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Thank you to Chair Krueger, Chair Weinstein, and members of the Senate Finance and Assembly Ways and Means and Committees for the opportunity to testify today. I am pleased to provide testimony on behalf of the New York Health Foundation (NYHealth), a private, independent, statewide foundation dedicated to improving the health of all New Yorkers, especially people of color and others who have been historically marginalized.

As we recover from the pandemic and build back a better health system, the main focus must be expanding and strengthening primary care. Specifically, New York should:

- **Devote a greater share of its total health spending to primary and preventive care;**
- **Develop the non-clinical segments of the primary care workforce; and**
- **Use primary care to improve racial equity.**

The Proven Benefits of Primary Care

Primary care is often a patient's first point of contact in the health care system. High-quality primary care provides ongoing, relationship-based care that meets the health needs and preferences of individuals, families, and communities. Time and again, evidence has shown the importance of accessible, high-quality primary care. People who receive primary care are significantly more likely to get effective preventive care like cancer screenings, flu shots, and nutrition counseling.[1] They also exhibit better health outcomes and management of chronic diseases like diabetes and asthma.[2] And primary care is a rare "win-win" for health care: it is associated with both better health and lower costs. Better access to primary care is associated with fewer hospital visits, fewer emergency department visits, and fewer surgeries, which means reduced health care costs.[3]

Investing in Primary Care

Despite this mountain of evidence showing its value, we continually underinvest in primary care. Primary care accounts for approximately 35% of health care services in the United States each year, but represents only an estimated 5–7% of health care spending.[4,5] In simple terms, we only spend about a nickel of every health dollar on primary care.

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[1] Levine DM, Landon BE, Linder JA. "Quality and Experience of Outpatient Care in the United States for Adults With or Without Primary Care," JAMA Internal Medicine 2019;179(3):363–372. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2721037.

[2] Shi L, "The Impact of Primary Care: A Focused Review," Scientifica. 2012; 2012:432892. https://www.hindawi.com/journals/scientifica/2012/432892/.

[3] Kravet SJ, Shore AD, Miller R, Green GB, Kolodner K, Wright SM. "Health Care Utilization and the Proportion of Primary Care Physicians," The American Journal of Medicine, 2008 Feb;121(2):142-8. https://www.amjmed.com/article/S0002-9343(07)01088-1/fulltext.

[4] Patient-Centered Primary Care Collaborative, "Investing in Primary Care: A State-Level Analysis," July 2019. https://www.pcpcc.org/sites/default/files/resources/pcmh_evidence_report_2019_0.pdf.

At the same time, we already spend vast sums on health care overall in New York—20% higher than the national average by some accounts.[6] But that spending isn't providing enough value for New Yorkers; our health outcomes are average and often poor in comparison with other states.[7]

We can do better. The solution is to rebalance health care spending by allocating a greater percentage of what we spend to primary care. Doing so doesn't require spending more on health care; it requires spending in smarter and better ways that return more value for our dollars. Rebalancing primary care spending is a vehicle for expanding access to preventive care, ensuring more entry points into the health care system, and promoting more cost-effective and equitable care.

Almost all states face the same problem of underinvestment, and a growing number are taking action to correct it. At least 18 states have implemented or considered policy changes to increase investments in primary care.[8] For example, in Oregon, legislation requires that primary care spending increase by 1% annually, with a goal that primary care account for 12% of total spending by 2023.[9] States have also demonstrated how increased primary care spending is tied to overall decreases in health care costs. A prime example is Rhode Island, which set targets to increase the share of commercial insurer primary care expenditures by 5% over a five-year period. Over that same period, the State's total expenditures fell by 14%.[10] Both Oregon and Rhode Island were able to increase the number of per capita primary care providers, suggesting that investment in primary care also reduces strain on the workforce.

New York should not lag other states. The Legislature recognizes the importance of this issue and has attempted to address it. Last year, both houses of the Legislature demonstrated leadership by passing bills to jumpstart the process of increasing primary care investment and testing out programs to identify the most promising models. Those bills were vetoed by the Governor. 2023 should be the year that New York joins other states and an effort to increase investment in primary care gets going.

Building the Non-Clinical Primary Care Workforce

High-quality primary care is patient-centered and team-based, with both clinical and non-clinical workers providing primary care services. The proposed Executive Budget includes Medicaid reimbursement for community health workers (CHWs), who play a critical role on the primary care team. New York State's 7,000 or so CHWs are frontline public health workers who are trusted members of their communities; more than half of CHWs are people of color.[11] CHWs are associated with improving access to care and health outcomes, addressing social determinants of health like housing and food access, and lowering health care costs. One study showed that having CHWs for children with asthma reduced days with

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[5] National Academies of Sciences, Engineering, and Medicine, Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care, Washington, DC: The National Academies Press, May 2021. https://www.nationalacademies.org/our-work/implementing-high-quality-primary-care#sectionPublications.

