

July 30, 2014

Via Email

Dear Sexually Transmitted Diseases (STD) Controllers, Communicable Disease Controllers, and Other Community Partners:

Welcome to STD Control Branch Health Reform eUpdate #6. In this issue, we discuss **I) Federally Qualified Health Centers and Patient Centered Medical Homes**; and **II) Updates on Previous Editions of STDCB eUpdate.**

I. Federally Qualified Health Centers and Patient Centered Medical Homes

This issue addresses five key questions:

1. **What are federally qualified health centers (FQHCs) and who do they serve?**
2. **What is the role of FQHCs in health care reform implementation?**
3. **What is a patient-centered medical home (PCMH) or health home?**
4. **What is the role of health homes in ACA implementation?**
5. **How can local health departments (LHDs) and community-based organizations (CBOs) partner with FQHCs and health homes?**

1. What are federally qualified health centers (FQHCs) and who do they serve?

FQHCs are organizations that provide comprehensive primary care to underserved populations. Services are provided to all, with fee adjustments based on ability to pay. FQHCs are governed by a community board composed of a majority (≥51%) of health center patients. FQHCs receive federal grant funding and must meet federal reporting requirements. Other clinics, known as “look-alikes,” are not federally funded but are certified as health centers by the U.S. Department of Health and Human Services (HHS) and receive some of the benefits (such as 340B drug purchasing discounts) afforded to FQHCs. There are also some non-FQHC health centers operated by tribal organizations or urban Indian organizations. For more information on FQHCs, visit <http://www.bphc.hrsa.gov/about/index.html>.

In 2012, the 121 FQHCs in California served 3,261,720 patients. More than three-quarters (77%) of these patients had incomes below 100% of the federal poverty level and most were on Medi-Cal (44%) or uninsured (41%). Nearly two-thirds (62%) of FQHC patients were Latino; 9% were African-American; 8% Asian/Pacific Islander; 1% American Indian/Alaska Native; and one-third were children. Two-thirds of FQHC patients aged 15-64 were female. According to the HHS Uniform Data System (UDS), FQHCs in California served more than 14,500 patients with a diagnosis of HIV in 2012; 22,000 patients with a hepatitis C diagnosis; 12,000 with an STD diagnosis; 4,000 with a hepatitis B diagnosis, and 3,800 with a tuberculosis diagnosis. For more California-specific UDS data, visit <http://www.bphc.hrsa.gov/healthcenterdatastatistics/index.html>.

2. What is the role of FQHCs in health care reform implementation?

The Affordable Care Act (ACA) invested \$11 billion to increase the capacity of FQHCs to serve the large number of persons who would become newly insured through coverage expansion. ACA highlighted FQHCs as playing an essential role in serving newly insured individuals because of the health centers' history of serving geographically, culturally, and linguistically diverse and low-income communities, through a multidisciplinary, team-based and coordinated approach to primary care and preventive services. Federal funds were directed to create new FQHC sites; support FQHC operations, construction and renovation projects at existing sites; expand primary and preventive health services; and support health center-based medical residencies. ACA also required health plans sold through state health benefit exchanges (such as Covered California) to contract with FQHCs, and to reimburse FQHCs at the same or better rate that FQHCs receive from Medicaid. For more information on the FQHCs and health care reform, visit <http://www.bphc.hrsa.gov/about/healthcenterfactsheet.pdf>.

3. What is a patient-centered medical home (PCMH) or health home?

A primary care medical home--also referred to as a patient-centered medical home or a health home--is a promising model for transforming the delivery of primary care. As defined by the Agency for Healthcare Research and Quality (AHRQ), the PCMH encompasses five core functions and attributes:

- *Comprehensive care* (team-based)
- *Patient-centered* (oriented to the whole person)
- *Coordinated care* (facilitates communication/transitions among providers)
- *Accessible services* (24/7 phone/email access; evening/weekend hours)
- *Quality and safety* (evidence based, quality improvement)

