PRIMARY CHALLENGE: HOW NEW YORK CAN SAVE BILLIONS BY INVESTING IN PRIMARY CARE

A Report of the Primary Care Coalition, March 2010

Community Health Care Association of New York State
Primary Care Development Corporation
New York State Area Health Education Center System
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New York State Academy of Family Physicians

PRIMARY CARE
New York's Healthcare Home

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EXECUTIVE SUMMARY

INTRODUCTION

At a time when New York is in a major financial crisis, this report by New York's Primary Care Coalition has identified key ways to create cost savings while also improving health outcomes.

At $160 billion a year and growing, New York has one of the most expensive health systems in the country. A major driver of cost is New York's excessive rates of hospital and emergency department use, compounded by high rates of readmission. Much of this utilization is attributable to chronic disease.

New York could save at least $10 billion per year by reducing hospitalizations to the national average – a 6% savings in the state's overall health bill. But those savings are only possible with a primary care sector that is accessible to all New Yorkers and that is organized to provide essential services known to be effective in preventing and managing chronic illness, including prevention, early disease identification and intervention, care management and coordination, and patient engagement. That means both expanding capacity and building a robust model of primary care.

CHRONIC DISEASE

An estimated $100 to $110 billion of New York's $160 billion health care bill goes for hospitalizations, medications, medical treatments, and long-term care for patients with one or more chronic diseases, a group of patients that is expanding rapidly. The growing financial impact of chronic disease on the health care system is pervasive and far-reaching. Examples of the annual cost of chronic disease in New York, attributable to both direct medical costs and lost productivity include:

- Cardiovascular disease — $21 billion
- Diabetes — $12 billion
- Cancer — $11 billion
- Asthma — $1.3 billion
- Arthritis — $11 billion
- Osteoporosis — $2.2 billion

Obesity is a major contributor to New York's health care challenges, costing $12.6 billion in direct and indirect expenses (this includes obesity-related conditions, such as diabetes and cardiovascular disease).

AVOIDABLE HOSPITALIZATION AND EMERGENCY DEPARTMENT USE

Chronic illness and the lack of effective primary care capacity often lead to high inpatient and emergency department use. With $30 billion in inpatient costs, hospitals make up the largest share of New York's health care tab. New Yorkers enter the hospital more often than people in most states, and once they are in the hospital, they stay longer than people in nearly every other state. Compared to the rest of the country, New York is:

- 50th out of 51 in avoidable hospital use and cost;
- 5th highest in the number of days patients spend in the hospital, and 50% higher than the national average;
- 12th highest among the states (including Washington, DC) in hospitalizations for conditions that are generally avoidable with good primary care;
- 11th highest in hospital admissions – with admissions 13% higher than the national average;
- Among the states with the highest readmission rates nationally, with a 30 day readmission rate of 20.7 percent;

- Heavily reliant on care provided in emergency departments, with as many as two million of the roughly 6.7 million emergency room visits not involving a true emergency.

SEVERE PRIMARY CARE UNDERINVESTMENT IN NEW YORK

New York has historically underinvested in primary care, and while this is starting to change, our primary care system is still episodic and uncoordinated, and severely under-resourced.

- More than 5 million New Yorkers live in communities without ready access to a primary care provider.
- While New York spends more per Medicaid enrollee than every state in the nation except Rhode Island, it is ranked third lowest in Medicaid fees paid to primary care physicians.

PRIMARY CARE REDUCES COSTS — AND IMPROVES CARE

Investing in primary care will significantly improve the health outcomes and reduce costs for all New Yorkers by preventing unnecessary complications, reducing hospital stays and emergency room visits, avoiding unnecessary hospital readmissions, and better management of chronic conditions. The literature shows that:

- Counties with higher proportions of primary care providers have significantly lower hospital and emergency department use, as well as fewer surgeries.
- Greater continuity of care is also associated with lower hospitalization rates and emergency department use among Medicaid patients.
- Greater supplies of family physicians are associated with earlier detection of breast, colon and cervical cancer, as well as melanoma.

THE PATIENT-CENTERED MEDICAL HOME — A PATHWAY TO BETTER PRIMARY CARE AND LOWER COSTS

The Patient-Centered Medical Home (PCMH) is a robust model of primary care which emphasizes coordinated, comprehensive care, including an ongoing relationship with a healthcare provider, a team approach to patient care, coordination of care across the healthcare system, the use of electronic medical records, 24/7 access to clinical advice, and the use of e-mail and telephone consultations. Evidence increasingly shows that, configured into this model, primary care is highly effective in achieving better health outcomes, reducing costs, and eliminating outcome disparities between socioeconomic groups.

- Recent studies have shown that PCMH could lead to: 5.6% savings in health care spending, including a 15.2% reduction in spending on specialist care, and a 9.2% reduction in hospital spending. Businesses are also seeing major savings.
- Pennsylvania's Medicaid program saved $36 million through enhanced primary care management of diabetes, heart disease and pulmonary disease.
- Companies implementing medical home programs for their employees saved millions: Boeing netted a 20% savings and a 56% reduction in missed work days. After saving nearly $200 million through preventive care and wellness programs, IBM recently eliminated co-pays for primary care visits for all of its employees.

KEY RECOMMENDATIONS

A strategy exists that can deal with New York State's burgeoning growth of chronic disease, its costly excessive rates of avoidable hospitalizations and emergency department use and its runaway health care costs, while improving the health of its population. New York must expand its primary care capacity and support transformation into a Patient-Centered Medical Home as a model of care. New York's Primary Care Coalition thus recommends the following:

1. COMPLETE THE REFORM OF THE MEDICAID PAYMENT SYSTEM FOR PRIMARY CARE

Payment reform is the most important of all measures required to address the primary care agenda in New York State because underpayment underlies virtually every other problem and explains the underdevelopment of the sector. Specifically, it should:

- Protect and increase the investment in primary health care payment reforms.
- Increase Medicaid fees for office-based primary care physicians to 100 percent of the Medicare fee schedule.
- Build into Medicaid rates the increased provider cost of adopting, using and maintaining electronic health records and other new technology which is critical to care management, coordination and improved health outcomes.
- Pay providers a fee for each visit combined with a care management fee or a monthly payment covering the infrastructure needed to provide medical home services.

- Consider whether collective bargaining between primary care providers and payers can be used as a better method of determining payment amounts and methods.
- Assure that fee-for-service reforms are required of Medicaid managed care plans. These plans now pay for the majority of Medicaid, as well as Child Health Plus, Family Health Plus and public employee patients. The State should encourage private payers to similarly support a robust and effective model of primary care.

2. PRESERVE AND EXPAND PRIMARY CARE INFRASTRUCTURE AND WORKFORCE CAPACITY

Many communities lack the primary care capacity needed to ensure that all New York residents have a medical home. Workforce shortages are growing as many current and future providers turn away from primary care medicine in the face of increasing demands and continued underpayment.

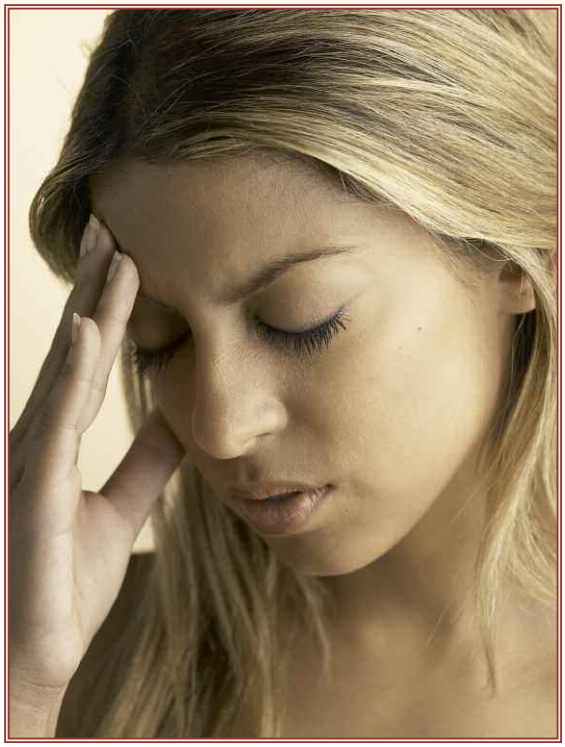
- Fully fund the future phase-in of the Doctors Across New York loan repayment, physician practice support and community based ambulatory care programs, and once these programs are fully funded, expand them to include nurse practitioners and physician assistants. Create a New York State public service corps to pay medical school and nursing school tuition for students who commit to practicing primary care in medically underserved areas of New York for five years after completing their professional education.
- Assure that capital is available for creating new, expanded and renovated practice sites. Specifically, fund a Primary Care Capital Access Fund designed to induce much larger private investment into the primary care lending. Similarly, the state should address how capital funding might be used to expand private practitioner practice.
- Continue to expand Area Health Education Centers (AHEC) and other community-based initiatives to recruit health professionals into primary care and into communities of need.
- Assure that communities experiencing the downsizing or closing of hospital capacity retain or build adequate primary care capacity to meet their needs.

3. ACCELERATE PILOT TESTING AND ADOPTION OF INNOVATIVE CARE MODELS, INCLUDING THE PATIENT-CENTERED MEDICAL HOME

Care too often is fragmented, entails multiple visits and may involve long waits for appointments due to provider shortage. Moreover, doctors are not rewarded for the long-term management of specific conditions, coordinating care with other providers, prevention, and teaching patients how to manage their conditions.

