
Oregon School-based Health Center Sustainability Report
Health Service, Billing and Reimbursement

2008



**Oregon School-Based
Health Care **Network****

SCHOOL BASED HEALTH CENTERS (SBHC) IN OREGON

School-based health care is patient-centered and prevention-oriented primary health care delivered in an environment with a focus on accessibility to students and integration within the school community. This model is centered on the child and is generally delivered regardless of ability to pay. Integration with the school community school affords opportunities for interactions between clients, their families, health care providers, and the school that are unique to the SBHC model of care.

The State has a certification program, and while certification is voluntary it is required to receive state grant dollars. The certification process addresses organizational, facility, availability, staffing, lab, and other areas and provides minimum and recommended standards. For more information go to:

<http://www.whalespoken.org/DHS/ph/ah/sbhc/certreqs.shtml>.

In 2008 there are 45 state certified SBHCs in Oregon. Another 18 sites have received state planning grant funding to begin the process of developing new SBHCs

SCHOOL-BASED HEALTH CENTERS AND REVENUE GENERATION

In 2007 the State of Oregon Public Health Division Adolescent Health Section's School-Based Health Centers Program prepared "**An overview of costs and revenues of Oregon's SBHCs.**" This document will be cited frequently as the Overview.

The Overview poses the following question: "Does billing revenue have the potential of generating a large proportion of program income, and thus ensure financial sustainability?" An answer is inferred: "The data indicate that a substantial proportion of program income can be generated from billing insurances. Seven of the 23 centers under FQHC sponsorship are able to cover more than 60% of their total program cost from billing revenue."

THIS OREGON SCHOOL-BASED HEALTH SERVICE BILLING AND REIMBURSEMENT REPORT

This immediate report examines two related questions: how can SBHCs become more effective at billing and collecting revenue, and how can sources of revenue and amounts that they pay be increased?

This report makes recommendations regarding the basic revenue cycle. These recommendations include consideration of internal and external factors unique to SBHCs that affect this cycle.

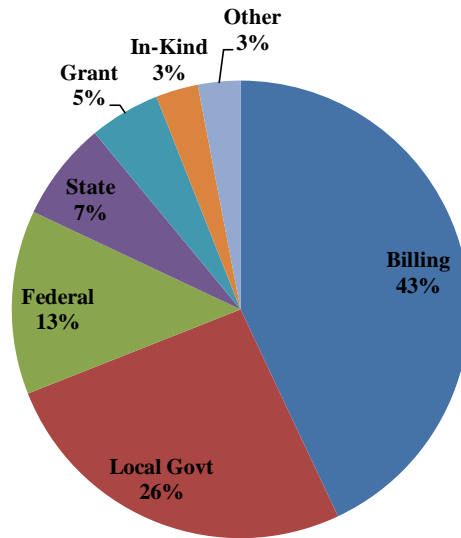
This report also examines key sources of revenue, describes barriers and options for removing those barriers, and makes recommendations designed to improve revenue opportunities related to school based health services.

Findings and recommendations included in this report was informed by structured interviews with staff at four Oregon school based health centers, supplemented by open ended interviews with other stakeholders and subject matter experts and a review of related Oregon and national literature. A list of stakeholders is included at the end of this report.

SOURCES OF REVENUE FOR SBHCs¹:

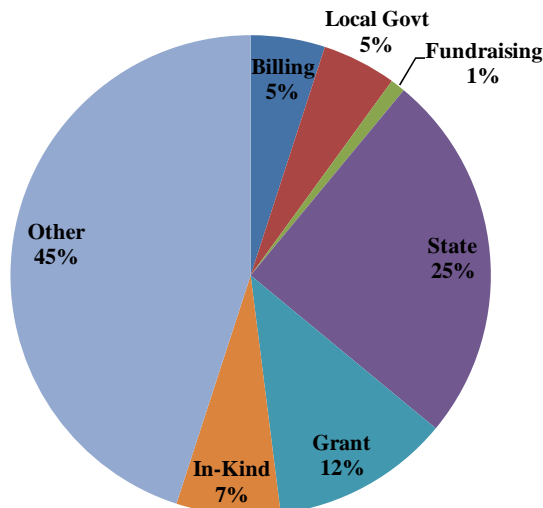
Medical sponsorship plays a defining role in SBHCs ability to generate revenue. More than half of Oregon’s SBHCs are sponsored by a Community Health Centers (also referred to as Federally Qualified Health Centers, or FQHC).

**Sources of Revenue for SBHC under FQHCs
(n = 23)**



For SBHC not affiliated with a CHC, sponsorship includes hospitals, school districts, county health departments, universities, and other organizations.

