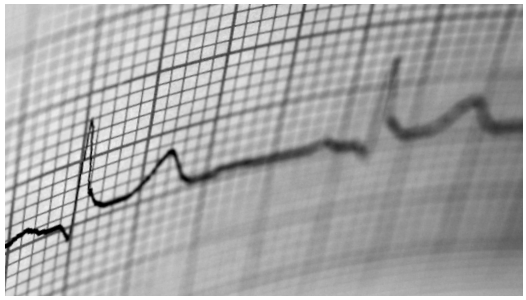
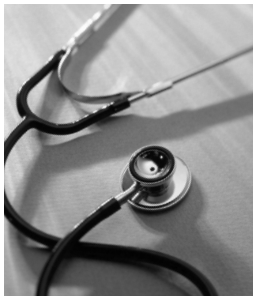
United Hospital Fund

The Evolution of Patient-Centered Medical Homes in New York State: Current Status and Trends as of September 2012



AN ISSUE BRIEF



United Hospital Fund

The United Hospital Fund is a health services research and philanthropic organization whose primary mission is to shape positive change in health care for the people of New York. We advance policies and support programs that promote high-quality, patient-centered health care services that are accessible to all. We undertake research and policy analysis to improve the financing and delivery of care in hospitals, health centers, nursing homes, and other care settings. We raise funds and give grants to examine emerging issues and stimulate innovative programs. And we work collaboratively with civic, professional, and volunteer leaders to identify and realize opportunities for change.

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The Evolution of Patient-Centered Medical Homes in New York State: Current Status and Trends as of September 2012

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UNITED HOSPITAL FUND

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the United Hospital Fund's website, www.uhfnyc.org.

Foreword

As part of the Fund's work to promote positive change by sharing good ideas and innovative solutions, we have produced several reports detailing the evolution of the medical home model in New York State. In October 2011, *The Patient-Centered Medical Home: Taking a Model to Scale in New York State* served as background for last year's Invitational Conference on the Patient-Centered Medical Home (PCMH) in New York State, which was co-sponsored by the Fund, the Primary Care Development Corporation, and the American College of Physicians. That report, prepared by Gregory Burke, described the characteristics and unique attributes of the patient-centered medical home, its spread across New York, and some of the challenges to its further adoption.

This most recent report in the series, prepared as background for a second statewide invitational conference, deepens our focus on this innovative area. It provides a detailed picture of the number of providers in New York State who work in practice sites that the National Committee for Quality Assurance has recognized as PCMHs. The total number of PCMH providers in the state grew by over 40 percent between July 2011 and September 2012, with much of that growth occurring in upstate communities. However, many challenges noted in last year's report remain, notably the continued slow growth of the model among small practices, and the variability among payers in their support for the PCMH model, beyond pilot and demonstration projects. These are linked phenomena.

The Fund's interest in the PCMH model of care is part of our continuing focus on identifying, analyzing, and helping disseminate promising innovations in health care. We are tracking changes in the organization and delivery of health care services, and in the way that care is paid for — changes with the potential to improve the quality, coordination, and cost-effectiveness of health care.

A growing body of evidence suggests that the PCMH model improves care, improves the patient experience of care, and reduces costs. It has particular value in the care of patients with multiple chronic conditions, who represent the health system's highest-use, highest-cost patients. However, until the model is more widely and consistently supported by commercial payers (and by self-insured employers), and until Medicare participates more regularly in these efforts, it will be difficult to achieve or sustain the further diffusion of this promising approach in New York.

James R. Tallon, Jr.
President
United Hospital Fund

Acknowledgment

This report was prepared as background for the 2012 Invitational Conference on the Patient-Centered Medical Home in New York State, co-sponsored by the United Hospital Fund, the Primary Care Development Corporation, and the American College of Physicians. This conference, like last year's, was organized at the request of the New York State Health Commissioner, Nirav Shah, MD, MPH.

The provider profiles presented in this report are the result of analyses conducted by the author, based on data provided by the New York State Office of Health Insurance Programs, the New York State Center for Health Workforce Studies, and the National Committee for Quality Assurance, all of whom were extremely helpful in generating, sharing, and helping to interpret those data.

This report was supported in part by the New York Community Trust, TD Bank, EmblemHealth, and Excellus BlueCross BlueShield.

Introduction

This report and chartbook update the census of patient-centered medical home (PCMH) providers published in the United Hospital Fund report, *The Patient-Centered Medical Home: Taking a Model to Scale in New York State*, released in October 2011. Both reports describe the spread of the PCMH model of care across the state using three descriptors: region, level of National Committee for Quality Assurance (NCQA) recognition, and type of practice within which those providers worked. The reports provide insights into the further spread of the PCMH model over the past year, and identify some issues for consideration by the provider community, by payers, and by the State Department of Health as the "medical home" movement matures.

New York State continues to exhibit strong growth of the PCMH model, and leads the nation in PCMH adoption. This growth is particularly strong in certain regions of the state and among certain provider types. This update describes PCMH from two perspectives: the current status of PCMH adoption in New York as of September 2012 (Figures 1-14), and changes in PCMH adoption between July 2011 and September 2012 (Figures 15-21). All the figures appear at the end of this report.

Data Sources

This update uses the same data sources as the original report. The NCQA provided the United Hospital Fund with a list of all providers working in NCQA-recognized PCMHs as of a specific date. The 2011 file included all PCMH providers as of July 2011, with some basic demographics and descriptors. The file upon which this report is based includes all PCMH providers as of September 2012, with additional data and descriptors included.

Definitions

For consistency, we have maintained the definitions of the four main metrics used in last year's report:

PCMH providers includes all providers listed in the NCQA report. In both 2011 and 2012, this definition included physicians (MD and DO) as well as mid-level providers (nurse practitioners, physician's assistants, et al.). The 2012 file from NCQA specified the individuals' licensure but the 2011 file did not. Analysis of the 2012 data showed that over 85 percent of the providers listed (4,550 of 5,312) were either MDs or DOs. For consistency with the 2011 report, we have used the total number of providers listed, and the term "PCMH providers" in this report.

Level of NCQA recognition was included as a specific data element in each of the two files received from NCQA. The original NCQA PCC-PCMH standards, published in 2008, were used by NCQA in its recognition process for all PCMHs analyzed in last year's report. In 2011, NCQA published and began to use a revised set of standards for PCMH recognition. This new set of standards includes several changes in the "must-pass" elements, and in the weighting and scoring of measures — particularly those related to care management, patient engagement and self-management training for patients with chronic conditions — that determine the different levels of recognition (Level 1, 2, or 3).

2012 has been a transition year. Most of the state's NCQA-recognized practices and providers have been recognized under the 2008 standards; that status is valid for three years from the date of recognition. Although NCQA has been accepting applications for recognition under the 2011 standards since mid-2011, they also continued to accept applications under the 2008

standards through June 2012. Since July 1, 2012, all new applicants and all providers recognized under the 2008 standards and applying for an "upgrade" to the new standards have been reviewed using the 2011 standards.

As of September 2012, roughly 250 providers in New York had received NCQA recognition under the 2011 standards. This number will increase over the coming years, as providers' initial three-year recognitions expire, and they (and other, new providers) apply for recognition under the 2011 standards.

New York State regions. In the 2011 report we used a variant of New York State's insurance regions as a way of grouping and analyzing PCMH providers across the state; we have used this approach again. This methodology (see Appendix for the county-region groupings used in this report) groups the state's counties into 7 regions: New York City (given its size and diversity, also analyzed at a borough level); Long Island; the Hudson Valley; Albany/Northeast New York; Rochester area; Syracuse/Central New York; and Buffalo/Western New York.

Practice type. Providers who work in different settings (e.g., large group vs. solo practice) often have access to different resources (e.g., care managers and electronic medical record systems) and they face different challenges in achieving and sustaining PCMH recognition. This update uses the same six practice type categories that the 2011 report did.

- Group practice: Group practices with five or more physicians listed on the NCQA roster
- Health center: Federally qualified health centers and State-licensed diagnostic and treatment centers
- HHC: Hospitals and centers that are part of New York City's Health and Hospitals Corporation
- Hospital clinic: On-site and community-based clinics of hospitals, licensed by New York State
- Hospital/AMC practice: Private practices and faculty practice plans based in hospitals and academic medical centers
- Practice: Small private practices with fewer than five physicians listed on the NCQA roster

In some cases these different types serve as markers for population served.

PCMH Status as of September 2012

Total PCMH Providers

As of September 2012, there were 5,312 providers working in NCQA-recognized PCMHs in New York State. This is by far the largest number of PCMH providers in any state in the nation. As shown in Figure 1, roughly half of the total (2,768 PCMH providers, 52 percent) were located in New York City, and half (2,544 providers, 48 percent) were in other regions of the state.

Level of NCQA Recognition

Level 3 is NCQA's highest level of recognition, given to practices that meet all of the key elements and achieve a specific aggregate score on the certification process. Of the 5,312 PCMH providers in New York, 78 percent were working in practices that NCQA recognized as Level 3 PCMHs, 5 percent were in Level 2 practices, and 17 percent were in Level 1 practices (see Figure 2). As shown in Figure 3, the vast majority (over 95 percent) of the state's 5,312 NCQA-recognized PCMH providers received their NCQA recognition using the 2008 standards. As of September 2012, roughly 250 PCMH providers in New York State had received NCQA recognition using the 2011 standards, most of them at Level 3.

Distribution by Region, and Level of NCQA Recognition

As shown in Figure 4, the total number of PCMH providers varied substantially across the state regions and New York City boroughs, as did the distribution of Level 1, 2, and 3 PCMHs.

Measuring PCMH Penetration

To assess the "penetration" of the PCMH model in a given county or region, or across the state, we developed a series of measures comparing the number of PCMH providers and physicians to all primary care physicians practicing in that area, and to the region's population. For the first two analyses, we used the most recent available data (2008) from the New York State Center for Health Workforce Studies (CHWS) on the total supply of primary care physicians (PCPs) in the state's 62 counties to estimate the number of PCPs in the seven regions.

In 2011, lacking the ability to separate physicians (MDs and DOs) from mid-level practitioners, we generated an estimate of PCMH penetration using the total number of PCMH providers as the numerator, and the CHWS estimates of PCP capacity in 2008 as the denominator. In 2011, the statewide ratio of PCMH providers to primary care physicians was 18.5 percent.

For comparability, we used this same methodology in the first of three analyses of PCMH penetration included in this report, yielding county-, region-, and state-level rates of PCMH providers to estimated PCPs. The statewide ratio of PCMH providers to all PCPs in September 2012 was 26 percent (Figure 5), an increase of 40 percent over the past year. The September 2012 rates varied widely across the state's regions (Figure 6), from a low of 7 percent on Long Island to a high of 45 percent in Albany/Northeast New York.

In our second assessment, we used the additional detail provided in the 2012 database to generate an "apples-to-apples" comparison (Figure 7), using only PCPs in the numerator. This resulted in a slightly lower statewide rate of PCMH penetration (22 percent) and lower rates in most regions, particularly those (e.g., Albany/Northeast New York) where mid-level practitioners were more heavily used by PCMH provider groups (Figure 8).

In our third assessment, we developed a population-based measure (PCMH providers per 100,000 population) to estimate PCMH penetration across the state, displaying the resulting county-level rates (which vary widely) both as a chart (Figure 9) and as a map (Figure 10).

PCMH Providers by Practice Type and Region

We analyzed the number of PCMH providers by practice type both statewide (Figure 11) and by New York City and non-NYC regions (Figure 12). Statewide, large group practices and health centers — organizations with the scale and infrastructure to more easily support the PCMH model — accounted for the largest numbers of PCMH providers, followed by the New York City Health and Hospitals Corporation, hospital clinics, and hospital/AMC practices. Small practices (practices with fewer than five providers listed in the NCQA database, with the least scale and infrastructure) were the smallest group.

As shown in Figure 13, the composition of the PCMH provider base differed greatly between New York City and the rest of the state. In New York City, health centers and hospital-based clinics and practices predominated; elsewhere, large groups were by far the largest cohort. Small practices represented a comparatively small cohort in both regions. Within that broad trend, however, there were some stark differences among the seven regions of the state, and across the five boroughs of New York City. Manhattan had the largest concentration of PCMH providers within hospital/AMC practices. Outside the city, while all regions showed a substantial proportion of PCMH providers in groups, the Hudson Valley and Albany had the largest cohort within health centers, and Syracuse and Rochester had the largest concentrations within hospital-based clinics and practices.

Level of NCQA Recognition by Practice Type and Region

Finally, we analyzed the relationship between the level of NCQA recognition and practice type (Figure 14). Most providers across all practice types (including all providers in HHC) were in practices that achieved Level 3 NCQA recognition, but a few practice types had higher proportions of providers in sites with Level 1 or 2 recognition: hospital clinics (both in New York City and in non-NYC regions), and hospital practices and small practices in New York City.

Growth in PCMH Recognition, July 2011 to September 2012

Growth in Total PCMH Providers

Between July 2011 and September 2012, the number of providers working in NCQA-recognized PCMHs grew by 42 percent, from a statewide total of 3,741 in July 2011 to 5,312 in September 2012. That growth was uneven, however, between New York City and other parts of the state. As shown in Figure 15, the number of PCMHs in non-NYC regions increased by 72 percent over that period, while the number in New York City grew by only 22 percent.

Each of the regions in upstate New York showed a substantial increase in the numbers of PCMH providers, led by Syracuse/Central New York, where the number tripled, and Rochester, where it more than doubled. In Albany and Buffalo the numbers of PCMHs increased by over 70 percent (Figures 16 and 17). Year-to-year growth in New York City and the Hudson Valley were more moderate (increases of 22 percent and 31 percent, respectively), but both were quite robust in absolute numbers. Between 2011 and 2012, the number of New York City PCMH providers grew by over 500, with roughly equivalent growth trajectories in all boroughs; and the number of PCMHs in the Hudson Valley increased by 126. Long Island, with the lowest PCMH penetration in 2011, also experienced the slowest growth between 2011 and 2012, an increase of only 16 percent.

