

Increasing Access to Health Insurance Coverage and Moving Toward More Consistent Healthcare Reimbursement Public Hearing October 3, 2007

Commissioner Daines, Superintendent Dinallo, thank you for the opportunity to testify today. My name is Rod May and I am the Executive Director of the Northwest Buffalo Community Health Care Center, Inc. (NW BCHCC) with offices at 155 Lawn Ave in Buffalo and 3674 Commerce Dr. in Hamburg. We are extremely grateful and heartened that our State's leaders are reaching out to try to make our health care infrastructure work better for more New Yorkers.

My message to you today will focus on three points:

Coverage matters

The primary care infrastructure matters.

The intersection between the two – coverage and access – is key.

Before addressing the critical issues confronting the Commission, let me first provide some background on Northwest Buffalo Community Health Care Center. Northwest Buffalo is one of 2 community health centers (or FQHCs) in Buffalo and one of 50 in New York with over 400 sites, that serve as “family doctors” for more than one million New York residents. As federally qualified community health centers, we are required to provide comprehensive health services regardless of ability to pay. We must also meet stringent standards designed to break down barriers to care in low-income or medically-underserved communities. We are required to make our services available in the various languages that are prevalent in our community and in a culturally-sensitive manner.

Along with breaking down geographic and cultural barriers to care, we also overcome financial ones. No one is turned away from our health center due to lack of insurance or lack of resources to pay for care. We have an income-based sliding fee scale. If a patient cannot pay the sliding fee, we provide the care. And, we must provide enabling services, such as transportation, eligibility and enrollment assistance, and health education.

In 2006 NW BCHCC provided more than 42,700 health care encounters to more than 9300 individual patients. In addition to primary and preventive medical care, our health center also provides dental, obstetric and gynecological care, low cost pharmacy via our active 340B Program and nutrition services.

Coverage Matters

Reliable, affordable, comprehensive insurance coverage for all New Yorkers is essential to ensure continuity in primary and preventive care as well as coverage for chronic conditions. People who are both poor and uninsured are more likely to delay needed medical care for chronic diseases, less likely to fill a prescription, and more likely to be hospitalized for a condition that could have been avoided with timely health care. Uninsured persons receive less preventive care, are diagnosed at a more advanced stage of illness and, once diagnosed, tend to receive less therapeutic care and have a higher mortality rate. Lack of insurance leads to higher rates of emergency room use, especially for conditions that could have been treated more successfully in a primary care setting.

Coverage matters for health care providers, too. Gaps in insurance coverage affect community health

centers. The extremely low rates paid by commercial insurers to community health presents a significant and growing problem. Inadequate reimbursement for care provided for both uninsured and commercially insured patients is starving the very providers the people of our State rely on to ensure access in underserved areas.

We support universal coverage, including expanding Medicaid, Child Health Plus and Family Health Plus coverage.

We support simplifying eligibility and renewal for public health insurance and recommend an aggressive outreach in the Medicaid, Family Health Plus and Child Health Plus programs; this should include an intensive and expansive facilitated enrollment program.

We support moving forward with the Governor's stated intent to cover all children.

We support expansions of our public health insurance programs that are affordable to low-income New Yorkers. Cost sharing should be minimized for those with very low-income. Co-payments, co-premiums and high deductibles are not the answer for low-income New Yorkers; people need coverage that they can and will use.

The Primary Care Infrastructure Matters

Coverage is necessary but not sufficient. We need to be concerned about a state where everyone is covered, but access to effective primary health care is limited. Primary care is the front end of our health care system and it is a *part* of the solution to covering everyone. It is the form of care that is the singularly least expensive and most effective in preventing expensive emergency room visits and avoidable hospitalizations. Despite the well-known benefits of primary care, New York State's primary care system is uniquely underdeveloped in comparison with its expansive and expensive acute care system. New York ranks 45th among the 50 states in Medicaid spending on primary care, while spending more than any other state on Medicaid overall.

We need to readjust; the more a state spends on its primary care system, the less it spends overall. Investing in our primary care infrastructure will lower costs and improve outcomes. A strong community-based, primary care infrastructure reduces unnecessary hospitalizations and associated costs, improves overall health status and reduces disparities.

There remain large areas of the state with severe shortages of primary health care. Nearly all of western New York has been designated as medically underserved. New York should ensure that all New Yorkers, including those without health insurance, are able to access a primary care home.

The Intersection Between Coverage and Infrastructure is Crucial

Coverage has to be done right if we want better outcomes. Even with the best of intentions, if health care providers are not paid enough to remain financially viable, they will close their doors and we'll all lose. Primary care remains a sector that is seriously under-reimbursed, which has implications for the primary care infrastructure's viability in terms of capital and workforce.

To ensure that health centers are effectively positioned to maximize care, federal law requires state Medicaid programs to pay health centers for the services they provide at a cost-based rate. This federal requirement helps to ensure that health centers do not incur losses when they care for Medicaid patients.

The situation is different when it comes to payments from commercial payers. Some community health centers, including mine, serve a significant number of patients with private/commercial health insurance. We are being hobbled by the extremely low payments we receive when we provide care for commercially insured patients. In an environment where commercial insurance companies negotiate rates with stand-alone providers in underserved communities, health centers accept whatever payments they can get from the commercial plans, rather than turning those patients away. Health centers are put in the untenable situation of choosing to accept a particular insurance plan, despite payments that do not cover the cost of care or telling the patient, who may not have other viable options, that they do not accept that insurance. There is particular irony in this situation, since the primary and preventive care provided at community health centers, even when fully reimbursed, saves money and yields better results in the long run. Yet there is no strong incentive for a commercial plan to cover the costs associated with providing high quality primary care when there is a significant likelihood that the insured person will be covered by another carrier in a few years.

The widening gap between reimbursement rates received from public versus private payers is threatening our ability to serve commercially insured patients, and eats away at the limited public resources intended for the uninsured and other public funds.

New York's community health centers care for growing numbers of uninsured and underinsured patients each year. It makes more sense to provide these patients the high quality primary and preventative care of community health centers rather than to rely on crisis care and emergency rooms. As we continue to work toward universal coverage, the State needs to increase funding for the diagnostic and treatment center (D&TC) indigent care pool. As hospitals reconfigure their services and convert facilities to D&TCs, more facilities will draw from the fixed D&TC pool. This will exacerbate an already intolerable primary care indigent care funding shortfall for primary care providers. We need to ensure the viability of the safety net so that all New Yorkers have access to appropriate care.

As New York designs a new health coverage and access infrastructure which ensures the health care system is affordable and accessible, we also need to address the viability of the people and institutions providing the care. Our system for paying for health care needs to be examined and addressed in a comprehensive way (not just Medicaid) to ensure that payers actually pay the cost of providing care. We look to our policy leaders for comprehensive, all payer reimbursement reform to ensure the stability of our safety net.

I appreciate the opportunity to be heard today. I look forward to continuing to work with you and our policy leaders to improve our ability to deliver high quality health care to all New Yorkers.

Thank you.