Are SBHCs Becoming Patient-Centered Medical Home Recognized?

March 7, 2014

School-Based Health Centers and the Changing Face of Health Care

Health Reform Legislation & SBHCs

2009 The Children's Health Insurance Program Reauthorization Act (CHIPRA)

2009 Health Information Technology for Economic and Clinical Health Act (HITECH)

2010 The Patient Protection and Affordable Care Act (ACA)

Affordable Care Act

GOAL:
Increase Access to Quality Health Care While Reducing Overall Costs

PROCESS & COVERAGE IMPROVEMENTS (PROVIDERS & STATES)
Health Information Exchange
Data reporting requirements

PROCESS & COVERAGE IMPROVEMENTS (CONSUMERS)
Medicaid Expansion
Health Insurance Marketplace

DELIVERY SYSTEM REFORM
Patient-Centered Medical Home (PCMH)
Accountable Care Organizations (ACOs)

Adapted from a presentation given by Cindy Mann, Center for Medicaid and CHIP Services at the Health Action 2013 Conference in Washington, D.C.

Patient-Centered Medical Home (PCMH) – The building blocks for most reforms

The medical home is an approach to providing coordinated and high quality health care that is accessible, culturally competent, comprehensive, and uniquely suited to each patient.

– American Academy of Pediatrics

PCMH Components	SBHCs as Medical Home
Access	• SBHCs are located in the most accessible location for young people: their schools.
Care Coordination & Management	• SBHCs utilize an interdisciplinary team approach to deliver coordinated primary care.
Comprehensive Services	• SBHCs effectively provide behavioral, medical and oral health services.

PCMH Components	SBHCs as Medical Home
Clinical Quality Measures	• SBHCs are engaged in quality improvement activities
Patient & Family Engagement	• Youth and parents are active members in the SBHC community
Community-based	• SBHCs are an integral part of their community

School-Based Health Centers and the Patient-Centered Medical Home

Background/Purpose

State Medicaid PCMH Programs

School-Based Health Alliance examined the role of SBHCs in state Medicaid PCMH programs

Case Study Inclusion Criteria:

- ✓State has an SBHC program
- ✓State has at least 40 SBHCs
- ✓PCMH program led by the state Medicaid agency
- ✓Payment incentives tied to PCMH status
- ✓State PCMH legislation/regulation defines SBHCs as an eligible provider

Case Study in 5 States

Colorado
Connecticut
Illinois
North Carolina
Oregon

Policies & Legislation

Informant Interviews

Findings

PCMH Program Part of Medicaid System Reform

Primary Care Case Management

Accountable Care Organizations

Enhanced Fee For Service

State Medicaid PCMH Standards

	State Developed	The Joint Commission	NCQA Measuring quality. Improving health care.
Colorado	✓		
Connecticut		✓	✓
Illinois	✓		
North Carolina	✓		
Oregon	✓		

Medical Home Standards Shared Principals

Access

Usual Source of Care

Primary Care

Prevention

Care Coordination Continuity

Data Tracking & Reporting

Year Round 24/7 Access

Enhanced Payment Tied to PCMH Recognition

1. Per Member Per Month Care (PMPM) Payment to Providers
   - Support care coordination services
2. Enhanced FFS Rates
   - Reward primary care and/or maternal & child health services
3. Pay for Performance (P4P)
   - Reward quality performance

Medicaid PCMH Payment Models

State	PMPM	Enhanced FFS Rate	P4P
Connecticut		✓	✓
Colorado	✓		✓
Illinois	✓	✓	✓
North Carolina	✓		
Oregon	Contingent upon contract agreements between the ACOs and PCMH recognized providers		

