New York

Advancing the Medical Home Model for Children and Youth
Created in Collaboration with the National Academy for State Health Policy

The National Center for Medical Home Implementation (NCMHI) and the National Academy for State Health Policy (NASHP) are collaborating on the development of state profiles designed to highlight public programs implementing and advancing the medical home model in pediatric populations. These updates are part of a formal partnership between NASHP and the NCMHI that focuses on exchanging information to improve medical home access for children and youth in medically underserved populations. If you have any questions about the information included in the updates, contact medical_home@aap.org.

The NCMHI is a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration.

New York has pursued numerous health care reform initiatives over the past several years that aim to improve health outcomes for its residents. Most recently, New York received a $99.9 million State Innovation Model Testing Award (SIM) to improve its primary care model and transition from a fee-for-service environment to a system that uses value-based payments. Recognizing an important component of creating high quality primary care is through promoting patient-centered medical homes (PCMH), New York's SIM plan intends to strengthen primary care capacity and increase access to medical home services by building on New York's existing PCMH model, which has demonstrated success in improving care for children and adults.

In 2009, legislation supporting the delivery of care through a PCMH model to Medicaid recipients created two medical home initiatives—the Adirondack regional multi-payer medical home demonstration and a statewide Patient-Centered Medical Home (PCMH) Program. Both programs serve children and adults enrolled in Medicaid or Child Health Plus (New York's Children's Health Insurance Program (CHIP) program).

New York State utilizes the National Committee for Quality Assurance (NCQA) PCMH recognition for both initiatives, and currently has the highest number of NCQA recognized PMCH practices in the country

PROGRAM COMPONENTS

ADIRONDACK MEDICAL HOME DEMONSTRATION

In response to a critical shortage of primary care physicians in the Adirondack region, New York established a five-year regional multi-payer initiative in 2009 as a pilot in the Northeast corner of the state to provide additional support to primary care practices. In July 2011, Medicare also began participating in the Adirondack Medical Home Demonstration through the Multi-payer Advanced Primary Care Practice demonstration. The resulting regional Adirondack Medical Home Demonstration is governed by a multi-stakeholder committee of payers and providers while chaired and overseen by an official from the New York State Department of Health (NYSDOH).

STATEWIDE PATIENT-CENTERED MEDICAL HOME PROGRAM

As a result of the 2009 legislation, the New York State Department of Health (NYSDOH) established a statewide initiative to incentivize the development of patient-centered medical homes. Medicaid providers participating in the Adirondack Medical Home Demonstration are not eligible for the enhanced payments through this statewide PCMH program.

New York includes 13 pediatric quality measures in its statewide PCMH program in areas including prevention, acute care, and chronic disease. Examples of specific measures include childhood and adolescent immunizations, well care and preventive care visits, weight assessment, nutrition and physical activity counseling, and medical management for people with asthma.

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PAYMENT MODEL

ADIRONDACK MEDICAL HOME DEMONSTRATION

The Adirondack Medical Home Demonstration is organized into three geographic regions, each of which includes a "pod" supporting the practices in its region through shared administrative and care coordination services. Participating practices received a readiness assessment to develop individualized work plans and incentive payments to support practice transformation and new care coordination services. Practices continue to receive these payments once they obtain NCQA PCMH Level 2 or 3 recognition within a 12-18 month period. Grant funding has also enabled all participating providers to implement an electronic health record.

Enhanced payments are made by commercial payers, Medicaid and Medicare Fee-For-Service, and Medicaid managed care plans to participating practices equivalent to $6.50 per member per month (PMPM). Providers share a portion of the payments with the pods and with the organization providing supports to the practices, the Adirondack Health Institute. A $0.50 PMPM pay-for-performance incentive payment is also available to practices based on member satisfaction, utilization, and the development of a practice improvement plan.

STATEWIDE PATIENT CENTERED MEDICAL HOME PROGRAM

Hospital outpatient clinics that have received NCQA PCMH recognition, including federally qualified health centers (FQHC) and office-based practitioners (both physicians and registered nurse practitioners), are eligible to receive enhanced payments for specific services for participating enrollees.

Payments are made through a patient's health plan via capitation payments or are paid as an 'add-on' for qualifying visits for Medicaid fee-for-service patients. Payments vary by level of NCQA recognition and whether services are provided within Federally Qualified Health Centers (FQHC) or by office-based practitioners. As of April 2015, a PCMH fiscal incentive policy will encourage providers who had initially qualified through earlier NCQA standards to meet 2014 NCQA standards. Incentive payments for 2008 NCQA PCMH standards will be eliminated, and 2011 NCQA PCMH standards will be reduced. Clinicians who obtain 2014 NCQA PCMH standards will receive incentive payments ranging from $6 -$8 PMPM.

OUTCOMES

As of December 2014, approximately 30% of pediatricians in the state are practicing in NCQA patient-centered medical homes. As of September 2014, 50% of New York Medicaid managed care enrollees in assigned to a PCMH-recognized provider are between the ages of 0 and 20. Evaluations on selected pediatric quality measures consistently show better performance on metrics within PCMH sites on weight assessment, counseling for nutrition, and childhood and adolescent immunizations. A 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey comparing Medicaid enrollees who received care from a PCMH practice versus those receiving care from a non-PCMH practice also showed significantly higher scores on receiving reminders between visits, having discussions on a child's prescription medications, child development, and injury prevention and wellness.

FAST FACTS:

2,799,685 : The number of children ever enrolled in Medicaid and CHIP in New York in FY 2013 (2,309,571 Medicaid; 490,114 CHIP)

91.7% : The participation rate for children eligible for the New York Medicaid/CHIP program

87.2% : The national participation rate for those eligible for the CHIP program

For more information on state public health initiatives related to pediatric medical home, visit www.medicalhomeinfo.org.