PRIMARY CARE DEVELOPMENT CORPORATION

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Testimony from the Primary Care Development Corporation (PCDC) to the Joint Senate Finance, Assembly Ways and Means Public Hearing on the FY2021 Executive Budget Proposal: Health and Medicaid
January 29, 2020

Thank you for the opportunity to testify before the committee today. The Primary Care Development Corporation (PCDC) is a New York-based non-profit organization and a U.S. Treasury-certified community development financial institution dedicated to building excellence and equity in primary care. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening primary care through capital investment, practice transformation, applied research, and policy advocacy.

PCDC's History of Impact and Service

Over the last 27 years, PCDC has worked with over 950 health care sites in the Empire State, including seven DSRIP (Delivery System Reform Incentive Payment) Performing Provider Systems (PPS) in all corners of the state. Thanks in part to the New York State Legislature, we have financed and enhanced health care facilities and practices in more than 92% of New York's Senate Districts (58 of 63) and 86% of Assembly Districts (129 of 150) to increase and improve the delivery of primary care and other vital health services for millions of New Yorkers. Our legacy includes the financing of key regional health providers such as Hometown Health Centers (Schenectady), HRHCare Community Health (Poughkeepsie and Monticello), Community Health Center of Buffalo (Buffalo), Hudson Headwaters (Fort Edward), and Callen-Lorde (New York City). In just the last five years, PCDC arranged nearly $75 million in affordable and flexible financing to expand access to primary care across New York State.

Since our founding in 1993, PCDC has improved primary care access for more than 1 million patients nationally by leveraging more than $1.2 billion to finance over 130 primary care projects. Our strategic community investments have built the capacity to provide 4 million medical visits annually, created or preserved more than 15,000 jobs in low-income communities, and transformed more than 1.8 million square feet of space into fully functioning primary care practices. Through our capacity building programs, PCDC has trained and coached more than 9,000 health workers to deliver superior patient-centered care. We have also assisted over 570 primary care practice sites — encompassing more than 2,500 providers — to achieve Patient-Centered Medical Home (PCMH) recognition, improving care for more than 5 million patients. In partnership with the Montefiore School Health Program and the New York School-Based Health Alliance, PCDC developed the first and only nationwide recognition program approved by the National Committee for Quality Assurance (NCQA) for school-based health centers.

Protect Primary Care Gains and Savings in Medicaid Redesign

The FY2021 Executive Budget calls for the formation of a new Medicaid Redesign Team (MRT II), tasked with an ambitious April 1st deadline to identify $2.5 billion in savings. PCDC is heartened by the Executive Budget's directive that the gap-closing savings will be achieved "with zero impact to beneficiaries" because the state's 6 million Medicaid beneficiaries rely on the robust benefit structure of the Medicaid program to achieve and maintain healthy lives and to contribute fully to New York's economy, culture,

and future.

However, we are deeply concerned that cuts will be made that will compromise New York's primary care safety net.

We support the Governor's goal to root out waste, fraud, and abuse as well as to identify inefficiencies in the health care system. A growing body of evidence demonstrates wasteful practices are a major contributor to growing health care costs and can be harmful to patients. Actual fraud and abuse, however, are just a small percentage of health care spending. A 2019 study estimates that more than 60% of health care waste come from high prices – mostly from pharmaceuticals, procedures, and testing – as well as administrative complexity that does not yield any clinical benefit, with a lesser amount stemming from overtreatment, low-value care, and failure of care delivery and coordination. Most of these issues are best addressed through incentivizing evidence-based, whole-person care and reorienting the health care system to have primary care at its center. Nationally, it is estimated that almost 25% of the health care spend could be saved by addressing these issues.

Therefore, we recommend that any Medicaid redesign should focus on increasing high-value, accessible primary care in order to fully protect the 6 million NYS Medicaid beneficiaries.

Primary care is the "4Cs" – first contact, comprehensive, coordinated and continuous care. It makes the difference between a life-threatening chronic condition and a manageable or treatable condition; it is a small slice of New York's overall health care spending yet has a significant impact on downstream costs and quality. While many delivery system reform efforts are underway statewide through DSRIP, the State Health Innovation Plan (SHIP), and other initiatives, these initiatives rely heavily on primary care to deliver better health outcomes and lower costs, but they do not provide the full and necessary support to ensure success. Drastic underinvestment in primary care drives providers to chase and struggle for every dollar instead of focusing on whole person and patient-centered care.