SBHC Capacity to Becoming a Medical Home

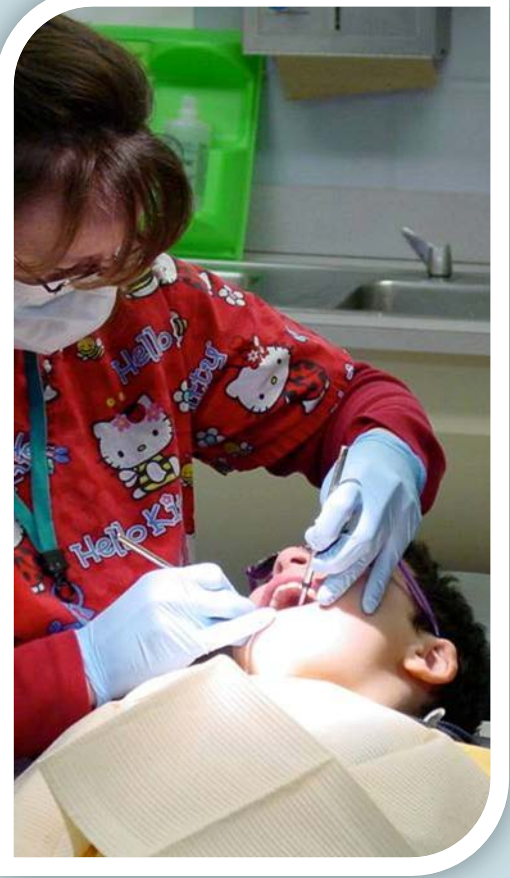
Potential Challenges for PCMH Participation

- Ensuring 24/7 access
- Tracking & reporting quality measures
- Patient attribution

Ensuring 24/7 Access to Care

COMMON ASSUMPTION ABOUT SBHCS:

SBHC closed during non-school hours & summer months

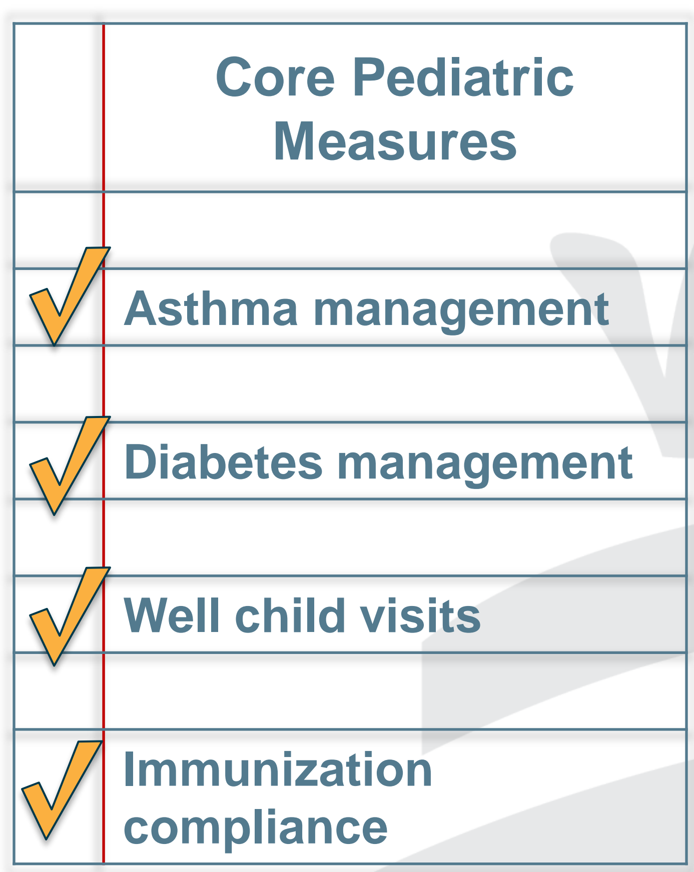
> 31 HOURS/WEEK	AFTER SCHOOL	BEFORE SCHOOL
66.6%	73.1%	60.8%
		
(n=1295)	(n=1284)	(n=1285)

70.6% have a pre-arranged source of after-hours care

(n=1295)

Data Tracking & Reporting

- Collecting at least 2 quality measures is a must
- More challenging for SBHCs w/o an electronic health record (EHR)



Nationally: SBHCs are Tracking Quality Measures

41.1%

Joint Commission
(n=1240)

40.1%

CHIPRA/Medicaid Measures
(n=1240)

37.2%

Healthcare Effectiveness Data and Information Set (HEDIS) measures (n=1240)

29.2%

NCQA Patient-centered medical home standards (n=1240)

Nationally: SBHCs use EHRs

52.7%

Use Electronic Health or Medical Records (EHR/EMR) (n =1087)

Patient Attribution

- How a patient relates to a provider
- Medicaid claims data used to determine "designated primary care provider"

PCMH Payment Tied to Location of Service

- Was the service provided at the SBHC or at the sponsoring agency site?
- Medicaid claims data must **identify SBHCs as site of service**

Potential Solutions:

- ✓ Bill & code with locator code
- ✓ SBHC as Medicaid provider type

Are SBHCs Becoming Medical Homes?

