The Community Health Care Association of New York State (CHCANYS) appreciates the opportunity to comment regarding the PHHPC Health Planning Committee's review of facility licensure requirements and state oversight of Retail Clinics, Urgent Care, Upgraded D&TCs (UDTC) and Freestanding EDs.

We applaud the Committee's work and leadership in undertaking this critical reform effort. As New York works to rebalance its health care delivery system from one reliant on expensive emergency and inpatient care to one that makes available strong, effective, affordable primary and preventive care, we must also embrace the Triple Aim of better care, better health for populations, and lower costs.

As the State explores whether and how to exercise oversight over this spectrum of care, we urge this Committee and other policy makers
to consider the impact of their decisions on underserved populations, on the viability of entities whose mission is to serve those populations, and whether those decisions advance our State's goal of reforming the system of care and how it is delivered in all communities.

Serving the Medically Underserved

As New York's Primary Care Association, CHCANYS works closely with more than 60 federally qualified health centers (FQHCs) that operate approximately 600 sites across the state. Serving 1.6 million New Yorkers, FQHCs are central to New York's health care safety net. According to their mission and mandate, community health centers must be located in designated underserved communities and provide access to primary and preventive health care regardless of insurance status or ability to pay. In order for a FQHC 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 and family size. At an FQHC, each patient receives the best

and most appropriate care for his or her needs, regardless of which insurance company is paying the bill, or if the patient is uncompensated.

Health centers are a provider of choice for Medicaid beneficiaries. They are significantly more likely than other providers to accept new Medicaid patients. While Medicaid patients account for 20% of New York State's population, they comprise 46% of health center patients.

With more than half of the State's FQHCs recognized as Patient Centered Medical Homes (most with Level III designations), they have repeatedly proven to be cost effective while providing timely and high quality services that reduce racial, ethnic and socioeconomic disparities in health care. FQHCs improve health outcomes – not only for individual patients, but also for the communities they serve in terms of lower infant mortality; lower rates of chronic conditions, especially among minority and medically underserved patients; and greater use of preventive services. FQHCs are successful where other providers are not because they provide a multi-disciplinary care model (inside and outside of their "four walls") that combines biomedical, psychological, and social approaches to care for patients, families, and entire communities.

A comprehensive strategic approach to the regulation of the health care delivery system needs to consider the entire system of care including, the scarcity and fragility of the existing safety net system. The business model of safety net providers, like FQHCs and all health care providers located in and focused on serving our most vulnerable communities, is often a delicate balancing act. Everyone loses if an FQHC is forced to close its doors.

Recommendations

There are many questions to be addressed as we examine the entire spectrum of ambulatory care. A primary question is are these additional new entities needed or could they be addressed through an expansion of the existing Diagnostic and Treatment Center (D&TC) regulatory structure? It seems much of what is being proposed could be

addressed through the existing D&TC provider structure under the current regulatory environment. D&TCs could expand their scope of services but are often limited by inadequate reimbursement methodologies that do not promote expansion of services and/or barriers to co-location ventures. These barriers include factors tied to sustainability of business operations as well as licensure issues.

However, if we are to examine whether and how to regulate Retail Clinics, Urgent Care, UDTCs and Freestanding EDs a number of factors should be reviewed including:

- community need
- access to primary and specialty care
- level of community and cross-service integration, and
- integration with existing sources of primary care (including FQHCs)

Licensure/Registration

There must be oversight to ensure care quality and cost efficiency of those entities receiving public dollars. Creating consistent expectations across provider types creates a high standard for quality. We therefore recommend that the standard to which Article 28s are currently held be applied across all provider types in order to create a consistent, level playing field. However, as we acknowledge that requiring CON for all provider types may not be realistic, we also recommend the following:

Retail Clinics

As currently proposed, Retail Clinics would become a category under the Article 28 Diagnostic & Treatment Center regulations as “Limited Services Clinics” (LSCs). The LSCs should only be able to provide a limited set of services that reflect that they are not intended to be patient-centered medical homes. We support the recommendation of prohibiting services for patients 24 months of age or younger as well as childhood immunizations (excluding influenza vaccine). We also recommend that in lieu of a full CON review, Retail Clinics should be subject to an administrative community needs review process that promotes local health planning input and access in medically underserved areas. Additionally,

all Retail Clinics should be required to establish active affiliations with safety net primary care providers, including FQHCs when possible, as a condition of approval.

Urgent Care

As discussed above, we recognize that a full CON review may not be practical for all Urgent Care providers. However, it is crucial that Urgent Care providers are held to the same high standard of quality and cost effectiveness as Article 28s. A robust registration process, to minimally include a requirement for national accreditation and a community needs review as discussed above, may be one way to achieve this. Additionally, all Urgent Care providers should be required to treat all patients regardless of insurance status and to establish active affiliations with safety net primary care providers, including FQHCs when possible, as a condition of approval.

Upgraded D&TCs

The regulations governing upgraded D&TCs provide an important opportunity to underscore the scope of services that many D&TCs are able to provide. However, the current licensure is limited by lack of reimbursement methodology and geographic restrictions.

FQHCs are in many ways already meeting the definition of what we envision Upgraded D&TCs to be. FQHCs provide comprehensive primary and preventive care, including oral and behavioral health services and substance abuse treatment. Many have specialists on staff to ensure access and coordination of care for their patients. The FQHC model has been proven to reduce unnecessary visits to emergency rooms and prevent hospitalizations. Compared to other primary care providers, health centers have a higher rate of accepting new patients, particularly publicly insured and uninsured patients. They are also more likely to offer evening or weekend hours than their non-FQHC primary care

counterparts. These features, and in addition their cultural competency, reflect many of the attributes that we imagine would be required of UD&TCs.

