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

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Low Risk / Low Reward — **Potential Payment Mechanisms for SBHCs** — **High Risk / High Reward**

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

Partial Capitation
- Per Member Per Month payment (PMPM)
- All-inclusive or for primary care (or mental/dental health) only

Pay For Performance (P4P)
- Shared savings
- Based on quality, outcomes, metrics
- Global budgets

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.

Introduction

In 2014-15, Oregon had 68 certified SBHCs in 20 counties, and 9 sites undergoing the planning process. Oregon SBHCs provide an important, patient-centered access model for the delivery of preventive and acute health care services to all youth, regardless of insurance status and ability to pay. Because SBHCs are such an integral part of the delivery system to young people in select communities, they are impacted heavily by national- and state-level health care transformation implementation. Payment reform is a substantial component of this transformation and SBHCs, given their uniqueness as a model, are wrestling with the actual and potential impact of changing payment strategies.

Why APMs for SBHCs?

Passage of the 2012 Affordable Care Act was based, in part, on the widespread recognition that health care costs are increasing at an unsustainable rate. Implementation of the ACA has forced a fundamental shift in how health care service delivery is conceptualized and valued. For primary care in particular, fee-for-service payment is being phased out in favor of payment strategies that emphasize quality and flexibility over quantity. School-Based Health Centers provide exactly the kind of preventive primary care that is being emphasized and valued in health reform. SBHCs are also heavily dependent on fee-for-service payment mechanisms. There is a great need to investigate and demonstrate what systems of payment reform will support the SBHC model and allow SBHCs to continue providing accessible preventive and acute care to school-aged youth.

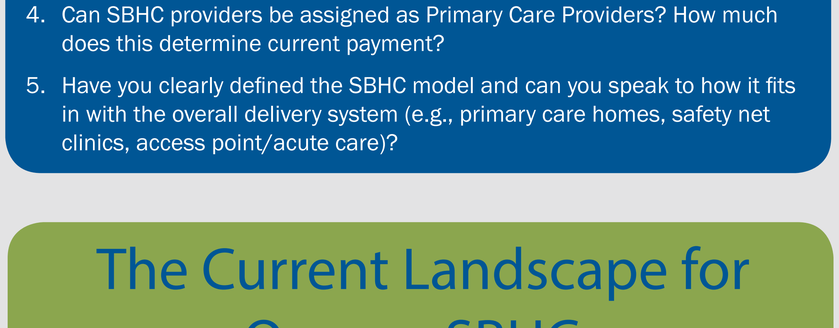
SBHC Readiness Assessment: So You Want to Consider an APM...

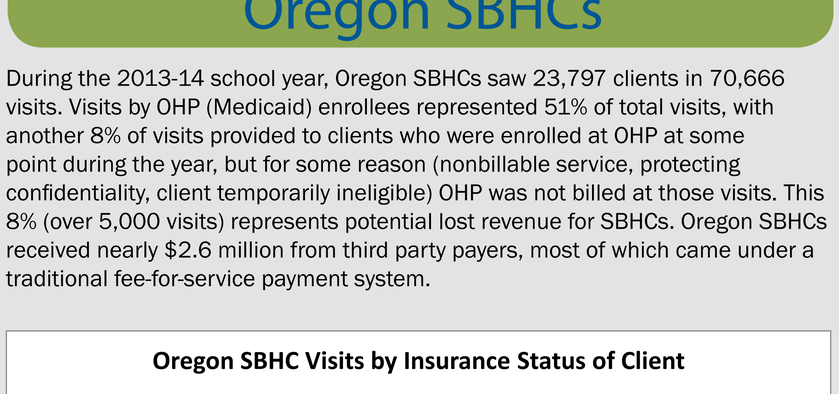
For policy makers and administrators who want to begin thinking about payment reform for SBHCs, here are some questions to consider:

1. Can SBHCs claims be uniquely identified by payors? If it is difficult for payors to distinguish SBHC claims from those that were provided by the medical sponsor/system, you may need to develop something unique to "mark" the claims (procedure code modifier, modifying the billing provider name, etc).
2. What is the insurance mix of current SBHC clients? If an SBHC serves predominantly Medicaid enrollees, focus on the one or two MCOs that cover those clients when thinking about payment strategies.
3. How are SBHCs currently contracting with payors? Contract details around payment and types of services that are reimbursable are essential to understanding the current financial environment. Are most payments fee-for-service? Are SBHCs only paid for certain primary care services? Do they need prior authorization for some or all services before they can bill?
4. Can SBHC providers be assigned as Primary Care Providers? How much does this determine current payment?
5. Have you clearly defined the SBHC model and can you speak to how it fits in with the overall delivery system (e.g., primary care homes, safety net clinics, access point/acute care)?

The Current Landscape for Oregon SBHCs

During the 2013-14 school year, Oregon SBHCs saw 23,797 clients in 70,666 visits. Visits by OHP (Medicaid) enrollees represented 51% of total visits, with another 8% of visits provided to clients who were enrolled at OHP at some point during the year, but for some reason (nonbillable service, protecting confidentiality, client temporarily ineligible) OHP was not billed at those visits. This 8% (over 5,000 visits) represents potential lost revenue for SBHCs. Oregon SBHCs received nearly $2.6 million from third party payers, most of which came under a traditional fee-for-service payment system.





