2013 to 2015 cont.

Measure	2013			2014			2015		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Antidepressant Medication Management-Effective Continuation Phase Treatment	47%	42%	5	40%	41%	-1	42%	39%	3
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	22%	14%	8	26%	14%	12*	21%	15%	6
Breast Cancer Screening	71%	66%	5*	75%	65%	10*	78%	69%	11*
Cervical Cancer Screening	75%	68%	7*	65%	73%	SS	88%	69%	SS
Chlamydia Screening (Ages 21-24)	59%	55%	4	62%	62%	0	63%	60%	3
Cholesterol Level Controlled (<100mg/dL)	NA	NA	-	NA	NA	-	NA	NA	-
Cholesterol Screening Test	NA	NA	-	46%	60%	SS	NA	NA	-
Follow up after Hospitalization for Mental Illness within 30-Days	77%	55%	22*	76%	64%	12	70%	58%	12
Follow up after Hospitalization for Mental Illness within 7-Days	77%	55%	22*	76%	64%	12	70%	57%	13
Medical Management for People with Asthma 50% Covered (Ages 19-64)	71%	79%	-8	68%	71%	-3	63%	66%	-3
Use of Imaging Studies for Low Back Pain	77%	69%	8	74%	58%	16*	68%	61%	7
NA: Not available. Measure was not collected that year.									
*Relative differences between rates is statistically significantly different (p<0.05)									
SS: Small sample < 30									

The pediatric cohort attributed to an ADK provider showed better, statistically significant results for three of eight of the measures in this analysis for all three measurement years, as displayed

in Table 2.7b. These measures included: Well Child and Preventive Care Visits in the Third, Fourth, Fifth, and Sixth Year of Life, Adolescent Well Care Visits, and Appropriate Testing for Pharyngitis.

The ADK group also performed better for the Well Child and Preventive Care Visits in the First 15 Months of Life (five or more visits), but the differences were not statistically significant. Additionally, the ADK group outperformed the comparison cohort for the Adolescent HPV Immunization Measure, but the sample size was too small and statistical significance could not be determined.

In the 2015 measurement year, the Chlamydia Screening (age 16-20) measure was the only measure where the non-ADK non-PCMH cohort scored statistically significantly higher than the ADK group. Table 2.6b includes all measure results for both groups for all three years of this analysis.

Table 2.7b: Comparison of ADK and Non-ADK Non-PCMH Rates for Medicaid Pediatric Quality Measures for 2013 to 2015									
Measure	2013			2014			2015		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Adolescent HPV Immunization	58%	42%	16	48%	36%	SS	75%	44%	SS
Adolescent Well-Care Visits	66%	60%	6*	64%	55%	9*	77%	69%	8*
Appropriate Testing for Pharyngitis	92%	82%	10*	95%	86%	9*	92%	82%	10*
Chlamydia Screening (Ages 16-20)	40%	47%	-7	39%	47%	-8*	41%	55%	-14*
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NA	NA	-	56%	75%	-19*	29%	33%	-4
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NA	NA	-	27%	35%	-8	54%	72%	SS
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NA	NA	-	4%	1%	SS	30%	30%	SS
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	85%	80%	5*	86%	80%	6*	91%	84%	7*

Table 2.7b: Comparison of ADK and Non-ADK Non-PCMH Rates for Medicaid Pediatric Quality Measures for 2013 to 2015 cont.

Measure	2013			2014			2015		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Well-Child Visits in First 15 Months of Life (5+ Visits)	93%	92%	1	95%	90%	5	92%	90%	2
NA: Not available. Measure was not collected that year.									
*Relative differences between rates were statistically significantly different (p<0.05)									
SS: Small sample < 30									

Utilization Results

Table 2.8 includes utilization results PMPY from 2013 through 2015 for ADK and non-ADK non-PCMH cohorts, split by adult and pediatric metrics. Utilization rates from 2012 can be found in the [previous ADK report](#).

Across all three years the ADK cohort, of both adults and children, had statistically significant, lower rates for ED visits, meaning the ADK enrollees utilized emergency room services significantly less often. This is potentially indicative of the extra support and efforts of the demonstration, more specifically, the \$7.00 PMPM investments from the plans is used for; additional care management services, higher compensation for physicians in order to maintain a strong workforce to meet the healthcare demanded needs in the region, performance improvement projects, and demonstration governance structure to manage and allocate resources as needed, including the contract oversight for a data collection, management, and evaluation vendor to monitor the demonstrations progress. This may also be explained by the results of the Outpatient Primary Care Visits for both Children and Adults as well. Across all three years presented in this report, the ADK group had significantly higher rates of Outpatient Primary Care Utilization.

There were no statistically significant differences found between the two groups for the adult inpatient hospitalization measure or the prevention quality indicator composite measure, although, the rates were better for the ADK group. There was also no statistically significant difference found for the Inpatient Hospitalization Pediatric measure between groups. Statistical significance differences could not be calculated for the Pediatric Quality Indicator measure due to small sample size.

