Expanding Sustainable Community Health Centers in New York City

OCTOBER 2015

CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State

Contents

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In this report, CHCANYS re-evaluated the priorities for the sustainable expansion of federally qualified health centers (FQHC) originally published in its 2013 Plan for Expanding Sustainable Community Health Centers in New York. CHCANYS would like to acknowledge the expert panel and strategy group convened to help guide the 2013 report. The methodology developed under the guidance of the expert panel and strategy group was replicated in this report.

CHCANYS would like to acknowledge the New York State Health Foundation for its continued support of CHCANYS and commitment to improve the health of all New Yorkers.

Executive Summary

In 2013, CHCANYS published its *Plan for Expanding Sustainable Community Health Centers in New York* with support from the New York State Health Foundation.[1] This plan was written to serve as a rational, data-based report for building the capacity of Federally Qualified Health Centers (FQHC) and expanding their reach to serve more patients.

FQHCs are located in medically underserved areas and provide community-based, comprehensive primary care to anyone who needs it, regardless of ability to pay. FQHCs offer a range of services, including primary and preventive care, behavioral health services, dental care, and substance abuse services, as well as enabling services such as transportation, interpretation, and outreach.

It is essential to expand the capacity of FQHCs, which are at the center of both federal and state health care reform strategies. The Affordable Care Act (ACA) is reliant on expanded primary care capacity to both care for the influx of newly insured people and ensure a strong safety net for those who remain uninsured. The federal law recognizes this and has made FQHCs a cornerstone of its plan for expanding access to health care.

Initiatives in New York State reinforce the need for enhanced primary care capacity. In 2011, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT) and tasked it with finding ways to reduce costs and increase quality and efficiency in the State's Medicaid program. A central strategy of the MRT has been promoting more integrated and Triple Aim-oriented[2] systems of care that produce better care and better health at lower costs and have community-based primary care as the foundation. The State's Medicaid Section 1115 waiver, granted in April 2014, was developed to secure funds to implement the MRT's action plan. New York State's Delivery System Reform Incentive Payment (DSRIP) program, a key component of the waiver, will provide $6.42 billion to support this transformation of the State's health care delivery system.

FQHCs are well-positioned to participate in and lead these transformations and develop the capacity to serve more patients. In addition, there are many communities throughout New York that currently lack adequate primary care capacity to meet either their current or their future needs.

CHCANYS' Expansion and Sustainability Plan – 2015 Update for New York City

In his budget for Fiscal Year (FY) 2016, Mayor Bill de Blasio has included $8 million in working capital to New York City-based FQHCs to support the development of at least eight new sites in neighborhoods rated highest on measures of need and sustainability originally developed for CHCANYS' Expansion Plan. To better inform this initiative, CHCANYS has updated its 2013

1 Plan for Expanding Sustainable Community health Centers in New York, April 2013. http://www.chcanys.org/clientuploads/2013%20PDFs/Statewide%20Expansion/CHCANYS_ExpanSustain_April2013.pdf

2 The Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. http://www.ihi.org/offerings/initiatives/tripleaim/pages/default.aspx. Accessed December 7, 2012.

report to identify neighborhoods with unmet needs. Specifically, CHCANYS re-evaluated the tiers representing potential opportunities for FQHC expansion among 42 United Hospital Fund (UHF) New York City neighborhoods using the most current data available. The geographic rankings are intended to help inform, but not dictate, which regions to prioritize for supporting the expansion of community-based primary care, including FQHCs. However, this analysis does not capture all the factors that would determine the prospects for expansion.

Key Findings

In New York City, 16 neighborhoods fall into Tier One, the category of highest priority for expansion:

- **Five neighborhoods in the Bronx:**

  Fordham-Bronx Park, Pelham-Throgs Neck, Crotona-Tremont, High Bridge-Morrisania, Hunts Point-Mott Haven

- **Six neighborhoods in Brooklyn:**

  East New York, Sunset Park, Borough Park, East Flatbush-Flatbush, Coney Island-Sheepshead Bay, Williamsburg-Bushwick

- **Two neighborhoods in Manhattan:**

  Washington Heights-Inwood, East Harlem

- **Three neighborhoods in Queens:**

  West Queens, Flushing-Clearview, Jamaica

Environmental Scan

Since publication of the original Expansion Plan in 2013, considerable policy changes and events have occurred that have impacted health care in New York City. An environmental scan was conducted to assess how these changes and events, including the addition of new FQHC sites and Superstorm Sandy, have affected the need and sustainability of primary care in New York City. In addition, we have highlighted how current and continuing changes in federal and state health policy will likely increase the demand for primary care services provided by FQHCs.

Introduction

Background

Federally Qualified Health Centers (FQHC) are at the center of both federal and state health care reform strategies. FQHCs are located in underserved areas and provide community-based comprehensive primary care to anyone who needs it, regardless of ability to pay. They offer a range of services, including primary and preventive care, behavioral health services, dental care, and substance abuse services, as well as enabling services such as transportation, interpretation, and outreach. Federal health reform, the Affordable Care Act (ACA), is reliant on expanded primary care capacity to care for the influx of newly insured people and ensure a strong safety net for those who remain uninsured. The federal law recognizes this and has made FQHCs a cornerstone of its plan. The ACA allocated $11 billion for FQHCs nationally over 5 years (FY2010-FY2015). Originally set to expire at the end of FY2015, the mandatory ACA funding for FQHCs was recently extended to provide $7.2 billion for the Health Centers Program, as well as continued funding for the National Health Service Corps (NHSC) and Teaching Health Centers (THC) for two years.