We cannot cut our way out of the Medicaid deficit, especially not by cutting primary care systems and community-based health providers. Rather, we must invest deeply in primary care to see both the health improvements and fiscal stability that New Yorkers deserve.

The original Medicaid Redesign Team recognized primary and preventive care as critical to reforming New York's expensive and inefficient health care system, with the goal of ensuring universal access to high-quality primary care. These included expanding access to patient-centered medical homes (PCMH), expanding the primary care workforce, expanding physical primary care access points as well as telemedicine, and more. PCDC believes that this work is not yet complete, and we urge the Legislature and the Executive to make primary care the central focus of any new Medicaid redesign.

It is also critical that New York State Medicaid continues its valuable efforts to integrate primary care and behavioral health: by supporting additional screening and treatment for mental health and substance use in primary care settings, and by better enabling behavioral health providers to address physical health care needs. One such federally funded demonstration program in which New York State participates, Certified Community Behavioral Health Clinics (CCBHC), is showing the power of a prospective payment to provide more coordinated mental health and substance use treatment as well as to address key chronic conditions. We encourage the Legislature to consider additional budget support for more CCBHCs and

other innovative approaches to drive down the high cost of diabetes, end stage renal disease and cardiovascular events that are the result of the lack of primary and preventive care for New Yorkers with severe mental illness and substance use disorder.

Investment in Primary Care

PCDC believes New York should be a national leader in its commitment to funding a strong primary care system; however, we currently do not know how much New York State actually invests in primary care. We encourage the legislature to measure, track, and increase investments in primary care across all payers.

Other states are advancing policies and paving the way forward to strengthen, prioritize, and invest in primary care through measuring and increasing primary care investments. Starting in 2010, Rhode Island required that commercial plans increase spending on primary care by 1% per year so that by 2014, 10.5% of total spending would be on primary care—through payments supporting quality and efficiency, such as incentives tied to Patient-Centered Medical Home recognition. During this period, Rhode Island was the only state in New England to increase the supply of primary care physicians per capita, while spending by commercial health insurers grew more slowly compared with other states in the region. Six other states have now followed suit.

At this month's World Economic Forum in Davos, the World Health Organization (WHO) called for all countries to accelerate progress towards universal health coverage by allocating 1% more of their gross domestic product (GDP) to primary care. And earlier, at the 2018 Global Conference on Primary Health Care, WHO, UNICEF (United Nations Children's Fund), and world leaders declared "strengthening primary health care is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being, and that primary health care is a cornerstone of a sustainable health system for universal health coverage and health-related Sustainable Development Goals."

New York's underserved communities have the most pressing need for primary care services but are served by dwindling numbers of providers and institutions that lack resources to expand and improve services. Without primary care, families risk costly and serious complications from illnesses that can threaten their long-term well-being and financial security as well as worsen other social and economic inequities.

We must protect and make the necessary investments to support primary care providers and systems in New York if we hope to achieve better health care, healthier communities, and lower costs statewide because the entire premise of health system reform rests on a robust primary care system.

Prioritize Primary Care Funding for the Remainder of DSRIP and Post-DSRIP

PCDC has advocated for a strong and sustained commitment to expanding access to quality primary care throughout the NYS DSRIP program as a crucial opportunity to strengthen and expand primary care. As reported in the FY2021 Executive Budget, New York State has submitted to the Centers for Medicare &

Medicaid Services (CMS) an 1115 Medicaid Waiver Amendment proposal. The request includes an extension to utilize approximately $625 million in current unspent funds and a renewal proposal for a

new $8 billion of federal investment to allow New York to continue its existing delivery system transformation efforts, increase efficiencies across delivery systems, and continue down the road to value-based care.

As we have shared in past budget hearings and testimonies, DSRIP PPS funds did not fundamentally support the stated DSRIP primary care goals. Fund flows and engagement of primary care and other community-based providers have varied by PPS. Overall, less than 10% of DSRIP funding went to primary care, behavioral health, or community-based social service organizations, even though these organizations provide direct services to patients and have the greatest ability to provide interventions that reduce expensive tertiary or quaternary care. We must prioritize funding primary care and preventative services with the currently unspent DSRIP funds and in any future 1115 Waiver request.

