Primary Care Development Corporation
New York State Chapter, American College of Physicians
New York State Academy of Family Physicians
Community Health Care Association of New York State
New York State American Academy of Pediatrics

April 7, 2016

VIA EMAIL
Mr. Paul Francis
Deputy Secretary for Health and Human Services
New York State Office of the Governor
Executive Chamber, State Capitol
Albany, NY 12224

Dear Deputy Secretary Francis:

New York State's health care transformation efforts depend heavily on investment in primary care, including the medical home model. It is therefore important that New York State and all payers operating in and regulated by New York State (commercial and Medicaid):

- Measure and publicly report how much they invest in primary care, and
- Ensure sufficient investment on primary care as a share of overall spending.

Currently, New York State is embarking on a major shift to value-based payment that is largely built on primary care and the medical home model. While New York State is considering different implementation approaches (e.g., Patient Centered Medical Home, Advanced Primary Care, payer-driven innovations), we are not advocating here for any specific approach, and consider the medical home to mean primary care that is organized and delivered to be patient-centered, comprehensive, coordinated, accessible and focused on improving quality of care.[i]

To our knowledge, there is no assessment of how much New York State spends on primary care, though incomplete information suggests that primary care represents between 3-7 percent of national health care expenditures.[ii] [iii] This underinvestment is a key reason why there are primary care provider shortages in communities throughout New York State; why more than 2.4 million New York State adults do not have a regular primary care provider;[iv] and why the vast majority of primary care providers do not have the resources to transform and operate effectively as medical homes. Certain factors constrain New York State and its health plans from making investments in primary care that are in the best interests of patients, purchasers and payers themselves. For instance, the Medicare fee schedule, on which most plans base their reimbursement, distorts the value of primary care and leads to significant underpayment. Primary care providers are further disadvantaged when negotiating contracts because they lack the market power of other health care services.

Quality primary care is a basic right and necessity for all New York State residents, and is essential for keeping families and communities healthy and out of more expensive care. There is growing evidence that the medical home model works. A recent review of 30 peer-reviewed studies, government evaluations and industry reports on this model from across the U.S. found that 21 of 23 studies on cost showed reductions in one or more measure, and 23 of 25 studies on utilization (including ED, hospital, specialty, urgent care and imaging), showed reductions in one or more measure.[v] Numerous other studies have demonstrated positive results on health outcomes, access, improved prevention services and improved patient and clinician satisfaction.[vi]

Investment in primary care must address: 1. Adequate reimbursement for providing primary care and operating a financially viable practice; 2. Upfront investment to help practices transform\; 3. Ongoing payment to sustain improvements; and 4. Financial rewards (including shared savings) resulting from improved quality and reduced overall health care costs. While after-the-fact financial rewards for cost savings may be useful incentives, it is sufficient and timely reimbursement for service and ongoing investment that is fundamental to building and sustaining high performing primary care. This is why all payers, and New York State, should:

Measure and publicly report how much is spent on primary care. Information about primary care cost and utilization is not publicly available, either at a plan level or as a share of total health care spending in New York State. To the extent that primary care cost and utilization data is being collected and reported, it is unclear if primary care is being defined uniformly, and what services within the primary care category are measured and reported. All payers, and New York State as a whole, should measure and publicly report how much is spent on primary care as a share of total health care spending, using a common definition, and provide a breakdown of spending by service within the primary care category. This information should be reported in a way that enables consumers, providers and policy makers to easily compare spending on primary care across health plans, and to measure primary care spending in New York State regionally and as a whole.

Ensure sufficient investment in primary care as a share of overall spending. The overall spending on primary care is clearly insufficient. While there is likely spending variation between plans, all health plans – and New York State – need to invest adequately on primary care as a share of total health care spending. We need the level of investment to reflect the value that primary care brings to individual and community health, the health care system and payers' networks. Sufficient investment is essential to fostering partnerships with primary care providers and building strong primary care networks that have the infrastructure to share data, coordinate patient care, improve individual and population health and generate savings in overall health care costs. We believe New York State has the authority, particularly through commercial health insurer rate review and the Medicaid managed care contracting process, to work with payers and providers to secure sufficient investment in primary care.

Initiatives to measure, report on and increase primary care spending are being considered and adopted in other states that are undertaking health care payment and delivery reform. Rhode Island, for instance, required all commercial plans to increase primary care spending by one percent of total spending per year over five years, which nearly doubled primary care spending as a share of total health

care spending over that period. Additional funds supported non fee-for-service investments including PCMH, and payers and providers had broad flexibility to innovate within this context.[vii] A recently passed Oregon state law now requires that state to report on the percentage of medical spending allocated to primary care by all health plans under its authority.[viii]

We commend New York State for embracing primary care and the medical model as a means of improving the health of families and communities and reducing overall health care costs. Adopting these recommendations would enable New York State and all health care stakeholders to gain critical data necessary to make informed decisions about the allocation of health care resources, help reverse the structural underinvestment in primary care and support the State's efforts to adopt value-based payment approaches. We urge you to work collaboratively with representatives of New York State's primary care and health insurance sector to measure, report and sufficiently invest in primary care to accomplish these goals.

Sincerely,

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CC: Howard Zucker, MD, JD, Commissioner, New York State Department of Health
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Hon. Richard Gottfried, Chair, Assembly Committee on Health
Hon. Kevin Cahill, Chair, Assembly Committee on Insurance
Hon. Kemp Hannon, Chair, Senate Standing Committee on Health
Hon. James Seward, Chair, Senate Standing Committee on Insurance

[i] AHRQ – Defining the PCMH https://pcmh.ahrq.gov/page/defining-pcmh Accessed 3/27/16

[ii] Primary care spending is 3% of total spending for 50 million individuals under age 65 with employer-sponsored health insurance. "2014 Health Care Cost and Utilization Report" and Appendix, Table A18, pp 32-33. Health Care Cost Institute. http://www.healthcostinstitute.org/2014-health-care-cost-and-utilization-report Accessed 12/18/2015

[iii] Primary care spending is about 6-7% of Medicare spending. Phillips, R. L., and A. W. Bazemore. "Primary Care And Why It Matters For U.S. Health System Reform." Health Affairs (2010): 806-10. Print.

[iv] NYS Prevention Agenda Dashboard: Age-adjusted percentage of adults who have a regular health care provider – Age 18+ https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=ig&ind_id=pa4_0 Accessed 3/27/16

[v] The Patient-Centered Medical Home's Impact on Cost and Quality: Annual Review of Evidence, 2014-2015 https://www.pcpcc.org/resource/patient-centered-medical-homes-impact-cost-and-quality-2014-2015 Accessed 3/27/16

[vi] Primary Care Innovations and PCMH Map by Outcomes. Patient Centered Primary Care Collaborative. https://www.pcpcc.org/initiatives/evidence Accessed 2/37/16

[vii] Primary Care Spending in Rhode Island: Commercial Health Insurer Compliance. Office of the Health Insurance Commissioner, State of Rhode Island. January 2014. http://www.ohic.ri.gov/documents/Primary-Care-Spending-generalprimary-care-Jan-2014.pdf Accessed 3/31/2016

[viii] Primary Care Spending in Oregon: A report to the Oregon State Legislature. February 2016. Primary Care Spending in Oregon A report to the Oregon State Legislature. http://www.oregon.gov/oha/pcpch/Documents/SB231_Primary-Care-Spending-in-Oregon-Report-to-the-Legislature.pdf Accessed 3/31/16