Levels of NCQA Recognition

The total numbers of Level 1 and 2 providers in the state remained stable from 2011 to 2012 (Figure 17); almost all of the growth in total PCMH providers over that period was in Level 3 providers. Some new providers achieved Level 3 recognition, and some providers previously recognized as Level 1 or 2 progressed to Level 3.

Growth by Practice Type and Region

Figure 18 depicts the growth in PCMH providers by practice type. While there were substantial increases in the number of PCMHs in each category, most of the statewide growth between 2011 and 2012 occurred among groups and health centers.

The growth patterns were quite different between New York City and non-NYC regions (Figures 19 and 20). Outside New York City, most of the growth occurred in groups, health centers, and hospital clinics; in New York City, the growth came mainly from increases in health centers, small practices, and the HHC.

The composition of the PCMHs and their growth patterns varied substantially by region (Figure 21). Notable regional differences in growth patterns include the following.

- In Albany/Northeast New York, where the PCMH census was relatively evenly spread among groups, health centers, hospital clinics, and practices in 2011, there was marked growth in groups, health centers, and hospital clinics in 2012.

- In Buffalo/Western New York, where the PCMH census was dominated by groups in 2011, there was further growth in groups, as well as in health centers and practices in 2012.

- In the Hudson Valley, which was dominated by groups and health centers, there was further growth in both types in 2012.

- In Syracuse/Central New York, which had a comparatively low PCMH penetration

in 2011, there was a large increase in 2012, driven by major increases in hospital clinics and groups.

- In Rochester, where the PCMH census was evenly spread in 2011 among groups, health centers, hospital clinics, and hospital/AMC practices, there was substantial growth in 2012, driven in large part by an increase in hospital/AMC practices.

- On Long Island, which had the lowest PCMH penetration of any region, largely composed of groups, there was slight growth in 2012.

The boroughs of New York City were similarly diverse in their composition and growth trajectories.

- In 2011, New York City's PCMH profile was broadly based, with HHC, hospital clinics, health centers, and hospital/AMC practices all accounting for substantial proportions of the total. In 2012 each category showed overall growth; the largest absolute growth was in health centers, HHC, and practices.

- The Bronx, which had a more institution-based PCMH profile in 2011, mainly in health centers, HHC, hospital clinics, and hospital/AMC practices, grew in both health centers and HHC.

- Brooklyn, which in 2011 had the most PCMHs in HHC, and smaller numbers in groups, health centers, hospital clinics, and practices, showed the largest growth in health centers and hospital clinics.

- Manhattan, which had a relatively even spread of PCMHs among health centers, HHC, and hospital clinics, as well as the state's largest cohort in hospital/AMC practices, grew slightly in all of the practice types.

- Staten Island, which had the smallest number of PCMHs of any borough, was spread between groups and practices in 2011, both of which grew (particularly groups) in 2012.

Conclusion

As this updated profile indicates, the adoption of the PCMH model continues to expand across New York State as a new way to organize and provide primary care services. The number of New York State providers working in NCQA-recognized PCMH practices, already by far the largest of any state in the nation, has continued to grow, increasing by another 40 percent between July 2011 and September 2012. The penetration of the PCMH model across the state, however, continues to be uneven; it differs markedly from one region to another, and it varies substantially among different types of providers and settings.

As we observed in last year's report, the spread of PCMH continues to be dominated by organized groups of providers: groups, health centers, and hospital-based clinics and practices. These are organizations with sufficient scale to support the investments and working capital that practice transformation requires, as well as the relevant infrastructure — electronic medical records, regional data exchanges, registries, and the staff and systems needed to perform care management and improve patient engagement.

In some parts of the state, small physician practices have received assistance enabling them to pursue and gain PCMH recognition from NCQA, using creative approaches to acquiring resources and sharing them with the involved practitioners. Examples include New York City, where support has been provided by the Primary Care Information Program (PCIP); the Hudson Valley, where the effort has been supported by the Taconic Health Information Network and Community (THINC) and the Taconic Independent Practice Association; the Adirondacks, where ongoing support has been provided through the Adirondack Health Institute; Buffalo, where the P^2 Collaborative, the Health Foundation of Central and Western New York, and Catholic Medical Partners have provided small practices with ongoing support and technical assistance; and Rochester, where support has been provided through the Finger Lakes Health Systems Agency. Our 2012 analysis shows that such efforts and trends are continuing to appear.

Another continuing theme is the differential rate of PCMH growth, shaped in part by providers receiving consistent support from payers, including augmented payment for services they provide as PCMHs.

- Medicaid has adopted the PCMH model as a standard of care, providing support for PCMHs statewide. This accounts in large part for the penetration of the model in the state's health centers and safety-net provider systems.

- Payer-specific PCMH pilots and demonstration projects in particular regions with specific providers are continuing to have some impact, but such efforts alone cannot produce the saturation needed to affect the entire community.

- In some areas (e.g., the Adirondacks and now the Hudson Valley), the major payers, including Medicare, have organized multipayer arrangements to support the PCMH model. Such arrangements have allowed and enabled further expansion of the PCMH model in those regions.

- In still other communities, such as Rochester, the payer base is sufficiently concentrated that the coordinated efforts of a few major commercial payers (along with Medicaid) have been able to stimulate and support the regional growth of PCMHs.

One interesting development, continuing a trend noted in 2011, is the adoption of the PCMH

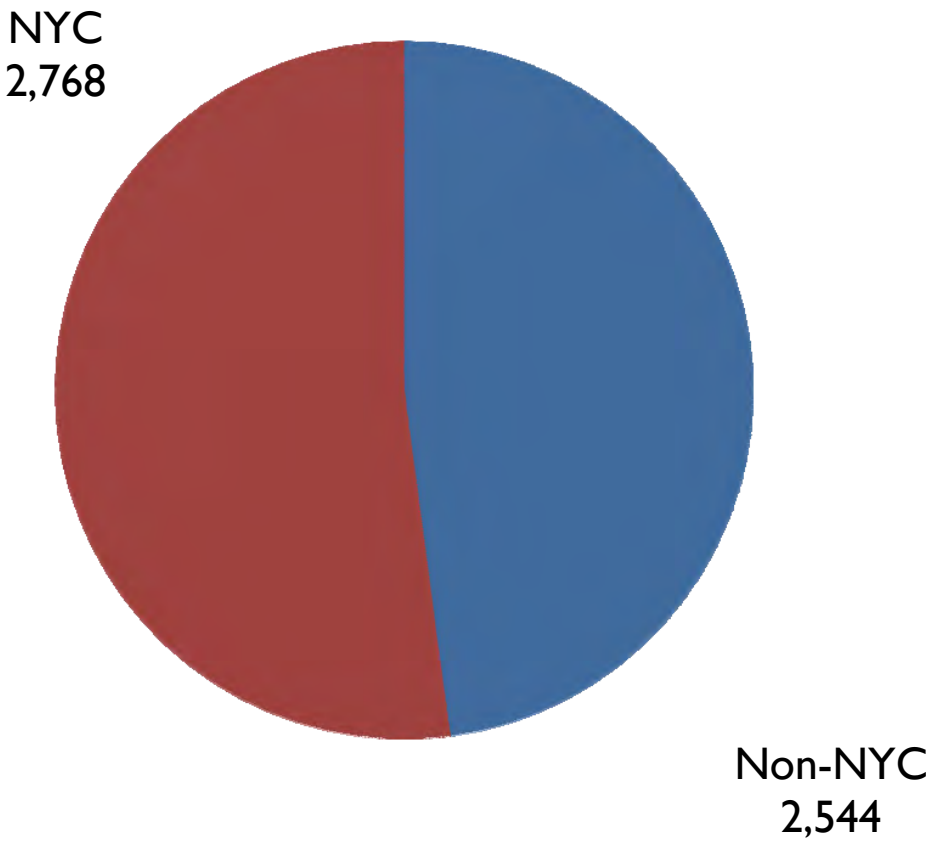
model by large organized group practices that participated in one or more payer-specific PCMH demonstrations covering comparatively small proportions of their patients. These groups — including the Crystal Run Medical Group in Middletown, WestMed and Mount Kisco Medical Group in Westchester, and the FamilyCare Medical Group in Syracuse — all adopted the PCMH model because they considered those capacities to be a foundation for their efforts to manage population health. Each of these groups is now participating in Medicare's ACO Shared Savings program.

Finally, in 2011 we noted the relatively low rates of PCMH adoption by two types of providers: hospital clinics and small practices. Over the past year, the State Department of Health received a federal grant to provide resources and technical assistance to teaching hospitals and clinics, enabling them to change their practice model to that of a PCMH, targeting the receipt of NCQA Level 3 recognition by all participating hospitals within two years.

The continued slow growth of PCMH adoption among small practices in New York State, however, is likely to prove more difficult to change. Such practices are still the main source of primary care for many patients across the state, including many covered by Medicare and commercial insurance. Generating enough payer support for the PCMH model, and increasing the model's spread among small practices, will likely remain a challenge.

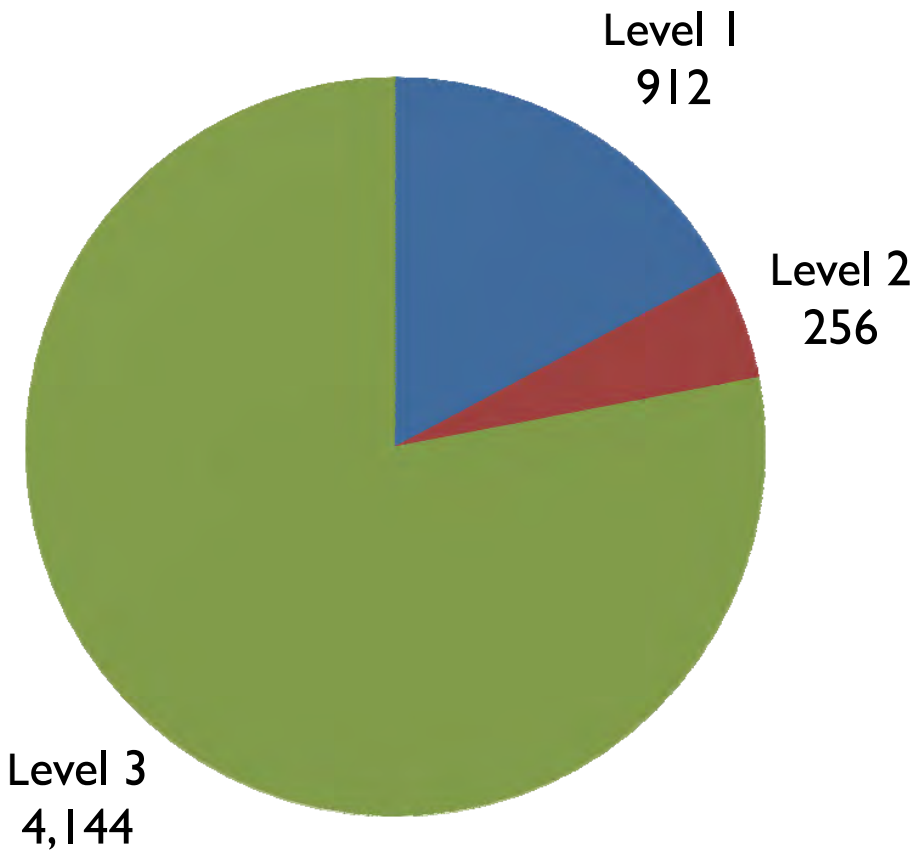
Figures 1-14:
PCMH Status as of September 2012

Figure 1. **PCMH Providers by Region**



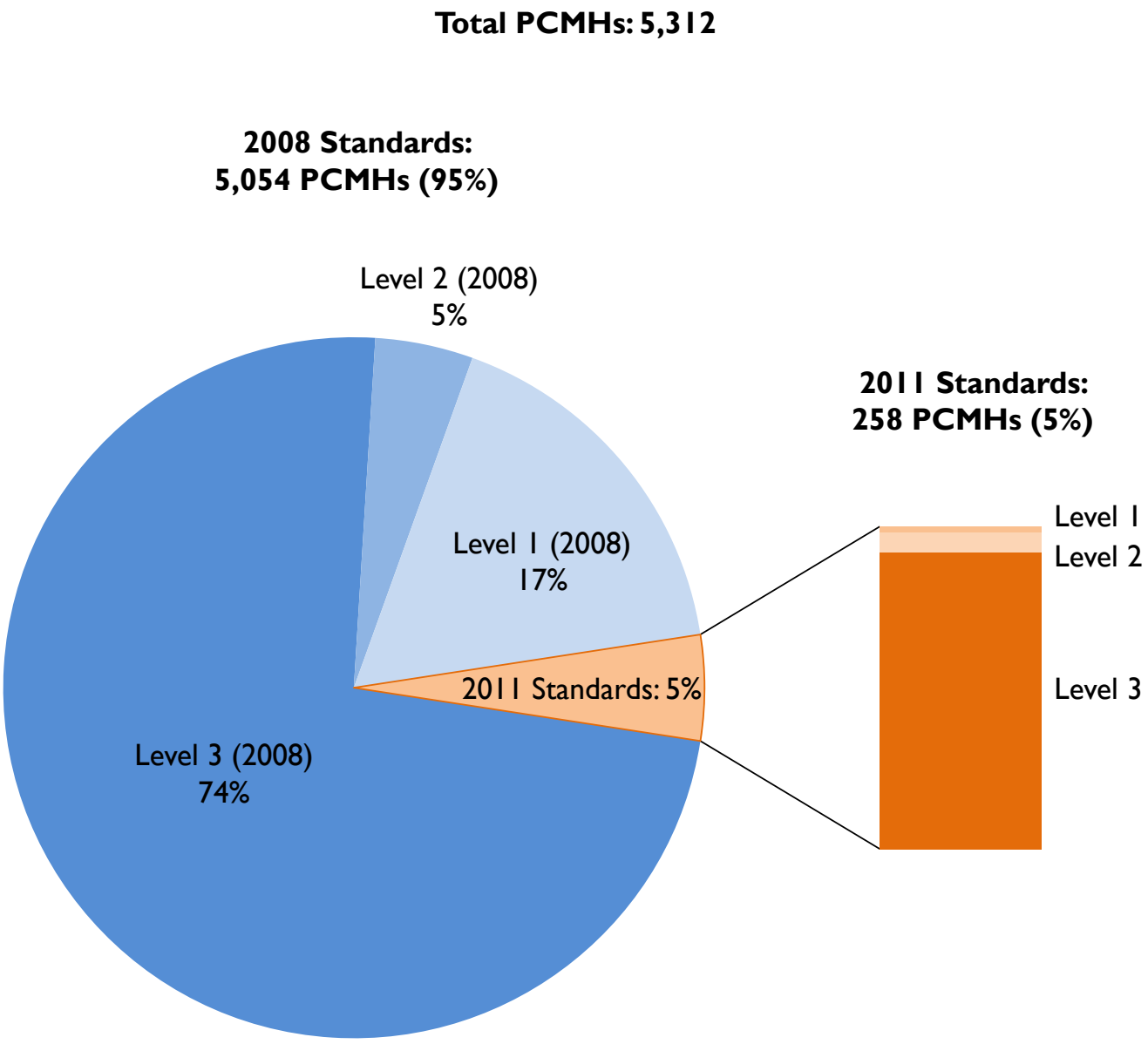
Source: NCQA Provider files, as of September 2012.