Table 2.8: Comparison of ADK and Non-ADK Non-PCMH PMPY Utilization Rates for 2013 to 2015

Measure	2013			2014			2015		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Adults									
Inpatient Hospitalization	0.14351	0.14354	-0.00003	0.13874	0.13692	0.00182	0.14279	0.14439	-0.0016
Prevention Quality Indicators	0.00268	0.00469	SS	0.01486	0.01171	0.00315	0.01545	0.01547	-0.00002
ED Visits	1.11790	1.13396	-0.01606	0.89285	1.08004	-0.18719*	0.90318	1.12631	-0.22313*
Outpatient Primary Care Visits	6.74959	6.22375	0.52584*	6.34331	6.20468	0.13863*	6.95158	6.71984	0.23174*
Pediatric									
Inpatient Hospitalization	0.03727	0.03924	-0.00197	0.03548	0.03672	-0.00124	0.03163	0.02572	0.00591
Pediatric Quality Indicators	0.00022	0.00022	SS	0.00248	0.00144	SS	0.00166	0.00132	SS
ED Visits	0.44301	0.59951	-0.15650*	0.43272	0.56799	-0.13500*	0.45983	0.61212	-0.15229*
Outpatient Primary Care Visits	4.92524	5.07632	-0.15108*	4.61901	4.83509	-0.21608*	4.76671	5.30928	-0.54257*
*Relative differences between groups were statistically significantly different (p<0.05)									
Note: lower rates are desirable for all measures except the outpatient primary care visit measure									
SS: Small sample									

Multipayer QARR Analysis

In 2014, health plans began to submit enrollee-level commercial QARR data to the NYS DOH. The 2014 QARR submission contained quality measures for services rendered in 2013 and the 2015 submission contained quality measures for services rendered in 2014. In order to evaluate clinical quality of care across all the payer populations for enrollees in the ADK, ADK-participating health plans submitted lists of their enrollees in the demonstration to the NYS DOH to match to the previously submitted QARR data to identify and create an ADK and non-ADK non-PCMH cohort across payers. These data were used to replicate the MMC quality of care analysis described in the previous section of this report.

Demographic data for non-Medicaid enrollees was limited to age, gender, and health plan. Therefore, the one-to-one match to create the comparison group could not control for confounding factors as robustly as the Medicaid-only analysis and only included these three variables. Medicare enrollees were not included in this analysis.

Study Population

Table 2.9 displays how many enrollees were included in this analysis by year. For both years half of the enrollees in the study population were attributed to a PCMH-recognized provider and the other half were attributed to a non-PCMH-recognized provider. The matched cohorts for both years looked relatively similar across years: around half were age 18 or younger, slightly more than half were female, a large proportion were considered to be ‘healthy’ as defined by their CRG, and most were continuously enrolled in Medicaid.

Year	Number of Enrollees	Proportion of Enrollees in ADK vs. non-ADK regions	Age 18 or Younger	Female	UHC	Excellus	CDPHP	MVP	BCBS	Fidelis
2013	38,286	50%	35%	60%	24%	26%	7%	3%	7%	39%
2014	49,378	50%	35%	62%	24%	12%	7%	9%	4%	44%

Results

Table 2.10a shows that results for the adult population and the analysis revealed that the ADK cohort had statistically significantly better results for Breast Cancer Screening measure in both 2013 and 2014. The ADK group also performed statistically significantly better than the comparison cohort for Cervical Cancer Screening measure in 2014. Although not significant, the results identified better outcomes for the ADK group for Avoidance of Antibiotic Therapy in Adults with Acute Bronchitis, Medical Management for People with Asthma 50 Percent Covered (Ages 5-64), and Use of Imaging Studies for Low Back Pain measure.

The non-ADK non-PCMH group performed better for the Antidepressant Medication Management-Effective Acute Phase Treatment, Antidepressant Medication Management-Effective Continuation Phase Treatment, and Chlamydia Screening Ages 21 to 24 but was not statistically significant.

Measure	2013			2014		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Adult BMI Assessment	96	78	8*	NA	NA	-
Antidepressant Medication Management-Effective Acute Phase Treatment	57	57	0	56	57	-1
Antidepressant Medication Management-Effective Continuation Phase Treatment	57	56	1	58	62	-4

Table 2.10a: Comparison of Multipayer ADK and Non-ADK Non-PCMH Rates for Adult Quality Measures for 2013 and 2014

