



Community Health Care Association of New York State

**Increasing Access to Health Insurance Coverage and
Moving Toward Universal Healthcare Coverage
Public Hearing
October 30, 2007**

Assistant Deputy Baker, Commissioner Daines, Superintendent Dinallo, thank you for the opportunity to testify today. My name is Elizabeth Swain and I am the Chief Executive Officer at the Community Health Care Association of New York State, CHCANYS. We are extremely grateful and heartened that our State's leaders are reaching out to try to make our health care infrastructure work better for more New Yorkers. You have a challenge ahead of you and we look forward to being a part of the solution.

CHCANYS is New York's primary care association and the statewide association of community health centers. Community, migrant and homeless health centers serve as the family doctor and healthcare home for over 1.1 million New York State residents at more than 425 sites, rural and urban.

- Though we try hard to ensure that people are enrolled in health insurance if they are eligible, 28 percent (324,000 people) of health center patients are uninsured; 43 percent are covered by Medicaid;
- Most (70%) health center patients have family incomes below the federal poverty level; and
- 74 percent of health center patients are racial or ethnic minorities;

According to our mission and our mandate, community health centers are only located in designated underserved communities and they provide access to primary and preventive health care regardless of insurance status or ability to pay. In order for a federally qualified community health center to meet federal expectations, it must create and implement a sliding fee scale, allowing low-income patients without health insurance to pay discounted medical bills in proportion to their income. At a community health center, each patient receives the best and most appropriate care for their needs, regardless of which insurance company is paying the bill.

Health centers offer family medicine as well as comprehensive primary care, including obstetrics and gynecology, pediatrics, dental, laboratory, mental health and substance abuse services.

As we all know, here in the United States, a person's race, ethnicity, and class have a strong bearing on their health care and health outcomes. Community health centers were born out of an

idea that this is not the way it has to be. In fact, health centers have documented results in reducing disparities through prevention and management of chronic conditions and have demonstrated the ability to save money *and* offer high quality care.

But still, we've got a problem. Despite a lot of good research and positive remarks from policymakers and the public, primary care is in crisis.

In the interest of time, I'd like to address two of the most pressing issues facing the primary care safety net in New York State:

- Reimbursement Reform and
- The Current State of the Community Health Center Infrastructure

Reimbursement Must Support High Quality Primary Care and All Payers Must Pay Enough to Cover the Cost of Providing the Care

Even with the best of intentions, if health care providers are not paid or reimbursed enough to cover the costs associated with providing high quality care and remain financially viable, they will need to close their doors and we'll all lose. Primary care remains a sector that is seriously under-reimbursed by all payers, which has implications for our entire health care infrastructure. Reimbursement – by all payers – should be logical, transparent, fair and should incentivize and reward high quality and service to all in need (financial access, linguistic access, etc.)

Medicaid Has Not Kept Pace With Current Trends and Needs

To ensure that health centers are effectively positioned to maximize care, federal law requires state Medicaid programs to pay health centers for the services they provide at a cost-based rate. This federal requirement helps to ensure that health centers do not incur losses when they care for Medicaid patients. These costs are reviewed and vetted by auditors, as well as state and federal regulators. This means that, when it comes to Medicaid, community health centers are paid an amount that approaches the cost of providing the care. However, this methodology does not allow for costs associated with installing or operating information technology. It further does not recognize the increased costs to the provider of doing business in a managed care environment. And it does not cover the costs of the very types of care management services that we know (there is a significant body of research) help to keep people with chronic illnesses healthier and out of more expensive settings. These include patient education, nutrition counseling for people with diabetes/cardiovascular disease, etc.

Providing Care for the Uninsured

According to the Institute of Medicine, community health centers are an integral part of the “core health care safety net.” In many communities in New York State, health centers are the main or only provider of care to the uninsured, the publicly-insured and residents of medically underserved areas. Until we achieve universal coverage, there will be uninsured New Yorkers who require access to primary care. Yet funding for primary care providers that care for the uninsured, through the Diagnostic and Treatment Center (D&TC) Indigent Care Pool, is woefully inadequate. The “coverage ratio” describes the amount of reimbursement received for each dollar expended on providing indigent care. The D&TC Indigent Care Pool reimburses

approximately 30 cents per dollar of indigent care costs incurred by D&TCs providing primary health care to uninsured people. In sharp contrast, the coverage ratio for hospitals, from the much larger hospital-based Indigent Care Pool, funds approximately 50 to 60 cents per dollar.

To the extent possible, it makes more sense to serve people in community health centers than in emergency rooms. To ensure that uninsured people get the best care in the most appropriate setting and that safety net primary care providers can survive and thrive, the State needs to increase funding for primary health care for uninsured people by adding funds to the D&TC Indigent Care Pool or through some other mechanism. As hospitals reconfigure their services and convert facilities to D&TCs, more facilities will draw from the fixed D&TC pool. This will only exacerbate an already intolerable primary care indigent care funding shortfall for primary care providers.

Commercial Payers Don't Cover Costs of Providing Care

Community health centers – in rural and urban areas across the State -- are being hobbled by the severe under-payment they receive when they provide care for commercially insured patients. In a recently completed analysis looking at a sample of six health centers in areas across the State, community health centers lose, on average, \$41 on each medical visit that they provide to commercially insured patients.