Figure 2. **PCMH Providers by Level of NCQA Recognition, New York State**



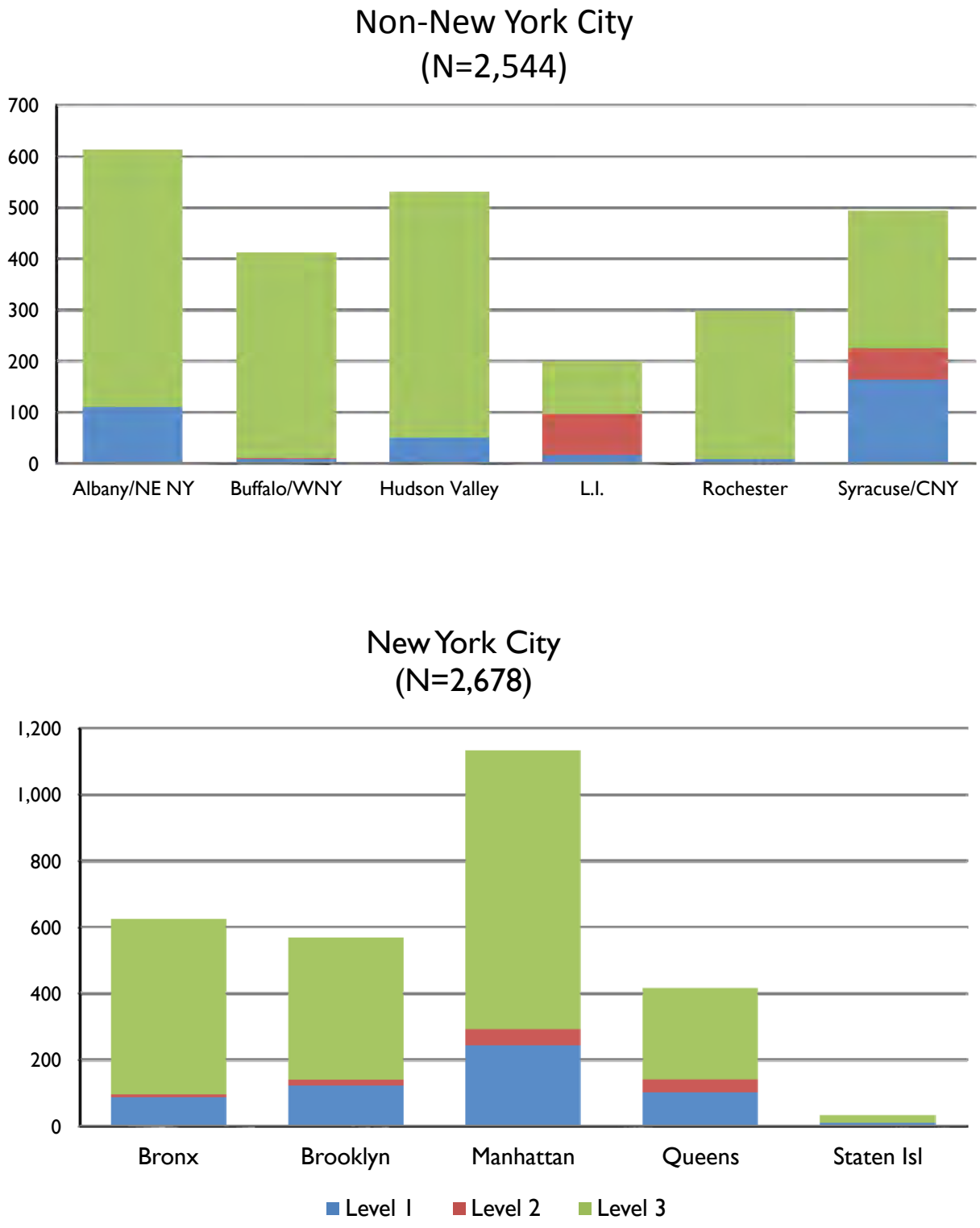
Source: NCQA Provider files, as of September 2012.

Figure 3. **NCQA Recognition Levels; 2008 and 2011 Standards**



Source: NCQA Provider files, as of September 2012.

Figure 4. **PCMH Providers by Level and Region**



Source: NCQA Provider files, as of September 2012.

Figure 5. **PCMH Providers as Percentage of Estimated PCPs, by Region**

	2012 PCMH	Est. # PCPs	PCMH as % of PCPs
Albany/NE NY	612	1,353	**45%**
Buffalo-WNY	412	1,242	**33%**
Hudson Valley	531	2,405	**22%**
L.I.	199	2,955	**7%**
Rochester	297	1,225	**24%**
Syracuse/CNY	493	1,413	**35%**
NYC	2,768	9,685	**29%**
NYS Total	**5,312**	**20,278**	**26%**

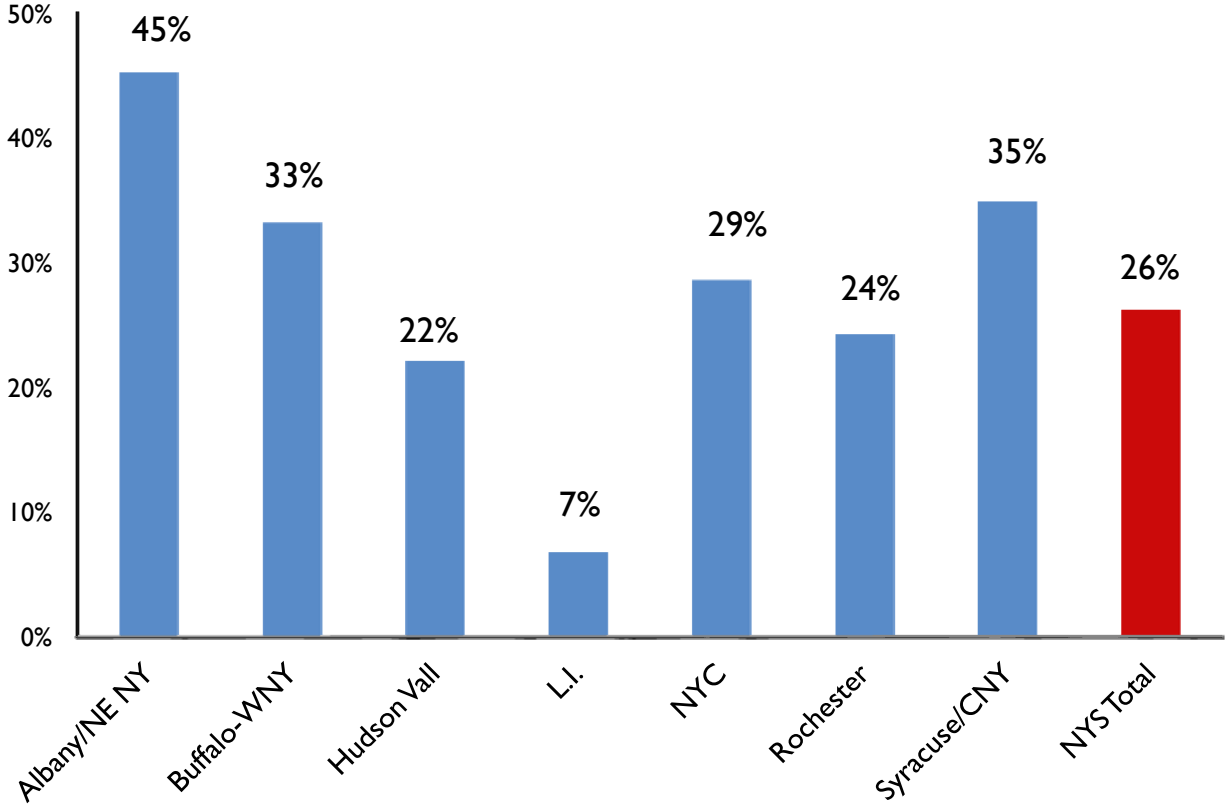
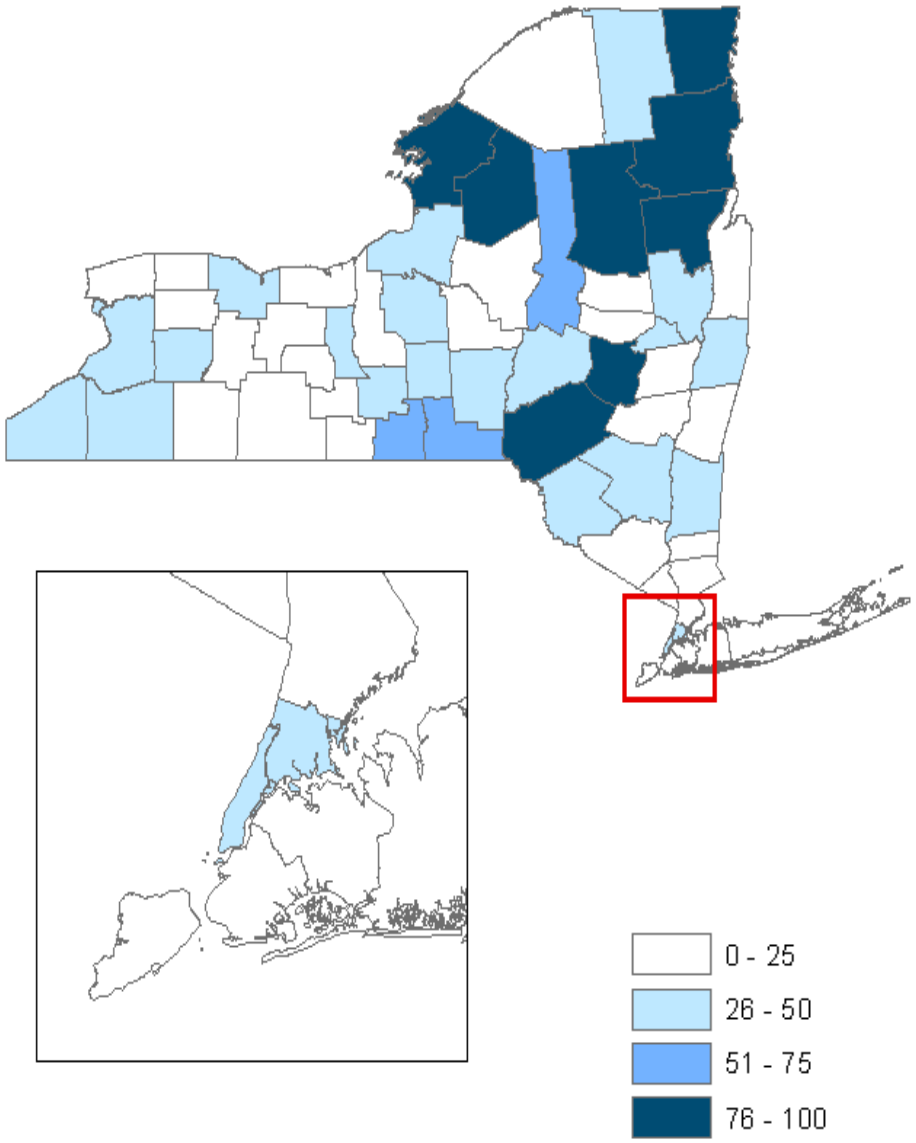


Figure 6. **PCMH Providers to Estimated PCPs, by County**



Sources: NCQA database, September 2012 (PCMH providers); Center for Workforce Statistics, 2008 (estimated PCPs).

