Primary Care Development Corporation

Primary Care Development Corporation Testimony for the Joint Legislative Hearing on Health/Medicaid for the 2023-2024 Executive Budget Proposal

To Senator Krueger, Assemblymember Weinstein, and the members of the Joint Legislative Budget Committee on Public Health,

Thank you for the opportunity to provide testimony to the legislature today. Primary Care Development Corporation (PCDC) is a New York-based non-profit organization and a U.S. Treasury-certified community development financial institution (CDFI). Our mission is to create healthier and more equitable communities by building, expanding, and strengthening access to quality primary care through capital investment and practice transformation, as well as policy and advocacy.

PCDC urges the legislature and Governor to specifically center primary care in this year's health budget and to begin to shift New York's health system towards primary care as the best means to ensure health equity, healthy people, and healthy communities.

I. PCDC's History of Impact and Service, With New York's Support

PCDC provides capital and technical assistance to primary care providers in communities that need it the most and unlocks insightful data and analysis to drive effective policy change that strengthens primary care and advances health equity. Since our founding in 1993, PCDC has leveraged more than $1.42 billion to finance over 213 primary care projects. Across the country, these strategic community investments have built the capacity to provide 4.7 million medical visits annually, created or preserved more than 19,362 jobs in low-income communities, and transformed 2.5 million square feet of space into fully functioning primary care and integrated behavioral health practices.

In New York State specifically, we have worked with health care organizations, systems, and providers across the state on over 3,200 financing and technical assistance projects to build, strengthen, and expand primary care operations and services. Thanks in part to the funding from the New York State Legislature, we have financed and enhanced health care facilities and practices in more than 95% of New York's Senate Districts (61 of 63) and 89% of Assembly Districts (134 of 150) to increase and improve the delivery of primary care and other vital health services for millions of New Yorkers. In just the last five years, PCDC provided nearly $126 million in affordable and flexible financing to expand access to primary care across New York State.

Through our capacity building programs, PCDC has trained and coached more than 17,254 health workers to deliver superior patient-centered care, from helping more than 1,000 primary care practices achieve Patient-Centered Medical Home (PCMH) recognition, to working with the Montefiore School Health Program and the New York School-Based Health Alliance to develop the first and only nationwide recognition program approved by the National Committee for Quality Assurance for school-based health centers, to training more than 5,000 staff at over 400 health centers to integrate high-impact HIV services into their practices. Through this work and

more, PCDC supports the expansion of quality primary care, helping make primary care affordable, accessible, community-based, whole-person, and integrated with behavioral health care.

A. Continue Funding for the Primary Care Development Corporation

The Legislature included $450,000 for PCDC in the FY23 budget, and we are very appreciative of your continued support. This funding enabled PCDC to undertake important initiatives to understand and better support primary care in New York. To allow us to continue this important work, PCDC respectfully requests an FY24 appropriation of $450,000.

Last year's allocation enabled PCDC to carry out our critical mission, including research to understand primary care access issues in rural parts of New York State, encouraging the integration of reproductive health care into primary care, strengthening care delivery by promoting strategies for interdisciplinary care, identifying promising state primary care policy ideas from around the country, and developing public and payer policies critical to the advancement of primary care, among other important successes.

In the last several years, the legislature has supported PCDC to conduct original research on primary care in New York State that has helped policymakers, advocates, providers, and other stakeholders understand the landscape, challenges, and potential solutions to primary care access in the state. These reports clearly make the case for investing in primary care and expanding access to quality primary care in disinvested communities, rural communities, and communities of color. Our research reports provide quantitative and qualitative analyses of primary care access issues in the state, from how the history of redlining impacts primary care access in New York City to the association between FQHC access and decreased COVID-19 mortality. In 2022, PCDC published:

- *Access to Primary Care in New York State: A Special Report During the COVID-19 Pandemic,* which explores how primary care access differs across the state and how COVID-19 has created new challenges;
- *Poor Access to Care Drives COVID-19 Outcomes in New York: Federally-Qualified Health Centers help reduce community-level COVID-19 mortality,* and;
- Ford et al., *Federally Qualified Health Center Penetration Associated With Reduced Community COVID-19 Mortality in Four United States Cities*, Journal of Primary Care and Community Health, Nov. 30, 2022.