New York State FQHCs served more than 1.8 million patients in 2014, and have seen nearly 42% growth in FQHC patient volume between 2008 and 2014. It is anticipated that New York City FQHCs will serve over 1 million patients in 2015. Massachusetts' experience with health reform implementation suggests that as more New Yorkers gain health insurance coverage, community-based primary care providers should be prepared to see significantly more patients.[3]

Initiatives in New York State reinforce the need for enhanced primary care capacity. In 2011, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT) and tasked it with finding ways to reduce costs and increase quality and efficiency in the State's Medicaid program. A central strategy of the MRT has been promoting more integrated and Triple Aim-oriented[4] systems of care that produce better care and better health at lower costs and have community-based primary care as their foundation.

The State's Medicaid Section 1115 waiver, granted in April 2014, was developed to secure funds to implement the MRT's action plan. The Delivery System Reform Payment (DSRIP) program, a key component of the waiver, presents a significant opportunity to accelerate progress toward creating efficient, high-quality systems of care. As one of the main ways in which the State is pursuing the Triple Aim, DSRIP incentivizes collaboration among hospitals, FQHCs, and community-based organizations to improve the value of care provided to patients and the overall health of the communities these organizations serve.

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3 Researchers who assessed data from Massachusetts after the State's health care reform law that was enacted in 2006 saw a 31% increase in the number of patients receiving care at Massachusetts' community health centers from 2005 to 2009. (Leighton Ku; Emily Jones; Peter Shin; Fraser Rothenberg Byrne; Sharon K. Long. Safety-Net Providers After Health Care Reform: Lessons From Massachusetts. Arch Intern Med. 2011;171(15):1379-1384. doi:10.1001/archinternmed.2011.317.)

4 The Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. http://www.ihi.org/offerings/initiatives/tripleaim/pages/default.aspx. Accessed December 7, 2012.

FQHCs are well-positioned to participate in and lead both State and federal transformation efforts. Community-based primary care provided by FQHCs is essential to achieving the goals of DSRIP, and FQHCs are active participants in this program. All New York City FQHCs are involved in DSRIP and participating in an average of eight projects.[5] FQHCs are also active participants in Center for Medicare and Medicaid innovation projects like the Medicare Accountable Care Organization, State Health Innovation Plan, and Comprehensive Primary Care Initiative.

As state and federal health reform efforts emphasize the critical role of primary care in achieving improved delivery system outcomes, increasing the capacity of FQHCs to meet these demands is vitally important. There are untapped opportunities to derive more capacity out of the existing primary care system by changing how patients access care and how care is delivered. There are also many communities throughout New York that do not have adequate primary care capacity to meet the current and future needs of their communities.

In addition to serving more patients, expanding community-based primary care, including FQHCs, can also drive economic development. Primary care providers employ many residents in the communities they serve, with some being the largest employers in their service area. The Primary Care Development Corporation estimates that the $515 million they invested in more than 100 primary care projects has not only produced 1.06 million square feet of new or renovated primary care space and the ability to care for 765,000 more patients, but it has also created 5,275 jobs in low-income communities.[6] The development of state-of-the-art health centers—often from previously dilapidated spaces—has also made communities more attractive for other investments, spurring the influx of additional businesses such as pharmacies and labs.

CHCANYS' Expansion and Sustainability Plan – 2015 Update for New York City

In his FY 2016 budget, Mayor de Blasio proposed providing $8 million in working capital to New York City-based FQHCs to support the development of at least eight new sites in neighborhoods rated highest on measures of need and sustainability in CHCANYS' Expansion Plan. Since the original Plan was completed in 2013, more recent data has become available. This version of the Plan, compiled using the new data, is an effort to reflect a more current and realistic view of the primary care landscape in New York City. Specifically, CHCANYS re-evaluated the tiers representing opportunities for FQHC expansion among 42 United Hospital Fund New York City neighborhoods using the most current data available. In addition to updating data used to derive the need and sustainability measures, CHCANYS incorporated data from city agencies into these measures where applicable.[7] Appendix A outlines our data sources.

5 This information comes from a survey conducted among New York State FQHCs between December 2014-January 2015.

6 http://www.pcdc.org/capital-financing/impact.html. Accessed May 29, 2015.

7 Gotham Health, affiliated with New York City's Health and Hospital Corporation (HHC), was granted FQHC look alike status in 2015. HHC provided data on their Gotham Health sites so that this information could be incorporated into the analysis. In addition, New York City Department of Health and Mental Hygiene provided data from the Community Health Survey, which was incorporated into the analysis

Methods and Findings

Geographic Framework for Planning

For the analysis, CHCANYS used the 42 neighborhood boundaries derived by the United Hospital Fund (UHF).[8]

Measuring Need and Sustainability

CHCANYS identified factors commonly associated with the need for additional primary care generally and for FQHC services specifically. CHCANYS also identified factors that might enhance or limit an area's ability to sustain expanded FQHC physical capacity. CHCANYS then identified specific measures associated with such factors for which there were data available statewide and at the required geographic levels.

In the 2013 Plan CHCANYS identified the following 10 measures of need and 5 measures of sustainability and vetted the measures with FQHC leaders and experts on the project's Expert Panel.[9] Appendix A provides detailed descriptions of these measures.

NEED:

- Adjusted rate of preventable hospitalizations
- Adjusted rate of preventable Emergency Department (ED) visits
- Uninsured rate
- Percentage of population that missed medical care
- Percentage racial and ethnic minority
- Percentage low-income (i.e., below 200% of poverty level)
- Percentage elderly (i.e., age 65 and older)
- Percentage non-citizen
- Percentage with limited English proficiency
- Percentage of births with late or no prenatal care

8 An alternative would have been to use the Community Board Districts, which are nearly synonymous with the Census Bureau's Public Use Microdata Areas in New York City. However, the UHF neighborhoods are more often used for health care assessment (e.g., for the City's annual Community Health Interview) and are built from ZIP codes, the reported geographic unit for several NYSDOH measures used here.