Measure	2013			2014		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	17%	13%	4	21%	16%	5
Blood Pressure Controlled (<140/90)	57%	45%	12	NA	NA	-
Breast Cancer Screening	82%	73%	9*	83%	72%	9*
Cervical Cancer Screening	79%	78%	1	82%	70%	12*
Chlamydia Screening (Ages 21-24)	NA	NA	-	54%	56%	-2
Cholesterol Level Controlled (<100mg/dL)	56%	40%	16	NA	NA	-
Cholesterol Screening Test	89%	85%	4	NA	NA	-
Comprehensive Diabetes Care	24%	21%	3	NA	NA	-
Controlling High Blood Pressure	NA	NA	-	62%	68%	-6
Dilated Eye Exam	57%	47%	10	NA	NA	-
HbA1c and Lipids Controlled	24%	21%	3	NA	NA	-
HbA1C Control (<7.0%)	NA	NA	-	NA	NA	-
HbA1C Control (<8.0%)	42%	38%	4	NA	NA	-
HbA1c Testing	83%	93%	-10	NA	NA	-
Lipids Controlled (<100 mg/dL)	56%	40%	16	NA	NA	-
Medical Management for People with Asthma 50% Covered (Ages 5-64)	63%	67%	-4	68%	62%	6
Nephropathy Monitoring	81%	81%	0	NA	NA	-
Poor HbA1c Control † (lower rate is desirable)	50%	46%	4	NA	NA	-
Received All Tests	42%	35%	7	NA	NA	-
Use of Imaging Studies for Low Back Pain	78%	75%	3	77%	76%	1
NA: Not available. Measure was not collected that year.						
*Relative differences between ADK/Non-ADK rate is statistically significantly different (p<0.05)						
SS: Small sample						

Table 2.10b shows the results for the pediatric population. The ADK pediatric cohort had statistically significantly better results for Adolescent Well-Care Visits and Well-Child Visits in the First 15 Months of Life measures in 2013 and 2015.

In three pediatric measures, the ADK group outperformed the comparison cohort in 2014 but was not found to be statistically significant. These measures are: Adolescent HPV Immunization, Medical Management for People with Asthma 50 percent Covered Ages five to 18, and Well-Child Visits in third, fourth, fifth, and sixth Year of Life.

The Chlamydia Screening measure (Ages 16-20) and Metabolic Monitoring for Children and Adolescents on Antipsychotics were the only measures in which the ADK group performed worse than the comparison group and was found to be statistically significant, although the difference in rates between years for Chlamydia Screening is directionally positive. The ADK group also performed worse in the Appropriate Testing for Pharyngitis measure, but was not statistically significant. Significance testing could not be performed for the Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics due to a small sample size, although the rate for the non-ADK group was better. There was no difference between groups for the Use of Multiple Concurrent Antipsychotics in Children and Adolescents.

Table 2.10b: Comparison of Multipayer ADK and Non-ADK Non-PCMH Rates for Pediatrics Quality Measures for 2013 and 2014

Measure	2013			2014		
	ADK	Non-ADK	Difference	ADK	Non-ADK	Difference
Adolescent HPV Immunization	49%	44%	5	49%	33%	16
Adolescent Immunization-Combo	74%	63%	11	NA	NA	-
Adolescent Well-Care Visits	66%	56%	10*	63%	57%	6*
Appropriate Testing for Pharyngitis	89%	77%	12*	93%	94%	-1
Chlamydia Screening (Ages 16-20)	40%	50%	-10*	44%	50%	-6*
Counseling for Nutrition	88%	67%	21*	NA	NA	-
Counseling for Physical Activity	81%	64%	17	NA	NA	-
Follow-Up Care for Children Prescribed ADHD Medication: Continuation Phase	64%	67%	-3	NA	NA	-
Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	57%	56%	1	NA	NA	-
Medical Management for People with Asthma 50% Covered (Ages 5-18)	69%	63%	7	75%	66%	9
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NA	NA	-	23%	34%	-11*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NA	NA	-	50%	70%	SS
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	NA	NA	-	3%	3%	0
Weight Assessment- BMI Percentile	91%	75%	16*	NA	NA	-
Well-Child Visits in 3rd, 4th, 5th & 6th Year of Life	87%	80%	7*	85%	84%	1

Well-Child Visits in First 15 Months of Life (5+ Visits)	96%	90%	6*	93%	79%	14*
NA: Not available. Measure was not collected that year.						
*: Relative differences between groups were statistically significantly different (p<0.05)						
SS: Small sample						