Figure 7. **PCMH Physicians (MD/DO only) as Percentage of Estimated PCPs, by Region**

	2012 PCMH MD/DO	Est. # PCPs	PCMH as % of PCPs
Albany/NE NY	410	1,353	**30%**
Buffalo-WNY	364	1,242	**29%**
Hudson Valley	464	2,405	**19%**
Long Island	191	2,955	**6%**
Rochester	271	1,225	**22%**
Syracuse/CNY	408	1,413	**29%**
NYC	2,442	9,685	**25%**
NYS Total	**4,550**	**20,278**	**22%**

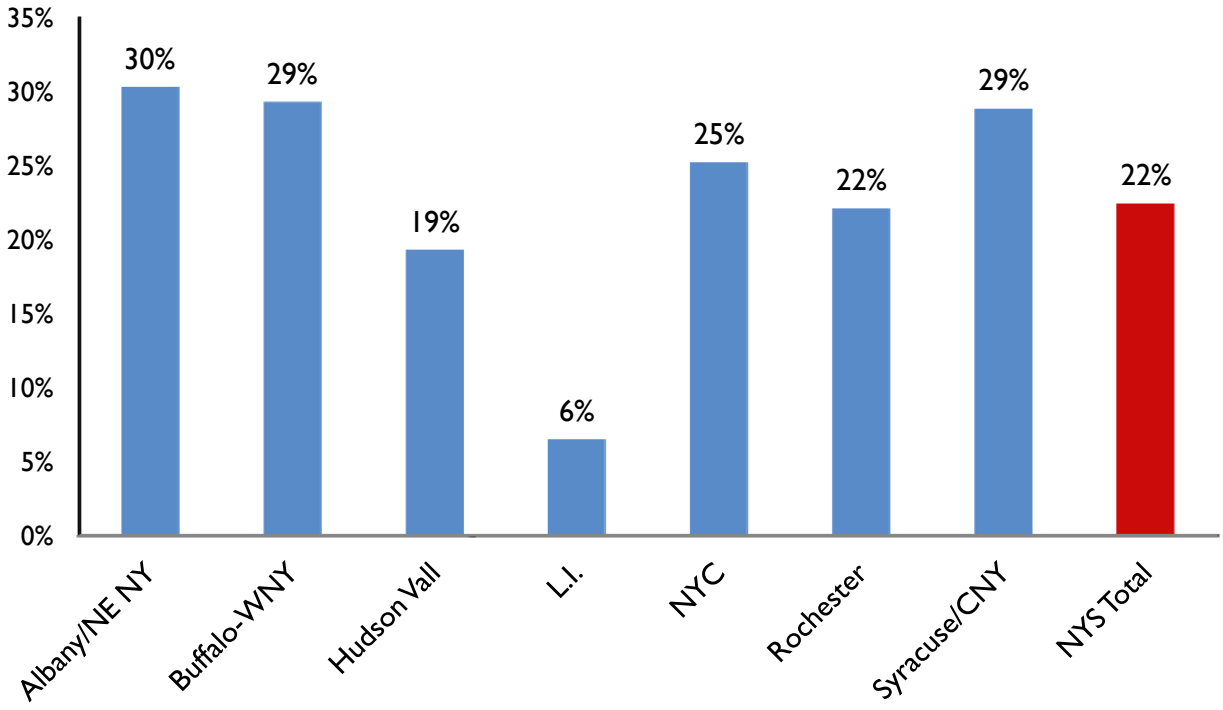


Figure 8. **PCMH Providers to Estimated PCPs (MD/DO Only), by County**

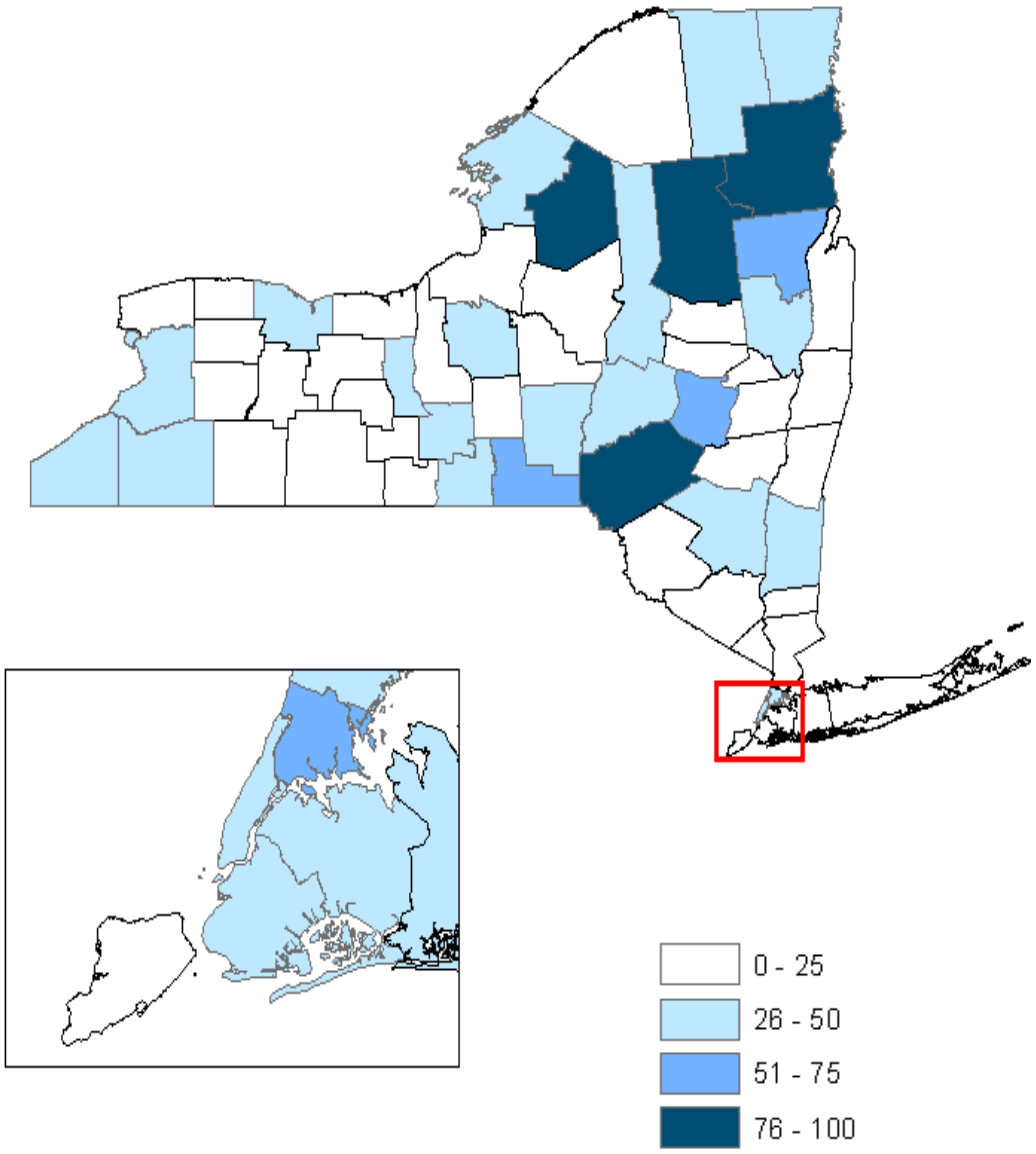


Figure 9. **PCMH Providers per 100K Population, by County, September 2012**