- Expand opportunities for patient-centered medical care adoption and practice transformation as a means of enhancing primary care capacity.
- Assure that the State's payment methods support the Patient-Centered Medical Home model (see payment system recommendations above).

- Assure that office-based practitioners have access to HIT resources similar to those being made available to hospitals and health centers.
- Provide technical assistance resources for implementing HIT and the Patient-Centered Medical Home. Both processes are expensive and complex and require major transformation of workflow and care processes. These can be greatly facilitated by the availability of technical assistance.
- Seek to make a Patient-Centered Medical Home available to every patient, particularly those with chronic conditions and those being discharged from hospitals.



4. EXPAND AND IMPROVE COVERAGE

Uninsured and underinsured persons avoid or delay seeking medical care, and therefore receive less preventive care, are diagnosed at a more advanced stage of disease and, once diagnosed, tend to receive less therapeutic care and suffer higher mortality. Uninsured or underinsured persons have little alternative to use of the emergency department and delays in seeking care result in avoidable hospitalizations, especially for conditions that could have been prevented or treated with primary care services. Gaps in insurance coverage also contribute to economic instability of primary care providers.

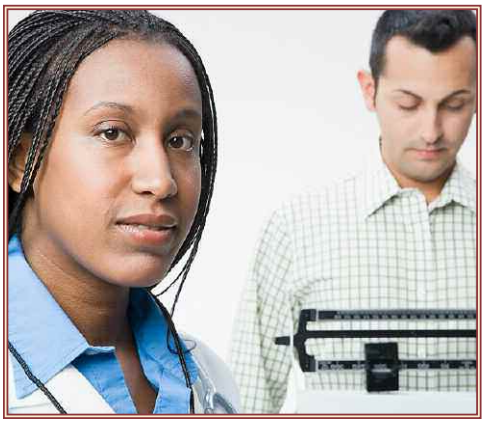
- Continue to expand public health insurance programs and to simplify processes to assure that all New Yorkers are covered. Assure that coverage expansion efforts proceed hand-in-hand with reimbursement and health service delivery reform so they achieve the ultimate aim — that all New Yorkers receive the right kind of care in the right setting at the right time and for the right price.

The steps above would slow down the rapidly growing costs of the health care system. This *Agenda for Action* is a feasible, practical strategy to reforming approximately 1/7th of the New York State economy that is the health care sector.

INTRODUCTION

New York's health care bill has become unaffordable, and expenditures are growing rapidly. Yet New Yorkers are not necessarily healthier for it. Many health indicators, such as asthma hospitalizations, heart disease mortality and unnecessary hospital readmissions, are worse in New York than nationally. The relationship between spending and health is complex — the state of a population's health is both a driver of health expenditures as well as a result of them.

Increasingly, the state of the population's health is marked by a seemingly inexorable tide of chronic diseases. These conditions, which often lead to costly hospitalizations and need for other services, now account for an estimated two-thirds of health expenditures in New York. While the aging of the population, of course, is an important contributing factor, chronic diseases and their complications are not inevitable and are not limited to the geriatric population. In many instances their onset can be prevented or delayed and, once present, they can often be controlled to prevent more serious and costly problems.



Prevention and management of chronic disease, however, requires a different approach to health care, much of which now focuses, of necessity, on reacting when people get sick. Breaking the chronic disease cycle that contributes to the paradox of more spending and poorer health requires a proactive approach. Primary care is well-positioned for this challenge. A particularly promising primary care model is the Patient-Centered Medical Home, which emphasizes development of strong patient-provider relationships and coordination of care.

This paper examines some of the key factors contributing to health care costs in New York State and reviews the evidence for primary care and how the Patient-Centered Medical Home model of care can help control costs while improving health.

I. OVERVIEW OF EXPENDITURES

In 2008, an estimated $160 billion was spent on personal health care services in New York State, roughly 16 percent of the Gross State Product (GSP) of $1.056 trillion (Note A). Health care spending is up from 1991 when it totaled $57 billion, or 12 percent of state GSP. New York State, with 6.5 percent of the U.S. population, accounted for an estimated 8.3 percent of national health care expenditures in 2008.

New York State's health care spending has grown an average of 6.2 percent annually since 1991, or approximately $10 billion over the last year. In 10 years those costs could spike to as high as $292 billion and represent 20 percent of the state's GSP (Note B). Worse, this estimate may be conservative, given the coming boom in the age 65+ population – 5.8 million New Yorkers currently are age 50 years or older.

A. Expenditure data are trended to 2008 from information published in "New York Personal Health Care Expenditures, All Payers, State of Residence, 1991-2004," Office of the Actuary, Federal Centers for Medicare and Medicaid Services. Annual trend factor is 6.2 percent, which is based on the CMS tables 1991-2004

B. The rate of increase in national health care spending slowed recently during the recession, but it nevertheless continued to claim a growing portion of GDP, rising from 15.9 percent of GDP in 2007 to 16.2 percent in 2008 (Hartman M, Martin A, Nuccio O, Catlin A. Health spending growth at a historic low in 2008. Health Aff. [Millwood]. Jan-Feb 2010;29-1:147-155). Updated state-level figures will not be available until next year (Personal communication, Centers for Medicare and Medicaid Services, January 26, 2010).

Despite New York's expensive health care system, the health status of New Yorkers compares poorly to residents of other states. A recent report by the Commonwealth Fund ranked the state 21st on the basis of 38 health system performance indicators.[1] New York ranks 12th highest among the states in hospitalizations for conditions that are generally avoidable with good primary care.[2] As the New York State Department of Health observed:

"Despite the State's apparent wealth of health care resources, New Yorkers are not necessarily experiencing better health outcomes or better access to care than residents of other states. In fact, New Yorkers experience higher than average rates of asthma hospitalizations, coronary heart disease mortality and incidence of tuberculosis and HIV. In addition, New York has lower-than-average rates of early (first trimester) prenatal care and immunization of the elderly against influenza and pneumonia."[3]

II. THE ROLE OF CHRONIC DISEASE

Chronic disease, such as heart disease, cancer, diabetes, hypertension, stroke, pulmonary conditions and arthritis are the leading causes of death and disability in the state. Chronic diseases affect the lives of six million New Yorkers and account for 73 percent of deaths in the state every year. A report by the Milken Institute recently ranked New York 22nd nationally on the basis of the concentration of chronic disease, noting that differences in lifestyle, demographics and urbanization partly explained variations among states.[4]

An estimated $100 billion to $110 billion of New York's $160 billion health care bill goes for hospitalizations, medications, medical treatments, and long-term care for patients with one or more chronic diseases (Note C). These costs result from both the large numbers of people suffering from chronic disease and the high per capita costs of chronic disease, roughly $16,000 per case per year. Many people experience two or more chronic conditions simultaneously, such as high blood pressure, high cholesterol, and arthritis. Of chronically ill New Yorkers over 44 years of age, roughly two-thirds have two chronic conditions and nearly 20 percent have four or more conditions.[5] Expenses for people with one chronic condition are twice those of people without any. Spending for people with five or more chronic conditions is roughly 14 times greater than spending for those without any chronic conditions.[6] Persons with five or more conditions predictably have higher hospital expenditures. Of all patients admitted to a hospital in New York State in 2002, the 27 percent with five or more chronic conditions accounted for 47 percent of all inpatient costs.[7]

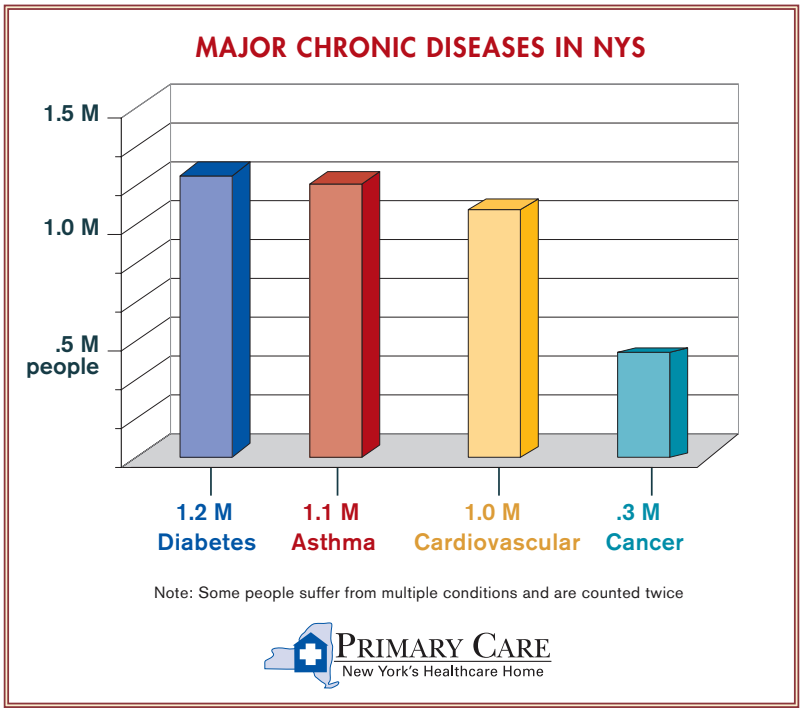
Chronic disease accounts for about half of physician private office visits nationally, or over 40 million in New York State.[8] Similarly, it accounts for 80 percent of all hospitalizations in the US,[9] or about 2 million in New York State. Nationally, people with chronic disease account for over 70 percent of private health insurance spending, much of which is employer-based.[10]

C. National estimates for the portion of health care spending consumed by chronic disease range from about 75% (Anderson G, Horvath J. The growing burden of chronic disease in America. Public Health Rep. 2004;119(3):263-70) to 83% (Partnership for Solutions. Chronic conditions: Making the case for ongoing care [September 2004 Update]. Baltimore, MD: Johns Hopkins University and Robert Wood Johnson Foundation). Thus, the estimate of $100 billion to $110 billion for New York State (63% to 69% of total spending) is conservative.