Health care providers can apply to be recognized as a PCMH through accrediting agencies (such as the National Committee for Quality Assurance (NCQA) (www.ncqa.org)) and the Joint Commission (www.jointcommission.org)¹ by meeting specific PCMH standards, which can be accessed on the NCQA website.² PCMH standards include important provisions of interest to public health, such as requirements to demonstrate performance measurement and quality improvement in areas such as immunization, preventive care, chronic care, and health disparities. The PCMH standards also reinforce ACA's emphasis on health information technology by requiring PCMHs to demonstrate their capacity for electronic reporting to public health, including cancer and immunization registries. In 2012, one-third of California FQHCs were certified as PCMHs, and more have likely been certified since that time. Provider groups, hospitals, and clinics in California are also pursuing PCMH recognition, often with the support of federal agencies (such as HHS), foundation grants (such as from the California Endowment) and technical assistance from PCMH-certifying organizations. For more information on PCMHs, visit <http://pcmh.ahrq.gov/>.

¹ <http://www.jointcommission.org/accreditation/pchi.aspx>

² <http://store.ncqa.org/index.php/recognition/patient-centered-medical-home-pcmh/2014-pcmh-standards-and-guidelines-epub-single-user.html>

4. What is the role of health homes in ACA implementation in California?

Health homes will play a central role in achieving the “Triple Aim”³ of health care reform: 1) Improving the patient experience of care, 2) Improving the health of populations, and 3) Reducing health care costs. ACA authorizes state Medicaid programs to establish health home models to achieve the “triple aim” for people with: a) two or more chronic conditions; b) one chronic condition and risk for another chronic condition; or c) one serious and persistent mental health condition. States establishing Medicaid health homes will receive temporary federal funding increases. ACA (Section 2703) lists specific chronic conditions as qualifying for inclusion in a health home, such as mental health, substance abuse, asthma, diabetes, and heart disease. However, additional chronic conditions, such as HIV and viral hepatitis, may be considered by the Centers for Medicaid and Medicare Services (CMS) for approval. For more information on Medicaid health homes, visit the CMS, Medicaid website (www.Medicaid.gov).⁴

The California Department of Health Care Services (DHCS), which oversees Medi-Cal, is currently assessing the feasibility of developing health homes. In 2014, DHCS will share their assessment and begin gathering stakeholder input, which may be followed by developing and submitting a Medicaid State Plan Amendment to request permission from CMS to carry out a health homes pilot. To get DHCS updates on opportunities to provide input, sign up for the DHCS stakeholder listserv at <http://www.dhcs.ca.gov/Pages/DHCSListServ.aspx>. DHCS is also coordinating with the California Health and Human Services Agency (CHHS), California State Innovations Model (CalSIM) planning process. The CalSIM plan describes California’s vision for transforming its health care delivery and payment systems to realize the triple aim, including through health homes. Of potential interest to community-based organizations is a CalSIM white paper exploring potential models for funding the efforts of community health workers, which is available at the CHHS website (www.chhs.ca.gov).⁵ For more information on the CalSIM plan, visit: <http://www.chhs.ca.gov/pages/pritab.aspx>.

5. How can local health departments (LHDs) and community-based organizations (CBOs) partner with FQHCs and health homes?

- Find the FQHCs and PCMH-certified providers in your area. For a list of FQHCs in California, visit <http://findahealthcenter.hrsa.gov/>. To search a database of providers recognized as patient-centered medical homes by NCQA, visit <http://recognition.ncqa.org/>. To find a list of organizations certified by the Joint Commission as of June 2014, visit the Joint Commission website (http://www.jointcommission.org/assets/1/6/PCMH_org_list.pdf).⁶

³ <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>

⁴ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>

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[http://www.chhs.ca.gov/Documents/Issue%20Brief%20on%20Leveraging%20Community%20Health%20Workers%20Under%20California%27s%20State%20Innovation%20Model%20\(SIM\)%20Initiative.pdf](http://www.chhs.ca.gov/Documents/Issue%20Brief%20on%20Leveraging%20Community%20Health%20Workers%20Under%20California%27s%20State%20Innovation%20Model%20(SIM)%20Initiative.pdf)