Oregon's APM Medicaid Pilot

Oregon has engaged in a massive health care experiment with its Medicaid population that is banking on being able to dramatically reduce Medicaid costs. Oregon's strategy focuses on delivering comprehensive physical, mental and dental health care through 16 regional Coordinated Care Organizations (CCOs), giving them substantial flexibility in provider contracting/reimbursement and service delivery and holding them accountable to a set of 17 Incentive 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 increased billing of office visits, and to integrate and coordinate services and management of patient needs in care teams. The pilot changes the way FQHCs are paid by using a Per Member Per Month (PMPM) formula instead of the traditional encounter-based FQHC Prospective Payment System (PPS) rate while also:

...Preventing declines in revenue

...Increasing satisfaction of patients and physicians

...Improving access to care and health care outcomes

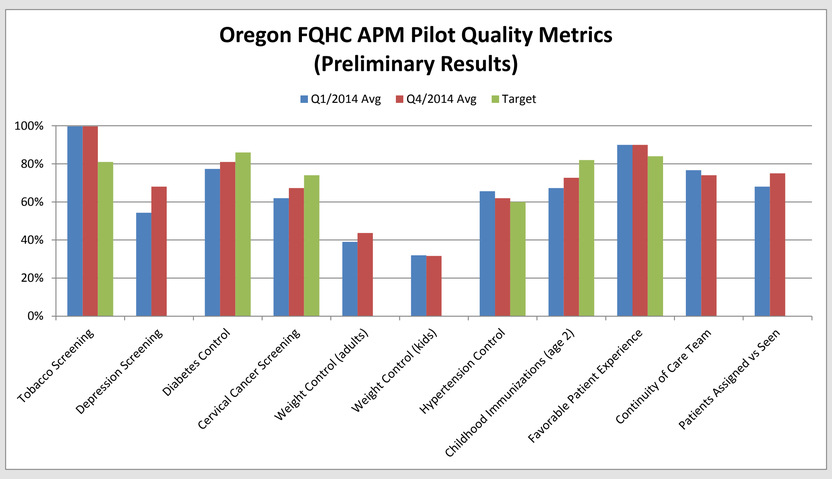
The State created a methodology to develop rosters of "assigned patients" for each FQHC based on an 18-month utilization history. A PMPM rate was for each participating FQHC (including their respective SBHCs) was then developed based off the encounter history of these assigned patients. Rather than getting the PPS rate for each encounter, clinics began receiving PMPM for each assigned patient regardless of utilization (excluding mental health and obstetrical services).

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 underneath the traditional PPS rate; if APM payments are less, the State reimburses clinics for the difference.

As of March 2015, 21 of Oregon's 68 certified SBHCs are participating in this pilot. In the early stages of the pilot, discussions centered on whether SBHCs should be excluded (similar to ER and Urgent Care centers), but they are left in because of a) the difficulty in separating out SBHC claims; and b) SBHCs do provide the types of essential primary care services that are being encouraged in this pilot.

APM Outcomes & Findings

Success of the APM Pilot is currently being measured by tracking identified patient outcomes ("quality metrics") over time, as well as beginning to track clinic activities that are typically unbilled and unrecorded ("patient touches"). Quality Metrics are being tracked to ensure that patient care is not compromised, and thus far, outcomes are looking promising. Patient Touches are being recorded to document trends in non-traditional ways of reaching out to patients outside of regular office visits.



Patient Touches

Accessing community resource/service	Home visits, non-billable
Ancillary Services	Home care visit encounter
Care plan setting activities	Interim notes encounter
Case Management (Assessment, Referral or Treatment)	Interpreter/Language services
Coordinating care clinical follow-up	Letter
Coordinating transitions in care setting	Medicaid eligibility assistance
Coordinating healthcare appointments for patient or family	MyChart encounter
Coordinating care information management	Outreach
Coordinating care dental	Panel management
Education provided: (1:1, group setting, written material)	Pre visit planning encounter
Eligibility Assistance/Financial Counseling	Problem List Update
Exercise class participant	Support group participant
Goal Update	Telephone/Telemedicine Encounter
Health Education Supportive Counseling	Transportation assistance
	Warm hand-off, non-billable

Special APM Challenges for SBHCs

—Separating SBHC claims from larger FQHC claims, while not impossible, is not easily done. Much of the financing depends on FQHCs tracing dollars to patients attributed to the SBHC versus other FQHC clinics.

—The PMPM rate was calculated based on overall FQHC claims data, and does not reflect SBHC-specific rates and utilization patterns

—The pilot can only be implemented in SBHCs sponsored by FQHCs (72%)

—PMPM models tend to succeed in higher volume clinics. SBHCs do not always fit this model, particularly given limited hours

—Quality Metrics aren't necessarily geared towards the SBHC client population, so difficult to measure impact on youth

—"Patient Touches" have the potential to capture non-billable SBHC services but are not being used for payment/financial purposes at the moment

—At this point, it is unclear whether this payment reform strategy is successful for SBHCs given their unique model of care.

The Path Forward: SBHCs Exploring Other APMs

In 2014, the Oregon SBHC State Program Office received $750,000 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 patients. 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 (well 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.

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Oregon SBHC School-Based Health Centers