Chronic conditions also reduce workplace productivity, because ill employees and their caregivers either miss work days (absenteeism) or attend work but perform poorly (presenteeism). The impact of lost workdays and lower employee productivity resulted in an annual economic loss in New York of $90 billion in 2003.[4]

NEW YORK'S CHRONIC DISEASE PROFILE

While chronic diseases are not the sole reason for rising health care costs, their effects on the health care system are pervasive and far-reaching. They account for a large portion of hospitalizations, the single largest component of New York's health care bill. Even when they are not the main reason for a hospital admission, their presence often drives up the volume and intensity of tests and other services required. Likewise, they play a large role in the growing use of medications, increasing the number of patients with multiple prescriptions and thus the risk of adverse drug interactions, which in turn leads to more medical care. Some of the most prevalent and costly chronic diseases include:

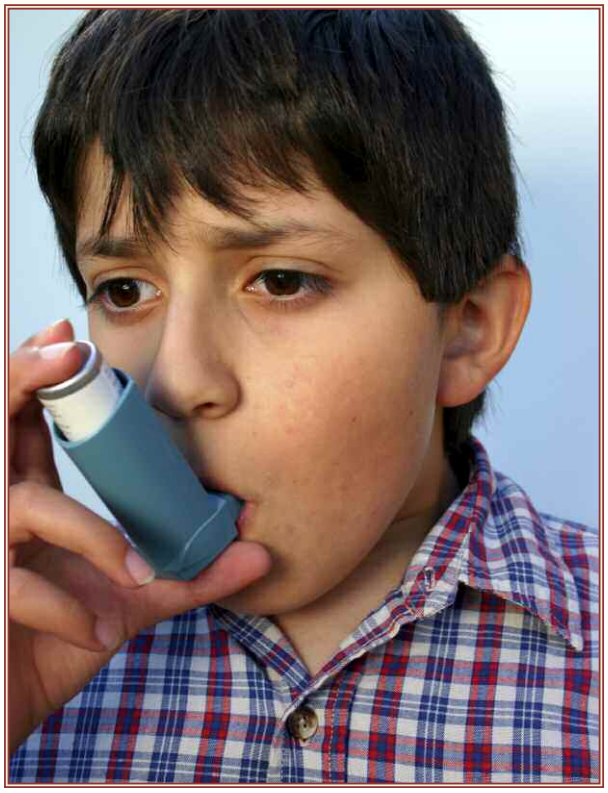


CARDIOVASCULAR DISEASE: About seven percent of adults, or slightly more than a million New Yorkers, suffer from some form of cardiovascular disease (CVD).[11] It is the primary cause of death for New York State residents, both men and women, regardless of race or ethnicity. The estimated direct medical care cost of CVD is nearly $14 billion (2008) and the indirect (lost productivity) cost is about $7 billion, for a total cost of $21 billion. During the period 2004-2006, New York State averaged about 380,000 hospitalizations per year for cardiovascular disease — roughly 15 percent of all hospitalizations. More than 20,000 coronary artery bypass surgeries are performed each year in the state, with a mean cost of approximately $32,000 per patient. A person with heart disease incurs substantial medical expenses for diagnostic tests, surgeries, hospital and doctor visits, physical therapy and drugs. A conservative estimate of the cost of treating one person with heart disease for a 20-year period is $121,200. For those needing special procedures and ongoing care, lifetime costs can reach more than $4.8 million per person.[12]

DIABETES: An estimated 1.5 million New Yorkers – nearly one out of every 12 people – have diabetes, and it is the most rapidly growing of all chronic diseases. Since 1994, New York has witnessed a nearly 100 percent increase in the number of people with diabetes, according to the NYS Department of Health. Equally troubling, nearly 450,000 of the 1.5 million people with diabetes are estimated to be undiagnosed, because their symptoms may be overlooked or misunderstood; therefore, they are not receiving the recommended medical care that has been proven to prevent diabetes complications.[13]

The increased number of children and adolescents, especially from minority populations, who have been diagnosed with diabetes is alarming. The federal Centers for Disease Control and Prevention recently predicted one of every three children born in the United States will develop diabetes in their lifetime; for Hispanics/Latinos, the forecast is one in every two.[13]

Diabetes is not only common and serious, it is also extremely expensive. Medical costs for diabetes in New York State are estimated to total $7.4 billion (Note D). The average yearly health care costs for a person without diabetes is $2,560; for a person with diabetes, that figure soars to $11,744. The annual cost of lost productivity is about $4.5 billion. The national annual cost of diabetes in medical expenses and lost productivity rose about 75 percent during the period 1997 to 2007, from $98 billion to $174 billion. Much of the human and financial cost can be avoided with proven diabetes prevention and management of care. For example, the average annual cost per case for a person age 65 or older being treated for pre-diabetes is $716 compared to $9,061 for those who progress to Type 2 diabetes.[14] For a patient with diabetes, keeping blood pressure under control can save up to $494 annually.[15]



CANCER: Roughly 300,000 New Yorkers have cancer; about 100,000 new cancer cases are diagnosed every year, and about 35,000 people die every year from cancer. Many people are diagnosed at late stages – nearly 40 percent of breast cancers, 55 percent of colorectal cancers, 80 percent of ovarian cancers, and 55 percent of cervical cancers – reflecting a major failure of the health care system. Cancer treatment cost the New York health care system nearly $6 billion in 2008 (Note E). Combined health care and lost productivity was estimated at $11 billion in 2002.[16]

ASTHMA: Asthma affects more than 1.1 million adults and approximately 370,000 children in New York State.[17] The estimated annual economic cost of asthma is over $1.3 billion, which includes direct health care costs of $950 million and indirect costs of $380 million. Asthma causes nearly 42,000 hospitalizations per year in New York State, of which nearly 15,000 are children.[17] Medicaid enrollees accounted for 45 percent of all asthma-related hospitalizations, and Medicare enrollees comprised an additional 20 percent. Expenditures for asthma hospitalizations in New York State totaled approximately $500 million, for an average cost of $12,700 per hospitalization in 2005. About 250,000 New Yorkers reported making a trip to the emergency department or urgent care clinic due to asthma.[18] Although there is no cure for this health condition, asthma attacks can be prevented or controlled with proper primary and preventive care.

ARTHRITIS: Roughly 25 percent of adult New Yorkers, 3.7 million people, report they have a doctor-diagnosed case of arthritis.[19] Nearly 60 percent of persons with arthritis are of working age, and they have a low rate of labor-force participation; arthritis trails only heart disease as a cause of work disability. Arthritis has a sizable economic impact, costing New York more than $11 billion in total direct and indirect costs (Note F). It is the

D. Direct medical costs were $116 billion in 2007 according to the U.S. CDC, National Diabetes Fact Sheet, 2007. Extrapolating this figure to NYS, the cost would be conservatively about $7.4 billion since NYS has 6.4 percent of national population.

E. The figure of $6 billion was extrapolated from different sources. The National Cancer Institute estimates that national cancer treatment costs were $72 billion in 2002 or $4.6 billion in NYS using our population percentage of 6.4 percent. The figure of $4.6 billion was trended to 2008.

F. New York State Department of Health. "Arthritis Fact Sheet." [Author's note: the Fact Sheet cited a 2003 cost of $8.7; that figure was updated to 2008].

source of an estimated 2.3 million visits to health care providers and 50,000 hospitalizations per year (Note G). When it occurs in patients who have another chronic disease, arthritis also can complicate management (e.g., limiting the ability of a patient with diabetes to get needed exercise).

OSTEOPOROSIS: In New York State, approximately three million women and men over age 50 either have osteoporosis or are at significant risk of developing the condition.[20] Osteoporosis causes bones to become thin and weak; thus, the major health consequence of osteoporosis is an increased risk of fractures. Approximately 75,000 fractures occur per year in New York State due to osteoporosis. Fractures can cause debilitating pain, reduced mobility, and a loss of quality of life. One in three women and one in eight men aged 50 years and older will experience an osteoporotic-related fracture in their lifetime. Health care costs for these fractures are estimated at about $2.2 billion per year for 2008 (Note H).

OBESITY CONTRIBUTING TO HEALTH CHALLENGES

Obesity contributes to many chronic diseases, including diabetes, heart disease, joint problems, and some types of cancer. Nearly 60 percent of New York's adult population (about 9 million people) is overweight or obese. The percentage of obese adults in New York State more than doubled in little over a decade, from 10 percent in 1997 to nearly 25 percent in 2008.

Obesity has tripled among children and adolescents nationally during the past three decades. Approximately 15 percent of New York State children aged two to four in the Women, Infants and Children (WIC) program were overweight in 2004-06.[21] Studies among elementary school-age children in the state found one in four children were obese and a 2004 survey of third-graders revealed 21 percent were obese. According to the U.S. Centers for Disease Control and Prevention, overweight children and adolescents are at higher risk for Type 2 diabetes and cardiovascular disease than other children and adolescents due to high blood pressure and high cholesterol.