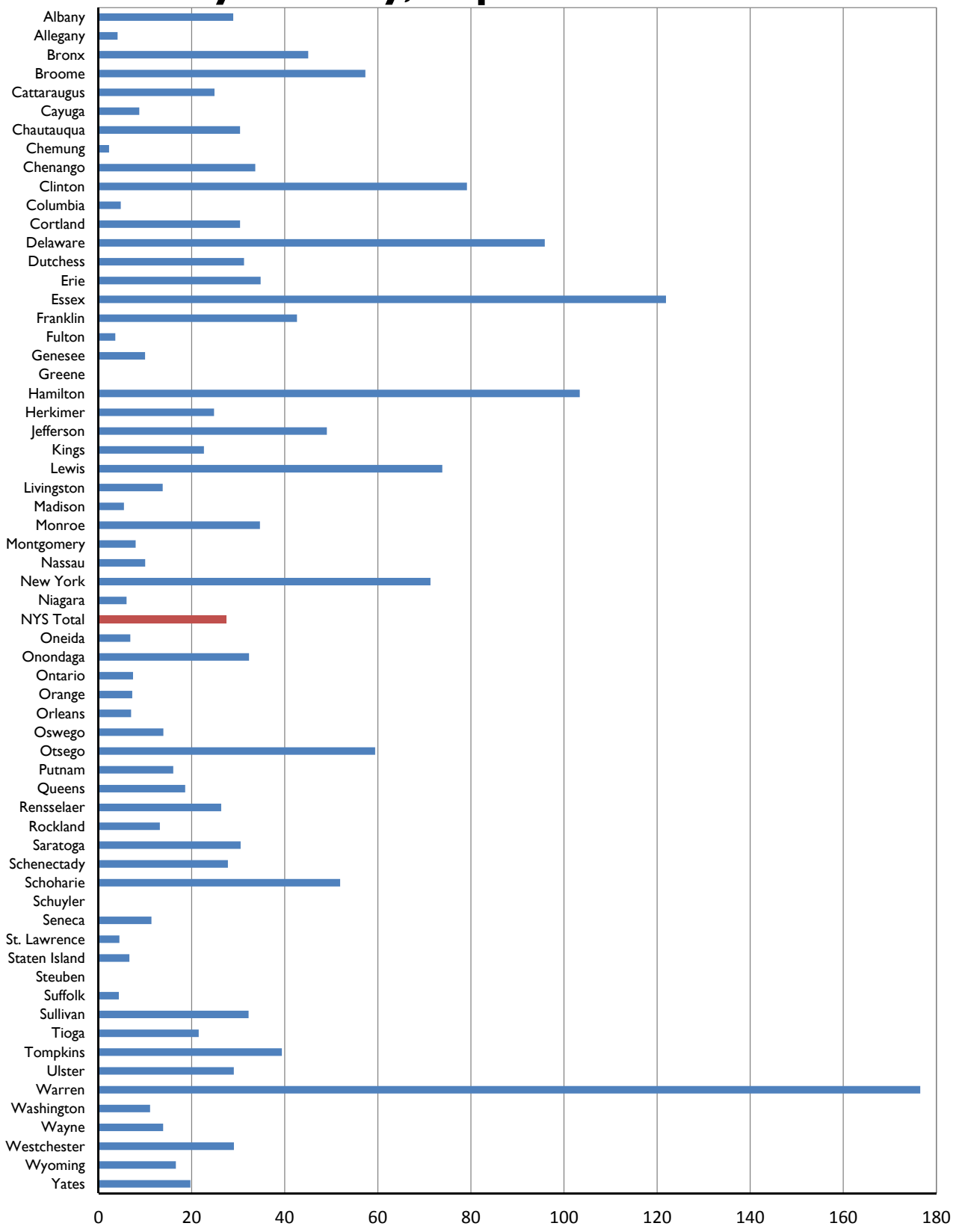


Figure 10. **PCMH Providers per 100K Population**

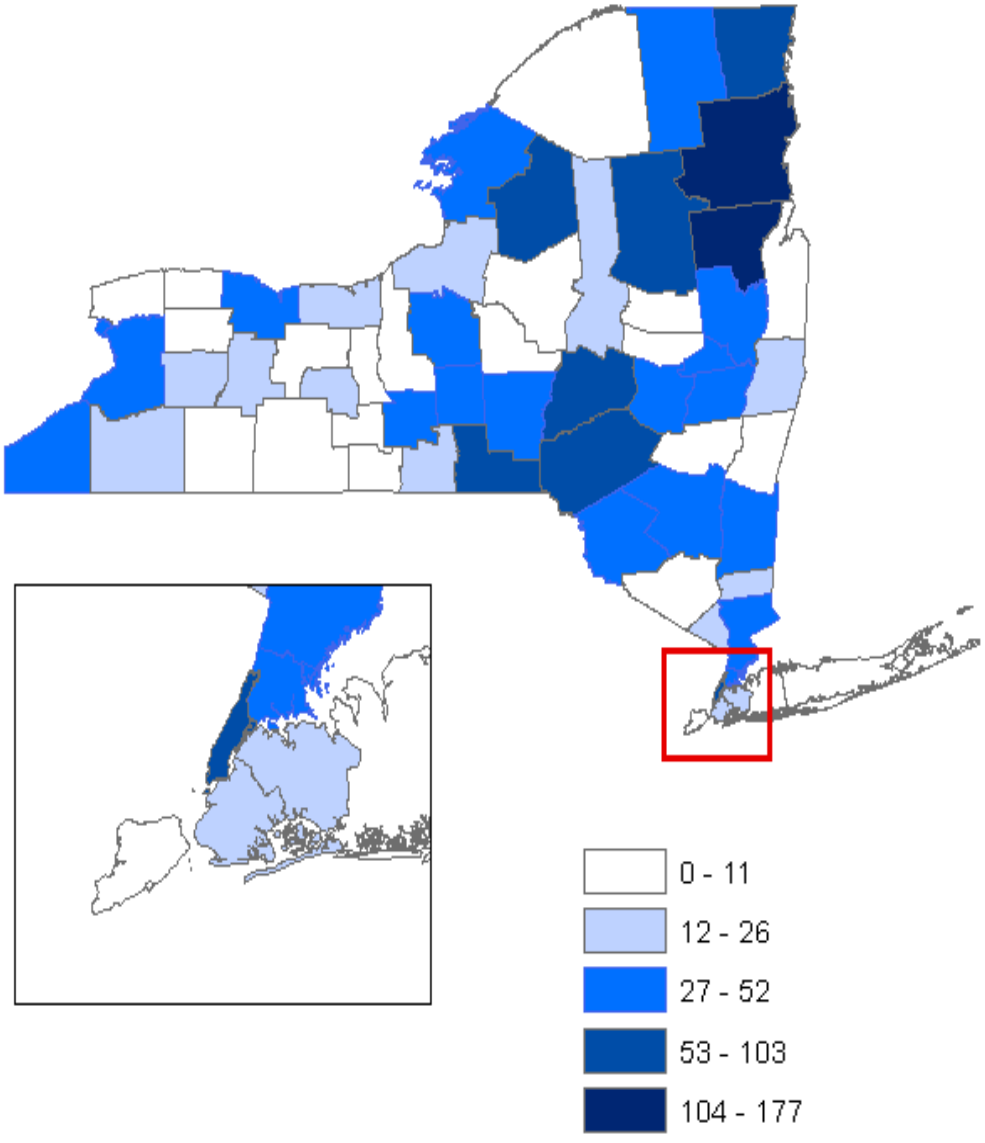
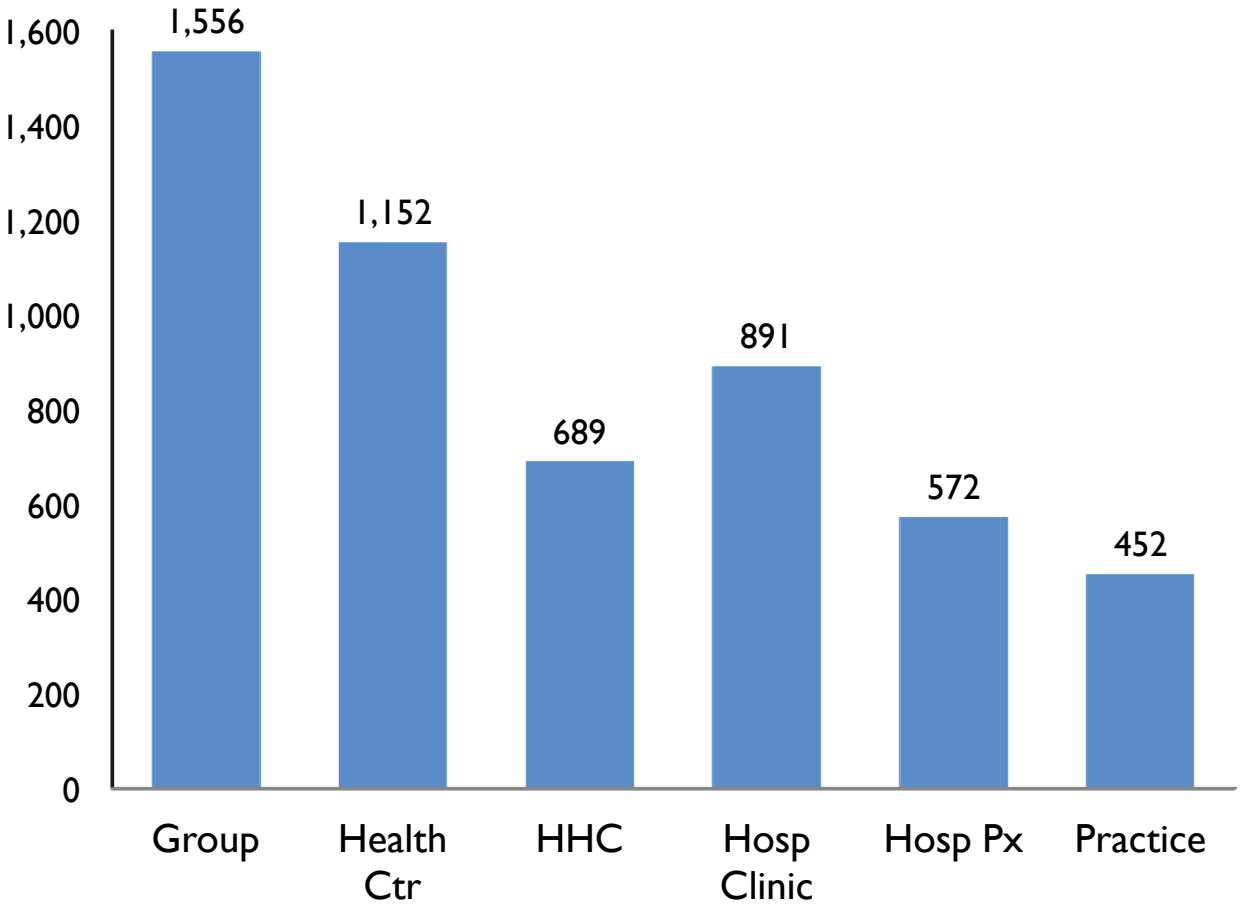
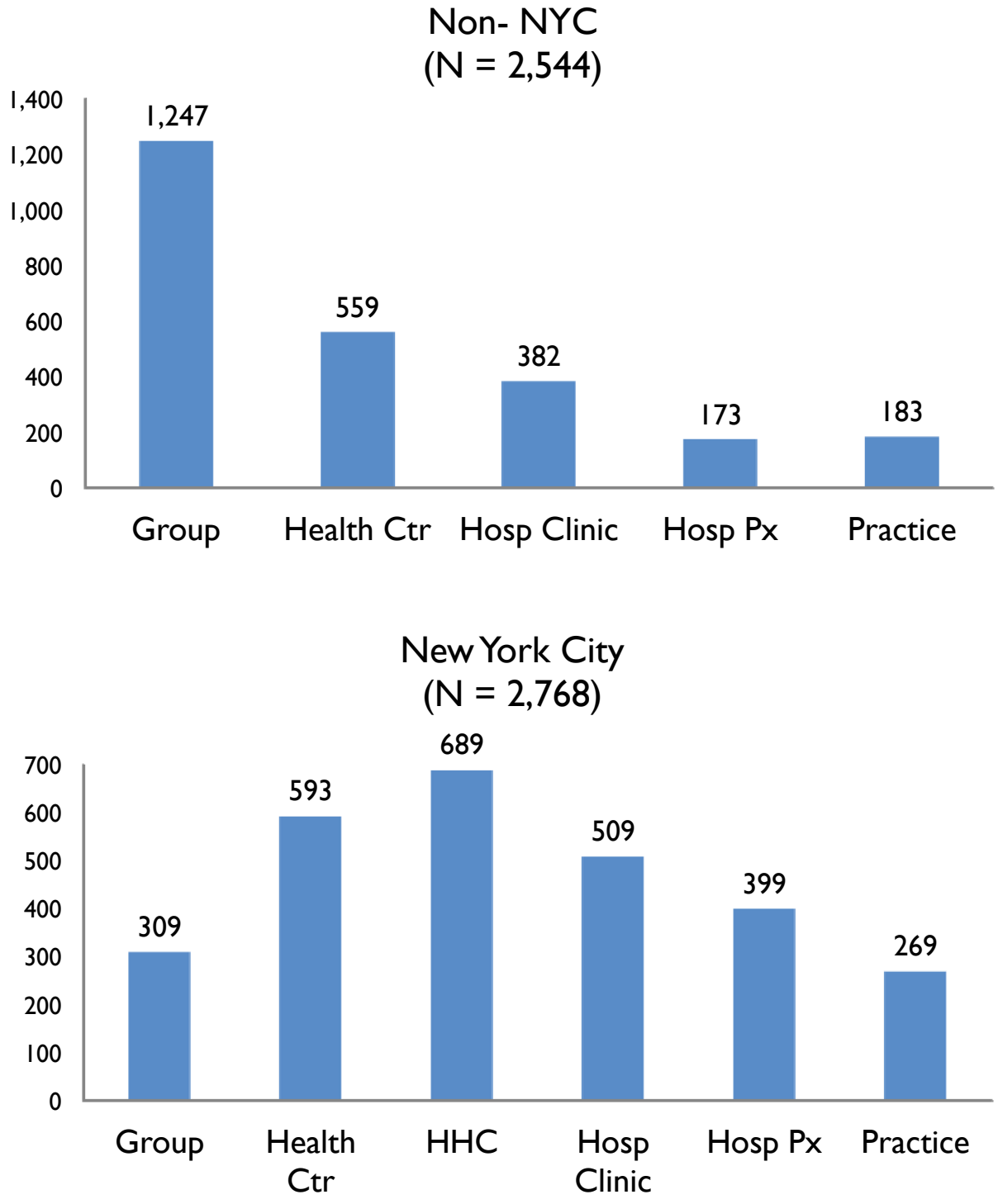


Figure 11. **PCMH Providers by Practice Type, New York State**



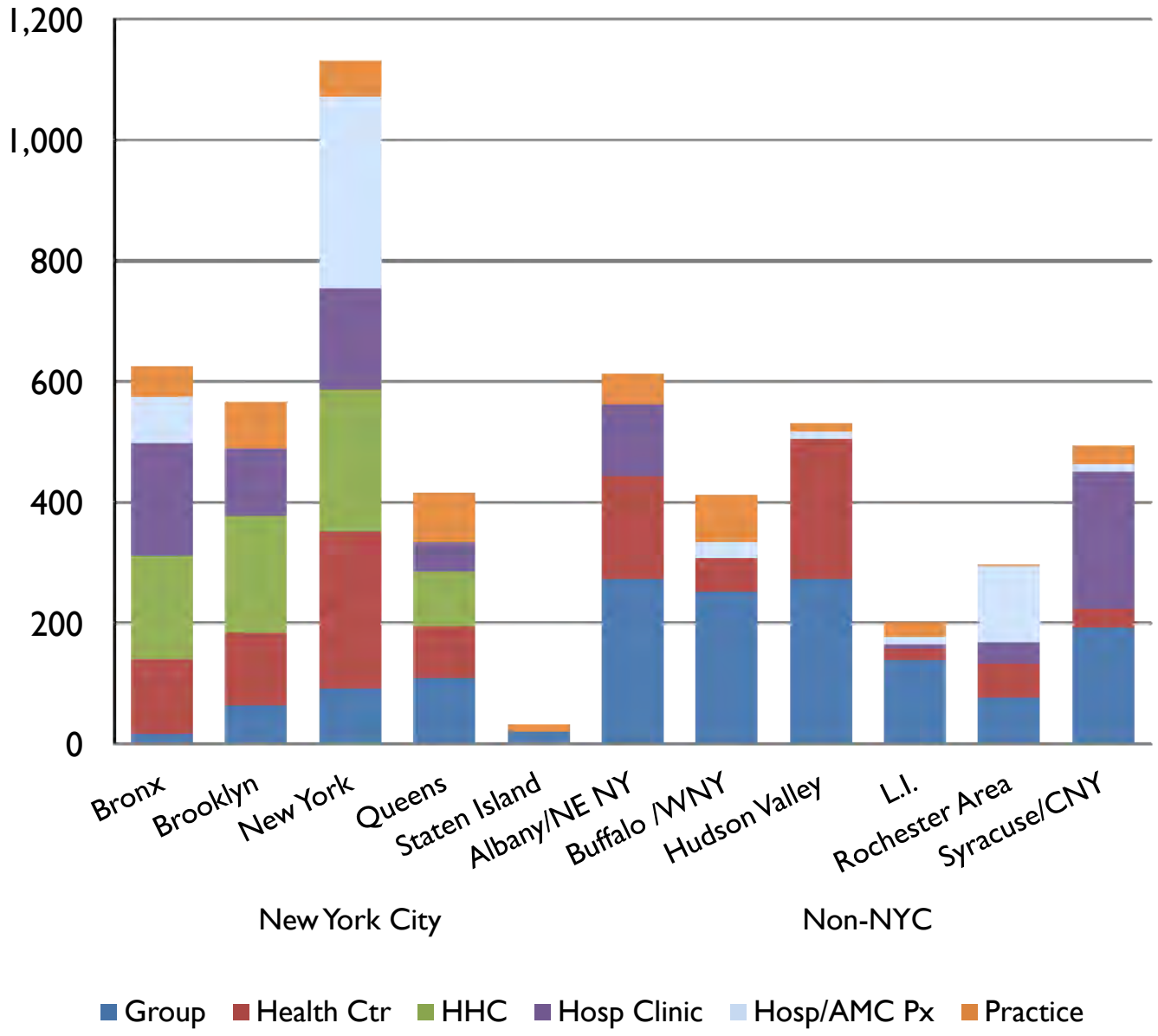
Source: NCQA Provider files, as of September 2012. UHF Categorization of "practice type."

Figure 12. **PCMH Providers by Practice Type, New York City vs. Rest of State**



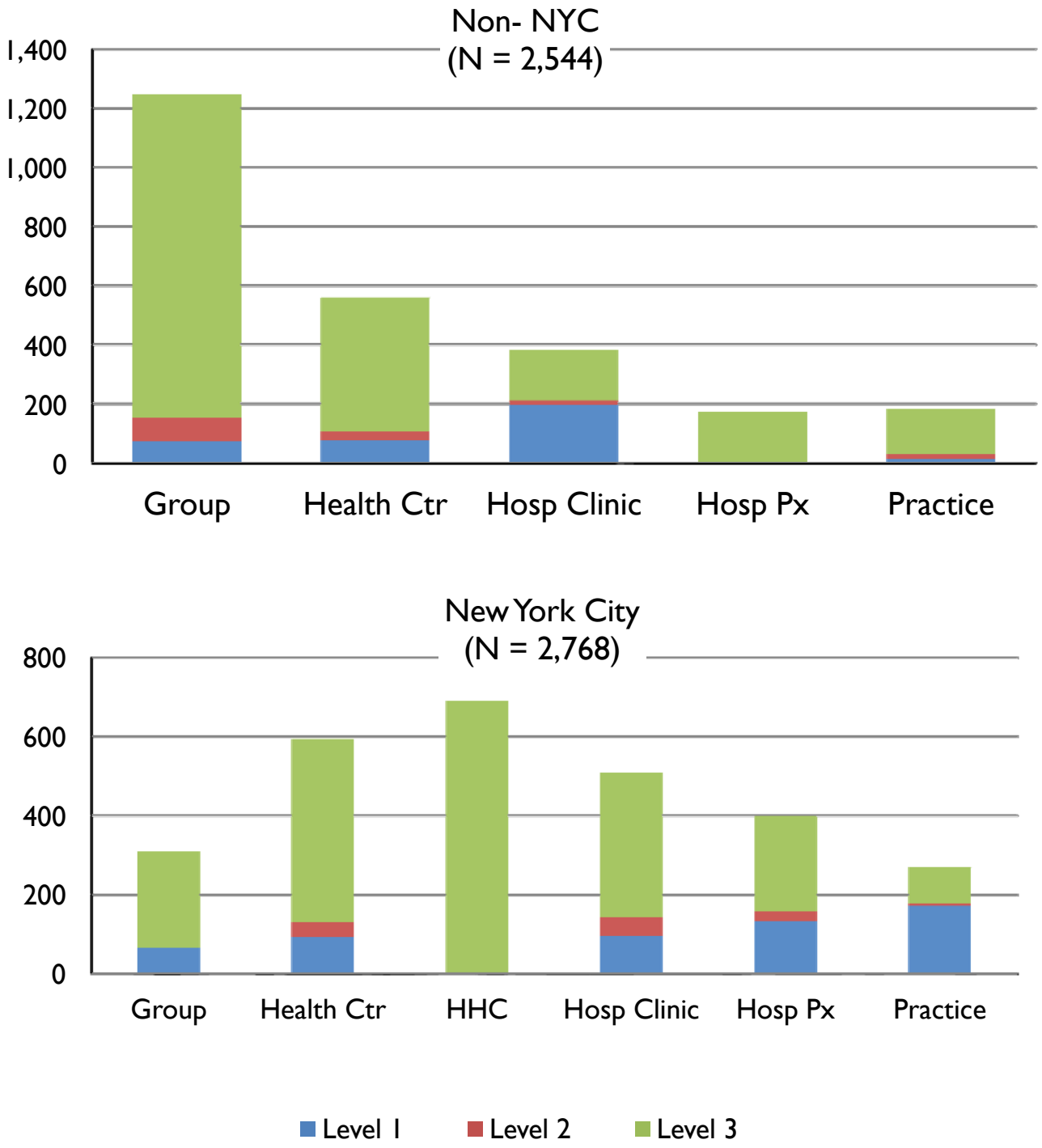
Source: NCQA Provider files, as of September 2012. UHF Categorization of "practice type."