Most recently, PCDC hosted a summit on the role of reproductive health care in primary care, https://www.pcdc.org/support-pcdc/events/summit/, and published a report documenting state legislative trends around the country, https://www.pcdc.org/wp-content/uploads/2022-State-Primary-Care-Legislation-Trends-FINAL.pdf, to help provide context for the policies being considered in New York State.

II. Expand Access to Primary Care By Increasing Capital Investment in Providers

A. Expand the Funds for and Uses of the New York State Community Health Care Revolving Capital Fund

Community-based health care providers – especially those located in historically disinvested communities, communities of color and rural communities – often have limited access to affordable financing from traditional sources such as banks.[1] The New York State Community Health Care Revolving Capital Fund ("the Fund") was created in 2015 to help address this lack of access to capital, with an initial investment of $19.5 million. The Fund can provide affordable loan capital for eligible providers, including Article 28, 31 and 32 NYS licensed facilities to support quality primary care, mental health and substance use facility expansion and behavioral health integration in the Empire State. In 2017, PCDC was designated the Administrator of the Fund by the Dormitory Authority of the State of New York (DASNY) for ten years. PCDC began making loans using this capital in 2018.

The Fund has already been successful and instrumental in providing affordable, flexible financing, making eleven loans to eight community health care organizations, and will soon exhaust the original funds. While a portion of the current loans will be repaid over the next five years, those repayments will only provide for one to two new loans to be made each year. As the Governor noted in her 2023 State of the State, "demand for capital funding continues to outpace supply" and there is an urgent need for additional primary care capital investment. While primary care projects slowed during the pandemic, as both the economy and the provision of health care began to recover in late 2021 and early 2022, providers that began planning capital projects before the pandemic or are starting new projects need the Fund more than ever before.

The State's Health Care Facilities Transformation Fund (HCFTF) grants are reimbursable and do not provide up-front funding, therefore, many providers who receive these grants still must come up with cash to begin their projects. In addition, some providers who were awarded HCFTF grants prior to the pandemic could not begin those projects due to the pandemic shut down; upon restarting in 2021 or 2022, costs in some cases have risen and have resulted in funding gaps for many projects. For these reasons, many of providers who have received grant awards from the HCFTF have turned to the Community Health Revolving Loan Fund program to support their project through to completion.

Further, while thus far, the Fund has been available only for construction or expansion projects, in the current economic environment, safety net providers could use debt refinancing to increase liquidity, pay for higher salaries and incentives for their workforce, and reduce their debt burden. In some cases, refinancing might help a provider maintain a comprehensive care team by saving thousands of dollars a month in debt service.

To help New York State fulfil its promise of expanded access to health care and improved health equity, the Fund should be replenished and should be adapted to help providers ensure greater financial stability and support comprehensive patient care.

PCDC encourages the legislature to include the following in the FY24 budget: First, given the success of the Fund in acting as a bridge for facilities that are grantees of the Health Care Facilities Transformation Fund and the continued expansion of that program, as well as an important source of capital for providers who do not or cannot access Health Care Transformation Funds, we urge the legislature to include an additional $19.5 million in the Revolving Fund to account for the greater need. Second, we urge the legislature to expand the use of the Fund to include debt restructuring to help providers maintain their financial stability.

B. Equitably Distribute the Health Care Facilities Transformation Fund

PCDC strongly supports the Health Care Facility Transformation Program (HCFTP), which has been an important investment in community providers. The Governor's proposal to add a new infusion of funding is an important step to help providers cope with and recover from the impact of the pandemic, and her proposal to split that funding between capital investment and technological investment reflects an understanding of the critical need for providers to transform their practices by adopting new technologies that help integrate services and better serve patients.

