**Community Health Care Association of New York State**
**Comments on the**
**New York State Health Innovation Plan**

**December 6, 2013**

## Introduction

There is broad consensus that a community-based health care infrastructure with sufficient high quality primary care at its center is critical to building and sustaining the high-performing, integrated systems of care that will achieve the Triple Aim of better health, better care, and lower costs.
Through this New York State Health Innovation Plan (SHIP), the State builds upon the initiatives developed by the Medicaid Redesign Team, the State's application for an 1115 Medicaid Waiver, and the State's Prevention Agenda and State Health Improvement Plan.

CHCANYS is pleased to provide comments and observations on the New York State Health Innovation Plan (SHIP). The SHIP's Pillars and Enablers closely resemble the framework used by national health policy leaders in the development of the "Access Across America" plan to ready federally qualified health centers (FQHCs) for national health reform in the first several years of the 21st century. FQHCs are designed to be fully integrated patient centered medical homes, with mental health, oral health and health promotion/disease prevention as required components of a comprehensive primary care setting. The provision of service to all, regardless of ability to pay, and demonstrated formal affiliations with specialty and hospital providers to allow "one stop shopping" for health care has been the hallmark of the FQHC model for decades.

Patient empowerment is an important part of the quality improvement approach at FQHCs as chronic disease prevention and management demonstrated the success of this model. The use of practice management technology at FQHCs became prevalent in the early 1990's, predating electronic health record systems by a decade. FQHCs lead the nation in adoption of fully integrated technology systems, and the accreditations and recognitions made possible by those. The move from volume to value is as much a charge at FQHCs as anywhere else; since our delivery systems must be competitive, sustainable, and capable of leading and taking risk, in the larger health system.

The three Enablers of Workforce Strategy, Health Information Strategy, and Performance Measurement and Evaluation are foundational to any effective system wide transformation.

The five Pillars, which form the framework for the SHIP proposal, are both important components of CHCANYS' strategy for growth of primary care capacity in New York State and represent several fundamental long-standing components of the FQHC model of practice. Our comments on SHIP's pillars are as follows:

## Increasing Access to High Quality Primary Care

It is not enough to increase the number of patients with a regular primary care provider, and measuring volume of visits is no longer a legitimate metric without data on health status associated with those services. In April, CHCANYS released "A Plan for Expanding Sustainable Community Health Centers

in New York State,"[1] the first-ever plan for building the capacity of the State's community health center system. The Expansion Plan focuses on how to increase the number of patients that health centers serve. Increasing capacity within FQHCs is critical to ensuring access to care, especially for low-income populations. FQHCs' ability to serve millions of new patients nationwide is one of the Affordable Care Act's (ACA) cornerstone delivery system strategies. In New York, it will be critical to care for the influx of newly insured, as people enroll in the New York State of Health, as well as to ensure a strong safety net for those who remain uninsured. Nationally, the number of people served by FQHCs is expected to reach 30 million annually by 2015. In New York State, FQHCs are expected to double capacity to serve nearly 3 million New Yorkers by 2015.

**Integration of Care is Central to the FQHC Model**

The move from care principles embodied in the NCQA-medical home to the Advanced Primary Care (APC) model is one that we embrace. Notably, FQHC patient volume has grown by 36% in New York City and 31% statewide in the past 5 years. In 2012, 1.6 million New Yorkers received 5.3 million medical visits, over 900,000 dental visits, over 500,000 mental health visits and about 380,000 "enabling services" visits at FQHCs. FQHCs offer a model of patient-centered care that is associated with demonstrated improved outcomes and reduced costs. For example, a recent study showed that Medicaid patients who use FQHCs are about *a third less likely to be hospitalized for preventable conditions*, compared to similar Medicaid patients who rely on other providers.[2] FQHCs are a vanguard of patient-centered medical homes, using technology to develop the best practices necessary to produce high quality primary care programs and services.

**Transparency and Value**

We share the goals of the SHIP in the transparency and value pillars. As we drive system-wide growth to care for more people in primary care locations, these new services must provide value to the patient and the community. FQHCs have led in many communities in their ability to reduce inappropriate and unnecessary ER utilization and hospital admissions. While this quality improvement greatly benefits the patient and the health system overall, rarely do those savings return to the primary care provider.

In 2011, CHCANYS launched the Center for Primary Care Informatics (CPCI), which provides detailed clinical data and advanced analytical support to guide and drive significant improvements in patient access to care, quality of care, patient and population health outcomes, and cost containment. This year, the CPCI is providing data and analytics to health care providers, localities, and the State; targeting scarce resources in the planning and implementation of new primary care services and models of care.

The CPCI has four components: 1) a statewide data warehouse, which integrates data from health center Electronic Health Records and Practice Management systems into a single, centralized and integrated database that provides system users with over 100 measures of clinical quality outcomes to target areas for improvement; 2) an advanced data analytic capacity that provides complex analyses, including those that integrate external databases ( including, potential data from an all-payer data base of the SHIN-NY) with health center data which could support data analysis efforts for non-health-center stakeholders; 3) visit planning and care management tools to support quality improvement at the

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

[2] J. Rothkopf et al. in *Health Affairs*, 2011 (vol 34, #7), reporting a Colorado study.

point of care; and 4) technical assistance to FQHCs to support improved performance and patient outcomes.