FQHCs tailor their services to fit the special needs and priorities of their communities, and provide services in a linguistically and culturally appropriate setting. They are successful where other providers are not because they provide a multi-disciplinary care model (inside and outside of their “four walls”) that combines biomedical, psychological, and social approaches to care for patients, families, and entire communities. We caution the Committee against dictating a narrow definition of UD&TC and instead encourage the development of a menu of options and services that could be added to the existing D&TC licenses. By building on the existing D&TC model, we avoid adding another complex and burdensome set of regulations on D&TC providers working to meet their community needs. Items to be included in this menu should include weekend and expanded hours, integrated behavioral health, urgent care services, imaging, and expanded lab services.

The UD&TC option recognizes the comprehensive role of FQHCs and gives them the additional flexibility to continue to grow and provide an expanded continuum of care to their patients. However, this will only be achievable with an equally robust reimbursement methodology that reflects the costs of these expanded services, including the additional staffing necessary to provide them. We therefore recommend that a reimbursement methodology be created that reflects the unique nature and costs of the service providers at UD&TCs.

Access to an UD&TC should not be restricted to rural communities. Access to comprehensive primary care is a statewide problem. More than 2.2 million New York residents lack sufficient access to primary care. The New York State of Health Marketplace and Medicaid expansion will add thousands of new patients to the insurance rolls seeking primary care. The financial instability and potential closure of hospitals in communities across New York State could further

exacerbate primary care shortages. Given all these factors, it does not make sense to geographically restrict U&DTCs.

However, U&DTC licensure should only be granted to providers that promote access for all patients. They should be required to treat patients regardless of their insurance status, including providing a sliding fee scale for those under 200% of the Federal Poverty Level (FPL). Enabling services and care coordination should also be required. Providers must provide culturally sensitive services as well as supportive services (translations, transportation, and care management) that promote access to health care.

Freestanding EDs:

It is our recommendation that Freestanding EDs be licensed as Article 28s and that they are subject to full CON review.

Stabilization of a Patient-Centered Medical Home

Care coordination with primary care providers should be emphasized across the care spectrum. In order to function well, primary care providers must be integrated within the spectrum of care. The development of practice arrangements that ensure that primary care providers are able to secure the information needed to respond as patient-centered medical homes is essential.

The newly-regulated delivery models should require a formalized plan to link patients back to their PCPs or connect them with a PCP if they don't yet have one. This primary care referral plan must be patient-focused and address ways to eliminate any financial or cultural barriers that would impede a patient's ability to establish a patient-centered medical home. The plan should identify and limit the number of repeat encounters with individual patients. The plan must also establish a formal affiliation with providers who provide comprehensive primary care services, as well as supportive services (sliding fee scale, translation, transportation, etc.) that promote access to health care.

Any reforms the State considers should encourage practices to collaborate with primary care safety net providers to facilitate access for the medically underserved, including the breaking down of regulatory barriers that limit co-location. Integration between these models and FQHCs can be mutually beneficial, especially with regard to the Medicaid population. FQHCs bring demonstrated success in chronic disease management and improved patient outcomes. However, regulatory restrictions of co-location limit collaborative models between providers, creating a bifurcated system that continues to encourage the misuse of Emergency Departments.

Consumer Disclosures

Providers should be required to display pricing information and guidelines for determining when it is appropriate to visit Urgent Care, Retail Clinics or EDs vs. a primary care provider. This should include posting the limited services that are provided and that any prescription or over-the-counter medication or other recommended supplies can be purchased at any location.

Health Information Technology Standards

Retail Clinics, Urgent Care, UD&TCs and Freestanding EDs should be required to utilize a certified electronic health record and be in compliance with the Statewide Policy Guidance for sharing of electronic patient health records, including providing patient visit information back to the patient's primary care provider. Urgent Care, Retail Clinics and Freestanding EDs should provide patients with a copy of the medical record following each visit. Additionally, it is strongly suggested that providers connect to the Statewide Health Information Network for New York (SHIN-NY) to ensure patients' health information is available to all authorized clinicians.

Additional Questions

We appreciate the opportunity to share our thoughts and recommendations with the Committee. We also would like to pose some additional questions:

1. How do we ensure consistency in regulatory oversight between UD&TCs and Urgent Care providers? We caution the Committee to examine this question to ensure that we do not inadvertently create an uneven playing field between these two provider systems. It is likely there will be significant overlap between required services and therefore, we should not create different expectations for regulatory oversight.
2. How do we ensure that the existing D&TCs are not inadvertently "downgraded" by the establishment of an UD&TC?
3. How do we ensure that Managed Care Organizations (MCO) have robust contracting with UD&TCs or Urgent Care facilities? In order to reach the goal of diverting non-emergent care from EDs, MCOs must expand their contracting with UD&TCs and Urgent Care providers. Patients should be able to easily access these services without concern of additional out-of-network fees, or they will continue to turn to EDs where they know they have health insurance coverage.
4. How do we protect our communities against opportunistic growth that is not based on rational health planning?

Closing

An essential component of good health depends on having a place to go for primary care. It was estimated about 2.5 million annual emergency department visits by NYS residents are likely to be non-emergencies or emergencies treatable in a primary-care setting, based on an estimation algorithm developed at NYU.

Primary care is critical for identifying and treating health problems so that people can access preventive, high quality and cost-efficient care. Patients with access to quality primary care are more likely to have health conditions caught early and managed effectively. They stay healthier and avoid more expensive care down the line that raises health care costs for everyone. If we want to ensure that unnecessary emergency department visits and hospitalizations are avoided, Urgent Care, Retail Clinics and Free

Standing EDs must be, under this new paradigm, linked closely (physically and clinically) with primary care.

Contact: Elizabeth Swain eswain@chcanys.org 212-710-3802