9 Note that some measures of sustainability could also be considered need measures; however, they were included as sustainability because the consensus was that they contributed more for sustainability. Additionally, the measures and analysis did not include assumptions about patients going to another area for care, although this is likely common. The analysis also did not include data or information on existing collaborations among providers and the impact of those collaborations on need or sustainability. The latter two issues speak to the importance of assessing those issues at a community level.

SUSTAINABILITY:

- Primary care doctors (FTEs) per 100,000 population
- Percentage change in population from 2000 to 2010
- Percentage of low-income population not served by FQHCs
- Labor force participation rate
- Percentage enrolled in Medicaid or Medicare

Weighting Measures

Since all measures may not have the same degree of importance or be as reliable as others, CHCANYS weighted each measure based on feedback from the Expert Panel used in the 2013 report. For example, in building the need index, greater weight was given to measures of preventable hospitalizations and avoidable ED use. In building the sustainability index, greater weight was ascribed to the proportion of low-income residents not already served by FQHCs.

Within each of the geographic areas, a weighted index of need and a weighted index of sustainability were constructed by standardizing the scores on each measure, weighting the measures, and summing the weighted components. The weighted index scores were ranked and the results used to produce the maps below.

Developing Tiers

Geographic areas were ultimately grouped into three tiers. To develop the tiers, a single score was developed for each area by combining and weighting the overall scores of need and sustainability, with need having double the weight of sustainability.[10] Three tiers of roughly equal size emerged from the analysis. Neighborhoods are not prioritized within each tier; rather, they are listed in alphabetical order within boroughs.

Key Findings

Sixteen neighborhoods in New York City fall into Tier One: five neighborhoods in the Bronx, six in Brooklyn, two in Manhattan, and three in Queens. There are 13 neighborhoods in Tier Two: two neighborhoods in the Bronx, three in Brooklyn, three in Manhattan, three in Queens, and two in Staten Island. There are 13 neighborhoods in Tier Three.

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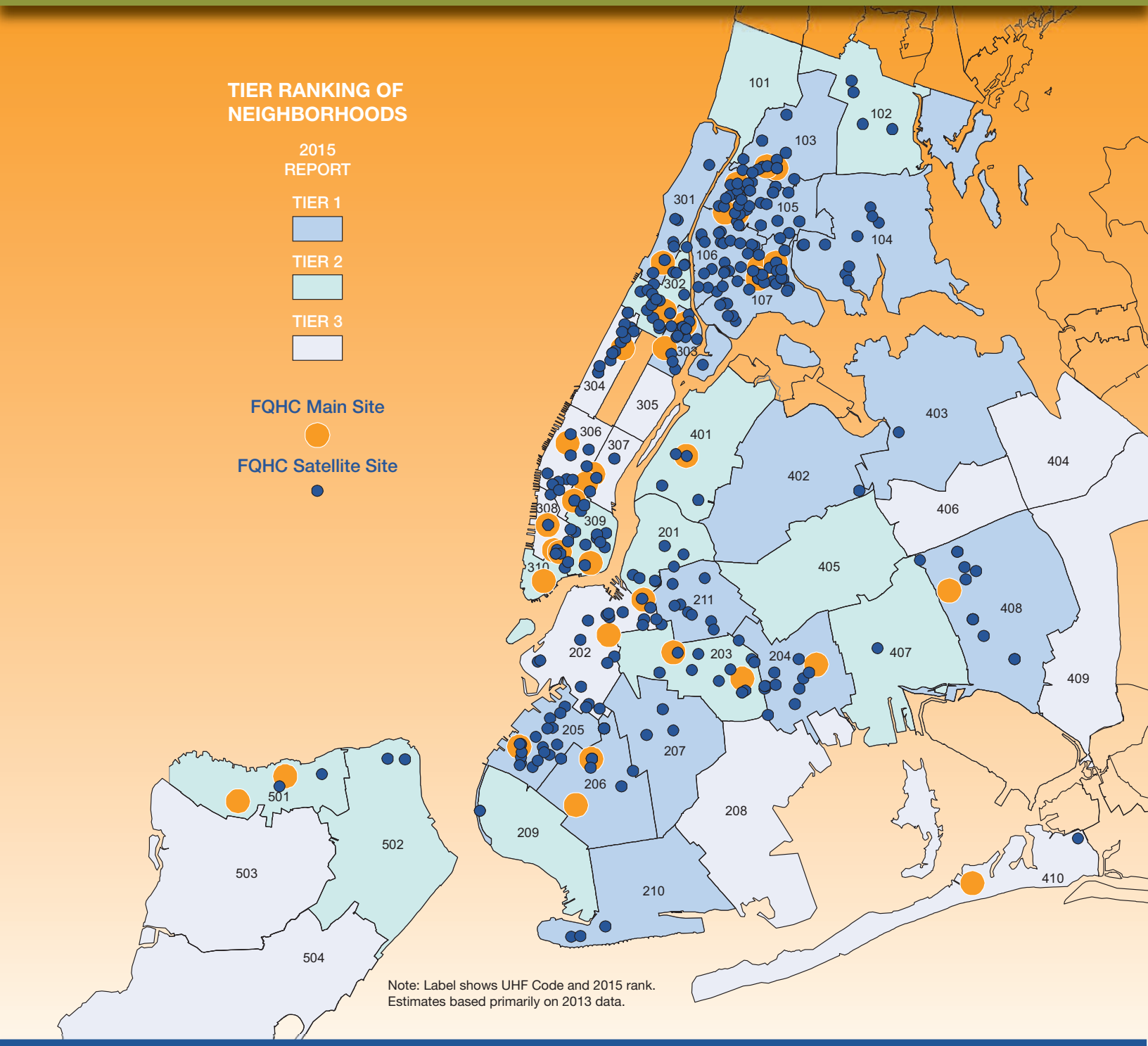
10 Sustainability was weighted lower in the combined score because we know that there are many factors that could contribute to sustainability that were not part of our analysis.