However, while previous budgets have earmarked at least some part of the fund for primary care, this budget makes no such designation, meaning that it is possible that the entire $500 million for capital investment and $500 million for technological transformation will be out of reach for primary care providers. This is troubling, and when it comes to the technological funding, deeply disappointing – primary care providers, particularly those in small and safety net practices, rarely have extra funds to upgrade their technology, to adapt their electronic health records so that they can integrate with larger systems, or to adopt new telehealth platforms and technologies. **PCDC encourages the legislature to set aside 12 to 14% of both the Health Care Facility Transformation capital and technological funds specifically for primary care providers.**

III. Repeal and Replace the 340B Carve-out

New York's 2020 final budget included, with a two-year delay, a pharmacy carve-out of Medicaid managed care that will eliminate vital savings that New York's safety net providers receive through the federal 340B drug pricing program. We are deeply concerned the carve-out will permanently damage the delivery of safety net care in New York, reduce access to affordable medicine, destabilize health center financing, and further harm communities already struggling with COVID-19's health care and economic crisis.

The federal 340B program is a drug pricing program, enacted by Congress in 1992, that allows qualifying providers to purchase outpatient drugs from pharmaceutical manufacturers at discounted prices. The explicit purpose of the program is "to stretch scarce federal resources as far as possible, reaching more eligible patients, and providing more comprehensive services." By definition, 340B providers serve low-income and disabled patients. **These safety net providers use the savings from the 340B program as a financial lifeline that allows them to fund additional care and ancillary services for their patients, increasing overall access to primary care for their communities. It is effectively a form of value-based payment – that can be used without restrictions - and that can support the care management and integrated care that keeps people out of costly acute care.**

The 340B program offers substantial financial stability and additional unrestricted resources to eligible providers. The majority of safety net providers are not able to finance expansion, renovation, or remediation of facilities from their revenue, reserves, or fundraising alone; instead, they must seek out loans and other sources of capital funding. Commercial lenders are wary of lending to safety net providers because the very nature of these providers' mission to provide care to all regardless of ability to pay, and the worse health status of their patients, results in thin margins and can lead to financial instability. Even community development banks and CDFIs like PCDC need assurance that an entity's funding sources are sufficient and stable to approve a loan. Some have been reluctant to finance safety net provider facilities, particularly in the wake of the COVID-19 pandemic and the ensuing financial crisis. For lenders, the savings that safety net providers secure through the 340B program are seen as one stable component of their comprehensive revenues that demonstrate their financial sustainability and ability to manage debt over several years.

Changes to the 340B program that threaten the financial stability of these critical providers, particularly when combined with the impact of COVID-19 and the resulting economic crises, increase perceived and real risks associated with financing health centers and other safety net providers and may limit their access to necessary capital. These changes could have devasting effects on the safety net infrastructure, eroding the health center landscape after it has been proven to be critical for so many New York communities in the wake of the pandemic.

Although the Executive Budget proposes appropriating some funds to help 340B providers fill some of the large financial gaps that will be caused by the carve out, this is an insufficient way to address the problem caused by the carve out. First, **these funds would be subject to annual appropriations, leaving providers unsure of whether and how much funding they will have access to each year. Second, these funds are not tied to the patients' or providers' usage of the program but are rather fixed by the state, and so will not reflect the actual need of each provider**. Third, there is no funding mechanism specified in the Executive Budget, undoubtedly causing a lag in time between when the carve out is implemented and when providers are able to access these funds. In fact, if these funds are dispensed as a rate add-on, this would unnecessarily tie these funds to visit volume rather than being unrestricted and would cause further disparities between 340B covered entities and non-340B covered entities, without a differentiation in service provision.

The Safety Net Coalition has developed an alternative that would achieve the goals articulated in the original proposal, including increasing transparency, streamlining the process, retains savings for the state, and importantly allows providers to retain the 340B savings.

We urge the legislature to adopt this alternative to the 340B carve out in the FY24 Budget.

IV. The Critical Importance of a Primary Care-Centered Health System

Access to primary care is a key social determinant of health recognized by the World Health Organization (W.H.O.) and the U.S. Healthy People initiative framework.[2] Regular access to primary care is associated with **positive health outcomes**, especially when addressing heart disease, the leading cause of death in New York State, and other common chronic conditions

such as diabetes and asthma.[3] In addition, **primary care reduces overall health care costs** and is the only part of the health system that has been **proven to lengthen lives and reduce population level health disparities**.[4]

