PRIMARY CARE DEVELOPMENT CORPORATION

December 7, 2018

New York´s 1115 Waiver Programs Public Forum Comment by the Primary Care Development Corporation

Thank you for the opportunity to comment on New York's 1115 Waiver programs and issues related to primary care in the recent DSRIP Implementation Update.

The Primary Care Development Corporation (PCDC) is a nonprofit organization and Community Development Financial Institution dedicated to building equity and excellence in primary care. We provide capital financing and capacity building services throughout New York State and across the country. Our mission is to create healthier and more equitable communities by building, expanding, and strengthening the national primary care infrastructure.

Since our founding 25 years ago in 1993, PCDC has worked with over 600 health care sites across New York, including seven Delivery System Reform Incentive Payment (DSRIP) program Performing Provider Systems (PPS) in all corners of the state. Nationally, we have improved primary care access for more than one million patients by leveraging more than $1 billion to finance over 130 primary care projects. Our strategic community investments have built the capacity to provide 3.5 million medical visits annually, created or preserved more than 10,000 jobs in low-income communities, and transformed 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 7,000 health workers to deliver superior patient-centered care. We have also assisted more than 450 primary care practices — encompassing some 2,250 providers — to achieve PCMH recognition, impacting care for more than 5 million patients nationwide.

Lack of access to primary care linked to poor health status in New York State. In June, PCDC released our report, *The New York State Primary Care Profile*, which analyzed proprietary and publicly available data to assess primary care access county-by-county. We identified significant correlations — between primary care access and overall health status; higher poverty rates and worse health outcomes; and rural counties and a lack of primary care access — based on defined measures of access and need. Our recommendations included ensuring a sufficient number of primary care providers in every county, working toward primary care access parity for people living in rural communities, and encouraging capital access and reimbursement models that reward proven quality programs.

Underserved communities have the most pressing need for primary care services, but they 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.

DSRIP is a crucial opportunity to strengthen and expand primary care, which is central to achieving better health for patients and communities, and lower costs for everyone. PCDC has advocated for a strong and sustained commitment to expanding access to quality primary care throughout the DSRIP program. Primary care must be a central priority in DSRIP – and post-DSRIP - to ensure everyone has access to the critical, cost-effective care and services that help prevent, identify, and treat illnesses before they become more serious, costly, and difficult to treat.

Additionally, as the Department recognized in its *Medicaid Redesign Team Structural Roadmap*, the primary care physician/practitioner "is a pillar in the NYS health care system because they ensure comprehensive, continuous and coordinated primary and preventive care. Good primary care is foundational to optimizing the health of

individuals." We believe equitable and sustainable reform of the delivery and payment systems depends on primary care.

Primary care funding should be prioritized for the remainder of DSRIP and post-DSRIP. Although primary care is emphasized in DSRIP and the Value-Based Payment Roadmap, the primary care system continues to be underinvested under DSRIP. Primary care is fundamental to the improvements we are seeking in the transformation of the delivery and payment systems. Without a strong and vibrant primary care system that is adequately resourced, technologically enabled, and integrated with other components of the health and behavioral health care systems, the Triple Aim will not be achievable.

While there is a great deal of activity *involving* primary care, we believe that we need to increase the extent to which we are *investing in* primary care.

PPS funds have yet to sufficiently flow to support DSRIP primary care goals. Fund flows and engagement of primary care and other community-based providers have varied by PPS. Overall, according to the second quarter DY4 PPS update, while 45% of total cumulative funds flow dollars ($941,954,826) went to hospital systems and PPS project management offices, less than 4% of total funds on average have flowed to non-hospital primary care ($138,266,049), mental health ($69,559,233), and substance use treatment ($26,452,915) providers. These figures show that the primary care system — which is already under-resourced — lacks sufficient financial support from the current PPS Funds Flow mechanism. The Department must ensure every PPS is supporting primary care and other community-based providers through timely and adequate fund distribution for the remainder of DSRIP. Only with this support can the primary care system effectively transition to value-based payment (VBP) and sustain the goals of DSRIP in the future state.

Increase in primary care practices achieving NCQA Level 3 recognition should be applauded – as well as appropriately and sustainably supported. Over the last two years, 7,500 providers have achieved NCQA Patient-Centered Medical Home recognition at the highest Level 3. PCDC commends the PPS progress of significantly increasing the number of primary care practices qualifying for NCQA Level 3 recognition, and the increase of 2,500 primary care providers new to NCQA recognition. In addition, we support the Department's continued investment in practice transformation technical assistance for practices and providers to achieve NYS PCMH.

PCDC also supports the Department's efforts to promote the PCMH model as a vehicle to move towards integrated care and VBP. Leadership, staff, and providers 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.

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 to maintain it. Studies show that the longer a practice has been transformed, the overall impact of practice transformation, particularly the cost savings, is increased.

The Department must 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.

The administrative burden on primary care providers should be alleviated. As a result of the numerous NYS health insurance plan along with the additional payer arrangements, including Independent Practice Associations (IPAs) and Accountable Care Organizations (ACOs) as well as DSRIP and Health Homes, the administrative burden on large and small primary care practices has become increasingly complex and burdensome. Under the current NYS

system, primary care providers are often contracted with several managed care organizations (MCOs) for commercial as well as Medicaid and Medicare, in addition to serving some patients with Medicaid and/or Medicare fee-for-service coverage. This, in addition to the significant overlap of providers being part of more than one PPS and several Health Homes, creates enormous complexity and administrative burden for providers. As NYS continues to reduce silos and work towards high performing networks, a critical focus should be on leveraging this process to identify streamlined approaches to reporting, billing, and contracting that support providers who are engaged with multiple actors within the system.

The health system transformation sought by New York State through the 1115 waiver can only be accomplished with sufficient, quality primary care that is accessible to all families and communities. 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. We are optimistic about the commitment New York State has made to primary care. We also recognize the need more investment and more effective policies to achieve the promise of primary care.

We look forward to working with the Department and the many other stakeholders who share our concerns and our vision in the next stage of evolution of health care reform in New York State.

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