TABLE 1. Tiers Representing Opportunity Targets for FQHC Expansion Among New York City Neighborhoods	
BOROUGH AND UHF NEIGHBORHOOD #	**NEIGHBORHOODS**
TIER ONE	
Bronx 103	Fordham – Bronx Park
Bronx 104	Pelham – Throgs Neck
Bronx 105	Crotona – Tremont
Bronx 106	High Bridge – Morrisania
Bronx 107	Hunts Point – Mott Haven
Brooklyn 204	East New York
Brooklyn 205	Sunset Park
Brooklyn 206	Borough Park
Brooklyn 207	East Flatbush – Flatbush
Brooklyn 210	Coney Island – Sheepshead Bay
Brooklyn 211	Williamsburg – Bushwick
Manhattan 301	Washington Heights – Inwood
Manhattan 303	East Harlem
Queens 402	West Queens
Queens 403	Flushing – Clearview
Queens 408	Jamaica
TIER TWO	
Bronx 101	Kingsbridge – Riverdale
Bronx 102	Northeast Bronx
Brooklyn 201	Greenpoint
Brooklyn 203	Bedford Stuyvesant – Crown Heights
Brooklyn 209	Bensonhurst – Bay Ridge
Manhattan 302	Central Harlem – Morningside Heights
Manhattan 309	Union Square – Lower East Side
Manhattan 310	Lower Manhattan
Queens 401	Long Island City – Astoria
Queens 405	Ridgewood – Forest Hills
Queens 407	Southwest Queens
Staten Island 501	Port Richmond
Staten Island 502	Stapleton – St. George
TIER THREE	
Brooklyn 202	Downtown – Heights – Slope
Brooklyn 208	Canarsie – Flatlands
Manhattan 304	Upper West Side
Manhattan 305	Upper East Side
Manhattan 306	Chelsea – Clinton
Manhattan 307	Gramercy Park – Murray Hill
Manhattan 308	Greenwich Village – Soho
Queens 404	Bayside – Little Neck
Queens 406	Fresh Meadows
Queens 409	Southeast Queens
Queens 410	Rockaway
Staten Island 503	Willowbrook
Staten Island 504	South Beach – Tottenville

MAP 1. Re-estimated Opportunity for FQHC Expansion (2015)



Note: Label shows UHF Code and 2015 rank.
Estimates based primarily on 2013 data.

Interpreting the Rankings and Limitations

The geographic rankings are intended to help inform, but not dictate, which regions to prioritize for supporting the expansion of community-based primary care, including FQHCs. The rankings can also provide a platform for a more careful exploration of community-level conditions affecting need and sustainability. Areas identified in Tier One scored high in both need and sustainability and could be strong starting points for expansion efforts. Areas identified in Tiers Two and Three should also receive consideration and support to identify other factors that may demonstrate localized need and/or factors that would support sustainable expansion and/or increase their readiness to expand. For example, an area that has relatively high need but did not rank high in sustainability may require support to enhance sustainability factors.

This analysis does not capture all the factors that would determine the prospects for expansion. For example, this analysis does not assess the degree to which the areas have political and/or community support, whether there are existing FQHCs or other community-based primary care providers that are operationally ready to undertake an expansion, if there are capital resources available, or if there are other providers able to serve low-income populations—all of which are examples of critical factors for sustainable FQHC expansion.

Need is not static. Areas throughout New York experience changes in the demographics of their populations, which in turn can change the health care needs of the area. Although the analysis included overall population change as a measure, it did not include an analysis of changing demographics.

This analysis does not include an assessment of the needs of special populations. For FQHCs, special populations include Health Resources and Services Administration (HRSA)-defined population categories such as the homeless, migrant and seasonal farm-workers, and individuals living in public housing as well as those with HIV/AIDS and developmental disabilities, refugees, and children and youth in school settings. An analysis of special populations will be important for any local health planning effort and should be used to identify appropriate providers for expanding capacity and the type of expansion needed.

Our analysis does not include measures of the overall health and health status of residents within communities or counties and some of the social determinants of health that impact people's health. Since access to high-quality health care is necessary but not sufficient to produce healthy communities, this type of analysis will be critical to regional health planning. The University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation's *2015 County Health Rankings* provide county-level data to help guide these efforts. The rankings assess the overall health of most counties in all states and factors that affect people's health within the following four categories: health behavior, clinical care, social and economic factors, and physical environment.[11]

[11] www.countyhealthrankings.org.

Environmental Scan

Since publication of the original Expansion Plan in 2013, considerable policy changes and events have occurred that have impacted health care in New York City. An environmental scan was conducted to assess how these changes and events affect the need and sustainability of primary care in New York City.

New Sites

Gotham Health, affiliated with the New York City Health and Hospitals Corporation (HHC), was granted FQHC look alike status in early 2015. Gotham Health's six newly-designated centers, previously operating as HHC diagnostic and treatment centers (D&TC) and associated satellite sites, will bring the number of patients served by New York City –based FQHCs to well over 1 million. To ensure the most accurate count of the patients served, those who receive services at HHC D&TC sites that are now part of Gotham Health were incorporated into the analysis.

In addition to Gotham Health, thirteen New York City FQHCs were awarded New Access Point (NAP) grants from the Human Resources and Services Administration (HRSA) in 2015 to support the development of new sites. The impact of the 2015 NAP awards on access to sustainable primary care will not be known for the next few years. Though a step in a positive direction, the development of these new sites does not adequately address the considerable unmet need for access to affordable primary and preventive care in New York City.

