Paying for Care Differently: Where Do Oregon SBHCs Fit in the Alternative Payment Methodology Landscape?

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Potential Payment Mechanisms for SBHCs

Low Risk / Low Reward

- Fee-For-Service
  - Traditionally billable encounters
- Non-traditional encounters (care coordination, parent engagement, health education)

High Risk / High Reward

- Partial Capitation
  - Per Member Per Month Payment (PMPM)
  - All inclusive or for primary care (or mental/behavioral health) only
- Pay For Performance (P4P)
  - Shared savings
  - Based on quality, outcomes, metrics
  - Global budgets

Low Risk / High Reward

- Fee-mention
- Non-traditional encounters (care coordination, parent engagement, health education)

High Risk / Low Reward

- Fee-for-service revenue
- Partial capitation
- Pay-for-performance revenue

Designing a successful APM for SBHCs requires an understanding of how existing payment arrangements support the array of primary care and preventive services (often non-billable) that SBHCs provide. The payment strategies listed above can be used alone or in combination to support the reimbursement of SBHC care.

**Oregon’s APM Medicaid Pilot**

Oregon has engaged in a massive health care experiment with its Medicaid population that is testing on being able to dramatically reduce Medicaid costs. Oregon’s strategy focuses on delivering comprehensive primary, mental and dental health care through SBHCs. Regional Coordinated Care Organizations (CCOs), tying them substantial flexibility in providing continuous care and service delivery and handling their accountable to set 17 initiative Measures emphasizing quality, evidence based primary care prevention.

One element of Oregon’s reform effort has focused on overhauling payment strategies in Federally Qualified Health Centers. Beginning in March 2013, Oregon began implementing a rolling Alternative Payment Methodology (APM) pilot for select FQHCs that aligns with health-care transformation objectives to move away from fee-for-service, and focuses on prevention and primary care. The pilot changes the way FQHCs are paid using a Per Member Per Month (PMPM) formula instead of the traditional encounter-based fee-for-service prospective payment system (PSPS). See also:

- Improving declines in revenue
- Increasing satisfaction of patients and physicians
- Improving access to care and health care outcomes

The State created a methodology to develop systems of “assigned patients” for each FQHC based on an 18-month utilization history. A PMPM rate was determined for each participating FQHC (including their respective SBHCs), and then revised based on the encounter history of these assigned patients. Rather than setting the PPS rate for each encounter, clinicians began receiving PMPM for each assigned patient without incurring medical or other service costs. Participation in the pilot is optional. Clinics are assured that they bear no downside risk. The State compares APM payments to what the clinic would have received under the traditional fee-for-service. If APM payments are less, the State reimburses clinics for the difference.

As of March 2013, 23 of Oregon’s 40 certified SBHCs are participating in this pilot. In the early stages of the pilot, discussions centered on whether SBHCs should be paid to bill for fee-for-service and the PMPM rates are they are paid in because of the difficulty in separating out SBHC claims; and that SBHCs do in fact provide the types of essential primary care services that are being encouraged in this pilot.

**Introduction**

In 2012, Oregon had 84 Federally Qualified Health Centers (FQHCs) and was slow to undertake the planning process. Oregon SBHCs provide an important, patient-driven service model for the delivery of primary care and preventive services to all youth, regardless of insurance status and ability to pay. Because SBHCs are not yet integrated part of the delivery system in young people in several communities, they are impacted heavily by rural- and state-level health care access barriers. As evidence for the SBHC model, SBHCs are such an integral part of the delivery system to young people in select clinics, access point/acute care)?

SBHC Readiness Assessment: So You Want to Consider an APM…

For policy makers and administrators who want to begin thinking about payment reform for SBHCs, there are some questions to consider:

1. Can SBHCs claim the value of care they provide on a service level and allocate their costs to those clients who are paying for services?
2. What is the insurance mix of current SBHC clients? If an SBHC serves 40% Medicaid, do they have a Medicaid CoPACs that cover these clients when thinking about payment strategies.
3. How are SBHCs currently contracting with payors? Contract details around the actual and potential impact of changing payment strategies.
4. Why APMs for SBHCs?

SBHC Readiness Assessment: So You Want to Consider an APM…

The Current Landscape for Oregon SBHCs

During the 2013-14 school year, Oregon SBHCs saw 23,707 clients in 70,656 visits. Visits by OHP (Medicaid) enrollees represent 51% of total visits, with 40% of visits paid for by payers that are not enrolled in OHP at some point during the year. But for some reason (non-billable service, protecting visits. Visits by OHP (Medicaid) enrollees represented 51% of total visits, with some reason to continue providing accessible preventive and acute care to school-aged youth. SBHCs are such an integral part of the delivery system to young people in select clinics, access point/acute care)?

The Path Forward: SBHCs Exploring Other APMs

In 2014, the Oregon State Baker’s slate of initiatives included $720,000 from the Oregon Legislature to issue grants to SBHCs and their local Coordinated Care Organizations (CCOs) in order to improve care coordination and the effectiveness of the delivery of health care services to Medicaid-eligible SBHC clients. One of the grants awarded was to Multnomah County (Portland) to convene a collaborative Alternative Payment Improvement Plan (APIP) workgroup comprised of local CCOs and other local county SBHC representatives to lay the foundation for potential APMs for the SBHC model.

The workgroup is focusing on two distinct goals. (1) Clearly defining the uniqueness of the SBHC model in terms of the services and supports it offers that are generally not found in traditional clinics. These services and supports have been defined in terms of both billable and non-billable services — what do SBHCs bring to the table that is unique and of value? (2) Understanding the SBHC patient population in the context of the larger Medicaid System. The workgroup is in the process of pursuing an analysis of Medicaid data that would illuminate how SBHC services compare to other Medicaid providers for SBHC clients. Do SBHC “high utilizers” tend to also have high utilization in the rest of the Medicaid system? Are SBHCs more or less likely to be providing particular types of services (e.g., visits, reproductive health care, mental health, acute care, etc.) than other primary care settings that their patients access? How does payment differ in the SBHC versus non-SBHC setting? As work in each of these two areas evolves, the goal is to have a clearer sense of whether the current payment strategies are successful and appropriate for the care that SBHCs provide, and whether alternate payment strategies might be piloted.