New York State Health Commissioner Richard Daines, MD, reported recently that treatment of conditions related to overweight and obesity in adults costs $7.6 billion a year in the state, with the associated state and federal tax burden amounting to $771 per household.[22] One study ranked New York as number two in the nation in spending on obesity-related health care.[23] A large percentage of these costs are due to avoidable hospitalizations and to medications for cardiovascular conditions, diabetes, musculoskeletal disorders, and other afflictions. The indirect cost (absenteeism, disability, lost productivity) adds another $5 billion.

G. New York State Department of Health. "Arthritis Action Plan." [Author's Note: the Action Plan cited national figures, which were extrapolated to NYS using the assumption that NYS has about 6.4 percent of the Nation's population].

H. US Department of Health and Human Services. "Healthy People 2010. Osteoporosis." 2000. [Author's Note: this document provided a 1996 cost estimate for fractures, which was extrapolated to New York State and updated to 2008].

III. THE ROLE OF AVOIDABLE HOSPITALIZATION AND EMERGENCY DEPARTMENT USE

The Commonwealth Fund State Scorecard 2009 puts New York 50 out of 51 states in Avoidable Hospital Use and Cost (down from 42 in 2007). According to data compiled by the Kaiser Family Foundation, New Yorkers enter the hospital more often than people in most states, and once hospitalized, they stay longer than those in nearly every other state. This use of inpatient care is costly. Some key facts:

- Nationally, New York ranks 11th highest among the states in hospital admissions. This rate is about 13 percent higher than the national average (132 admissions per 1,000 population vs. 117 nationally).[24] If New York's experience reflected the U.S. average, nearly 290,000 fewer admissions would take place.
- The number of days that New Yorkers spend in the hospital per 1,000 people is the fifth highest in the nation – nearly 50 percent higher than the national average (951 days/1,000 vs. 645/1,000).[25] If New York's rate reflected that of the nation, state residents would spend approximately 5.9 million fewer days per year in the hospital.
- New York's Medicaid program is the most expensive in the country. Yet, the state is ranked 12th highest in hospitalizations for conditions that are generally avoidable with good primary care.[2]
- New York hospitals have about 18 percent more beds per 1,000 people than the national average.[26] This high bed rate may reflect the demand for hospital services or may actually generate it. The Dartmouth Atlas Project, which studies regional variations in health care use and cost, noted recently that it has "consistently shown a positive association between the supply of staffed hospital beds and the rate of hospitalization for conditions that do not require surgery."[27] Better health outcomes do not necessarily result from additional utilization.[28]
- A significant portion of hospital use is by patients who are readmitted after an initial hospitalization. In New York State, 20.7 percent of Medicare beneficiaries discharged from a hospital in 2003-04 were readmitted within 30 days, placing New York in the highest quartile of states for such readmissions.[29] Nationally, about half of patients readmitted within 30 days did not see a physician between the hospitalizations, suggesting a failure by the health system to adequately follow up or coordinate post-hospital care. The cost of unplanned readmissions for Medicare beneficiaries in 2004 was $17.4 billion nationally.[29]

The cost of hospital overuse could be reduced by billions of dollars simply by creating the proper primary care incentives to manage patient care so that people did not enter or re-enter the hospital unnecessarily, and these savings could be realized even if New York did nothing to reduce chronic disease rates. However, New York could achieve large additional savings by creating a primary care system that also reduced the prevalence and severity of chronic diseases, which, in turn, would further reduce hospitalization.

INAPPROPRIATE USE OF EMERGENCY DEPARTMENTS

The inappropriate use of emergency departments (ED) costs New York about $1 billion per year. Using the emergency room for primary care is not only costly, but it is also not designed to provide continuity of care, follow-up or coordination. Furthermore, using the ED for primary care creates overcrowding, depriving timely access to patients who truly require emergency care.

> *"Patient access to high-quality primary care is essential for a well-functioning health care delivery system."*
>
> *— Medicare Payment Advisory Commission (U.S.). Report to the Congress: reforming the delivery system. Washington, DC: 2008.*

New Yorkers made nearly 6.7 million emergency department visits in 2006.[30] Roughly five million visits were for disease (75 percent) while about 1.7 million were for injuries. Some 5.4 million did not require an inpatient admission.

As much as 40 percent of emergency department visits do not involve a true medical emergency requiring services that only an emergency department can provide (Note I).[31-33] Therefore, as many as two million ED visits for disease in New York State were unnecessary. The median cost of an emergency room visit in New York State is conservatively estimated at $600. An average visit to a primary care physician costs less than $100; thus, the excess costs due to unnecessary ED visits approach $1 billion. This sum is corroborated by a 2004 study, which found that $1.1 billion is wasted annually in New York on avoidable emergency-room visits.[34]

Emergency departments have become the model of care for those lacking financial or geographic access to primary care. More than five million people in New York State reside in areas of the state in which there is a shortage of primary care doctors. Therefore, many have no alternative to the local ED for diseases and conditions that could have been treated in a primary care setting. About 2.5 million people in New York State are uninsured and millions more are under-insured (many of them are part of the three million residing in shortage areas). Unable to afford primary care visits, they instead turn to the local ED, which by law must provide them care. Many delay needed care for a relatively minor condition because they lack either geographic or financial access to a primary care doctor; thus, they wait until a minor condition becomes serious, requiring far more expensive intervention, including hospitalization, medications and the use of EDs and specialists.

> *"As policymakers, purchasers, payers, and non-affluent households intensify their search for a more affordable path to better health, there is likely no health care industry segment offering higher near-term potential for reduced total health care spending and improved clinical outcomes than primary care of patients with severe chronic illness."*
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> *— Milstein A, Gilbertson E. American medical home runs. Health Aff. (Millwood). Sep-Oct 2009;28(5):1317-1326*

The failure to prevent and better manage chronic disease results in complications and emergency conditions for which many New Yorkers seek care in the ED. Many of these trips could be prevented, however, if people had access to a comprehensive primary care system that emphasizes prevention and management of their chronic disease. Instead of developing a robust primary care system to address the growing level of chronic disease, New York is by default using the ED – the most

I. National Health Statistics, Reports. "Table 5. Percent distribution of emergency department visits, by immediacy with which patient should be seen." Number 7. August 2008. [Author's note: this table shows that about 32 percent of ED visits are either non-urgent (should be seen within 2-24 hours) or semi-urgent (1-2 hours)].

expensive setting – as a misplaced component in its model of primary care delivery for many people with chronic disease, thus failing to provide needed follow-up, generating unnecessary expenses and severely straining ED resources.

Savings are possible by reducing the inappropriate use of emergency departments through a comprehensive primary care system that maintains good patient health, reduces and manages the prevalence of chronic disease, and provides an alternative to the emergency department for primary care needs.

IV. THE ROLE OF PRIMARY CARE

Chronic diseases tend to develop slowly, but once present they generally cannot be reversed. Diet, physical activity and other patient behaviors contribute to chronic disease development, so there is an important role for prevention (by one estimate, 27 percent of the increase in health care spending from 1987 to 2002 was due to modifiable risks, such as obesity[35]).

Once a chronic disease has developed, the goal is effective management, which allows large numbers of patients to continue a high quality of life while avoiding more severe problems. Conversely, when chronic disease goes undetected or unmanaged, it often progresses and leads to serious complications. According to one estimate, more effective management to halt progression of chronic diseases could save $45 billion a year nationally.[36] Patients with one chronic condition are more likely to develop others, often due to the same risk factors that led to the first condition. In these cases, patients typically see a variety of specialists (for example, a cardiologist for advanced heart disease and an endocrinologist for severe diabetes), and they often require hospitalizations, increasing the complexity of care and the potential for conflicting treatment regimens. Continuity and coordination of services, therefore, is critically important to effective care, especially when patients have multiple chronic conditions or develop complications.

> *"The hallmarks of primary care medicine — first contact care, continuity of care, comprehensive care, and coordinated care — are going to be increasingly necessary in taking care of an aging population with growing incidence of chronic disease, and have proven to achieve improved outcomes and cost savings. Without primary care, the health care system will become increasingly fragmented and inefficient, leading to poorer quality care at higher costs."*
>
> *— American College of Physicians. How is a shortage of primary care physicians affecting the quality and cost of medical care? A comprehensive evidence review. Philadelphia, PA: American College of Physicians; 2008*

Research suggests that health care systems built on a strong primary care foundation are well-suited to address the challenges of chronic disease. This is because primary care is oriented not only toward meeting immediate health care needs, such as an acute disease, but also toward health promotion, regular assessment and ongoing patient-clinician relationships. Primary care emphasizes prevention, early detection and careful management. Primary care clinicians draw upon their broad scope of medical knowledge to help patients make the most effective use of other health services, such as specialty treatment and diagnostic tests. They are therefore uniquely situated to reduce the burden of chronic disease through the key avenues of prevention, management and coordination.