Superstorm Sandy

Health care services were significantly disrupted during, and following, Superstorm Sandy in October 2012, particularly in coastal communities like Coney Island and the Rockaways. These neighborhoods saw the closure of a number of health facilities, including FQHCs. Mobile clinics and other relief services were available to help mitigate the impact the storm had on access to care. The acute impact of Superstorm Sandy on measures like percentage of missed medical care was incorporated into our analysis. Though these health facilities have since reopened, our analysis cannot account for the complex and long-term impacts of the storm on the need for and sustainability of primary care services in these communities.

Policy Changes

CONTINUED IMPLEMENTATION OF THE AFFORDABLE CARE ACT

The major provisions of the Affordable Care Act (ACA) implemented during since the publication of the 2013 Expansion Plan include the opening of New York's state-operated health benefits exchange, the NY State of Health, and the expansion of Medicaid.

The NY State of Health, the Official Health Plan Marketplace (the Marketplace), opened on October 1, 2013. More than 2 million New Yorkers enrolled in health plans via the Marketplace by the end of the second open enrollment period in February 2015. Of these, 415,352 enrolled in Qualified Health Plans (QHPs), 159,716 enrolled in the Child Health Insurance Program (known in New York as Child Health Plus), and 1,568,345 enrolled in Medicaid.[12] The second enrollment period began on November 15, 2014.

As compared with other states, New York has not seen a substantial increase in Medicaid and CHIP insurance eligibility as a result of the ACA. Already a leader in terms of the expansion of public health insurance options, New York State currently offers public health coverage to parents with incomes up to 200% of the Federal Poverty Level (FPL) and children up to 400% of FPL, as well as to some childless adults. As projected, a relatively small percentage (13%) of the individuals who enrolled in Medicaid through the Marketplace were newly eligible as result of Medicaid expansion. Regardless, the volume of patients seeking care at FQHCs has grown since the implementation of the Marketplace.

The ACA expanded access to affordable health care coverage to millions of Americans, including certain immigrants, by expanding Medicaid eligibility limits and by providing financial subsidies for low-income households to purchase private insurance via the Marketplace. However, for undocumented adults and classes of deferred action residents, access to health insurance continues to be an issue. In New York, an estimated 250,000 undocumented and uninsured immigrants are ineligible for federally subsidized health coverage. In addition, they are not permitted to purchase insurance on the Marketplace, which presents a significant challenge both to the State and to the FQHCs that serve these individuals. Because FQHCs are required to serve everyone who requires medical care regardless of ability to pay, and to provide sliding fee discounts to patients whose income is under 200% FPL, health centers are particularly important to uninsured populations.

Thanks to a provision in the ACA that permits states to receive federal contributions toward the costs of covering certain classes of legally residing immigrants and others up to 200% FPL, New York State recently implemented a Basic Health Plan (BHP) option. On April 1, 2015, certain classes of immigrants who were previously receiving New York State-funded Medicaid were transitioned to BHP. Beginning in 2016, New Yorkers, including legally residing immigrants with income levels between 133% and 200% of FPL, will have the option to enroll in BHP with significantly reduced co-pays and out-of-pocket costs.

Implementation of the ACA will continue to reduce the number of people without insurance and encourage them to see health providers at places like FQHCs. Despite the increased access to coverage, however, hundreds of thousands of undocumented immigrants remain ineligible for coverage and thus remain uninsured. These changes will increase the need for, and sustainability of, FQHCs beyond what is accounted for in our analysis.

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12 Enrollment data from 2015 Open Enrollment Report; NY State of Health, July 2015. http://info.nystateofhealth.ny.gov/sites/default/files/2015%NYSOH%20Open%20Enrollment%20Report.pdf

NEW YORK STATE MEDICAID'S DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

To support the implementation of the Medicaid reform plan, New York State submitted an 1115 Medicaid waiver request to CMS in August 2012. After two years of negotiations with CMS over the details of the waiver, Governor Cuomo announced on April 14, 2014 that an agreement had been reached. The waiver amendment enables the State to reinvest $8 billion of the approximately $17.1 billion in federal savings generated by targeted Medicaid reforms in health system transformation projects conducted over a nine-month design phase and a five-year implementation phase. A central component of the waiver is New York State's Delivery System Reform Incentive Payment (DSRIP) program, which will provide $6.42 billion to support the transformation of the State's health care delivery system aimed at improving care and outcomes and reducing costs for Medicaid beneficiaries. The State's primary objective through DSRIP is to reduce avoidable hospitalizations by 25% statewide over five years. Community-based primary care services provided by FQHCs will be crucial in helping the State achieve this objective.

The plan includes elements that will have a significant and long-term impact on the role of FQHCs in the health care delivery system and on FQHC Medicaid payment. Through DSRIP, networks of providers have been created under lead applicants in regions of New York State to form new integrated delivery systems, called Performing Provider Systems. Performing Provider Systems are responsible for attributed Medicaid beneficiaries in a given geography or medical market area and are eligible to receive performance-based payments. Performing Provider Systems will achieve the objective of the State and meet their performance goals by completing a variety of projects focused on improving the health of the population they serve.

All FQHCs in New York are part of at least one Performing Provider System and will participate in an average of eight different DSRIP projects. Most FQHCs anticipate needing capital dollars to meet their DSRIP obligations. Capital dollars will be spent on projects like opening new sites or renovating existing sites in order to accommodate an increased demand for services. Also, FQHCs anticipate spending capital dollars on projects to update IT infrastructure and build space to co-locate medical and behavioral health services.[13]

Participation in DSRIP is expected to increase the need for FQHC services, as community-based primary care is essential to improving population health measures and reducing avoidable hospitalizations. At this point, however, it is unclear if the resources for this expansion will be available for FQHCs through the DSRIP program. As implementation of DSRIP projects will not begin until mid- to late-2015, this increase in need was not accounted for in our analysis. However, we expect DSRIP to increase the need for primary care state- and citywide.