Patient Satisfaction

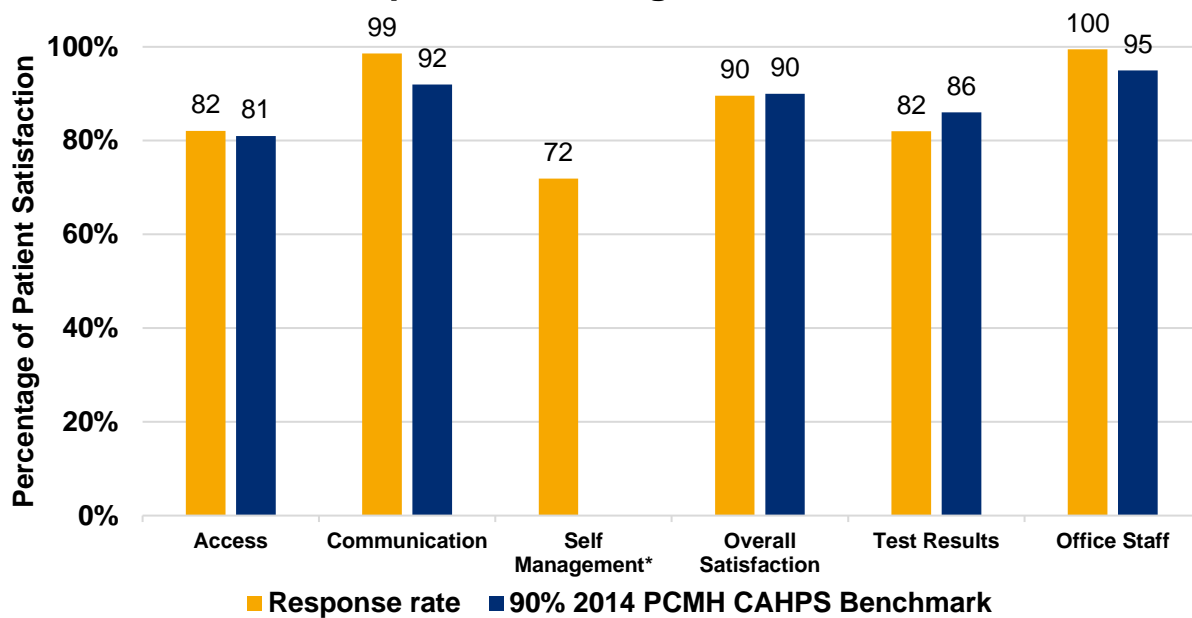
In previous years, the Adirondack Health Institute (AHI) conducted surveys of patients to assess their overall satisfaction with practices in the ADK demonstration using the CG-CAHPS instrument. The CG-CAHPS tool measures patient experience in the following domains: getting timely appointments, care, and information; how well providers communicate with patients; helpful, courteous, and respectful office staff; and patient ratings of the providers. The CG-CAHPS instrument was used to assess overall patient satisfaction in 2011 and 2013 and these results can be found in the [previous ADK report](#).

A transition from a mail survey to an online tool was made in April 2015. This change to online surveys was made to obtain more real time feedback and reduce recall bias. Other benefits of using the online surveys include reduced processing time.

There were 1,745 completed surveys for both adult patients and parents of pediatric patients from April through December 2015. Around 80% of respondents gave their provider a rating of 9 or 10 on a scale of 0 – 10 (10 was the best possible score). Providers in the ADK demonstration performed well on communication with patients (listening carefully to patients, showing respect for what patients have to say, explaining necessary information in a way that is easy to understand, knowing medical history of the patient, and spending enough time with the patient) and having courteous and respectful staff. However, there is still room for improvement in overall satisfaction.

Figure 2.11 shows the results of the survey as well as the 2014 PCMH CAHPS national benchmark for comparison. The benchmark data comes from NCQA’s CAHPS database. Participation for submission to the CAHPS is open to all users of the CG CAHPS survey that administer surveys according to the CAHPS specifications. For those that submit, NCQA allows users to utilize the reporting system to view their own results compared to relevant benchmarks. The patient satisfaction survey questions are included in Appendix D of this report.

**Figure 2.11: Patient Satisfaction Results
April 2015 through December 2015**



*CAHPS Benchmark for Self Management Composite not available

Provider Experience

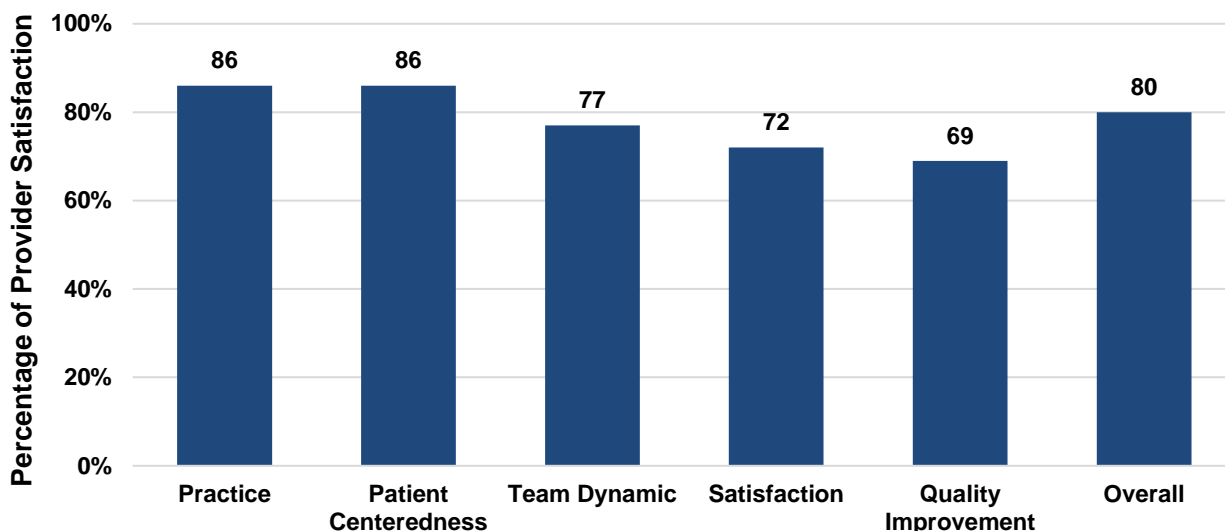
In 2016, AHI conducted a survey to capture providers' overall satisfaction. The 2016 survey was administered to assess the experiences of providers across the Adirondack region, analogous to the goals of the 2011 and 2013 surveys (see the [2014 ADK report](#)). This web-based survey was created by the American College of Physician's Center for Practice Innovation and included 17 questions that covered the following domains: Practice: accomplishment of administrative and clinical tasks; Satisfaction: work environment and aspects of care for patients; Team Dynamic: staff teamwork; Quality Improvement: quality of work performed, provider improvement; and patient centeredness: shared decision making with patient, incorporating patient input.