However, **primary care remains overburdened and underinvested**. The lack of focus on primary care in the American health system has been called a "medical emergency."[5] That emergency was undoubtedly heighted by the COVID-19 pandemic, which further highlighted existing disparities, as communities with less access to primary care before the pandemic experienced more COVID infections, severe illness, and deaths than communities with better access to primary care.[6]

Over the last two years, the Governor and legislature have recognized that the health system in New York is facing serious challenges, both for patients and for providers, and have put forward a range of proposals to address some of the specific problems. However, despite some steps in the right direction, **the FY24 Executive Budget continues to underemphasize primary care as the key to shifting health outcomes and health equity in New York**. There is an urgent need to re-orient New York's health care system towards primary care, investing in the care that will address long-standing health disparities, improve the health status of underserved communities across New York State, make New York's health system more effective now and help keep all New Yorkers protected in the future.

PCDC encourages the legislature to review each health proposal within the budget to ensure that primary care providers, patients, and the primary care workforce in general are included and prioritized, and **urges the legislature to offer a modified health budget that supports a more primary care-centered vision of health care in New York.**

A. Invest in Health Equity by Investing Directly in Primary Care

A recent landmark report from the National Academies of Science, Engineering, and Medicine (NASEM) entitled *Rebuilding the Foundations of Health Care*, concluded that "[w]ithout access to high-quality primary care, minor health problems can spiral into chronic disease, chronic disease management becomes difficult and uncoordinated, visits to emergency departments increase, preventive care lags, and health care spending soars to unsustainable levels."[7] Despite its proven impact, primary care continues to be underfunded and undervalued. In the United States, primary care accounts for approximately 35% of all health care visits each year – yet only about 5 to 7% of all health care expenditures are for primary care services.[8] In contrast, other similarly situated countries spend as much as 12-14% on primary care as a proportion of their total health care spending,[9] at the same time as spending more on social services and social determinants of health.[10] Experts including the World Health Organization and the authors of the NASEM report have called on governments to "increas[e] the overall portion of health care spending in their state going to primary care."[11]

New York's per-person health care costs are higher than the national average, yet consistently ranks below many states in key health indicators such as low birth weight, preventable hospitalizations, and childhood immunizations, all of which can be improved with better access to primary care.[12] Many parts of New York State lack an adequate number of primary care

providers, leaving residents in those areas without a resource for prevention, early diagnosis and treatment of common health issues such as diabetes, hypertension and depression.[13] The lack of sufficient funding for primary care impacts both patients and providers, leading to inadequate access, low-quality care, worse outcomes, and a burdened and burnt-out workforce that loses experienced professionals and has trouble attracting new ones.[14]

Almost 6.5 million New Yorkers live in HRSA-designated primary care Health Professional Shortage Areas.[15] Projection analysis predicts a shortage of physicians of any specialty by 2030 in New York State, and the COVID-19 pandemic has only exacerbated health care worker burnout, including in primary care.[16] Fewer medical graduates choose primary care in comparison to other specialties, in part because of disparate levels of anticipated income.[17]

Investing more resources into primary care is a critical way to achieve the kind of robust health care system our communities deserve, including by expanding the number and diversity of providers who enter primary care and who accept new patients, including those with Medicaid coverage. PCDC recommends that policy be adopted to ensure that at least 12% of health spending in New York state is on primary care. In this Executive Budget, there are several policies that help increase spending on primary care, while still far from this target.

1. Medicaid Rates Should Be Equal to Medicare Rates

More than 7.3 million New Yorkers are currently enrolled in Medicaid, a little over a third of the State's entire population.[18] Medicaid plays a foundational role in helping low-income New Yorkers stay healthy, has the potential to help address health disparities, and can drive overall health system policy. **Providing people with Medicaid coverage leads to "better access to health care[;] better health outcomes, including fewer premature deaths[; and] more financial security and opportunities for economic mobility**."[19]

However, Medicaid-insured individuals often struggle to find providers who will take their insurance, leading to delayed care and other adverse health outcomes.[20] A critical factor in providers' unwillingness to accept Medicaid is that Medicaid reimburses providers at far lower rates than other insurance programs, including both private plans and Medicare plans.[21]