⁶ http://www.jointcommission.org/assets/1/6/PCMH_org_list.pdf

- Learn more about the providers in your area and the services they offer. Introduce your organization, set up a call, arrange a site visit, and share information about your LHD or CBO's services, expertise, and personnel.
- Identify and formalize areas for collaboration. For example, LHDs can train providers in HIV, STD, tuberculosis, and viral hepatitis prevention; in screening, diagnosis, and linkage to care; and in helping providers meet their PCMH quality improvement and public health reporting requirements. CBOs can train providers on serving hard-to-reach populations, such as injection drug users; and providers can help enroll clients in coverage and primary care. Partnering organizations can also identify ways to share their expertise while preserving important public health and community-based infrastructure, and identify potential models for reimbursement.
- For a fact sheet on *Partnerships between Federally Qualified Health Centers and Local Health Departments for Engaging in the Development of a Community-Based System of Care*, visit the National Association of Community Health Centers website (www.nachc.com).⁷ For more information from the U.S. Centers for Disease Control and Prevention (CDC) on *Prevention of HIV/AIDS, Viral Hepatitis, STDs, and TB Through Health Care*, visit <http://www.cdc.gov/nchstp/PreventionThroughHealthCare/Index.htm>.

II. Updates on Previous Editions of STDCB eUpdate

Essential Community Providers

In Issue 3 (August 2013), we reported that Covered California did not consider sexually transmitted disease (STD) clinics to be Essential Community Providers (ECPs), which are providers that serve predominantly low-income, medically underserved individuals. This distinction was significant because health plans are required to contract with at least 15% of the ECPs throughout each county in their geographic coverage area.

Update: Covered California has changed its policy: all 340(B) providers are now considered ECPs, as are other service providers serving predominantly low-income, medically underserved individuals. Notably, STD and tuberculosis clinics are now included in the definition of ECPs for California. To read the updated policy, visit the Covered California Board website (<http://board.coveredca.com>).⁸

Preventive Services – HBV Screening

In Issue 4 (November 2013), we presented a table comparing the preventive services recommended by the Centers for Disease Control and Prevention (CDC) with those rated “A” or “B” by the U.S. Preventive Services Task Force (USPSTF). This information was significant because federal law requires most health plans to cover preventive services rated “A” or “B” by USPSTF without any patient cost-sharing (such as co-pays).

⁷ http://iweb.nachc.com/Purchase/ProductDetail.aspx?Product_code=ST_PART_10

⁸ <http://board.coveredca.com/meetings/2014/1-23/PDFs/2015%20New%20Entrant%20Application%20%28Redline%29.pdf>

Update: In June 2014, the USPSTF issued a final “B” rating for hepatitis B virus (HBV) screening of persons at risk. USPSTF now recommends HBV screening for:

- People born in areas with an HBV prevalence of 2% or more, including Africa, Asia, the Middle East, Eastern Europe, and parts of South America;
- HIV-positive patients;
- Injection-drug users;
- Men who have sex with men; and
- Household contacts of HBV-infected patients.

This new recommendation replaced the task force’s 2004 “D” rating of HBV screening for non-pregnant women and other persons at risk for HBV. It did not change the USPSTF rating endorsing HBV screening for pregnant women, which still stands. To view the full recommendation, visit the USPSTF website (<http://www.uspreventiveservicestaskforce.org/uspstf/uspshepb.htm>). For a plain language fact sheet on the HBV screening recommendations, visit <http://www.uspreventiveservicestaskforce.org/uspstf12/hepb/hepbrectfact.pdf>.

Preventive Services -- Hepatitis C Virus (HCV) Screening

Update: In June 2014, Medicare issued a national coverage determination letter endorsing Medicare coverage for screening persons at risk for hepatitis C virus (HCV) by an eligible Medicare primary care provider. Screening will now be covered for Medicare beneficiaries in the following populations:

- Persons who were born from 1945 through 1965 (one-time)
- Persons who have a history of receiving a blood transfusion prior to 1992
- Persons with a current or past history of illicit injection drug use (repeat screening is covered annually only for persons with ongoing injection risk).

To view the complete decision memo on HCV screening, visit the CMS website (www.cms.hhs.gov).⁹

For more information and if you have questions or suggestions for future topics of the STDCB Health Reform eUpdate, please contact:

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⁹ <http://cms.hhs.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=272&NcaName=Screening+for+Hepatitis+C+Virus+%28HCV%29+in+Adults&bc=AoAAAAAAgAAAA%3d%3d&>