VALUE OF PRIMARY CARE

A large body of research demonstrates the cost-effectiveness of primary and preventive care, and advocates a major investment in building a comprehensive primary care system that promotes health and prevents disease, manages multiple health problems, and deters the adverse impact of unnecessary medical interventions.[37-38] A primary care-based system will cost less than the current disease-oriented system because patients will experience fewer hospitalizations, emergency department visits and ineffective surgeries, less duplication of services and medications, and less unnecessary use of technology.[39-42]

Recently, two comprehensive literature reviews have examined the relevant research findings. One of these reviews reported that studies over the prior 20 years had produced evidence for primary care's contribution to: 1) lower mortality rates; 2) optimal preventive care; 3) reduced unnecessary hospitalization and emergency department use; 4) improved quality and outcomes; 5) continuity of care; and 6) reduced health care costs and utilization.[37] The other review, which examined the research in the context of the Patient-Centered Medical Home model of care, reported that studies have documented improvements in quality, safety and satisfaction when patients identify with a Medical Home.[43] Following is a small selection of key findings from the research literature:

> *"Evidence from multiple settings and several countries supports the ability of medical homes to advance societal health. A combination of fee-for-service, case management fees, and quality outcome incentives effectively drive higher standards in patient experience and outcomes."*
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> *— Rosenthal TC. The medical home: growing evidence to support a new approach to primary care. J Am Board Fam Med. Sep-Oct 2008;21(5):427-440.*

- States with more primary care physicians in their health workforce had both lower Medicare costs and higher quality care — an increase in the primary care physician-to-population ratio of 1 per 10,000 was associated with a savings of $684 per Medicare beneficiary.[44]
- Counties with higher proportions of primary care providers had significantly lower hospital and emergency department use, as well as fewer surgeries.[45]
- Counties with larger supplies of family physicians and general internists had per patient Medicare Part B reimbursements $261 lower than counties with the smallest supplies of those primary care physicians.[42]
- Medicare beneficiaries in fair or poor health were nearly twice as likely to have a preventable hospitalization if they lived in a primary care shortage area.[46]
- Annual health care expenditures for patients who had a primary care physician were 33 percent lower than for those using a sub-specialist as their personal physician (this was after adjusting for medical diagnoses, demographics and other factors). Those with primary care physicians also had lower mortality.[40]
- Among Medicare beneficiaries with congestive heart failure and chronic obstructive pulmonary disease in the last year of life, having more primary care visits was associated with fewer preventable hospitalizations and in-hospital deaths.[47]
- Among Medicaid patients with HIV/AIDS in New York, those who had a primary care provider as their usual source of care were less likely to use the emergency department than those having a specialty clinic as their usual provider.[48]

- For 23 out of 24 preventive care and acute illness conditions studied in a national analysis, patients who initially sought care from a primary care provider had overall expenditures that were half the amount incurred by patients who initially sought care from another source.[49]
- Medicare patients who had the same provider for at least 10 years had annual Medicare Part B costs $317 lower than a comparison group who had the same provider for no more than one year and thus lacked long-term continuity of care.[50]
- Greater continuity of care was also found associated with lower hospitalization rates and emergency department use among Medicaid patients.[51-52]

Barbara Starfield, a leading researcher on primary care, has found that industrialized nations with stronger primary care systems have lower costs and higher levels of health.[53] Starfield has also reviewed the evidence from other published studies to better understand how primary care achieves reported benefits. Examples from among the large number of studies she has examined include:

- Greater supplies of family physicians were associated with earlier detection of breast, colon and cervical cancer, as well as melanoma.[54-57]
- Increases of 15 to 20 percent in the ratio of general practitioners-to-population in the United Kingdom were associated with declines in hospital admissions for both acute and chronic diseases.[58]

Summarizing evidence in the research literature, Starfield suggests that the key mechanisms enabling primary care to achieve benefits include promoting prevention and early detection, serving as the patient's entry point to the rest of the health care system, and helping to avoid unnecessary or inappropriate services that could entail risks as well as costs.[59]

CHALLENGES TO PRIMARY CARE

While primary care clinicians have the expertise and orientation to meet the growing challenges of chronic disease, the primary care infrastructure in the United States and in New York State suffers from a reimbursement structure that generally does not cover the costs of primary care's prevention, management and coordination functions. New York fares among the worst. Indeed, while New York spends more per Medicaid enrollee than every state in the nation except Rhode Island, it is ranked second to last in Medicaid fees paid to primary care physicians (behind Rhode Island).

The Medicare Payment Advisory Commission recently recognized this, noting that "primary care services – which rely heavily on cognitive activities such as patient evaluation and management — are being undervalued and risk being underprovided relative to procedurally based services."[60] Moreover, a recent study of primary care reimbursement for low-income patients in New York State showed systematic primary care under-reimbursement by every payer.[61]

Approximately 20 percent of physician time is spent on activities such as telephone calls with patients and families, consulting with other physicians, interpreting laboratory results, and giving information to patients, all of which are important to

quality care but which are largely uncompensated, according to one study of primary care work flow.[62] Compounding this are administrative tasks, such as interacting with health plans. One recent analysis found that primary care physicians spend significantly more time (165 hours per year) than other doctors (100 to 124 hours per year) on these activities.[63]

Levels of compensation and workload have implications not only for the time and effort primary care practitioners can devote to patients; they also contribute to a decline in new physicians entering the primary care workforce. Between 2002 and 2007, the number of U.S. medical school graduates choosing careers in family medicine, internal medicine, OB/GYN and pediatrics dropped markedly, with family medicine alone registering a decline of nearly 27 percent.[64] The American Association of Medical Colleges has warned that the impact will fall especially hard on areas that are already medically underserved. As discussed above, in New York more than five million people reside in areas with an existing shortage of primary care doctors.

V. THE PATIENT-CENTERED MEDICAL HOME MODEL

Recognition of primary care's underutilized potential to improve health while controlling costs has led to growing interest in a practice model known as the "Patient-Centered Medical Home." The Medical Home is built upon primary care's traditional attributes, starting with a focus on the patient, and the patient having a regular, ongoing source for provision and coordination of their health care. Key features of the Medical Home model include: prevention and screening, coordination of diagnostic, specialty, inpatient, behavioral and other needed services; health promotion and maintenance, disease management and patient education services; diagnosis and treatment of acute and chronic diseases; and use of health information technology. This definition has been formalized as the "Patient-Centered Medical Home" (PCMH) by the National Committee for Quality Assurance, in conjunction with the major national primary care professional associations.

> *"Adjusting the systems of financing and delivering care to better meet the needs of people with chronic conditions requires a focus on preventing diseases when possible, identifying diseases early when they occur, implementing secondary and tertiary prevention strategies that slow disease progression and the onset of activity limitations, and coordinating chronic care across the service continuum."*
>
> *— Partnership for Solutions. Chronic conditions: Making the case for ongoing care. Baltimore, MD: Johns Hopkins University and Robert Wood Johnson Foundation;2002.*

Primary care practices typically include some Medical Home features, but few meet the full PCMH criteria, because services which are key to the model have been chronically under- or uncompensated. Examples of services and activities to be provided by primary care doctors and their staffs under the PCMH model include:

- Sending reminders to all patients about preventive care and to those patients who require routine and follow-up services;
- Ensuring that patients obtain needed immunizations and vaccinations;
- Ensuring that patients comply with health screening guidelines to identify and treat health care problems early, including chronic diseases;

- Coordinating diagnostic findings and care among specialists and other providers;
- Managing patient care by using care plans, assessing progress, addressing barriers and coordinating care and follow-up for patients who receive care in other settings, including inpatient and outpatient facilities and mental health and substance abuse services;
- Teaching patients to effectively manage their own diseases and risk factors;
- Responding to changing patient conditions;
- Providing 24-hour telephone access to clinical support and options other than the patient visit for communication (e.g., e-mail, group visits);
- Ensuring the availability of timely and appropriate appointments;
- Using electronic health information technology;
- Surveying patients' care experience and using the information for service improvement; and,
- Assisting patients to maintain or obtain public or private health insurance.

Although the additional functions of the PCMH model entail added expense, they render a much higher return in overall health care savings. One financial analysis of a Patient-Centered Medical Home structure projected that overall health care costs would decrease 5.6 percent if patients currently using a non-primary care specialist as their regular source of care shifted to a primary care provider.[65] According to the analysis, the 5.6 percent savings would occur even after accounting for higher spending on primary care because there would be a 15.2 percent reduction in spending on specialist care, a 9.2 percent reduction in hospital spending, and a 0.4 percent reduction in spending on other services, including prescription drugs. Although effective in reducing the need for specialty care, it is important to note, however, that the Medical Home model does not restrict specialty care. Instead it emphasizes obtaining, integrating and coordinating needed and appropriate care for the individual patient. Neither does the PCMH model preclude specialists and subspecialist practices from serving as Medical Homes, especially for patients with complex needs.[66-67]

The Patient-Centered Medical Home will prevent, mitigate and manage more effectively the chronic diseases afflicting six million New Yorkers and costing $100 billion per year. With the PCMH structure, people will benefit from health promotion measures and their diseases can be treated more quickly and comprehensively, avoiding costly, lengthy hospitalizations. People who have a primary care Medical Home will not go to the emergency department for conditions that could be treated in a primary care office. Patients with chronic diseases will have their care managed better, and the services they need will be coordinated through an integrated delivery system that provides a continuum of care. Primary care doctors, using the PCMH model, can be an integral part in helping their patients quit their use of tobacco, lose weight, comply with their health screening guidelines, receive their immunizations and vaccinations, obtain mental health counseling, and overcome alcohol and substance abuse.

Similarly, the PCMH will help prevent and manage other medical conditions that also affect millions of people and cost billions of dollars. Even though a person may not have a chronic condition, s/he will most likely visit a primary care doctor at least once within a 12-24 month period for routine treatment of a common disease. The PCMH will provide this treatment and use the visit as an opportunity to identify any other health problems or conditions and manage them accordingly.