The list of survey questions for each composite score (practice, satisfaction, team dynamic, quality improvement, and patient centeredness) can be found in Appendix E.

In 2016, 194 surveys were emailed and 110 were completed. The response rate was 57%; the 2016 survey had a much higher response rate as compared to the 2011 and 2013 surveys, 33% and 35% respectively.

The 2016 provider survey experience results were highest for the patient centeredness (86%) and practice (86%) composites. The quality improvement (69%) composite was the lowest. Figure 2.12 shows the results across all composites calculated. Results of this survey were not compared to external benchmarks.

Figure 2.12 Provider Experience Composite Score Summary



Caveats and Limitations

Evaluation results should be considered with the following caveats and limits for each analysis:

Quality and Utilization

The caveats and limitations related to Medicaid-specific analyses mentioned in the first chapter are also applicable for all Medicaid analyses presented in the second chapter.

The multipayer analysis cohorts were created with less specific mating criteria due to what was available. Therefore, the groups may be less alike than the Medicaid specific quality and utilization analyses. Fidelis insures the majority of individuals in the MMC population; there is not much racial diversity in the Medicaid plans included in the ADK quality and utilization analyses.

Patient Satisfaction

The patient satisfaction surveys moved to a new online platform in April 2015. Each time a patient had a visit they were eligible to provide feedback on their experience, creating opportunities for individuals to respond multiple times. The demonstration also did not track all visits, therefore a true response rate per individual is unknown. There may be underlying differences between those who had visits and chose to complete a survey verses those who had visits and chose not to complete a survey.

Provider Experience

The provider experience surveys were sent out to all providers in 2016 and the response rate was 57%. This is much higher than previous years surveyed but still only representative of approximately half of the physicians practicing in the ADK region. Higher response rates may allow for more meaningful conclusions on overall provider experience.

Discussion

In sum, the analyses show directionally positive results. The quality of care analyses for both Medicaid and multipayer populations indicate the positive impact of the program and specific

areas of strength such as breast cancer screening and well-child and preventive care visit rates across years.

Utilization results for the Medicaid population also show that enrollees in the ADK group utilize the emergency room significantly less often. This may indicate improved access to primary care and patient education.

The number of enrollees in the ADK demonstration has remained relatively consistent (between 90,000-100,000 enrollees) and the satisfaction results from this population indicate patients are pleased with the level and type of care they are receiving. Survey response scores were higher than the benchmark rates for all but one composite, where benchmarks were available.

The provider survey results should be evaluated closely as the providers are on the front lines taking care of patients. Ideally, results should be higher for a few domains, such as general satisfaction and quality improvement in order to keep attracting and retaining a strong workforce and continue to deliver high quality of care to the New Yorkers in this region.

Next Steps

The analyses presented in this report will be replicated in coming years to continue to monitor program successes and search for areas of improvement as the demonstration continues. The NYS DOH will carry out the next iteration of the quality and utilization analyses for both Medicaid and the multipayer population. Other payers will likely pursue similar analyses for their specific enrollees.