CONNECTICUT:
Person Centered Medical Home Program

CT PCMH Recognition Options

Components	Joint Commission	NCQA
PCMH program Name	Primary Care Medical Home	Patient-Centered Medical Home
Levels of recognition	Equivalent to NCQA level 3	Yes: 1, 2, 3
Documentation required	No	Yes
On-site survey process	Yes	No
On-site consultation	Yes	No
Scope of evaluation	Entire organization	Site specific (multi-site available)
Length of reward	3 years	3 years
Website	www.jointcommission.org	www.ncqa.org

Adapted from Joint Commission:
http://www.jointcommission.org/the_joint_commission_and_ncqa_a_comparison_of_requirements/

Enhanced FFS Payment Rates

Clinic Type	PCMH Payment Amount	
	NCQA Level 2 (intermediate)	NCQA Level 3 (advanced)
Non-Federally Qualified Health Center (FQHC)	20% increase in primary care codes	24% increase in primary care codes
FQHC	$7.77 fixed add-on	$9.07 fixed add-on
Hospital Out-patient	$7.77 fixed add-on	$9.07 fixed add-on

Source: Husky Health PCMH Reimbursement Summary
http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Reimbursement_Summary.pdf

Performance Bonuses

PCMH practices awarded performance bonuses based on achievement of quality benchmarks & ability to demonstrate quality improvement over the previous year's performance

Retrospective PMPM lump sum payment

No Cost PCMH Technical Assistance

Community Transformation Specialists

- Provide assistance to medical home providers in identifying and managing high-risk patients
- Offer training and technical assistance to support care coordination and to address any gaps of care

Glide Path Program

Offers financial and technical support for practices ***transforming*** their delivery of services to meet PCMH standards

Clinic Type	**Glide Path Payment**	
	Lump Sum Start Up Costs	PCMH Payment Amount
Non-Federally Qualified Health Centers	Amount contingent on CMS approval	14% increase in primary care codes
Hospital Out-patient	--	$5.18 fixed add-on

Source: Husky Health PCMH Reimbursement Summary
http://www.huskyhealthct.org/pathways_pcmh/pcmh_postings/PCMH_Reimbursement_Summary.pdf

SBHC Participation in PCMH Program

Not Participating (59%)

Participating (41%)

All participating SBHCs are sponsored by a Federally Qualified Health Center

OREGON:
Person Centered Primary Care Home Program

State-Developed PCMH Standards

Continuity	Coordination & integration	Person & family centered
Access	Accountability	Comprehensive whole-person care

Person Centered Primary Care Home Payment

Negotiated between ACO and PCMH recognized provider

PCMH payment structure may vary by ACO

PCMH Technical Assistance

Patient-Centered Primary Care Institute

- Tools & resources to implement medical home model
- Behavioral health integration training
- Learning collaborative
- Technical assistance
    - practice coaches, program managers and data/quality improvement professionals

SBHC Participation in PCMH Program

Not PCMH Recognized (57%)

PCMH Recognized (49%)

66% Of PCMH recognized SBHCs received Tier 2 status

34% Of PCMH recognized SBHCs received Tier 3 status

Key Take-Away Points

1. SBHCs are achieving PCMH status
2. Issues meeting PCMH criteria no different than those faced by smaller private practices
3. PCMH programs are evolving
4. Advocates and state SBHC program played critical role in ensuring SBHC eligibility and participation in PCMH program

Are SBHCs benefiting?

Dependent on SBHC billing practices & relationship with sponsoring agency

…only time will tell…

Medicaid is Heading in New Directions

Accountability

Tracking Quality Indicators
(Immunization, well child visits, asthma management)

Site-specific billing & coding

Care Coordination

Sharing encounter data with primary care partners

Referral tracking

Cost-Effective Care

Demonstrating better health outcomes at lower costs

Thank you!

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