The peer-reviewed literature supports the expectations of improved quality, reduced errors, and increased satisfaction when patients identify with a Medical Home. Evidence from multiple settings and several countries supports the ability of Medical Homes to advance societal health.[43] Additionally, the PCMH model has been shown to produce positive health outcomes, improve patient experiences, and reduce the costs of health care.[43] One promising example of a program using Medical Home principles is Community Care of North Carolina, a Medicaid program which pays a per-member-per-month case management fee in addition to fee-for-service reimbursement. Care is provided through provider-led, not-for-profit community networks whose activities include developing plans for specific goals, such as chronic disease management and lower emergency department use.[60] The statewide program is reported to have achieved savings of 11 percent in 2007.[68] Another initiative called ACCESS Plus in Pennsylvania achieved $35.9 million in net savings for 290,000 Medicaid beneficiaries in 2007 through enhanced primary care management of diabetes, heart disease and pulmonary disease.[69]

Business sector experiences are also encouraging. An investment of $79 million in preventive care and wellness initiatives between 2004 and 2007 has saved IBM and its employees nearly $191 million in health costs, and the corporation, which is participating in Medical Home pilots, eliminated copayments for primary care this year to encourage greater use.[70] The Boeing Company recently completed a pilot project using a Medical Home for employees with severe chronic disease and achieved savings of 20 percent, even after factoring in supplemental physician payments. The savings were largely due to reductions in hospitalizations and emergency department use.[71] Participating employees also experienced positive changes in physical and mental functioning, as well as a 56 percent decline in missed work days.

VI. LEVERAGING PRIMARY CARE TO ACHIEVE SAVINGS IN NEW YORK STATE

In recent years, New York State has taken some important steps in support of primary care. These include:

- Adopting a new methodology for Medicaid fee-for-service payments.
- The Doctors Across New York program, which funds educational loan repayment for physicians who locate in underserved areas and supports new practice start-up.
- Incentive payments to Medicaid providers who meet standards for recognition as an NCQA-approved Patient-Centered Medical Home model.

- An Adirondack Region Medical Home Pilot, which includes all commercial payers in addition to Medicaid.
- Grants to support adoption of Health Information Technology among hospitals and safety net health centers (but not other office-based providers).
- Expanded public insurance programs and support for individuals and small employers to acquire coverage.

These steps, however, are only a beginning. As discussed above, New York's health care system cost an estimated $160 billion in 2008, and that amount increases every year at a rate of $10 billion. Health care is steadily consuming a larger percentage of New York's Gross State Product, from 12 percent in 1981 to 16 percent in 2008 to a projected level of 20 percent by 2019. New York's experience mirrors the nation. As health care consumes more dollars, fewer and fewer resources are left for other critical needs.

IMPACT OF REDUCING TOTAL DAYS OF HOSPITALIZATION TO US AVERAGE BY REDUCING ADMISSIONS, READMISSIONS AND LENGTH OF STAY [a]

	NYS 2007	NYS Reduced to US Average	Decrease/ Savings	Decrease/ Savings (%)
Admission Rate (admissions per 1,000)	132	117	15	11%
Total Admissions	2,547,300	2,257,834	289,466	11%
Inpatient Days per 1,000 pop	951	645	306	32%
Total Inpatient Days	18,352,140	12,447,035	5,905,105	32%
Cost ($1,673 per day)	$30,703,130,687	$20,823,889,898	$9,879,240,789	32%

(a) Based on data (2007 is latest available) from The Kaiser Family Foundation statehealthfacts.org (http://www.statehealthfacts.org/index.jsp). Kaiser Data Source: AHA Annual Surveys, Copyright 2009 by Health Forum LLC, an affiliate of the American Hospital Association (http://www.ahaonlinestore.com).

How much can New York save by further strengthening its primary care system? Projections of at least $10 billion dollars a year appear realistic, if not conservative, based on reducing hospital and emergency department use through prevention, early detection, better care management, improved coordination and enhanced access. As shown below, reducing hospital admissions and length of stay to the national average alone would save nearly $10 billion. Another $1 billion could be saved if all inappropriate/unnecessary emergency department visits were eliminated (not shown in table).

If hospital use were reduced even further — to the level of utilization in the states with the lowest rates of admissions and inpatient days (those in the lowest quartile) — costs could be reduced by $15.8 billion, a 52 percent reduction from the current level.

IMPACT OF REDUCING HOSPITALIZATION TO LOWEST QUARTILE (THE AVERAGE OF THE 13 STATES [a] WITH THE LOWEST ADMISSION AND INPATIENT DAY PER POPULATION RATES) [b]

	NYS 2007	NYS Reduced to Lowest Quartile	Decrease/ Savings	Decrease/ Savings (%)
Admission Rate (admissions per 1,000)	132	89	43	33%
Total Admissions	2,547,300	1,717,498	829,802	33%
Inpatient Days per 1,000 pop	951	460	491	52%
Total Inpatient Days	18,352,140	8,876,955	9,475,185	52%
Cost ($1,673 per day)	$30,703,130,687	$14,851,146,284	$15,851,984,403	52%

(a) Alaska, California, Colorado, Idaho, Nevada, New Hampshire, New Mexico, Oregon, Utah, Vermont and Washington were in the lowest quartile for both admissions and inpatient days. Georgia and Hawaii were in the lowest quartile for admissions only, while Texas and Arizona were in the lowest quartile for inpatient days only.

(b) Based on data (2007 is latest available) from The Kaiser Family Foundation statehealthfacts.org (http://www.statehealthfacts.org/index.jsp). Kaiser Data Source: AHA Annual Surveys, Copyright 2009 by Health Forum LLC, an affiliate of the American Hospital Association (http://www.ahaonlinestore.com).

Reducing the need for hospitalization is consistent with the goals of the federal Healthy People initiative and the *New York State Department of Health's Prevention Agenda for the Healthiest State*, which address the burden of chronic disease.

- *Cardiovascular Disease:* Many cardiovascular conditions are preventable — 80 percent of strokes, for example – by making healthy lifestyle choices that help reduce risk and severity. Primary care can help meet the Healthy People 2010 goals of reducing mortality by 20 percent, the number of adults with high blood pressure by 40 percent, and the number of adults with high cholesterol by 20 percent, as well as help meet the State Prevention Agenda goal of reducing the 380,000 annual cardiovascular hospitalizations by one-fourth.
- *Cancer:* About half of all new cancers (50,000 a year in NYS) and one-third of cancer deaths (12,000 annually) are preventable. The State Prevention Agenda advocates reduction of the mortality rate for breast and colorectal cancer by 20 to 30 percent; Healthy People 2010 advocates a 20 percent reduction. Primary care can reduce the incidence of new cancers by helping patients adopt healthier lifestyles, and it can reduce mortality by identifying cancers earlier through patient screening tests and by coordinating the many services cancer patients need.
- *Diabetes:* The State Health Department's goal is to reduce by about 400,000 the estimated number of New Yorkers with diabetes (1.5 million) by 2013. Another five million New York adults have pre-diabetes. Primary care can work with patients to alter lifestyle, obtain the care and medications they need, and self-manage and monitor their conditions.

- *Asthma:* The State Health Department has set a goal of reducing asthma-related hospitalizations by about 10,000, a 25 percent reduction, by 2013. Meeting the Healthy People goal would result in cutting annual emergency department visits for asthma attacks from about 115,000 to 75,000.

A stronger primary care system – especially one based on the Patient-Centered Medical Home model – would also achieve additional benefits:

- *Prenatal care:* About 25 percent of the 250,000 women who give birth every year do not receive early prenatal care.
- *Immunizations:* Although over 2.5 million people age 65+ should receive an annual flu shot, about one-third do not. This same population also should receive a pneumonia shot at least once in their lifetime, but 40 percent have not.
- *Sexually Transmissible Diseases:* Despite the preventable nature of STDs, 91,000 cases occur each year in New York State. Primary care is a source for educating patients about STDs and their prevention, identifying symptoms, and testing and treating these cases.
- *Mental Health:* Mental disorders are widespread (an estimated 26 percent of adults). Many people, however, do not seek mental health services due to a fear of stigmatization, unawareness of the condition or lack of treatment capacity. Primary care can help screen and coordinate care as appropriate.

VII. THE PRIMARY CARE AGENDA: ACTION RECOMMENDATIONS

The Primary Care Coalition advocates a bold "Primary Care Agenda" for New York State. This Agenda identifies actions that will reduce health care costs, relieving the cost burden to patients, employers and the public while enabling the state to reinvest in further improving quality of care for patients and the environment for physicians to practice primary care medicine. Some of these recommendations build upon primary care reforms that are already under way, such as Doctors Across New York, Medicaid payment reform, the state's Prevention Agenda, and various local initiatives. Although these initiatives are certainly helpful, a comprehensive public policy needs to be adopted which commits resources to building an effective and enduring primary care system. If constructed properly, such a system will save billions of dollars and significantly improve the health status of New Yorkers.

Specifically, New York should:

1. Complete the reform of the Medicaid payment system for primary care;
2. Preserve and expand primary care infrastructure and workforce capacity;
3. Accelerate pilot testing and adoption of innovative care models, including the Patient-Centered Medical Home; and,
4. Expand and improve coverage.