Appendix A: Adult Quality Measures

Measure	Area	Description
Adult BMI Assessment	Prevention	The percentage of enrollees, 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 enrollees 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 enrollees 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 enrollees 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.
Blood Pressure Controlled (<140/90)	Chronic Disease	The percentage of enrollees with diabetes whose most recent blood pressure reading was below 140/90.
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	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 Controlled (<100mg/dL)	Chronic Disease	The percentage of enrollees, 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 enrollees, ages 18 to 75, with diabetes and the rate at which they received necessary components of diabetes care.
Controlling High Blood Pressure	Chronic Disease	The percentage of enrollees, ages 18 to 85 years, who have hypertension and whose blood pressure was adequately controlled (below 140/90).
Dilated Eye Exam	Chronic Disease	The percentage of enrollees with diabetes who had a retinal eye screening exam during the last year or who had a negative retinal exam in the year prior.
HbA1c and Lipids Controlled	Chronic Disease	The percentage of enrollees 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).
HbA1C Control (<7.0%)	Chronic Disease	The percentage of enrollees with diabetes whose most recent HbA1c level indicated poor control (>7.0 percent).
HbA1C Control (<8.0%)	Chronic Disease	The percentage of enrollees with diabetes whose most recent HbA1c level indicated poor control (>8.0 percent).
Lipid Profile	Chronic Disease	The percentage of enrollees with diabetes who had at least one cholesterol screening test done during the past year.
Lipids Controlled (<100 mg/dL)	Chronic Disease	The percentage of enrollees with diabetes whose most recent level of bad cholesterol was below the recommended level (LDL-C <100 mg/dL).
Medical Management for People with Asthma 50% Covered (Ages 19-50)	Chronic Disease	The percentage of enrollees 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.
Nephropathy Monitoring	Chronic Disease	The percentage of enrollees with diabetes who had at least one nephropathy screening test or had evidence of nephropathy during the last year.

Poor HbA1c Control	Chronic Disease	The percentage of enrollees with diabetes whose most recent HbA1c level indicated poor control (>9.0 percent).
Received All Tests	Chronic Disease	The percentage of enrollees 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.
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 B: Pediatric Quality Measures

Measure	Area	Description
Adolescent Human Papillomavirus Vaccine (HPV) for Female	Prevention	The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13 th birthday.
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: 4-3-1-33-1-4)	Prevention	The percentage of two-year olds who were fully immunized. The HEDIS specifications for fully immunized consist of the following vaccines: 4 Diphtheria/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 enrollees 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.
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Chronic Disease	The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics.	Acute Care	The percentage of children and adolescents 1 to 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	Overuse	The percentage of children and adolescents ages 1 to 17 years of age who were on two or more concurrent anti-psychotic medications.
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 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 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.

Appendix C: Utilization Measures

Measure	Area	Description
ED Visits	Utilization	Count each visit to an Emergency Department (ED) that does not result in an inpatient encounter once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.
Inpatient Hospitalization	Utilization	This measure summarizes utilization of acute inpatient care and services in the following categories; total inpatient, maternity, surgery and medicine.
Outpatient Primary Care Visits	Utilization	Outpatient visits (Ambulatory Outpatient Visits Value Set). Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits)
Prevention Quality Indicators and Pediatric Quality Indicators (PQIs)	Utilization	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.

Appendix D: Patient Satisfaction Survey

CAHPS Clinician & Group Survey

Version: 3.0

The CAHPS patient satisfaction survey questions delivered using AHI's survey platform are listed below. The survey is offered in English and in Spanish and contains supplemental PCMH questions developed by the CAHPS Consortium. The supplemental items are identified by question numbers beginning with PCMH. The survey uses branching logic and will not ask

questions that are not relevant. The actual numbering presented to the enrollees taking the survey may vary. The complete list of questions follows.

Reference: <http://www.ahrq.gov/cahps/index.html>

Welcome

Our goal is to give our patients the highest quality health care that we can. To do this, we need to know what we are doing right and what needs improvement. We depend on our patients and their families to keep us informed.

By sharing your thoughts and feelings about your health care experience with your provider, you can help make our care better for future patients and their families. Please take a few minutes to complete the following patient satisfaction survey. Feel free to express your opinions. **Your responses are completely confidential.**

Thank you, and please accept our best wishes for your good health.
Healthfully Yours,

<Practice Name>

Received Care

1. Have you received care from one of the providers at **<Practice Name>** in the last 6 months?
 - a. Yes
 - b. No → **If No, go to #24**

Instructions

Please rate the **services** you received from **<Practice Name>**. Choose the response that best describes your experience. If a question does not apply to you, please skip the next question. Space is provided for you to comment on good or bad things that may have happened to you.

When you have finished, please click the "Submit" button.

Provider

2. Which provider did you see during your most recent visit? Please think of this person as "the provider" as you answer the survey.
<List of Providers>
Write-in option
'I don't know'
3. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?
 - a. Yes
 - b. No
4. How long have you been going to this provider?
 - a. Less than 6 months
 - b. At least 6 months but less than 1 year
 - c. At least 1 year but less than 3 years
 - d. At least 3 years but less than 5 years

- e. 5 years or more

Your Care from This Provider in the Last 6 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times that you went for dental care visits.

5. In the last 6 months, how many times did you visit this provider to get care for yourself?
 - a. None → **if None, go to #24**
 - b. 1 time
 - c. 2
 - d. 3
 - e. 4
 - f. 5 to 9
 - g. 10 or more times

6. In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury, or condition that **needed care right away**?
 - a. Yes
 - b. No → **if No, go to #8**

7. In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

8. In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?
 - a. Yes
 - b. No → **if No, go to #PCMH1**

9. In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

PCMH1

Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?