Figure 13. **PCMH Providers by Practice Type and Region, New York State**



Source: NCQA Provider files, as of September 2012. UHF Categorization of "practice type."

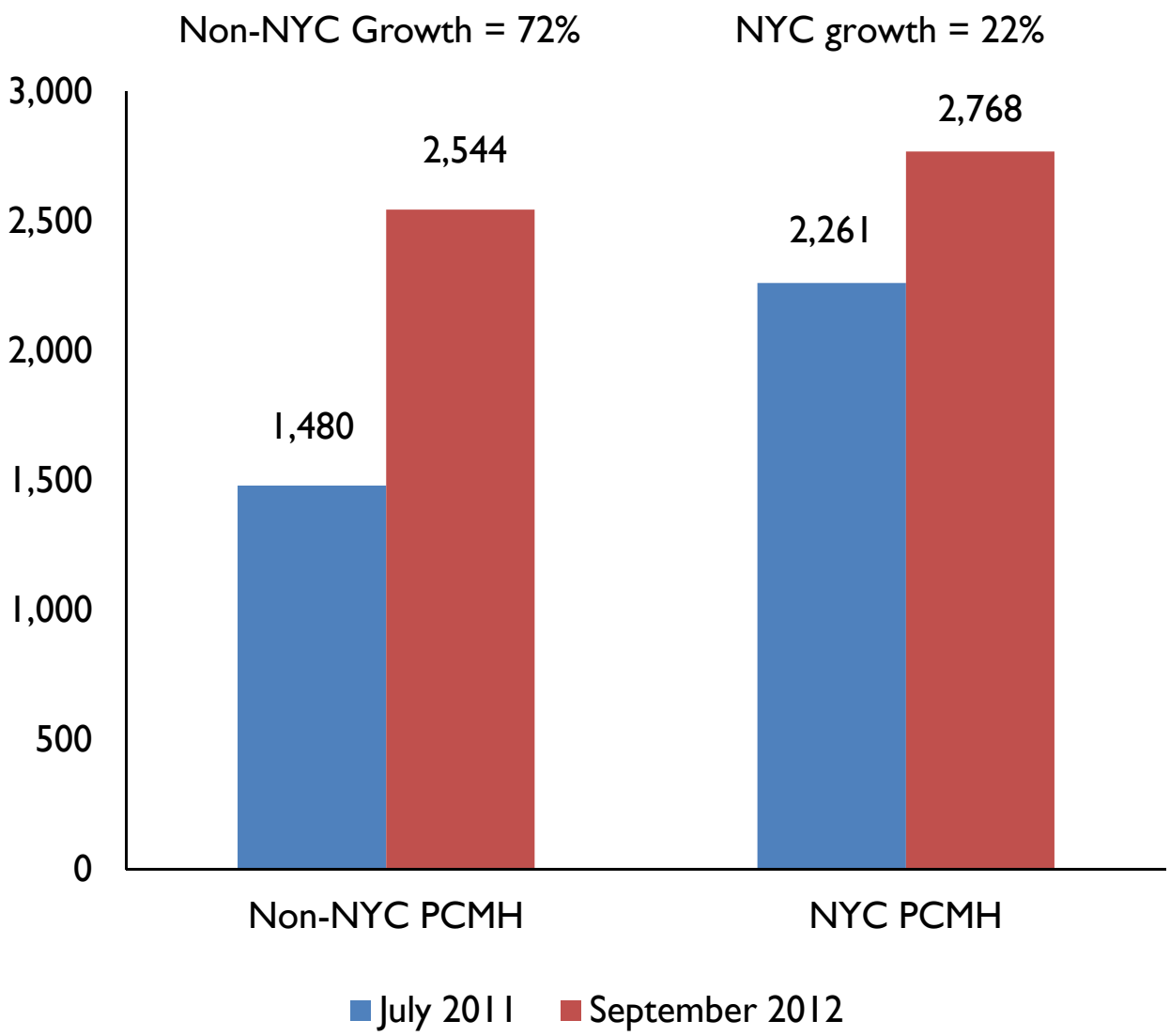
Figure 14. **PCMH Providers by Practice Type, Level, and Region**



Source: NCQA Provider files, as of September 2012. UHF Categorization of "practice type."

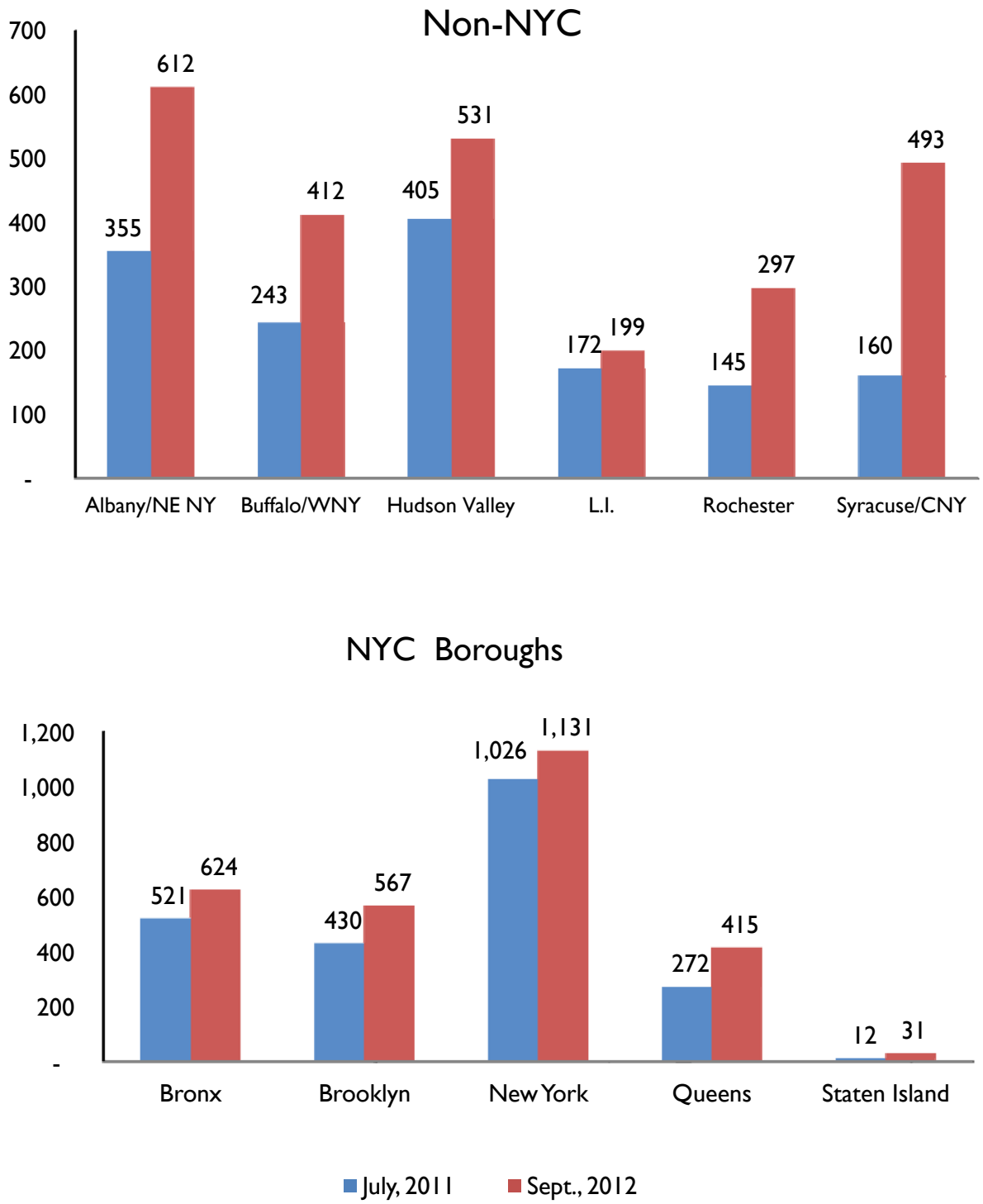
Figures 15-21: Growth in PCMH Recognition, July 2011 to September 2012

Figure 15. **Growth in NCQA-Recognized PCMH Providers, New York City vs. Rest of State**



Source: NCQA provider files, as of September 2012.

Figure 16. **Growth in NCQA-Recognized PCMH Providers, by Region**



Source: NCQA provider files, as of September 2012.

Figure 17. **Trends in NCQA PCMH Recognition by Region and Level**

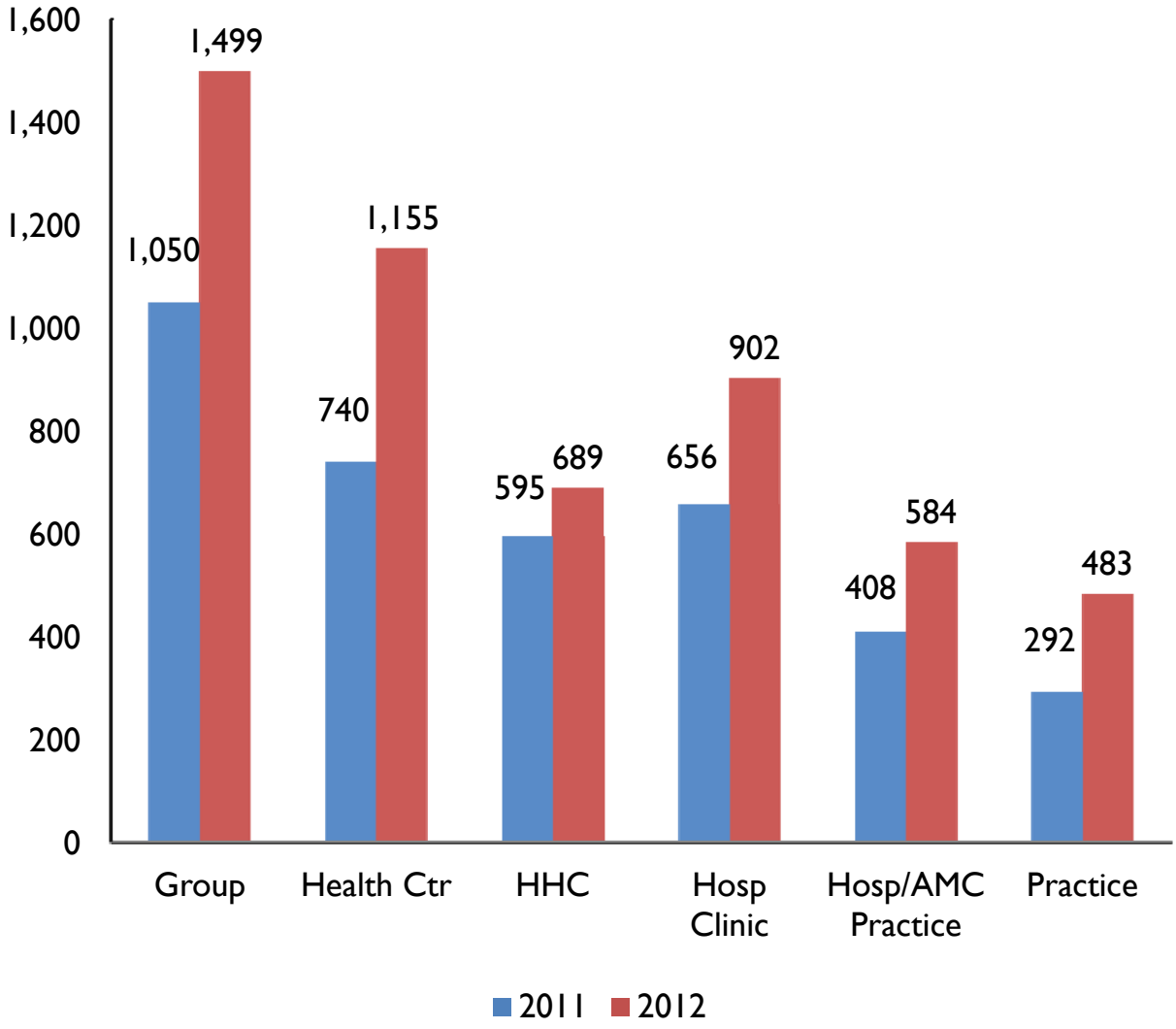
2011		Level 1	Level 2	Level 3	Grand Total	% NYS Total
	Albany/NE NY	55	3	297	355	9%
	Buffalo Area	2		241	243	6%
	Hudson Valley	11	10	384	405	11%
	L.I.	6	79	87	172	5%
	Rochester Area	19		126	145	4%
	Syracuse/Cent NY	37	31	92	160	4%
	NYC	745	151	1,365	2,261	60%
	Grand Total	**875**	**274**	**2,592**	**3,741**	**100%**