[6] New York Health Foundation, "Health Care Spending Trends in New York State," October 2017, https://nyhealthfoundation.org/resource/health-care-spending-trends-in-new-york-state/. Accessed February 2023.

[7] America's Health Rankings analysis of America's Health Rankings composite measure, United Health Foundation, State Findings: New York, 2021. https://www.americashealthrankings.org/explore/annual/state/NY.

[8] Primary Care Development Corporation. Primary Care Legislative Trends 2022. January 2023. https://www.pcdc.org/what-we-do/policy-advocacy/2022-trends-in-primary-care/. Accessed February 2023.

[9] Primary Care Development Corporation, "Primary Care Spend: State Policy Overview," updated April 2021, https://www.pcdc.org/resources/primary-care-spend-state-policy-overview/.

[10] Koller C. & Khullar D. Primary Care Spending Rate - A Lever for Encouraging Investment in Primary Care. New Eng. J. Med. 2017. 377(18) 1709-1711. Doi:10.1056/NEJMp1709538.

[11] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics, May 2021: 21-1094 Community Health Workers. https://www.bls.gov/oes/current/oes211094.htm. May 2021. Accessed February 2023.

asthma symptoms and urgent care usage, with positive returns on investment.[12] Another study found CHWs had $2.47 in returns for every dollar spent on Medicaid payers.[13] Increasing support for CHWs is one way to expand access to primary care. It can also reduce strain on clinicians and enhance health equity for CHWs themselves by promoting advancement in health careers.[14] The budget proposal is an essential starting point for ensuring sustainability for this essential workforce.

Improving Racial Health Equity

Expanding access to primary care is inextricably linked to enhancing racial health equity, as shortage areas in New York State are often communities of color where patients face barriers to getting care when and where they need it. Communities that are predominantly Black and Latino have fewer primary care providers and lower-quality health care facilities than communities that are mostly white.[15] The odds of being in an area with poor access to primary care providers were 28 times greater in Census tracts with a high Black population than in areas with a low Black population.[16]

Improving racial health equity through primary care also requires improving the quality of care to address persistent racial disparities. The State can leverage its role as a payer, purchaser, and regulator of health care to advance racial health equity in primary care. For instance, the State could use racial equity-focused metrics for clinical or patient experience data to drive payment incentives. Centering racial health equity should be a key component of a comprehensive strategy to advance primary care access and quality.

Conclusion

Primary care is the backbone of a high-functioning health care system. Greater investment in primary care as a percentage of total health spending will lead to a healthier New York and a more cost-effective system. Having the required workforce in place and doing it all through the lens of racial equity will ensure New York's position as a national leader.

NYHealth has long supported efforts to advance primary care, including the development of regional plans to expand access in rural areas, integration of behavioral health and social services into primary care, and advocacy for increased investment. This year, we launched a new priority area focused explicitly on primary care. We stand ready to work with you to achieve a healthier state.

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[12] Campbell JD, Brooks M, Hosokawa P, et al. Community health worker home visits for Medicaid-enrolled children with Asthma: Effects on asthma outcomes and costs. American Journal of Public Health. 2015. 105, no. 11: 2366-2372. https://pubmed.ncbi.nlm.nih.gov/26270287/.

[13] Kangovi S, Mitra N, Grande D, et al. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. Health Affairs. 2020. 39, no. 2. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981.

[14] Centers for Disease Control and Prevention (CDC). Collaborating with community health workers to enhance the coordination of care and advance health equity. Atlanta, GA: CDC. https://www.cdc.gov/nccdphp/dch/pdfs/dch-chw-issuebrief.pdf. N.D.

[15] Institute of Medicine Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Smedley BD, Stith AY, Nelson AR, editors, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," Washington (DC): National Academies Press 2003. 2, The Healthcare Environment and Its Relation to Disparities. https://www.ncbi.nlm.nih.gov/books/NBK220358/pdf/Bookshelf_NBK220358.pdf.

[16] Brown E, Polsky D, Barbu C, Seymour J, Grande D. "Racial Disparities in Geographic Access to Primary Care in Philadelphia," Health Affairs 2016; 35(8). https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1612.