- a. Yes
 - b. No
-
10. In the last 6 months, did you contact this provider's office with a medical question during regular office hours?
 - a. Yes
 - b. No → **If No, go to #12**

11. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

12. In the last 6 months, how often did this provider explain things in a way that was easy to understand?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

13. In the last 6 months, how often did this provider listen carefully to you?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

14. In the last 6 months, how often did this provider seem to know the important information about your medical history?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

15. In the last 6 months, how often did this provider show respect for what you had to say?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

16. In the last 6 months, how often did this provider spend enough time with you?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

17. In the last 6 months, did this provider order a blood test, x-ray, or other test for you?
 - a. Yes
 - b. No → **If No, go to #19**

18. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
 - a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

19. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- a. 0 Worst provider possible
- b. 1
- c. 2
- d. 3
- e. 4
- f. 5
- g. 6
- h. 7
- i. 8
- j. 9
- k. 10 Best provider possible

PCMH2

Specialist are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of healthcare. In the last 6 months, did you see a specialist for a particular health problem?

- a. Yes
- b. No → **If No, go to #PCMH4**

PCMH3

In the last 6 months, how often did the provider named in Question1 seem informed and up-to-date about the care you got from specialists?

- a. Never
- b. Sometimes
- c. Usually
- d. Always

Please answer these questions about the provider named in Question1 of this survey.

PCMH4

In the last 6 months, did someone from this provider's office talk with you about specific goals for your health?

PCMH5

In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health?

- a. Yes
- b. No

PCMH6

In the last 6 months, did you and someone from this provider's office talk about things in your life that worry you or cause you stress?

- a. Yes
- b. No

20. In the last 6 months, did you take any prescription medicine?

- a. Yes
- b. No → **If No, go to #22**

21. In the last 6 months, how often did you and someone from this provider's office talk about all of the prescription medicines you were taking?
- a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

Clerks and Receptionists at this Provider's Office

22. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?
- a. Never
 - b. Sometimes
 - c. Usually
 - d. Always
23. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?
- a. Never
 - b. Sometimes
 - c. Usually
 - d. Always

About You

24. In general how would you rate your overall health?
- a. Excellent
 - b. Very good
 - c. Good
 - d. Fair
 - e. Poor
25. In general, how would you rate your overall mental and emotional health?
- a. Excellent
 - b. Very good
 - c. Good
 - d. Fair
 - e. Poor
26. What is your age?
- a. 18 to 24
 - b. 25 to 34
 - c. 35 to 44
 - d. 45 to 54
 - e. 55 to 64
 - f. 65 to 74
 - g. 75 or older

27. Are you male or female?
- Male
 - Female
28. What is the highest grade or level of school that you have completed?
- 8th grade or less
 - Some high school but did not graduate
 - High school graduate or GED
 - Some college or 2-year degree
 - 4-year college graduate
 - More than 4-year college degree
29. Are you of Hispanic or Latino origin or descent?
- Yes, Hispanic or Latino
 - No, Not Hispanic or Latino
30. What is your race? Mark one or more.
- White
 - Black or African American
 - Asian
 - Native Hawaiian or Other Pacific Islander
 - American Indian or Alaska Native
 - Other
31. Did someone help you complete this survey?
- Yes
 - No
32. How did that person help you? Mark one or more.
- Read the questions to me
 - Wrote down answers I gave
 - Answer the question for me
 - Translated the questions into my language
 - Helped me in some other way
33. Do you have Health Insurance for Medical Care?
- Yes
 - No

<Submit Survey>

Thank You

Appendix E: Provider Experience Survey Questions

Practice composite questions

1. Indicate how well each of the following is currently accomplished at your practice:
 - a. Answering phones
 - b. Appointment systems
 - c. Messaging
 - d. Scheduling Procedures
 - e. Ordering Diagnostic Test Results
 - f. Reporting Diagnostic Results
 - g. Prescription Renewals
 - h. Making referrals
 - i. Pre-authorization for services
 - j. Billing and Coding
 - k. Phone Advice

2. Indicate how well each of the following is currently accomplished at your practice:
 - a. Orient of patients to your practice
 - b. New patient work-ups
 - c. Minor procedures
 - d. Education for patients and families
 - e. Prevention assessment and activities
 - f. Chronic disease management
 - g. Coordination of patient care

Satisfaction Composite Questions

3. How would you rate the following aspect of your work environment?
 - a. Opportunities for growth through education and additional training
 - b. Utilization of your abilities
 - c. Amount of time you are able to spend with each patient
 - d. Degree of responsibility you have
 - e. Assistance and support from your coworkers

4. How satisfied are you with each of the following aspects of care for patients in your practice?
 - a. Quality of healthcare
 - b. Stability of patient relationships
 - c. Ability to provide continuity of care for the patients
 - d. Your familiarity with the patients

5. How would you rate the following?
 - a. Your morale and attitude about working here
 - b. Other people's morale and attitudes about working here