[13] This information gathered from a survey of New York State FQHCs administered December 2014-January 2015.

NEW YORK STATE HEALTH INNOVATION PLAN

In December 2014, New York State was awarded a $99.9 million grant from the Center for Medicare and Medicaid Innovation to implement the State Health Innovation Plan (SHIP). The SHIP aims to create a model of advanced primary care that moves beyond NCQA Patient Centered Medical Home (PCMH) criteria to better promote meaningful improvements in population health measures and control health care costs. Within five years, the State aims to have 80 percent of its population receiving care in an advanced primary care setting.

Sixty-six percent of New York FQHCs received PCMH recognition as of December 31, 2014 and all New York FQHCs have implemented electronic health record (EHR) systems. Both of these standards will be fundamental steps in achieving advanced primary care status. FQHCs are therefore expected to play an important role in the SHIP. As the advanced primary care model is still under development, it is uncertain how it will impact our measures of need and sustainability.

VALUE BASED PAYMENTS

Both DSRIP and SHIP seek to increase the use of Value Based Payment (VBP) methodologies in New York. Although the focus of SHIP is the implementation of the advanced primary care model, the State has decided to implement a gradual approach toward payment reform and as such is beginning the transition to VBP in Medicaid Managed Care. It is expected that the experience in Medicaid will then inform future discussions for the commercial marketplace.

New York's stated goal is to have 85–90% of managed care payments to providers be reliant on VBP methodologies by year five of DSRIP. In June 2015, CMS approved DOH's New York State VBP Roadmap, which outlines the specific steps and reforms necessary to achieve this goal.[14] As major Medicaid safety net providers and comprehensive care providers, FQHCs have vast experience in caring for and designing effective interventions for at-risk populations, those who face health disparities and have inadequate access to quality health care. Accordingly, health centers are strongly situated to move toward value-based payments.

14 http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

APPENDIX A:
Measures of Need and Sustainability

Measures of Need

Prevention Quality Indicators (PQI)—Observed-to-Expected: This is the ratio of the observed (actual) number of preventable hospitalizations to the expected number after adjusting for an area's age and sex population differences. Because timely and effective primary care can reduce preventable hospitalizations, this measure is often seen as an indicator of the need for additional primary care resources. These values were obtained from the New York State Department of Health at: https://health.data.ny.gov/Health/Hospital-Inpatient-Prevention-Quality-Indicators-P/5q8c-d6xq

Emergency Department—Percentage Primary Care Treatable: This is the percentage of all treated-and-released ED visits that are evaluated as potentially preventable by the New York State Department of Health. The data were derived from the following: https://health.data.ny.gov/Health/All-Payer-Potentially-Preventable-Emergency-Visit-/gu5u-nze7

Uninsured: Because FQHCs are a critical resource for the uninsured, the proportion of an area's residents without health insurance can be a factor in assessing an area's need for FQHCs. This measure was obtained from the 2011-2013 New York City Department of Health and Mental Hygiene's Community Health Surveys.

Percentage Who Missed Medical Care: Obtained from the 2011-2013 New York City Department of Health and Mental Hygiene's Community Health Surveys, the percentage sampled who say they missed necessary medical care in the past year is an indicator of the need for additional primary care resources.

Percentage Minority, Percentage < 200% Poverty, Percentage >= Age 65, Percentage Non-Citizens, Percentage Limited English: Each of these demographic measures addresses a group for whom timely and effective primary care may be especially problematic. The data came from the five-year ZCTA estimates included in the 2013 American Community Survey data from the US Census Bureau. A greater prevalence of any of them may indicate a greater need for FQHCs, which are well-suited to address these populations.

Percentage Late/No Prenatal: The lack of timely prenatal care may indicate a need for FQHCs, both because they target such care and because poor performance on this measure is often associated with other deficits in primary care resources. The measure was available by ZIP code for 2010-2012 from the New York State Department of Health at: http://www.health.ny.gov/statistics/chac/perinatal/

Measures of Sustainability

Primary Care Physicians/100,000 (C-B PC Docs/100K): This measure is the number of full-time equivalent community-based primary care doctors per 100,000 of population, based on 2013 data from the SUNY Center for Health Workforce Studies released by the New York State Department of Health at: http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/workforce_information.htm. The expectation is that areas where such doctors are more abundant may offer better prospects for sustainable growth than areas where there is a relative shortage of such doctors.

Population Change Percentage: Areas where the population increased from the 2000 to 2010 censuses may be better able to support expansion than areas of decline. The data were obtained from the Census Bureau's ZCTA population files.