Congress included in the Affordable Care Act a temporary provision that mandated parity between Medicaid and Medicare reimbursement specifically for primary care providers, but only for 2013 and 2014.[22] Following the expiration of this mandate in 2014, a few states implemented policies to continue Medicaid parity within their jurisdictions. As of 2019, Medicaid parity status across the country varied drastically by state **with New York ranked 47th overall and 49th when it comes to primary care --** specifically for primary care, New York currently reimburses Medicaid providers 43% of Medicare rates.[23]

Therefore, the Executive Budget's proposal to lift Medicaid reimbursement rates to 80% of Medicare is a marked improvement over the status quo. **Nonetheless, PCDC recommends that ultimately, Medicaid be raised fully to parity with Medicare to ensure that providers are not incentivized to turn away the most vulnerable patients in the state.**

Moreover, the Executive's proposal continues to leave out a critical component of the safety net – **Federally Qualified Health Centers will not be eligible for this rate increase** because of their unique billing system that supports comprehensive care. PCDC strongly supports a solution that updates community health center Medicaid rates, which have not been changed in almost twenty years, so that they can continue to provide the critical, comprehensive, whole person primary care that is so essential for millions of New Yorkers.

2. Telehealth Payment Parity for Primary Care and Behavioral Health

PCDC believes, along with many other experts and government agencies,[24] that telehealth has proven its merits as a sustainable innovation that can support patient access to quality care as well as giving providers access to reliable revenue streams.[25] PCDC has long advocated for expansion of telehealth access for patients, given its potential to expand access for underserved patients, but this expansion must be coupled with policies that ensure that telehealth can be provided in a financially sustainable way.[26]

It is critical that health care providers be able to reach their patients when and where they need the care, and as we learned due to necessity during COVID, a provider need not always be in her office to provide quality health care. There should be no blanket reduction in rate based on the provider's location. The proposal in this year's Executive Budget does not allow for full reimbursement parity for all primary care providers – this year's proposal is focused on behavioral health providers but does not even include primary care providers, such as licensed Article 28 facilities, who provide behavioral health services. In fact, many behavioral health services are generally provided in primary care settings, including treatment for depression and anxiety.[27] Further, primary care providers, including those who practice in FQHCs and licensed Article 28 facilities, should have telehealth reimbursement parity for primary care services as well as behavioral health services.

3. Expansions of coverage to new primary care and mental health services

PCDC supports the coverage expansions proposed in the Executive Budget, including: requiring coverage of school-based mental health services; expanding primary care and urgent care coverage in the shelter system; expanding Medicaid to cover care provided by community health workers as part of the primary care team; coverage for licensed mental health counselors and licensed marriage and family therapists; coverage for nutritionists, dieticians and arthritis self-management training services.

III. PCDC Urges the Executive and Legislature to Center Primary Care in Health Policy and Supports Proposals That Expand and Protect Access to Care

It is critical that New York's health care system be centered around primary care if we are to move towards health equity and allow all New Yorkers "to attain his or her full health potential" as envisioned by the World Health Organization.[28] Therefore, PCDC encourages the legislature to review each health proposal within the budget to ensure that primary care providers, patients, and the primary care workforce in general are included at the table and are given the right proportion of relevant resources. As noted earlier, many countries and experts have determined

that 12-14% of health care spending should be spent on primary care – PCDC recommends that all health care appropriations follow that recommendation.

A. Expanding Access to Insurance

PCDC supports the expansion of the Essential Plan to include individuals up to 250 percent of the federal poverty level, and the expansion of the Medicaid Buy-In program for working people with disabilities.

However, PCDC strongly opposes delaying the expansion of Medicaid coverage for qualified New Yorkers over 65 who are currently ineligible due to immigration status. In 2022, both the legislature and Governor agreed to adopt this expansion as a compromise, a small step towards providing coverage for all of those who need it. PCDC strongly supports policies that make health insurance coverage accessible to and affordable for as many New Yorkers as possible, including those who are undocumented. Everyone deserves access to affordable health insurance. Affordable insurance increases access to primary care, among other health care services, and is critical to achieving health equity.