2012		Level 1	Level 2	Level 3	Grand Total	% NYS Total
	Albany/NE NY	109	1	502	612	12%
	Buffalo Area	8	1	403	412	8%
	Hudson Valley	50		481	531	10%
	L.I.	16	80	103	199	4%
	Rochester Area	8		289	297	6%
	Syracuse/Cent NY	162	62	269	493	9%
	NYC	559	113	2,096	2,768	52%
	Grand Total	**912**	**256**	**4,144**	**5,312**	**100%**

Difference 2011 vs 2012		Level 1	Level 2	Level 3	Grand Total	% Change 2011-12
	Albany/NE NY	54	(2)	205	257	72%
	Buffalo Area	6	1	162	169	70%
	Hudson Valley	39	(10)	97	126	31%
	L.I.	10	1	16	27	16%
	Rochester Area	(11)	0	163	152	105%
	Syracuse/Cent NY	125	31	177	333	208%
	NYC	(186)	(38)	731	507	22%
	Grand Total	**37**	**(18)**	**1,552**	**1,571**	**42%**

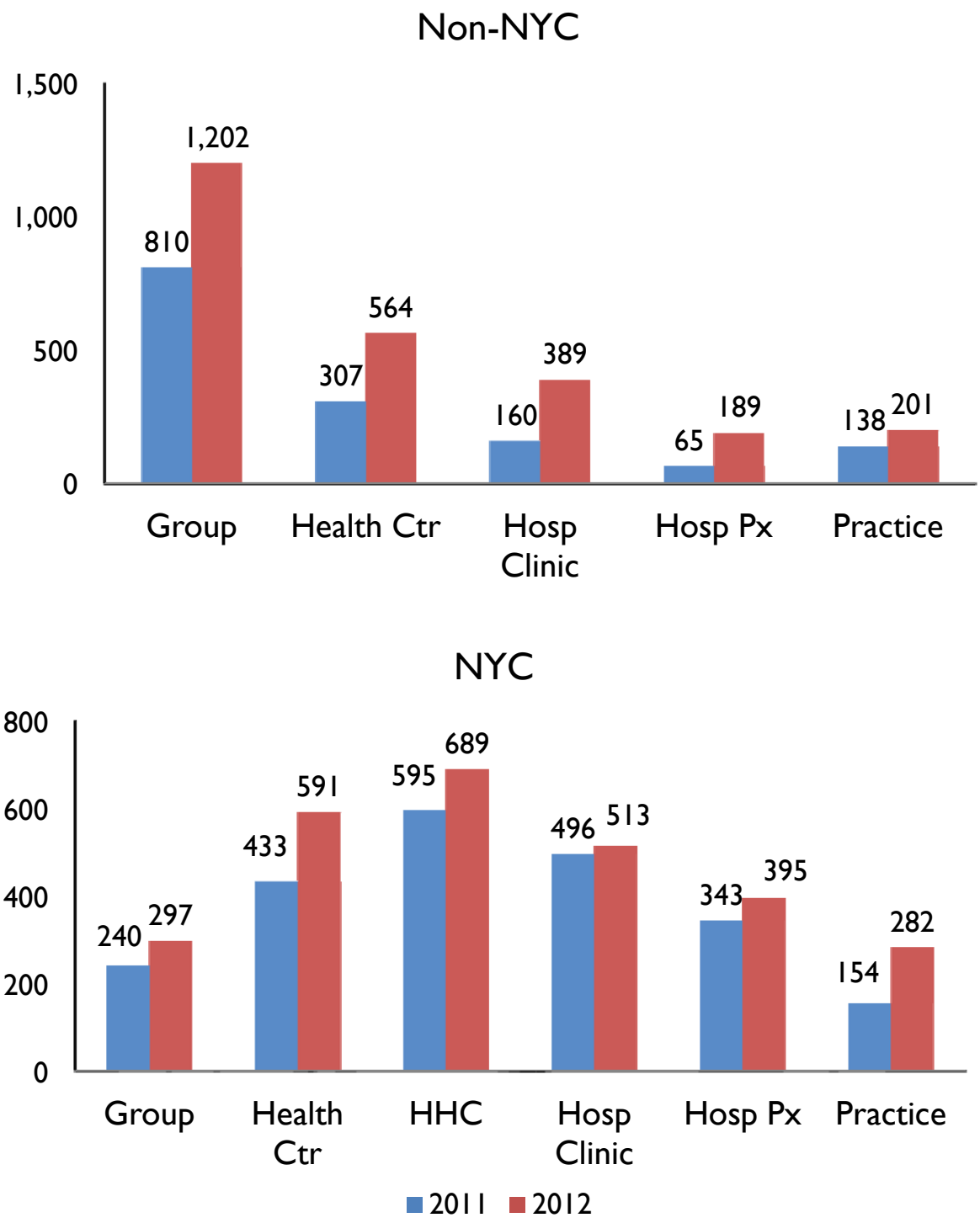
Source: NCQA provider files, as of September 2012.

Figure 18. **Growth in PCMH Providers by Practice Type, New York State**



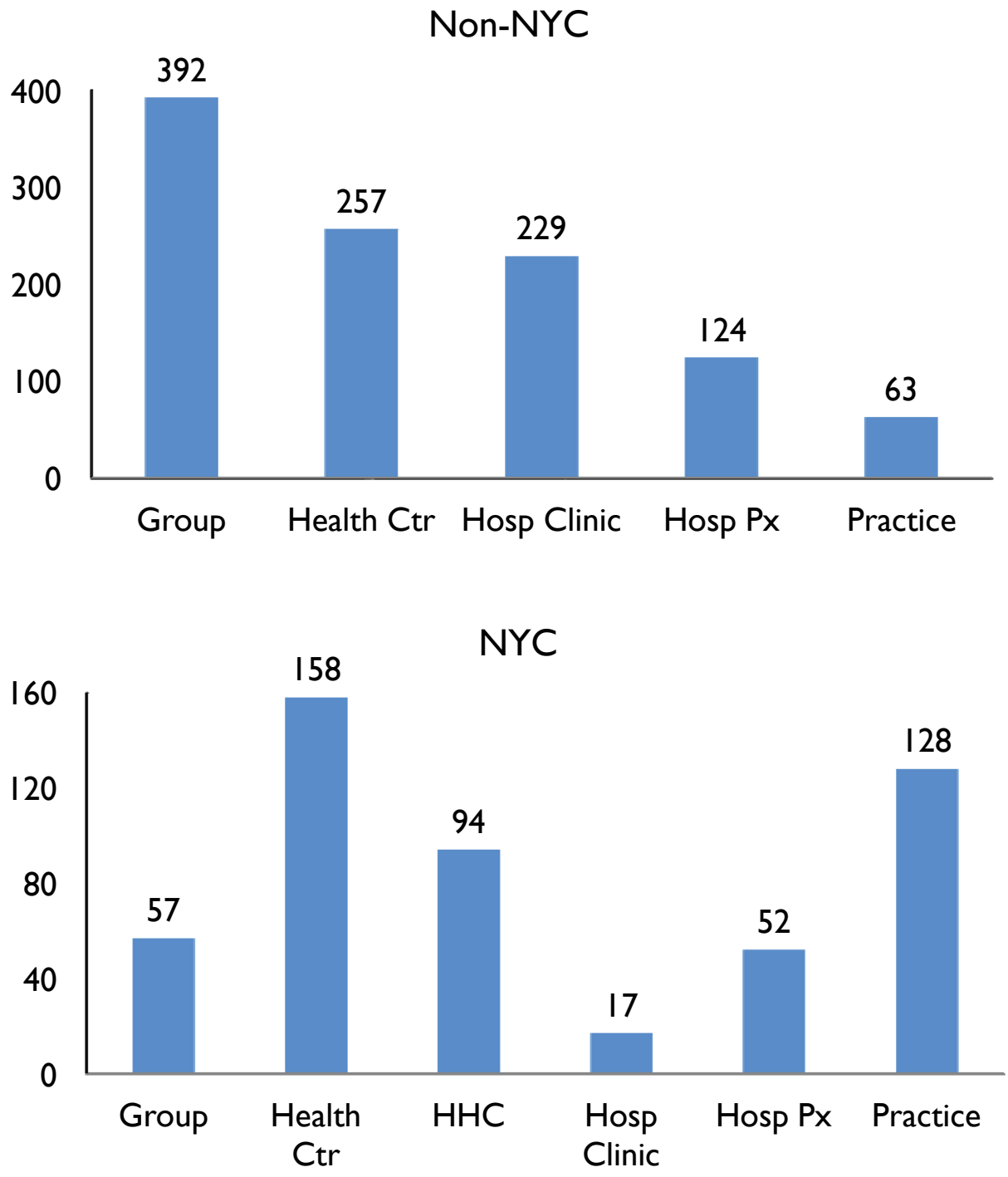
Source: NCQA provider files, as of September 2012. UHF Categorization of "practice type."

Figure 19. **Growth in PCMH Providers by Practice Type, New York City vs. Rest of State**



Source: NCQA provider files, as of September 2012. UHF Categorization of "practice type."

Figure 20. **Net Growth in PCMH Providers by Practice Type, New York City vs. Rest of State**



Source: NCQA provider files, as of September 2012. UHF Categorization of "practice type."