6. Over the last 12 months, how often have you felt:
 - a. Hurried or rushed
 - b. Stressed or overworked

Team Dynamic Composite Questions

7. For each of the following, please indicate how much you agree or disagree with the following statement:
 - a. The entire staff of your practice works together like a team
 - b. Other staff have the skills and knowledge to back you up if necessary
 - c. This practice has enough people and resources to meet the needs of your patients
 - d. Each enrollee' of this practice makes a contribution to the practices' success
 - e. Practice members are encouraged to express alternative viewpoints about service and clinical quality issues

Quality Improvement Composite Questions

8. For each of the following, please indicate how much you agree or disagree with the statement:
 - a. You know how to measure the quality of your work
 - b. You collect data about quality of your work
 - c. You know how to analyze (review) the quality of your work to see if changes are needed
 - d. You use these analyses for making decisions about your work
 - e. You know how well your practice is doing financially
 - f. You are recognized for your work

Patient Centeredness Composite Questions

9. For each of the following, please indicate how much you agree or disagree with the statement:
 - a. This practice does a good job of managing patients concerns and suggestions
 - b. This practice does a good job of assessing current patient needs and expectations
 - c. The staff promptly resolves patient complaints
 - d. Patients' complaints are studied to identify patterns and prevent the same problems from recurring
 - e. The practice uses data from patient complaints to improve services
10. Does your practice do the following?
 - a. Are patients asked for their ideas on their treatment plan?
 - b. Are patients asked to talk about any questions they are having with their medications?
 - c. Are patients asked about health habits in written or oral form?

Demographic Information

11. What is your current profession?
 - a. Physician
 - b. Physician's Assistant
 - c. Nurse Practitioner
 - d. Medical Assistant
12. How long have you worked in your position? (average years)
13. What is your gender?

14. What is your age?

15. Do you plan to retire in the next five years?

Establishing Criteria for Scheduling and Lifestyles

16. Please indicate how important each of the following were in establishing your schedule:

- a. Needs of family members (children, elderly relatives)
- b. Demands of other interests, volunteer work, and hobbies
- c. Maximization of practice revenue
- d. Achievement of a break-even point financially
- e. Attraction of new patients
- f. Need for frequent emergency sick visits (complex or high-need patient panel)
- g. Room to provide uncompensated care
- h. Local expectations
- i. other

Criteria for deciding Practice Location

17. Please indicate how important each of the following were when deciding where to locate or join your practice

- a. Trained nearby
- b. Grew up nearby
- c. Bought or inherited a practice
- d. Close to family
- e. Prove employment for family
- f. Close to other interests, volunteer work, hobbies
- g. Large population (ease of attracting patients)
- h. Need for medical services in the area (health professional shortage area)
- i. Scholarship or loan repayment requirement to locate in the region
- j. Maximization of practice revenue
- k. Achievement of a break-even point financially
- l. More relaxed lifestyle
- m. Faster-pace lifestyle
- n. Other

18. Are you aware of an unmet patient needs or other clinical issues that could be addressed through collective action at the Pod level? (Pod 1 and 3 only)

19. Do you feel you have a working knowledge of the challenges facing the operations of your group or hospital? (Pod 1 only)

20. Do you have suggestions to help with challenges? (Pod 1 only)

Resources

February 2015 Medicaid Update: Revised Policy and Incentive Payments

http://www.health.ny.gov/health_care/medicaid/program/update/2015/feb15_mu.pdf

About NCQA's Patient-Centered Medical Home Recognition

<http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx>

Joint Principles of the Patient-Centered Medical Home

<http://www.medicalhomeinfo.org/downloads/pdfs/jointstatement.pdf>

Information on New York State Medicaid Reimbursement per Provider Level

http://www.health.ny.gov/health_care/medicaid/program/update/2013/april13_mu.pdf

Comparison of NCQA's 2008 and 2011 Programs

<http://www.ncqa.org/Portals/0/Programs/Recognition/PPC-PCMH%202008%20vs%20PCMH%202011Crosswalk%20FINAL.pdf>

Comparison of NCQA's 2011 and 2014 Programs

<http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH/PCM H2011PCMH2014Crosswalk.aspx>

NCQA PCMH-Recognition State Comparison

<http://recognition.ncqa.org>

NCQA Diabetes Recognition Program

<http://www.ncqa.org/tabid/139/Default.aspx>

Previous PCMH Quarterly Reports

http://www.health.ny.gov/health_care/medicaid/redesign/pcmh.htm

Information on Level 1 NCQA Recognition Payments Ending

http://www.health.ny.gov/health_care/medicaid/program/update/2012/oct12mu.pdf

Information on 2008 Standard NCQA Recognition Payments Ending

https://www.health.ny.gov/health_care/medicaid/program/update/2015/mar15_mu.pdf

Information on the Adirondack Region Medical Home Pilot

<http://www.adkmedicalhome.org/>

Information on the Delivery System Reform Incentive Payment Program

https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

Questions?

Contact the Office of Quality and Patient Safety, NYS DOH, via e-mail at:

pcmh@health.ny.gov