Now, it is important to note that numerous studies have lauded the cost-effectiveness and high quality of community health centers. One recent study assessing primary care performance by type of provider found that health center patients were nearly 20 per cent less likely to use emergency departments and 11 per cent less likely to be hospitalized for ambulatory care sensitive (ACS) conditions compared with patients using office-based physicians or hospital-based practices.¹ Other studies found that community health centers produce significant savings for payers compared with private physicians.^{2,3}

Yet there is no strong incentive for a commercial plan to cover the costs associated with providing high quality primary care when there is a significant likelihood that the insured person will be covered by another carrier in a few years. In an environment where large and powerful commercial insurance companies negotiate rates with stand-alone providers in underserved communities, health centers end up on the short end, accepting whatever payments they can get from the commercial plans, rather than turning those patients away. Health centers are put in the untenable situation of choosing to accept a particular insurance plan, despite payments that do not cover the cost of care or telling the patient, who may not have other viable options, that they do not accept that insurance.

The inadequate payment from commercial payers threatens community health centers' ability to remain viable and to serve commercially insured patients, and whittles away at the limited public

¹ Falik M, Needleman J, Herbert R, et al. "Comparative Effectiveness of Health centers as regular source of Care." January – March 2006 *Journal of Ambulatory Care Management* 29(1):24-35.

² Proser M. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care." October-December 2005 *Journal of Ambulatory care Management* 28(4):321-330.

³ McRae T. and Stampfly R. "An Evaluation of the Cost effectiveness of Federally Qualified Health Centers Operating in Michigan." October 2006, Institute for Health Care Studies at Michigan State University.

resources intended for the uninsured and other public funds. In addition, health centers frequently have contracts with numerous (15+) commercial payers, which brings substantial administrative burdens that take resources away from patient care. These administrative burdens include credentialing, preauthorization requirements and the multitude of different plan incentives. Quality and pay for performance incentives are not standardized across different plans and there is significant confusion regarding how they work and which plans examine which measures. Commercial plans only rarely provide health centers with performance data or benchmark comparisons.

CHCANYS and our members strongly support universal coverage. Yet, at the same time, if New York continues to rely on an unbalanced delivery and payment system that emphasizes hospital emergency departments for primary care and pays well for specialty care while under-paying for primary care, universal coverage will certainly not solve our problems and will likely exacerbate them.

As New York designs a new health coverage and access infrastructure that aims to ensure that the health care system is affordable and accessible for patients, we need to address the viability of the people and institutions providing the care, with a special focus on primary health care. Our system for paying for health care needs to be examined and addressed in a comprehensive way (not just Medicaid) to ensure that payers actually pay for the costs of providing care. Payment for primary health care should be fair and transparent and should reflect quality of care, care management, enabling services and access. We look to our policy leaders for comprehensive, all payer reimbursement reform to ensure the stability of our primary health care infrastructure and safety net.

Many of New York's Health Centers Are Struggling with Serious Shortfalls

We are gravely concerned that, while New York strives to reach a long-term vision of improving and strengthening primary care and payment systems, the infrastructure that will help to take us there will not survive the intervening weeks and months. Several of our state's community health centers suffer from serious shortfalls. Many are barely able to meet payroll obligations from month to month. Facilities and equipment suffer from deferred maintenance. Many are unable to pay the salaries expected by physicians and mid-level practitioners and most have had difficulty recruiting and retaining professional staff because the primary care sector just can't meet market expectations. Lines of credit have been exhausted. Most centers have no reserves, making even a slight payment delay or glitch in reimbursement a major problem.

Though they are non-profit entities, health centers operate like a small business and, like other small businesses, they make a positive contribution to the economically disadvantaged communities that they serve. They employ local residents and, as much as possible, use local vendors and services. In the economically disadvantaged communities where they operate, health centers often are one of the best employers of local residents and are a lynchpin in the local economy.

Each health center's situation is unique and there is not a single policy solution that will solve all of the problems. The roots of the problems are many, though all relate to fiscal stability and the

need for adequate and timely funding to cover costs. As an association, we have been working to define the salient issues confronting New York’s health centers. The most pressing issues sort out as follows:

Payer Issues and Payer Mix – The chief revenue source for a health center is payment for the services it provides. When the payer mix shifts or when a payer is not paying an amount that covers the cost of providing care, revenue is unpredictable and frequently insufficient. I described in the previous section many of these issues, by payer. In addition, health centers are challenged by:

- Lengthy periods health centers wait for their providers to be credentialed by managed care plans, while the plans have little incentive to speed the process.
- Delays in payments owed to health centers from the State (Indigent Care funding, for example).
- Retroactive take-backs based on recalculations for services provided in past years.
- State changes in reporting/billing policies, which require reprogramming of billing/information capture systems and generate more work and confusion, and centers have to bring in billing or revenue consultants.

Community support – While health centers typically enjoy the respect, admiration and gratefulness of their local community leaders in the public and private sectors, local entities in poor communities generally do not have ample resources to share. Located in economically disadvantaged communities across the state, many centers have limited or no access to municipal (County or City) funding, local grants, relationships with academic institutions or generous hospitals, or other local financial support.

Workforce – A combination of the national problem of a primary care workforce that is inadequate to meet demand and the inability of the primary care sector to pay the salaries (see issues relating to reimbursement from all payers, above) expected by physicians, mid-level professionals and even administrative and billing staff have resulted in serious difficulties for health centers in recruiting and retaining staff. Finally, the current system of graduate medical education financing neither incentivizes nor rewards (i.e. does not pay for) primary care.

We appreciate the opportunity to be heard today and, even more, to continue to participate in New York’s endeavor to rationalize our health care infrastructure and delivery system through coverage and access. We look forward to continuing to work together with our policy leaders to improve, stabilize and strengthen our ability to deliver high quality health care to all New Yorkers.

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