PCDC strongly endorses the strategy that the next waiver amendment be fundamentally focused on strengthening the primary care system to achieve shared goals and urge that New York includes our recommendations to create a primary care-focused Medicaid program, which includes: allocating funds directly to primary care practices, appropriately attributing patients to the providers who manage their care, and creating geographic care systems to improve population health.

Maintain Support for the Patient-Centered Medical Home (PCMH) Program

Since 2008, PCDC has provided technical assistance to over 570 primary care practice sites to support them to achieve NCQA PCMH recognition. As a result, we have developed an in-depth understanding of PCMH concepts and competencies, the technicalities of the recognition process, as well as the range and scope of primary care practice operations and approaches to practice transformation.

PCDC supports DOH's efforts to promote the PCMH model as one vehicle to move towards integrated and value-based care. Primary care provider organizations made extensive commitments to the PCMH practice transformation journey, knowing that there would be incentive payments from the Medicaid program to help support continued sustainability of their often-comprehensive redesign, quality improvement, care management, and staffing activities and investments. This per member per month (PMPM) incentive payment, currently $6 PMPM, has already been cut from a high of $7.50 PMPM, and is critical to maintaining the gains of any transformation, including paying for systems, staff, outreach workers, and care coordination. Imagine if a practice with two providers serves 1,000 Medicaid patients. This payment would amount to $72,000 per year. Research shows that it takes an average of almost $14,000 per provider FTE to achieve PCMH, and an additional average of more than $8,000 per provider FTE monthly – or $96,000 yearly – to maintain it. This current payment does not adequately and sustainably cover the costs of achieving or maintaining PCMH.

We agree that PCMH is not the only activity that practices need to undertake to achieve the goals of a high performing health provider with excellent patient outcomes and lower cost. But, studies show that the longer a practice has been PCMH recognized, the overall impact of practice transformation, particularly the cost savings, is increased.

PCDC urges the legislature to ensure funding and investments in primary care providers during the remainder of DSRIP as well as through other current and future programs to assure that they can sustain patient-centered models of care. We urge you to work closely with DOH to ensure that

Medicaid reimbursement and waiver funds are spent as close to the primary care system as possible, as the most effective route to improve care and outcomes, while reducing cost.

Maximize Health Care Facility Transformation Program Grant Funds

PCDC applauds the Executive's proposed renewal of the Health Care Facility Transformation Program (HCFTP) and urge the continued preservation of allocation requirements for community-based health providers. We encourage DOH to continue to exceed the minimum allocation requirements to ensure more funds flow to primary care and community-based providers.

While the program has been an important and generous investment in community providers, it has not and will not meet the substantial capital needs of providers throughout the state.

PCDC urges the Legislature to maximize HCFTP funds and other future health care capital programs by more explicitly prioritizing applicants that request less than their full project costs and leverage state funding with other financing to accelerate the pace of development across the State. These investments could be debt, tax credits, or capital campaigns, including loans from the New York State Community Health Care Revolving Capital Fund. As many HCFTP-eligible applicants and projects are also eligible for the Revolving Capital Fund, this opportunity would multiply the impact and value of public dollars in two state funds with a shared goal of expanding and transforming New York's health care infrastructure.

We urge the legislature to require, and DOH to give strong preference to, health care infrastructure projects that identify additional sources of capital to support the total project cost. Enhancing HCFTP capital grants with private investments and other public funding would allow for greater impact, more providers to receive funding, and more robust public-private partnerships.

Regulatory Reform to Improve Behavioral Health and Primary Care Integration

Through PCDC's work on behavioral health and primary care integration, PCDC has several recommendations to make to the Legislature.

First, it is critically important that New York State renews its commitment to regulatory reform to improve and promote behavioral health and primary care integration. The current maze of physical plant requirements by the three involved agencies (DOH, OMH, and OASAS) along with other federal requirements, make it extremely difficult to provide needed primary care services in behavioral health settings. We urge the Legislature to simplify and streamline facility requirements, particularly for integrated behavioral health and primary care, which we believe will improve access and reduce cost, particularly for high utilizers of the Medicaid system.

Secondly, developing a workforce that understands the nexus between behavioral and physical health, and has been trained to work in a coordinated, collaborative environment is of utmost importance. New types of training programs must be funded to ensure we have a sufficient and trained workforce.

Thirdly, despite great advances in health information exchange, it remains difficult to get information across these three domains (mental health, substance use treatment, and primary care) at the point of care. Exchanging health care information between organizations improves patient care and will reduce cost by reducing unnecessary and duplicative diagnostic testing and prescriptions.

