New York State Department of Health
Medicaid Incentive Payment System (MIPS)
External Stakeholder Feedback

Community Health Care Association of New York State

(CHCANYS)

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New York State Department of Health

99 Washington Avenue

Albany, New York

Introduction

The American Recovery and Reinvestment Act (ARRA), signed into law on February 17, 2009, by President Obama, provided billions of dollars to states to implement Electronic Health Record (EHR) technologies. Administered through the U.S. Department of Health and Human Services' (DHHS) Center for Medicare and Medicaid Services (CMS), the Provider Incentive Payment Program provides incentive payments to eligible Medicaid and Medicare providers and hospitals to achieve "meaningful use" of EHR technologies. To inform and clarify the incentive payment program to the Medicaid provider community, the New York State Department of Health (DOH), Office of Health Insurance Programs (OHIP) provided more than thirty (30) presentations to stakeholder groups from throughout New York State. A number of stakeholder groups, in response, offered comment on the incentive program.

This document represents a summary of comments from the Community Health Care Association of New York State. CHCANYS is the advocacy group for Community Health Centers (CHCs) in New York State. In attendance were:

New York State Department of Health – Office of Health Insurance Programs

James J. Figge, M.D., M.B.A., Chair Medical Director
Phyllis Johnson, HIT Policy Coordinator

New York State Department of Health – Office of Health Information Technology Transformation (OHITT)

Roberto Martinez, MD, Medical Director

Community Health Care Association of New York State

Kate Breslin, Director of Policy
Lisa Perry, Program Director – IT Special Projects
Sandy Worden, Director of IT

New York State Technology Enterprise Corporation (Program Consultants)

Donna O'Leary, PMP, Program Consultant
Peter Poleto, Business Architect

New York State Community Health Centers – Overview

New York State is home to 59 Federally Qualified Health Centers (FQHCs), commonly referred to as Community Health Centers or CHCs. FQHC is a designation by the Health Resources and Services Administration (HRSA), which allows FQHCs to receive grant funding to provide medical care to medically underserved individuals. CHCs provide medical care at more than 400 sites in urban, suburban, and rural settings throughout New York State. CHCs provide comprehensive services including primary care, OB/GYN, pediatric, geriatric, mental health, wellness, radiology, laboratory services, dental and other services. The Community Health Care Association of New York State (CHCANYS) is the advocacy group for CHCs in New York State.

Summary Overview

- Electronic Health Record implementation for CHCs began in 2005.
- Of 445 community health locations, more than half now maintain electronic health records - another 20% have implementation in progress.
- Nine health centers in Brooklyn are coming live with their Regional Health Information Organization (RHIO).
- CHCs participate in both upstate and New York City Regional Health Information Technology Extension Centers (RHITECs).
- CHCANYS has been aggressively seeking grant funding from the Primary Care Development Corps, the Altman Foundation, and the New York State Health Foundation.

Physician Assistants as Eligible Providers

Currently, the proposed ruling from the Center for Medicaid Services does not include Physician Assistants (PAs). With nearly 140 PAs practicing in CHCs throughout New York State, CHCANYS believes it was Congress's intent to include PAs.

Meaningful Use Disconnect

Current meaningful use measures, still being defined by the Center for Medicaid Services, propose that patient interactions be reported based on individual provider, not the total aggregate of care provided to Medicaid members. This proposed process will be burdensome to CHCs and will likely reduce proper and fair funding levels. Medical care in CHCs is often provided by multiple care givers, including physicians, physician assistants, nurse practitioners, and other specialists, such as pediatricians or gynecologists. Individual care givers may not see patients at the 30% level required for funding, while others may be at far higher percentage. Because of the community it serves, an entire CHC taken in aggregate will surely have a 30% Medicaid case load.

Clinical Decision Support Rules

Regarding meaningful use, CMS is requiring each provider to make no fewer than five clinical decisions in the first year of use through EHR. With multiple providers in CHCs, tracking this is very burdensome, and CHCANYS believes that using an aggregate tracking figure would achieve the same result and would not place undue hardship on the CHC.

Payment Mechanism

Medicaid incentive payments will be distributed in two fundamental ways. The first is directly to providers. Providers can keep the incentive payments or assign the funds over to their practice. The second method will be payments made directly to a hospital. Community Health Centers fall into the former method. However, the nature of care and operations (multiple providers, varied services) mean that some CHCs operate more like a hospital than a medical practice. CHCANYS believes this is an area for consideration and requests that CMS consider allowing some CHCs to receive incentive payments in a model similar to hospitals.

Further, CHCANYS has commented to CMS that incentive payments should not be offset by other funding sources, such as HRSA grants.

Security Risk Analysis

CHCANYS has identified the need for a clear definition for security standards and practices.