Figure 21. **PCMH Growth by Practice Type and Region**

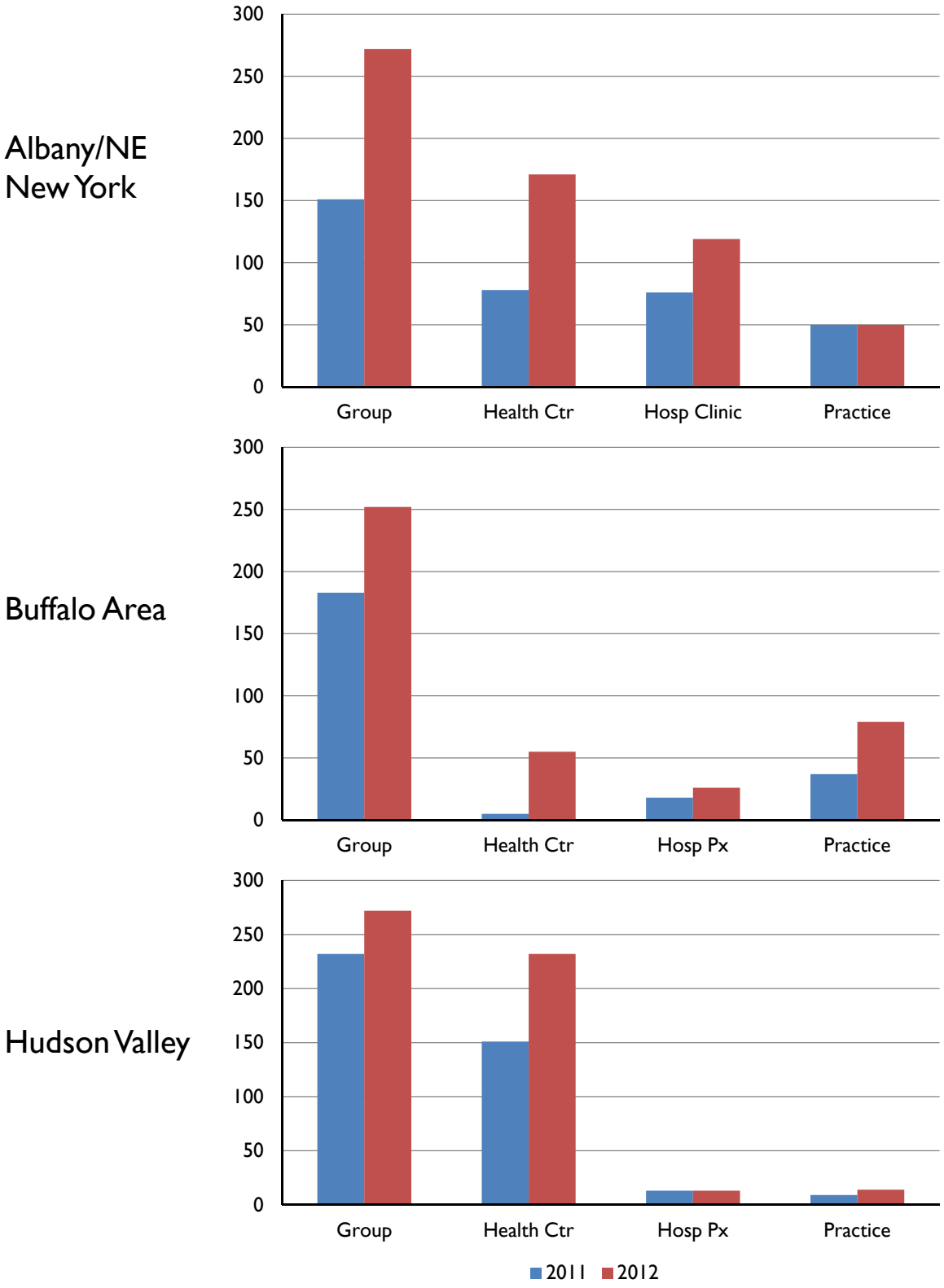


Figure 21 (continued). **PCMH Growth by Practice Type and Region**

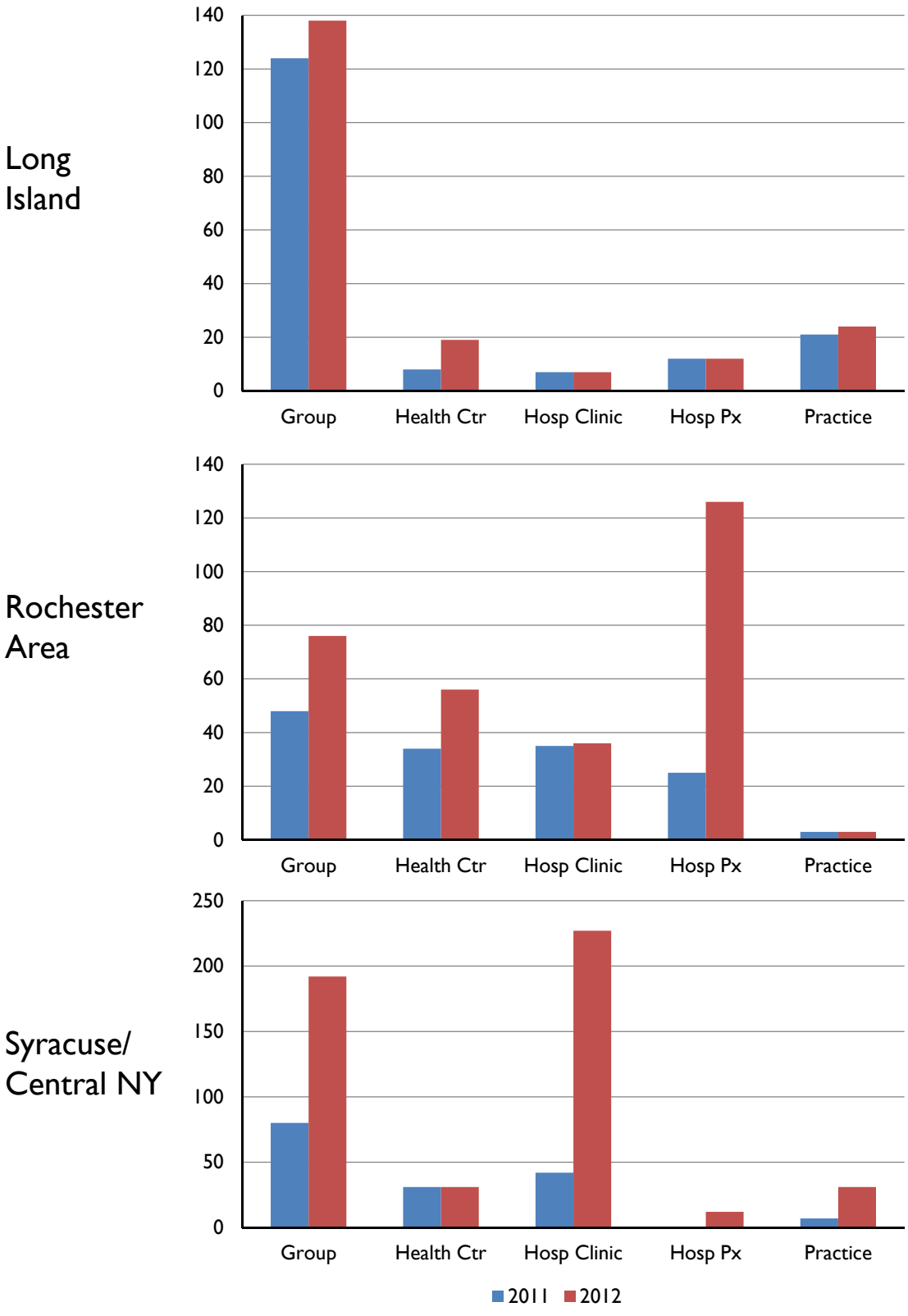


Figure 21 (continued). **PCMH Growth by Practice Type and Region**

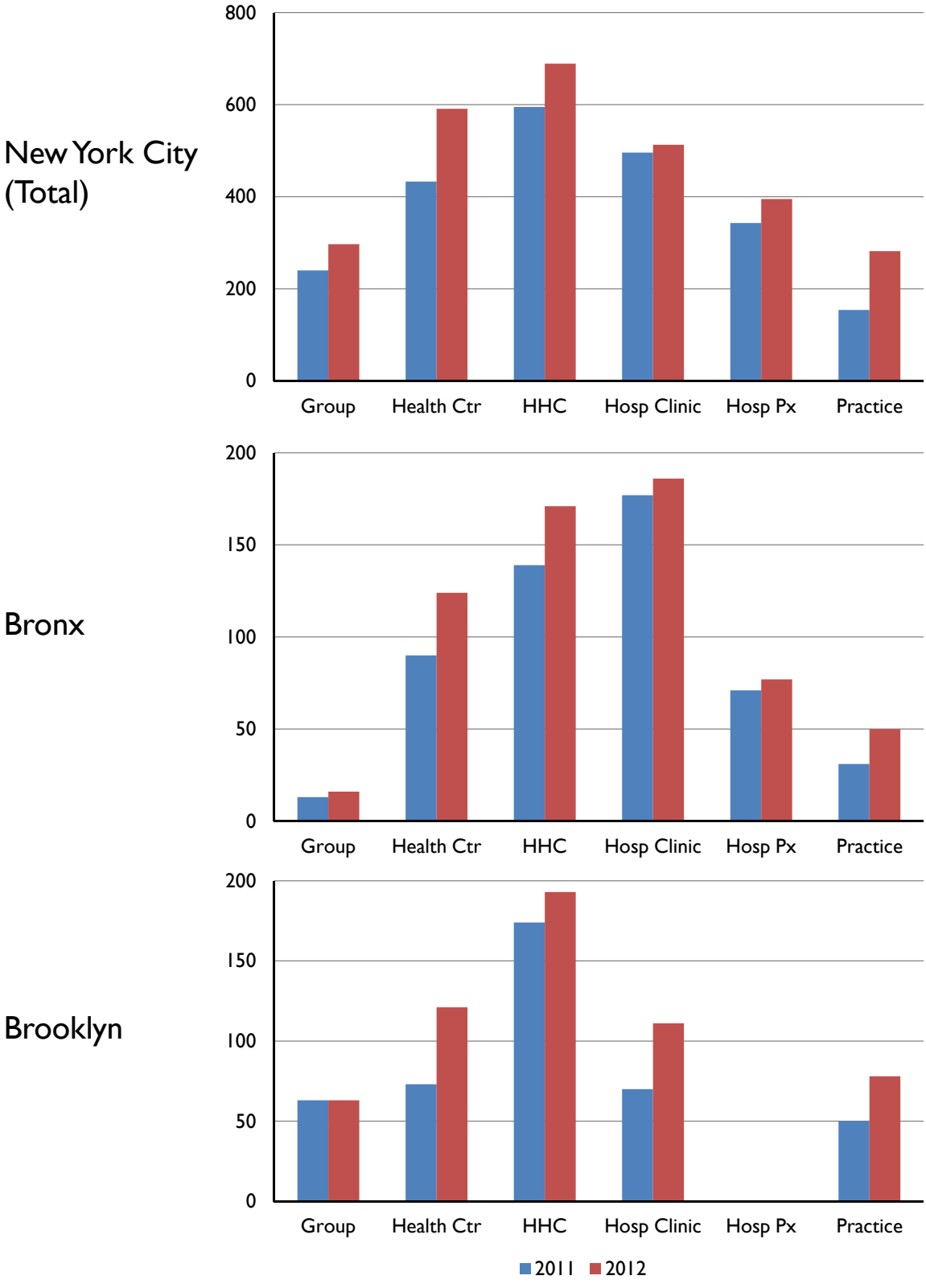
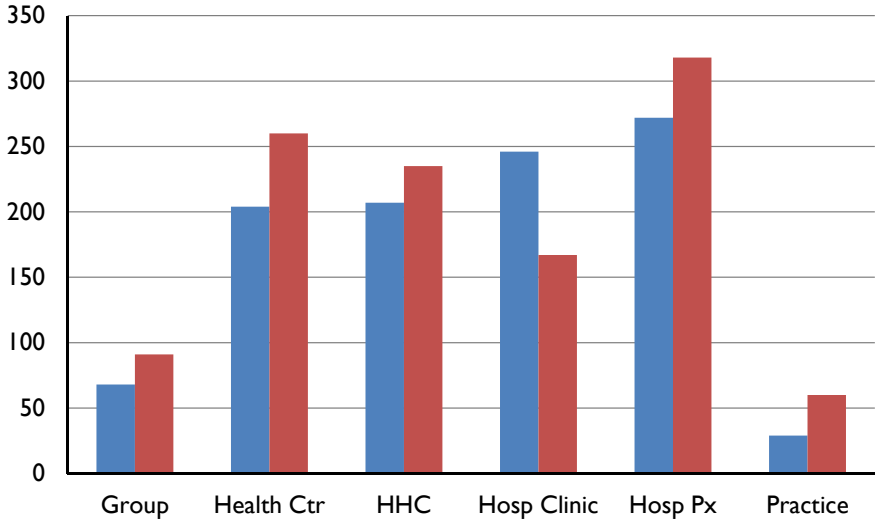


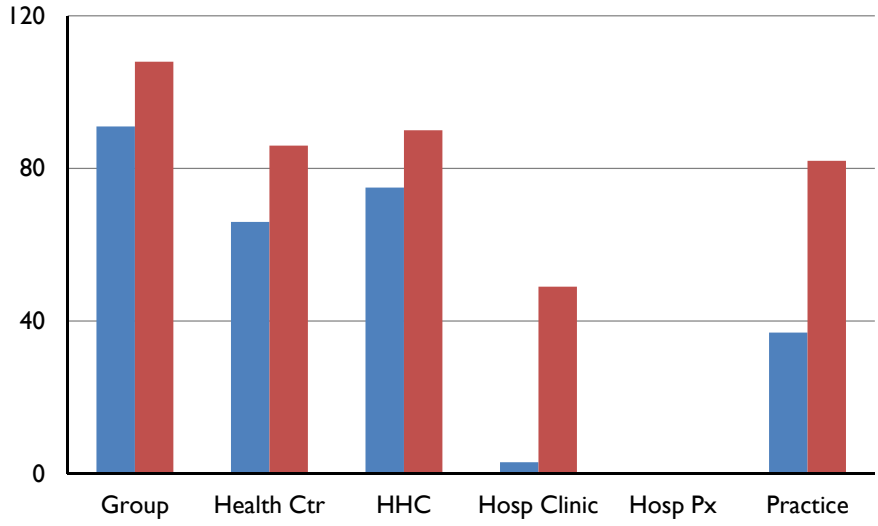
Figure 21 (continued). **PCMH Growth by Practice Type and Region**

Manhattan

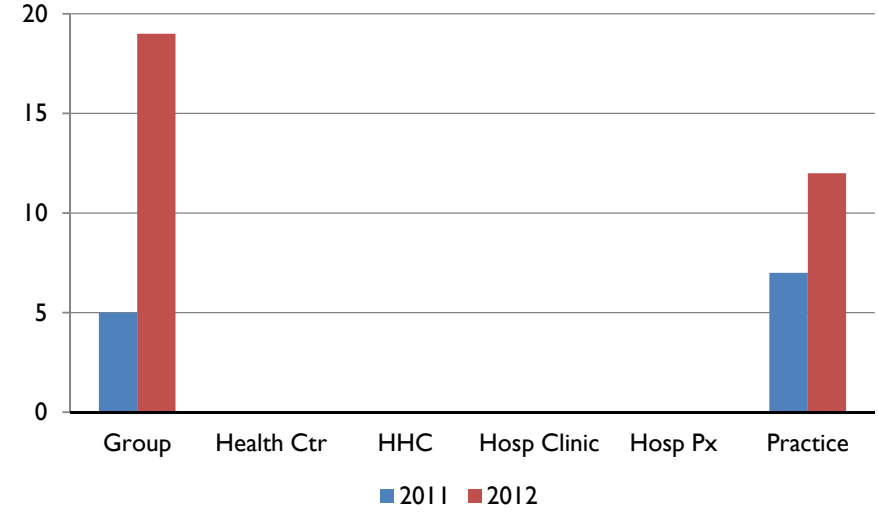
Note: 2011 data for hospital clinics in Manhattan was overstated because of duplicate reporting; the net growth in hospital clinics was in line with the other areas.



Queens



Staten Island



Appendix:
New York State Counties and Regions Used in PCMH Analysis

Appendix Figure 1. **Groupings of New York State Counties into Regions Used in PCMH Analysis**

Region/County	# PCMH Providers, Sept. 2012
Albany/NE NY	**612**
Albany County	88
Clinton County	65
Columbia County	3
Delaware County	46
Essex County	48
Franklin County	22
Fulton County	2
Hamilton County	5
Montgomery County	4
Otsego County	37
Rensselaer County	42
Saratoga County	67
Schenectady County	43
Schoharie County	17
Warren County	116
Washington County	7
Buffalo Area	**412**
Allegany County	2
Cattaraugus County	20
Chautauqua County	41
Erie County	320
Genesee County	6
Niagara County	13
Orleans County	3
Wyoming County	7
Hudson Valley	**531**
Dutchess County	93
Orange County	27
Putnam County	16
Rockland County	41
Sullivan County	25
Ulster County	53
Westchester County	276

Region/County	# PCMH Providers, Sept. 2012
L.I.	**199**
Nassau County	134
Suffolk County	65
NYC	**2,768**
Bronx County	624
Brooklyn /Kings County	567
Manhattan/New York County	1,131
Queens County	415
Staten Island/Richmond Cty	31
Rochester Area	**297**
Livingston County	9
Monroe County	258
Ontario County	8
Seneca County	4
Wayne County	13
Yates County	5
Syracuse/Cent NY	**493**
Broome County	115
Cayuga County	7
Chemung County	2
Chenango County	17
Cortland County	15
Herkimer County	16
Jefferson County	57
Lewis County	20
Madison County	4
Oneida County	16
Onondaga County	151
Oswego County	17
St Lawrence County	5
Tioga County	11
Tompkins County	40
NYS Total	**5,312**

Appendix Figure 2. **New York State Regions Used for PCMH Analysis**

United Hospital Fund

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