Finally, as noted above, we urge the Legislature to expand existing effective integration programs such as the CCBHCs.

Restore and increase funding for the Primary Care Development Corporation

- **Allocate $525,000 for PCDC, reflecting the $450,000 in the FY20 budget plus a $75,000 increase**

The Legislature included $450,000 for PCDC in the final FY20 budget, and we are very appreciative of your continued support. This funding enabled PCDC to undertake important initiatives to ensure sustainable growth of primary care in underserved communities, assist providers in becoming PCMHs, and support New York's commitment to primary care. Our work is even more critical as health care transformation projects continue to require more from the primary care sector and PCDC works with these providers to help them succeed.

To allow us to undertake this important work, PCDC respectfully requests restoration of $450,000 and an increase of $75,000 in the FY21 budget. This request is born of the tremendous need for PCDC's services as New York continues to undertake major health system reforms and respond to unprecedented change in the federal health care landscape. Before the 2009 budget crisis, the legislature regularly included $525,000 in the budget for PCDC.

Last year's allocation enabled PCDC to carry out our critical mission: evaluating primary care access across New York, strengthening the primary care sector by promoting strategies for interdisciplinary care, supporting the development of public and payer policies critical to the advancement of primary care, among other important successes.

Specifically, the funding supported PCDC programs to:

- **Build Sustainable Primary Care Capacity:** Over the last five years, PCDC provided nearly $75 million in affordable financing to expand access to primary care across New York State. In the previous years, PCDC financed innovative projects throughout New York, including Evergreen Health in Buffalo, Housing Works in Manhattan, St. Joseph's Rehabilitation Center in Saranac Lake, and Callen-Lorde Community Health Center in Downtown Brooklyn.

- **Ensure Practice Transformation:** PCDC provides expert consulting, training, and coaching to transform the delivery of primary care that includes working with small and large primary care practices across the state.

- **Analyze and Evaluate Primary Care in New York State:** In PCDC's report "What's the State of Primary Care in New York?" made possible through FY18 funding, rural areas were identified to have disparities in primary care access, health status, and socioeconomic position. Thus, we selected rural primary care access as the key issue area to further examine and highlight through

the FY19 award. We released our "Rural Access to Primary Care in New York State" report last year, which found that there are far fewer primary care providers per person in rural and small-town communities, resulting in lower access for residents. Where urban areas have 15 primary care providers per 10,000 residents, rural areas have only 3.4. The expanse of geography that rural providers must cover adds even greater barriers to care. Rates of potentially preventable emergency department visits are higher in rural areas than in metropolitan areas, revealing a need for increased access to high quality primary care to appropriately address residents' needs. We are currently analyzing the Medicaid data to understand primary care utilization patterns and the challenges facing primary care provision across the Empire State.

- **Integrate HIV/AIDS Prevention into Primary Care:** Primary care has never been more important to prevent HIV transmission. PCDC's High Impact Prevention (HIP) in Healthcare, a U.S. CDC-funded Capacity-Building Assistance program, provides free training and technical assistance to over 155 healthcare organizations, helping over 1,350 staff integrate high-impact HIV services into their practices. We are proud to be an active partner in New York State's effort to end the HIV/AIDS epidemic.

- **Promote Engagement and Innovation:** PCDC brings leaders together and provides essential resources aimed at building strong primary care that works for everyone. Last year's Primary Care Summit, PCDC's annual policy event, convened a panel of New York State policy experts gathered to discuss closing the behavioral health and primary care integration gap. We also published a report featuring a case study of the East New York Hub, an integrated care project of the Institute for Community Living (ICL) and Community Healthcare Network (CHN) financed in part by PCDC. Policy recommendations for the state include simplifying integrated facility requirements, establishing integrated systems to share patient information, and promoting a collaborative team-based approach to care, among other steps.

Conclusion

With overwhelming evidence of its positive impact on improving health care quality and outcomes while lowering health care costs, primary care is the most reliable means of ensuring patient and community health. To meet its responsibility, primary care must be reinforced with sound policies and adequate resources. We look forward to working with the Governor and Legislature to ensure that the FY2020 New York State Budget supports these goals.

Thank you for your consideration of PCDC's recommendations.