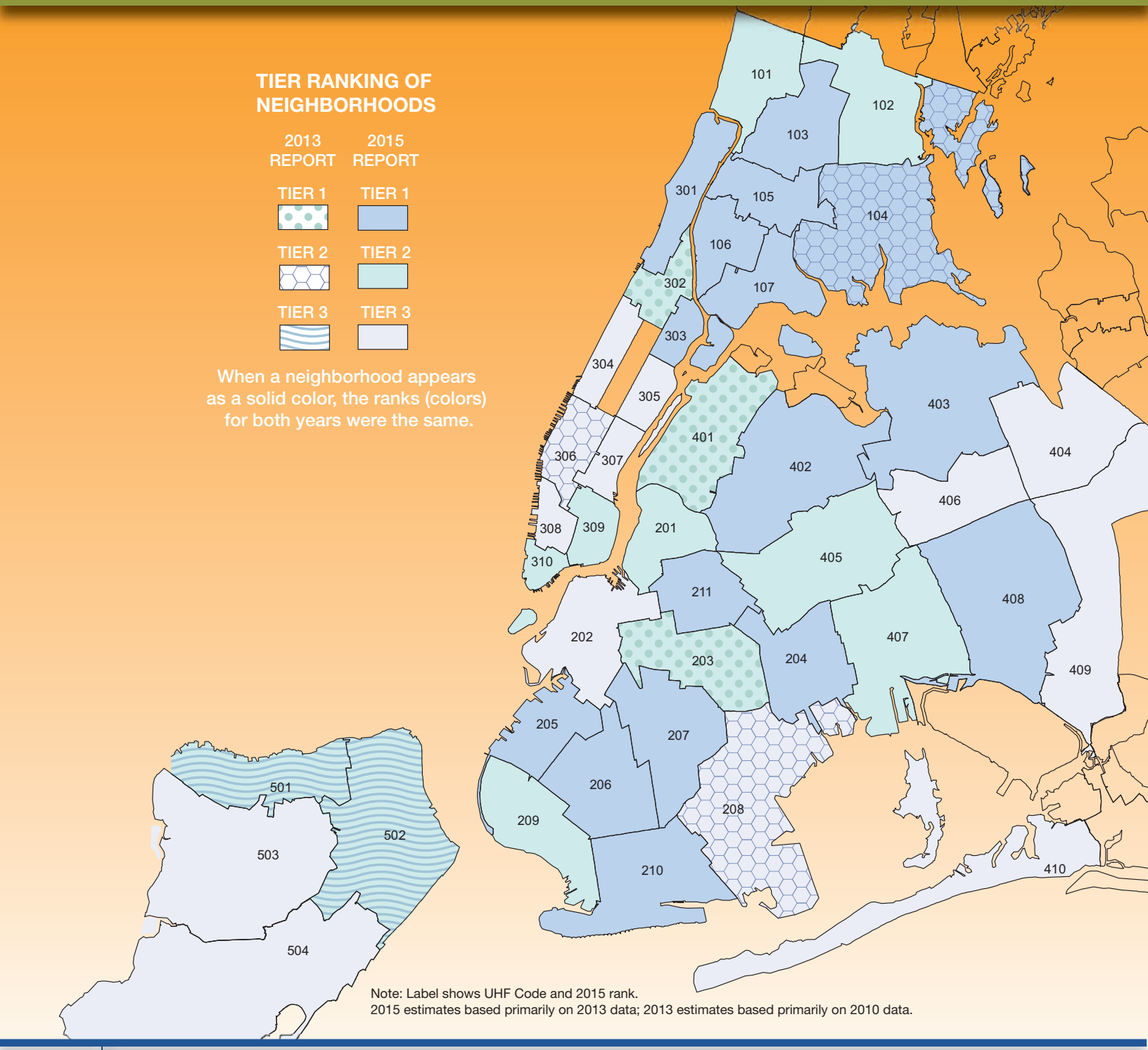
Percentage Low-Income not in FQHC: This measure subtracts the area's FQHC enrollees in 2013 from its population below 200% of the poverty level (from the five-year ZCTA estimates in the 2013 American Community Survey), and divides the result by the population under 200% of the poverty level. The result is a measure of the opportunity to enroll more FQHC patients: a measure of the area's ability to absorb more FQHCs. We included as FQHC enrollees those patients served by specific D&TCs of the New York City Health and Hospitals Corporation who are now part of the Gotham Health network.

Labor Force Participation Percentage: Labor force participation can be a gateway to health insurance; higher rates may indicate greater opportunity for FQHCs. The measure was taken from the five-year ZCTA estimates in the 2013 American Community Survey.

Medicaid/Medicare Percentage: The percentage of the population covered by Medicaid and Medicare may be related to better funding opportunities for FQHCs. This measure was obtained from the 2011-2013 New York City Department of Health and Mental Hygiene's Community Health Surveys.

APPENDIX B:
Comparison of 2013 to 2015 Results

MAP 2. Re-estimated Opportunity for FQHC Expansion (2015) Compared to Previous Estimates (2013 Report)



Note: Label shows UHF Code and 2015 rank.
2015 estimates based primarily on 2013 data; 2013 estimates based primarily on 2010 data.

Pelham-Throgs Neck, Borough Park, and Coney Island-Sheepshead Bay were previously Tier Two neighborhoods that moved into Tier One while Bedford Stuyvesant-Crown Heights, Central Harlem-Morningside Heights, and Long Island City-Astoria were Tier One neighborhoods in the 2013 report that moved to Tier Two.

APPENDIX C:
Need and Sustainability Rankings

TABLE 1: Rankings of Need and Sustainability in UHF Neighborhoods in New York City
The following two tables show the rankings of the UHF neighborhoods in New York City by need and by sustainability. The highest-ranking neighborhood is listed first

RANK ORDERED BY NEED: Neighborhood with Highest Need for FQHC Expansion Listed First		RANK ORDERED BY SUSTAINABILITY: Neighborhood with Highest Potential to Sustain FQHC Expansion Listed First	
RANK	NEIGHBORHOOD	RANK	NEIGHBORHOOD
1	Bronx 106: High Bridge – Morrisania	1	Manhattan 310: Lower Manhattan
2	Bronx 107: Hunts Point – Mott Haven	2	Manhattan 305: Upper East Side
3	Bronx 105: Crotona – Tremont	3	Manhattan 301: Washington Heights – Inwood
4	Brooklyn 205: Sunset Park	4	Brooklyn 201: Greenpoint
5	Bronx 103: Fordham – Bronx Park	5	Manhattan 307: Gramercy Park – Murray Hill
6	Brooklyn 211: Williamsburg – Bushwick	6	Brooklyn 211: Williamsburg – Bushwick
7	Manhattan 303: East Harlem	7	Manhattan 308: Greenwich Village – Soho
8	Manhattan 301: Washington Heights – Inwood	8	Queens 403: Flushing – Clearview
9	Queens 402: West Queens	9	Brooklyn 206: Borough Park
10	Queens 403: Flushing – Clearview	10	Bronx 103: Fordham – Bronx Park
11	Brooklyn 204: East New York	11	Brooklyn 210: Coney Island – Sheepshead Bay
12	Bronx 104: Pelham – Throgs Neck	12	Manhattan 306: Chelsea – Clinton
13	Queens 408: Jamaica	13	Queens 407: Southwest Queens
14	Manhattan 302: Central Harlem – Morningside	14	Queens 405: Ridgewood – Forest Hills
15	Brooklyn 207: East Flatbush – Flatbush	15	Manhattan 303: East Harlem
16	Staten Island 501: Port Richmond	16	Brooklyn 209: Bensonhurst – Bay Ridge
17	Brooklyn 203: Bed. Stuyvesant – Crown Heights	17	Brooklyn 205: Sunset Park
18	Queens 401: Long Island City – Astoria	18	Queens 402: West Queens
19	Manhattan 309: Union Square – Lower East Side	19	Staten Island 502: Stapleton – St. George
20	Brooklyn 206: Borough Park	20	Bronx 101: Kingsbridge – Riverdale
21	Brooklyn 210: Coney Island – Sheepshead Bay	21	Brooklyn 207: East Flatbush – Flatbush