1. COMPLETE THE REFORM OF THE MEDICAID PAYMENT SYSTEM FOR PRIMARY CARE

Payment reform is the most important of all measures required to address the primary care agenda in New York State because underpayment underlies virtually every other problem and explains the underdevelopment of the sector.

Problem:

Historically, reimbursement has been inadequate and often inequitable for primary care services, across all payers. Moreover, in the vast majority of cases, providers are paid on an episodic, individual visit basis and the rates do not support the time and activities needed for prevention, care management, coordination, patient education or other quality improvements, especially those needed by complex, chronically ill patients. Currently, primary care providers are expected to absorb these costs while the financial benefits of reducing emergency department visits and avoidable hospitalizations accrue to the insurers and payers.

Where are we now?

For private practitioners, New York State took a major first step toward reforming the Medicaid fee for service program by increasing physician payments to an intended target of 75 percent of the Medicare fee schedule. Because of the particular formulas used, however, the two major primary care specialties – Family Practice and Internal Medicine – have only achieved 60 percent of Medicare fees. New York State must raise these primary care physician fee for service rates to 100 percent of Medicare.

For health centers and outpatient departments, the Medicaid program adopted a new fee-for-service payment system known as Ambulatory Patient Groups (APGs), which pay according to the intensity of services required in different visits. In addition, Medicaid now pays for select components of prevention and care management (diabetes and asthma nurse educators, social worker counseling, cardiac rehabilitation, smoking cessation and screening, and brief intervention and referral to treatment for substance abuse). The state also moved to enhance capacity by paying add-ons for providers offering evening and weekend hours.

Many of these rate enhancements and add-ons are limited to private practice physicians and facilities being paid under the APG system. Under federal requirements, federally qualified health centers may elect to accept APG payment and it is as yet unclear whether or not it is to their advantage to do so. Finally, APGs remain cost-based, resulting in a hospital primary care visit being reimbursed at a much higher rate than the same visit in a health center.

Recently, the state added Medicaid incentive payments for providers who can demonstrate they meet the National Committee for Quality Assurance (NCQA) standards for a Patient-Centered Medical Home. These incentives currently range from $5.50 to $16.75 per visit for Medicaid fee-for-service patients and $2 to $6 per member per month for Medicaid managed care patients, depending on the provider's level of NCQA recognition.

Next Steps:

Reform of Medicaid primary care payments has been impressive, yet much still needs to be done to support a robust and effective model of primary care in New York State. For example:

- Protect and increase the investment in primary health care payment reforms;
- Increase Medicaid fees for office-based primary care physicians to 100 percent of the Medicare fee schedule;
- Build into Medicaid rates the increased provider cost of adopting, using and maintaining electronic health records and other new technology which is critical to care management, coordination and improved health outcomes;
- Pay providers a fee for each visit combined with a care management fee or a monthly payment covering the infrastructure needed to provide Medical Home services;
- Consider if collective bargaining between primary care providers and payers can be used as a better method of determining payment amounts and methods; and,
- Assure that fee-for-service reforms are required of Medicaid managed care plans. These plans now pay for the majority of Medicaid, as well as Child Health Plus, Family Health Plus and public employee patients. The state should encourage private payers to similarly support a robust and effective model of primary care.

2. PRESERVE AND EXPAND PRIMARY CARE INFRASTRUCTURE AND WORKFORCE CAPACITY

Problem:

Many communities lack the primary care capacity needed to ensure that all New York residents have a Medical Home. Workforce shortages are growing as many current and future providers turn away from primary care medicine in the face of increasing demands and continued underpayment.

In addition, existing providers, such as community health centers, lack the resources to expand, renovate or build new provider sites. The continuing credit crisis, layered on top of already unmet capital need in the primary health care market, severely limits New York's ability to expand its primary care capacity as part of its overall effort to reform the health care system and reduce Medicaid costs. Even operations with strong finances are finding credit unavailable or unaffordable.

Indeed, a recent capital funding grant initiative targeted to primary care development (HEAL 6) brought in applications for $800 million worth of projects. $100 million in HEAL grants were ultimately awarded for projects totaling $230 million, leaving $570 million worth of needed primary care capital projects unfunded. Similarly, federal stimulus funding for community health center capital projects drew $80 million in requests, but it funded only $15.6 million.

Where are we now?

New York State took significant first steps to address primary care capacity in recent years by creating the Doctors Across New York program, which funds loan repayment and practice support for physicians willing to practice in underserved areas and ambulatory care training in community-based sites. The original Doctors Across New York program included provisions to progressively increase both the slots and funding for physician placements in primary care, which did not happen in the initial appropriation. The Medicaid program also initiated enhanced reimbursement for providers offering evening and weekend hours. Finally, as mentioned above, the HEAL 6 program, funded at $100 million, provided capital grants for new primary care infrastructure in limited settings.

Next Steps:

- Fully fund the future phase-in of the Doctors Across New York loan repayment, physician practice support and community-based ambulatory care programs, and once these programs are fully funded, expand them to include nurse practitioners and physician assistants. Create a New York State public service corps to pay medical school and nursing school tuition for students who commit to practicing primary care in medically underserved areas of New York for five years after completing their professional education.
- Assure that capital is available for creating new, expanded and renovated practice sites. Specifically, fund a Primary Care Capital Access Fund designed to induce much larger private investment into primary care lending. Similarly, the state should address how capital funding might be used to expand private practitioner practice.
- Continue to expand Area Health Education Centers (AHEC) and other community-based initiatives to recruit health professionals into primary care and into communities of need.
- Assure that communities experiencing the downsizing or closing of hospital capacity retain or build adequate primary care capacity to meet their needs.

3. ACCELERATE PILOT TESTING AND ADOPTION OF INNOVATIVE CARE MODELS, INCLUDING THE PATIENT-CENTERED MEDICAL HOME

Problem:

Care too often is fragmented, entails multiple visits and may involve long waits for appointments due to provider shortage. Moreover, doctors are not rewarded for the long-term management of specific conditions, coordinating care with other providers, prevention, and teaching patients how to manage their conditions.

Health information technology (HIT) is essential to facilitating preventive care, care management and coordination, and the quality improvements necessary to build a Patient-Centered Medical Home model. However, HIT remains expensive, complex and risky. Unlike hospitals, primary care providers are many in number, small in size, and lack capacity and necessary financial reserves to invest in and maintain information technology systems.

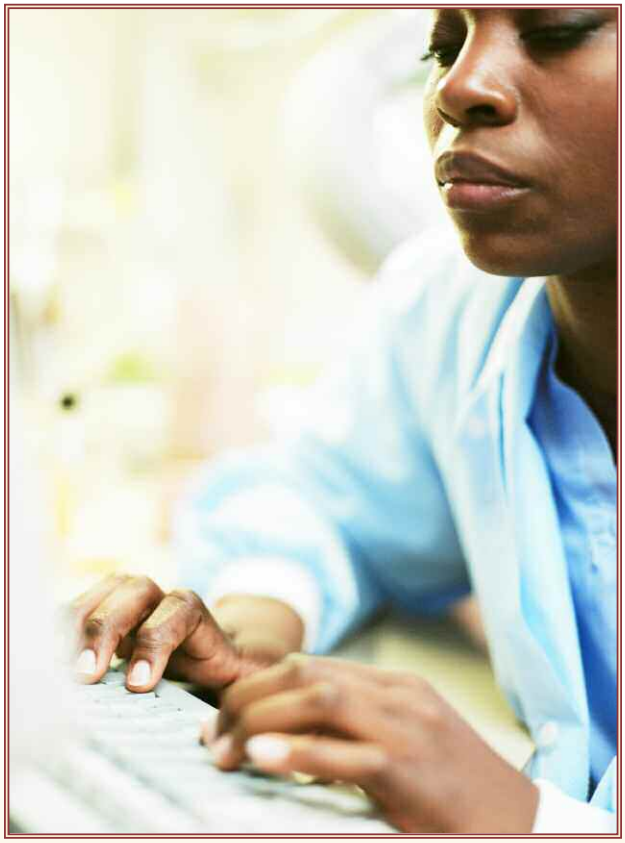
Financial support and technical assistance are required to help providers transform their practices to the PCMH model and also to obtain and maintain HIT. Once the PCMH is created, the payment system must be reformed to ensure that private practices can operate effectively as Medical Homes and deliver quality care.

Where are we now?

Payment reforms necessary to support the Patient-Centered Medical Home model are described above. In addition, the state has taken a number of other important first steps.

The state helped to create a multi-payer medical home pilot in the Adirondack region, which has just begun operations. Under the pilot, primary care providers in this region will receive increased reimbursement in exchange for expanded responsibility for coordinating care, providing preventive care and managing chronic diseases. The increased reimbursement is expected to be offset by decreased costs from fewer hospital admissions, decreased ED use, less frequent referral to specialists, lower prescription costs, and overall better health. Pilot participants include private practitioners, community health centers, hospitals and – most significantly – all payers, both public and commercial.

Through the HEAL NY program, New York State has allocated hundreds of millions of dollars in grants to support HIT adoption in communities across the state. This support has been targeted to hospitals and health centers, as well as health information exchanges, but it largely excludes office-based practitioners. In addition, technical assistance will be available through two federally-funded HIT extension centers, although such assistance does not address the cost of purchase, maintenance or operation.