Contact:
Primary Care Development Corporation
45 Broadway, 5th Floor, New York, NY 10006

Louise Cohen, Chief Executive Officer
(212) 437-3917 | lcohen@pcdc.org
Patrick Kwan, Senior Director of Advocacy and Communications
(212) 437-3927 | pkwan@pcdc.org

Points on Care
A data brief series examining all aspects of primary care access

PRIMARY CARE DEVELOPMENT CORPORATION

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Rural-Urban Gap in Uninsured Rates Closes in New York State Following the ACA

Health insurance coverage is an essential component of health care access in the United States[1,2] and has been shown to increase utilization of health services.[3] Health disparities observed among the uninsured, as with uncontrolled diabetes and hypertension, may be effectively addressed through improved access to primary care services.[4-5] Furthermore, a lack of health insurance coincides with access barriers, many of which are particularly pronounced in rural regions, including less geographically proximate services, lower provider availability, and higher poverty and disability rates.[6]

The 2010 Patient Protection and Affordable Care Act (ACA) required states to either open health insurance marketplaces or join the federal exchange, and gave states the option to expand Medicaid eligibility.[7] In 2013, New York State (NYS) both implemented the New York State of Health marketplace and Medicaid expansion in part to address health disparities in the uninsured population relative to their insured counterparts.[8]

We examined uninsured rates across the rural-urban continuum[9] before and after the implementation of the New York State of Health marketplace and Medicaid expansion (2012 vs. 2016) to better understand how the ACA implementation affected health insurance coverage, and therefore, access to primary care across the state.

Key Findings

The average uninsured rate among adults ages 18-64 years in NYS declined from 13.6% to 10.2% between 2012 and 2016

In 2012, urban areas had significantly lower uninsured rates (12.9%) when compared with small town (15.3%, p<.01) and rural areas (15.8%, p<.01)

In 2016, there were not any statistically significant differences in the adult uninsured rate along the rural-urban continuum in NYS

Reductions in uninsured rates were significantly lower in small town areas compared with more rural areas, resulting in small town regions surpassing rural regions with the highest average uninsured rates of all RUCA regions in NYS

Disparities in Health Insurance Coverage: Before & After the ACA

In 2012, uninsured rates in rural regions of NYS were statistically significantly higher when compared with metropolitan regions. Uninsured rates in rural regions were 2.9% higher on average (p<.001) and about 2.4% lower in small town regions (p<.05).

Following the ACA, uninsured rates decreased across all regions, and in 2016 there were no significant disparities between these four regions.

However, small town regions experienced the lowest reduction in uninsured rates, surpassing rural regions in having the highest average uninsured rates of all four Rural-Urban Commuting Area (RUCA) regions.

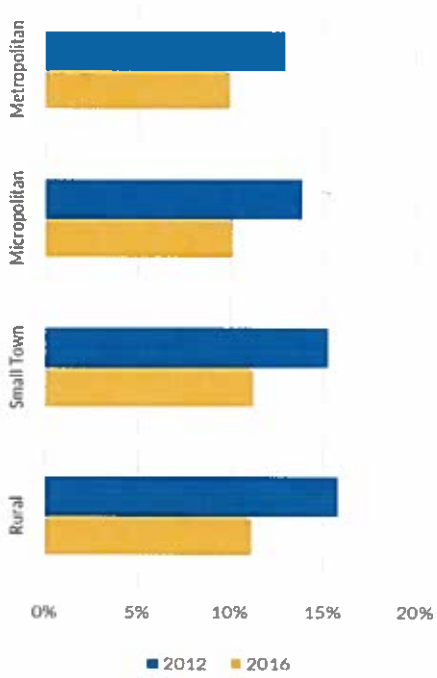

Fig 1. Percent of Uninsured Adults (18-64 years) in NYS, 2012 and 2016.
Data Source: United States Census via the American Community Survey, 5 Year Estimates