**Connecting Health Care with Population Health Improvement in the Community**

FQHCs are well situated to lead on population health initiatives, given their community health origins and community-based locations across the State. FQHCs were founded in 1965 as community health centers with broad community programs and services.[3] The Prevention Agenda provides an excellent partnership opportunity for the organized and standardized development of specific programs and collaborations with Local Health Departments and hospitals in those communities statewide. In many FQHC locations, these partnerships have been developed with schools, community centers, grocery stores, farmers, arts programs, other health system partners, and represent a fundamental commitment of the FQHC model to address the social determinants of health as well as provide high quality, accessible care.

**CHCANYS Comments Specific to Gaps in the SHIP**

**Growth and Sustainability of FQHCs, and Primary Care Capacity in general, in New York State**

The ACA set aside a Health Center Trust Fund and built the Medicaid Expansion across the United States with the goal to increase, by 20 million to 40 million, the number of patients at FQHCs by the end of 2015. In New York State, we have done years of planning and identified areas across the State with high need and sustainability factors. This data and the analysis it makes possible is key to the State's success in building primary care capacity.

In addition to the Medicaid and Public Health Service financing opportunities for the community, an FQHC designation brings with it a set of assets for the community from economic development, to participation in the National Health Services Corps tuition payment and loan repayment programs, professional liability coverage for providers through the Federal Tort Claims Act, participation on the 340B drug pricing program, and other valuable programs. Additionally, in the years since the ACA was signed into law, New York State FQHCs have been awarded $17,282,037 in New Access Point grants – to build the infrastructure of new FQHC capacity across the State. These grants represent ongoing operational funding which will be renewed every year as part of the base grant funding of the community health center funding program (HRSA) nationally.

Some mention of this significant federal-state partnership in reaching stated goals of the SHIP would strengthen the document in ways that would resonate with CMS.

**HIT System Development Should Include FQHCs and the CPCI**

Since 2007, CHCANYS has partnered with New York State, New York City and federal agencies in the transformation of the FQHC network through technology. Specifically, we have worked with all of the FQHCs and Look-alikes in NYS to fully adopt Electronic Health Records, achieve Meaningful Use, and transform nearly all of the FQHCs into NCQA Level 3 Patient Centered Medical Homes. All of these practices have advanced care coordination and population health

[3] Hawkins, D. and Groves, D. "The Future Role of Community Health Centers in a Changing Health Care Landscape," in Journal of Ambulatory Care Management, January-March 2011.

capacities. In 2012, we launched a statewide Health Center Controlled Network with ambitious clinical quality improvement goals through a bold HRSA strategic partnership tied to the ACA. We also have a significant program in partnership with the State and CDC to improve cancer screening rates in the poorest communities across New York – using the CPCI.

While the SHIP proposes that the State manage all of the change surrounding HIT development and deployment, we are concerned this approach may ignore community-level needs as well as data and analytics developed specifically to meet those needs. We encourage the State to consult with local data initiatives and consider incorporating some of the tools that have been developed.

We are also concerned that, due to cost, many FQHCs are still not interfaced to a RHIO. If the State envisions a large part of its data initiatives linked to the SHIN-NY, these critical primary care providers will be excluded unless efforts to simplify and fund these interfaces are successful.

Finally, **CHCANYS would like to be part of the Provider Steering Group**. One small but important omission in the SHIP occurs on Page 150, where the proposal to create a Provider Steering Group that would specifically include ACP, GNYHA, HANYS, HHC, MSSNY, and NYSNA . . . but no mention of CHCANYS.

**About CHCANYS**

CHCANYS is New York State's Primary Care Association, designated by the Health Services Resources Administration, through which a set of services and resources are provided. CHCANYS represents, and provides technical assistance and training to, a large primary care provider network across the State. All of the FQHCs and Look-alikes are part of this network. We also have as members organizations interested in becoming FQHCs and many of our stakeholder partners across the State.

Founded 40 years ago, CHCANYS' mission 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 by leading providers of primary health care in New York State. CHCANYS works closely with more than 60 FQHCs that operate approximately 600 sites across the state. These community health centers are not-for-profit, patient-centered medical homes located in medically underserved areas. They provide high quality, cost-effective primary health care to anyone seeking care, regardless of the patients' insurance status or ability to pay.

Health centers serve 1.6 million New Yorkers annually and are central to New York's health care safety net. The model of care provided by FQHCs is comprehensive and includes medical, dental, and behavioral health care, as well as care coordination and care management for a historically underserved patient population. FQHCs serve low-income patients, two-thirds are below the poverty level; one-fifth are best served in a language other than English; three-fourths are racial and ethnic minorities; one-quarter are uninsured; nearly 100,000 FQHC patients are homeless and a similar number are elderly. FQHCs provide a model of care, which is integrated with affiliated specialty and hospital partners in communities all over New York State.

Please contact Elizabeth Swain for additional information at eswain@chcanys.org or 212-710-3802.