Next Steps:

- Expand opportunities for patient-centered medical home adoption and practice transformation as a means of enhancing primary care capacity.
- Assure that the state's payment methods support the Patient-Centered Medical Home model (see payment system recommendations above).
- Assure that office-based practitioners have access to HIT resources similar to that being made available to hospitals and health centers.
- Provide technical assistance resources for implementing HIT and the Patient-Centered Medical Home. Both processes are expensive and complex and require major transformation of workflow and care processes. These can be greatly facilitated by the availability of technical assistance.
- Seek to make a Patient-Centered Medical Home available to every patient, particularly those with chronic conditions and those being discharged from hospitals.

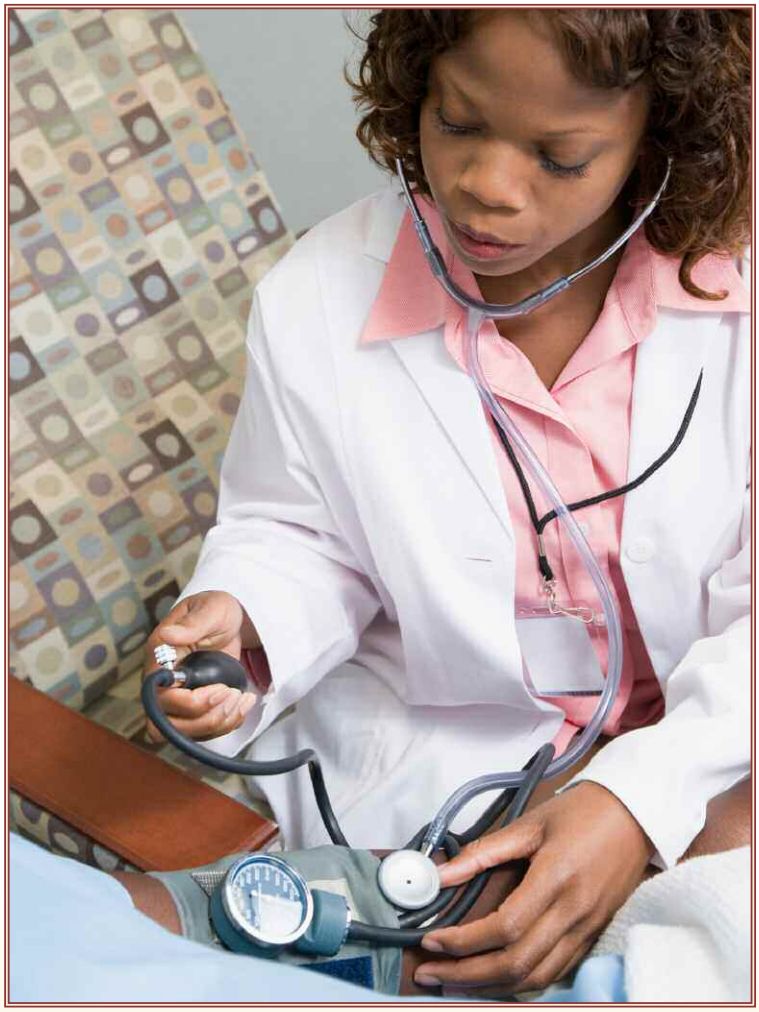
4. EXPAND AND IMPROVE COVERAGE

Problem:

Uninsured and underinsured persons avoid or delay seeking medical care and therefore receive less preventive care, are diagnosed at a more advanced stage of disease, and once diagnosed tend to receive less therapeutic care and suffer higher mortality. Uninsured or underinsured persons have little alternative to use of the emergency department, and delays in seeking care result in avoidable hospitalizations, especially for conditions that could have been prevented or treated with primary care services. Gaps in insurance coverage also contribute to economic instability of primary care providers.

Where are we now?

New York has taken laudable steps to expand public insurance programs and support coverage for individuals and small employers, with a vision of moving to universal coverage. Although the federal government is working to enact universal coverage, the state should be prepared to provide such coverage should national reform fall short. As coverage is expanded, however, the state must also ensure there is adequate primary care capacity (see *Recommendations* #1). Other states that have expanded coverage, such as Massachusetts, are experiencing a crisis of primary care access.



A variety of reasons dictate that expanded coverage and expanded primary care capacity go hand-in-hand. Patient care access will be unaffected by having new health insurance cards if providers are unavailable and services are provided only in emergency rooms or over-crowded, poorly organized clinics. Conversely, patients will not use even the finest primary care system if they lack financial resources or coverage to do so. Finally, the cost of expanded or universal coverage is unsustainable in an environment where access to effective primary health care is limited and care is left to high cost, acute care institutional settings. A strong primary and preventive care sector is essential if New York is to afford expanded coverage.

Next Steps:

- Continue to expand public health insurance programs and to simplify processes to assure that all New Yorkers are covered. Assure that coverage expansion efforts proceed hand-in-hand with reimbursement and health service delivery reform so they achieve the ultimate aim — that all New Yorkers receive the right kind of care in the right setting at the right time and for the right price.

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WHO WE ARE

COMMUNITY HEALTH CARE ASSOCIATION OF NEW YORK STATE

Established to give a voice to the state's network of community health centers as leading providers of primary care, the Community Health Care Association of New York State (CHCANYS) is a membership organization of Federally Qualified Health Centers, Look-Alikes and other health centers. Founded in 1971, its purpose is to ensure that the medically underserved living in New York State have access to quality community-based health care services regardless of insurance status or ability to pay. Encompassing more than 50 health centers with over 425 sites throughout the state, CHCANYS represents its members' interests in New York State and on the federal level, convenes and coordinates them for the purpose of information-sharing, education, training and advocacy and offers services that make them more efficient and effective. CHCANYS is part of a national network of Primary Care Associations which are coordinated through the National Association of Community Health Centers (NACHC) and the federal Health Resources and Services Administration (HRSA).

www.chcanys.org

PRIMARY CARE DEVELOPMENT CORPORATION

Primary Care Development Corporation (PCDC) is a nonprofit organization founded in 1993 to ensure that every community has timely and effective access to primary care. PCDC's goal is to increase the capacity and quality of primary care in underserved communities to achieve our vision of "Excellent Healthcare in Every Neighborhood." We achieve our mission by employing three key strategies; investing in primary care facilities, strengthening service delivery, and leading policy initiatives. Since 1993, PCDC has leveraged a public-private investment of $250 million in 77 primary care projects throughout New York State and worked with 400 primary care teams at more than 175 organization throughout the United States to redesign operations, adopt health information technology, prepare for emergencies, and become medical homes.

www.pcdcny.org

NEW YORK STATE AREA HEALTH EDUCATION CENTER (AHEC) SYSTEM

The New York State Area Health Education Center (AHEC) System is a community-based health workforce development initiative with a mission "to enhance access to quality health care and improve health care outcomes by addressing health workforce needs of medically disadvantaged communities and populations through partnerships between the institutions that train health professionals and the communities that need them most."

Through nine centers, located in urban and rural areas throughout the state, the New York State AHEC System develops clinical training opportunities for future health professionals in underserved areas; recruits faculty committed to working with them; encourages young people, especially from underrepresented and disadvantaged backgrounds, to pursue health careers; and provides continuing education and professional support to practitioners, develops career ladders, and promotes workforce re-entry programs.

New York State AHEC System community-based strategies cultivate a more diverse health workforce, assure each community has enough practitioners in the right categories, particularly primary care, and improve access to quality health care for all New Yorkers. The New York State AHEC System is "Connecting students to careers, professionals to communities, and communities to better health."

www.ahec.buffalo.edu

THE NEW YORK CHAPTER OF THE AMERICAN COLLEGE OF PHYSICIANS

The New York Chapter of the American College of Physicians (NYACP) is dedicated to advancing the specialty of Internal Medicine in New York State - assisting our members and our patients through advocacy, education, networking and communication. NYACP is the state's largest medical specialty organization representing 11,000 practicing general and subspecialty internal medicine physicians.

The goals of the Chapter are:

- Establish and promote the highest clinical standards and ethical ideals;
- Be the foremost comprehensive education and information resource for all internists;
- Advocate responsible positions on individual health and on public policy relating to health care for the benefit of the public, our patients, the medical profession and our members;
- Serve the professional needs of the membership, support healthy lives and improve the practice environment for physicians, and advance internal medicine as a career;
- Promote and conduct research to enhance the quality of practice, the education and continuing education of internists, and the attractiveness of internal medicine to physicians and the public;
- Recognize excellence and distinguished contributions to internal medicine; and
- Unify the many voices of internal medicine and its subspecialties for the benefit of our patients, our members, and our profession.

www.nyacp.org

THE NEW YORK STATE ACADEMY OF FAMILY PHYSICIANS

The New York State Academy of Family Physicians was founded in 1948 and represents more than 4,300 family physicians and medical students.

The Academy provides education, advocacy and information for members. Its public policy agenda has long included support for universal health care and patient choice in accessing health care services and providers. Family Physicians possess unique training, skills, and knowledge which qualify them to provide continuing and comprehensive medical care, health maintenance and preventive services to each member of the family regardless of sex, age or type of problem, be it biological, behavioral, or social. These specialists, because of their background and interactions with the family, are best qualified to serve as each patient's advocate in all health-related matters, including the appropriate use of consultants, health services, and community resources.

The Academy produces educational conferences for family physicians each winter and fall to update members on current developments in health care and clinical practice.

The Academy operates the nationally acclaimed Tar Wars program to educate 5th grade students about the dangers of using tobacco.

The Academy is located at 260 Osborne Road, Loudonville 12211.

www.nysafp.org

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