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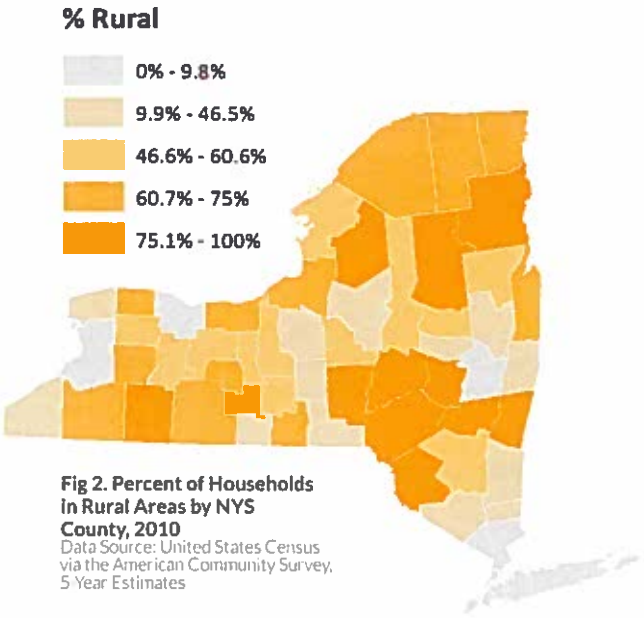

Fig 2. Percent of Households in Rural Areas by NYS County, 2010
Data Source: United States Census via the American Community Survey, 5 Year Estimates

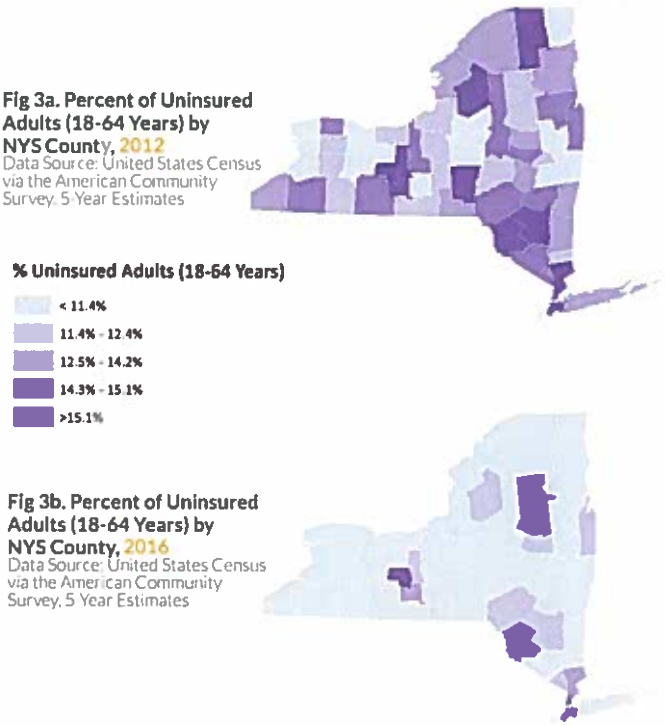

Fig 3a. Percent of Uninsured Adults (18-64 Years) by NYS County, 2012
Data Source: United States Census via the American Community Survey, 5 Year Estimates

Fig 3b. Percent of Uninsured Adults (18-64 Years) by NYS County, 2016
Data Source: United States Census via the American Community Survey, 5 Year Estimates

Turning Data into Action

Even though the NYS Medicaid program was already more expansive compared with those of most other states, PCDC's analysis found that rural-urban gaps in uninsured rates closed between 2012 and 2016, following the implementation of the ACA. Beyond health insurance coverage, persistent barriers in small town and rural areas continue to limit access to primary care. These results support maintaining the ACA and highlight the policy's success in improving a fundamental aspect of health care access in rural regions.

Future research should evaluate the degree to which Medicaid expansion, the removal of pre-existing condition exclusions, and introduction of The Essential Plan influenced regional health insurance coverage gaps in NYS.

Health advocates can cite these results to support future Medicaid expansion efforts, particularly in states that opted out of the Medicaid expansion and those with rural communities largely dependent on public insurance.

Efforts to further reduce the uninsured population should be supported in conjunction with efforts to reduce other access barriers for rural populations, including primary care workforce shortages and retention issues, difficulty maintaining resources for population-specific needs, challenges with financial stability, and social inequities.

Policymakers should consider how these results demonstrate the potential of state-wide health policy initiatives to achieve meaningful change and reduce access inequities in a relatively short period.

Suggested citation: Weisbeck, K., Ford, M.M., Cohen, L. (2019) Rural-Urban Gap in Uninsured Rates Closes Following the ACA. Points on Care. Primary Care Development Corporation.

Contact: Kirsten Weisbeck, MPH | kweisbeck@pcdc.org

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Primary Care Development Corporation (PCDC) is a nationally recognized nonprofit that catalyzes excellence in primary care through strategic community investment, capacity building, and policy initiatives to achieve health equity. For more information about PCDC, visit pcdc.org.