B. Expanding and Protecting Access to Sexual and Reproductive Health Care

High quality, comprehensive primary care includes the full suite of physical and behavioral health services people need to live healthy, productive lives. Sexual and reproductive health is relevant across every person's lifespan and both sexual and reproductive health care, including abortion, are essential components of primary care. Primary care providers both directly provide and refer patients to the reproductive health care they need, including birth control, preconception care, counseling, and abortion services, as well as sexual health care such as STI testing and treatment.

PCDC was pleased to see efforts to expand access to both reproductive and sexual health care proposed in the Executive Budget. Specifically, PCDC supports:

- Pharmacy provision of contraception
- Pharmacy provision of PEP and PREP
- Requiring CUNY and SUNY campuses to provide medication abortion access to all students enrolled at the college, whether directly or by referral (found in the Education section of the budget).
- Prohibition of geofencing around health care facilities, to ensure that patients are not harassed or misled about their health while accessing health care.

C. Expanding access to behavioral health care

PCDC supports a number of proposals found in the Executive Budget that would expand access to primary care, behavioral health care and integrated primary and behavioral care, including:

- Eliminating the need for prior authorization for detoxification or maintenance treatment of a substance use disorder

- Requiring insurers to meet network adequacy standards for mental health and substance use disorder.
- Creation of certified community behavioral health clinics.
- Additional funding for family-focused developmental health care through HealthySteps.

In addition, PCDC strongly supports the Executive Budget's proposal to address administrative barriers to integration of behavioral health care and primary care and to adopt regulatory changes to licensure requirements to encourage integration. PCDC encourages both the legislature and Governor to work with stakeholders to ensure that significant changes are adopted and providers are then given to support to shift to comply with the new standards so that there is a meaningful increase in access to integrated behavioral and primary care in every community.

XII. Conclusion

Primary care is the most reliable means of improving individual and community health, moving towards health equity, and ultimately lowering health care costs. We encourage the legislature to carefully consider how to best use vital state resources in the health budget to expand access to quality primary care.

We look forward to working with the Governor and Legislature to ensure that the FY24 New York State Budget supports these goals. Please contact Jordan Goldberg, Director of Policy, at jgoldberg@pcdc.org with any questions or to request any additional information.

Thank you for your consideration of PCDC's recommendations.

Louise Cohen
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[6] *See, e.g.* Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, *available for download at* https://www.pcdc.org/resources/nyc-council-district- primary-care-access-and-equity-report/.

[7] National Academy of Science, Engineering and Medicine, *Implementing High-Quality Primary Care Rebuilding the Foundation of Health Care*, Chapter 3 (2021), available at https://www.nap.edu/read/25983/chapter/3.; *see also* Mark W. Friedberg, Peter S. Hussey, & Eric C. Schneider, *Primary Care: A Critical Review of the Evidence on Quality and Costs of Health Care*, 29 Health Affairs Vol. 5, May 2010, abstract available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2010.0025.

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[13] *See* University of Albany, School of Public Health, The Center for Health Workforce Studies, *New York Physician Supply and Demand through 2030*, University of Albany 2009, *available at* https://www.albany.edu/news/images/PhysicianShortagereport.pdf; Primary Care Collaborative, *Quick Covid-19 Primary Care Survey*, 2021, *available at* https://www.pcpcc.org/sites/default/files/news_files/COVID19%20Series%2030%20National%20Executive%20Summary.pdf; Press Release, 80 Percent Of Primary Care Clinicians Say Their Level Of Burnout Is At An All-Time High, Larry Green Center, June 18, 2020, *available at* https://static1.squarespace.com/static/5d7ff8184cf0e01e4566cb02/t/606717481c473310b5437518/1617368905890/18June2020+Press+Release.pdf.

[14] Kriti Prasad et al., *Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study*, 35 E. Clinical Med. 100879 (2021), available at https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(21)00159-0/fulltext. Across New York State, primary care provider availability varies greatly, from 21 PCPs per 10,000 people to fewer than 10 PCPs for an

entire county. County Health Rankings and Roadmap, New York State Health Factors, Primary Care Physicians, https://www.countyhealthrankings.org/app/new-york/2021/measure/factors/4/data (last visited December 7, 2021); Primary Care Development Corporation, *New York State Primary Care Profile*, June 2018, *available for download* https://www.pcdc.org/resources/new-york-state-primary-care-profile/.

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