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Appendix C: Need and Sustainability Rankings continued

TABLE 1: Rankings of Need and Sustainability in UHF Neighborhoods in New York City
The following two tables show the rankings of the UHF neighborhoods in New York City by need and by sustainability. The highest-ranking neighborhood is listed first

RANK ORDERED BY NEED: Neighborhood with Highest Need for FQHC Expansion Listed First		RANK ORDERED BY SUSTAINABILITY: Neighborhood with Highest Potential to Sustain FQHC Expansion Listed First	
RANK	NEIGHBORHOOD	RANK	NEIGHBORHOOD
22	Queens 407: Southwest Queens	22	Brooklyn 208: Canarsie – Flatlands
23	Bronx 102: Northeast Bronx	23	Brooklyn 203: Bed. Stuyvesant – Crown Heights
24	Bronx 101: Kingsbridge – Riverdale	24	Queens 406: Fresh Meadows
25	Staten Island 502: Stapleton – St. George	25	Brooklyn 202: Downtown – Heights – Slope
26	Queens 405: Ridgewood – Forest Hills	26	Bronx 105: Crotona – Tremont
27	Queens 410: Rockaway	27	Queens 401: Long Island City – Astoria
28	Brooklyn 201: Greenpoint	28	Queens 408: Jamaica
29	Brooklyn 209: Bensonhurst – Bay Ridge	29	Staten Island 501: Port Richmond
30	Brooklyn 208: Canarsie – Flatlands	30	Manhattan 309: Union Square – Lower East Side
31	Brooklyn 202: Downtown – Heights – Slope	31	Bronx 106: High Bridge – Morrisania
32	Queens 406: Fresh Meadows	32	Queens 409: Southeast Queens
33	Queens 409: Southeast Queens	33	Staten Island 504: South Beach – Tottenville
34	Manhattan 310: Lower Manhattan	34	Bronx 107: Hunts Point – Mott Haven
35	Manhattan 306: Chelsea – Clinton	35	Brooklyn 204: East New York
36	Manhattan 304: Upper West Side	36	Manhattan 304: Upper West Side
37	Manhattan 307: Gramercy Park – Murray Hill	37	Queens 404: Bayside – Little Neck
38	Queens 404: Bayside – Little Neck	38	Staten Island 503: Willowbrook
39	Manhattan 308: Greenwich Village – Soho	39	Bronx 104: Pelham – Throgs Neck
40	Manhattan 305: Upper East Side	40	Manhattan 302: Central Harlem – Morningside
41	Staten Island 503: Willowbrook	41	Queens 410: Rockaway
42	Staten Island 504: South Beach – Tottenville	42	Bronx 102: Northeast Bronx

About the Authors

Community Health Care Association of New York State

CHCANYS' purpose is to ensure that all New Yorkers, including those who are medically underserved, have continuous access to high quality community-based health care services including a primary care home. To do this, CHCANYS serves as the voice of community health centers as leading providers of primary health care in New York State. As New York State's Primary Care Association (PCA), CHCANYS works closely with more than 65 federally qualified health centers (FQHCs) that operate over 600 sites across the state. Serving 1.8 million New Yorkers statewide, FQHCs form an extensive primary care network that is central to the health care safety net. This network includes community health centers as well as providers of health care to special populations such as homeless individuals, migratory and seasonal agricultural workers, and residents of public housing. FQHCs provide comprehensive primary and preventive care, including family medicine, pediatrics, obstetrics and gynecology, internal medicine, oral health, laboratory services, behavioral health, substance abuse services, and pharmacy services. Health centers are governed by community-based Boards of Directors, the majority of whose members are patients of the health center.

Since its founding over 40 years ago, CHCANYS has established itself both as the voice of New York State's FQHCs and as the most appropriate avenue through which to coordinate training and support for health centers, by leveraging its strong relationship with, immediate access to, and deep understanding of FQHCs and their communities. www.chcanys.org

Project Team

Authors:

- Beverly Grossman, Senior Policy Director
- James B. Welsh, PhD, Co-Director of Data Systems
- Lacey Clarke, Policy Analyst
- Abigail Zaylor, Program Analyst

Contributors:

- Elizabeth Swain, President & Chief Executive Officer
- Lisa Perry, Senior Vice President for Quality and Technology Initiatives
- Suzanne Rossel, Senior Director of Health Center Support

CHCANYS

Community Health Care
Association of New York State

NEW YORK CITY
111 Broadway
Suite 1402
New York, NY 10006
T: 212-279-9686
F: 212-279-3851

ALBANY
90 State Street
Suite 600
Albany, NY 12207
T: 518-434-0767
F: 518-434-1114

www.chcanys.org