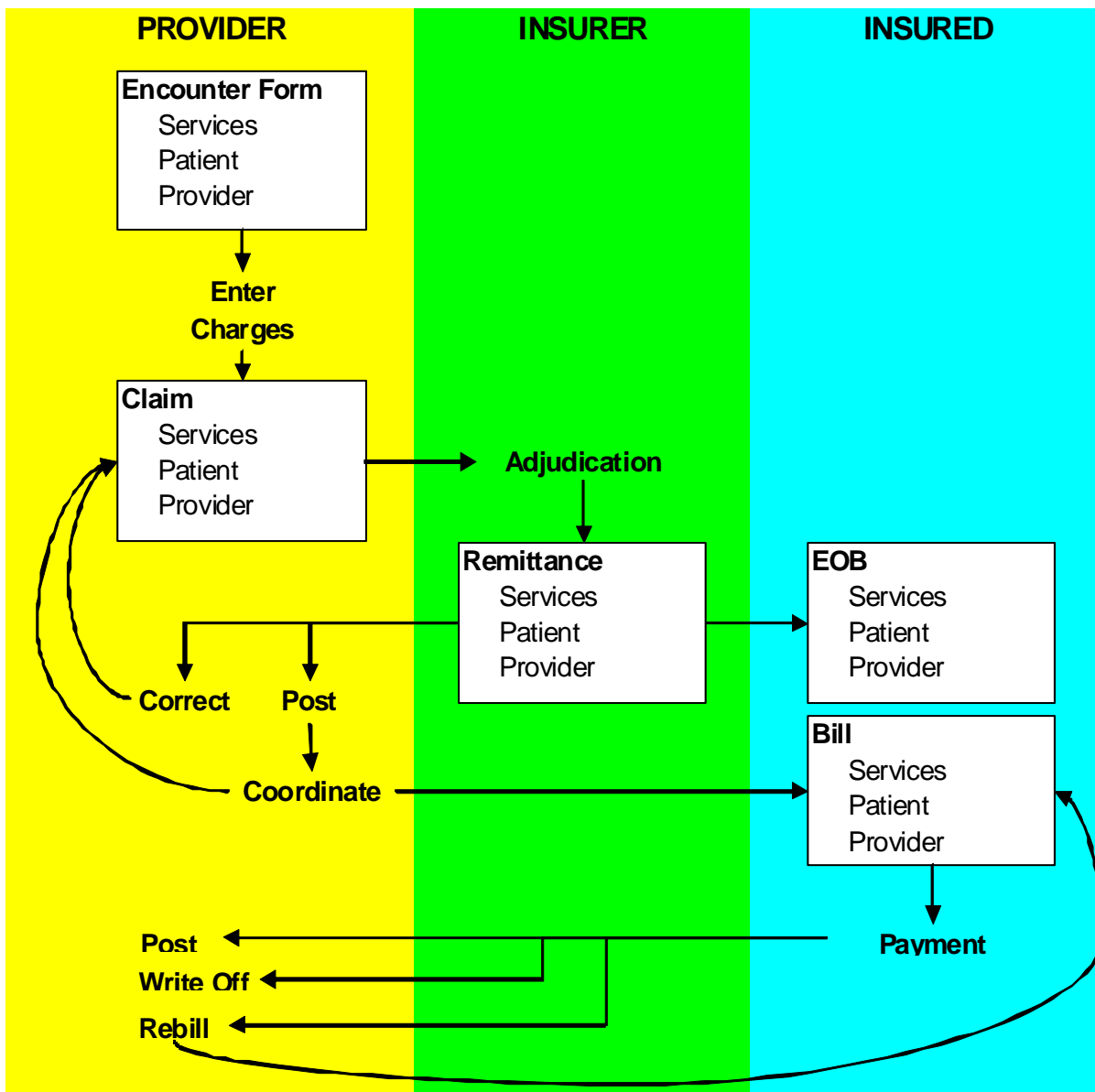
**Sources of Revenue for SBHC not under FQHCs,
(n = 19)**



¹ Source: SBHCs, An overview of costs and resources needed for startup and sustainability, State of Oregon, Public Health Division, Adolescent Health Section

THE REVENUE CYCLE

The insured / provider / third party payer relationship is at the core of the revenue cycle. This three party relationship defines the business model of most physician practices, and is the major influence on what care the patient demands, and how the provider delivers it.



SBHCs are challenged by the revenue cycle:

SBHCs are organized and operate in a manner that poses challenges for the basic insured / provider / third party relationship. Specifically, the creation and management of a claim for payment requires three basic elements:

1. **Patient identification.** For all payers the patient needs to be accurately identified and linked to the insurer. While SBHCs are well positioned to identify the presenting patient, they lack staffing and communication tools to identify and maintain coverage information on students. Also, though schools collect insurance information on students, the Family Educational Rights and Privacy Act (FERPA) prevent them from

sharing this information with the SBHC staff (for more information go to <http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html>).

2. **Provider identification.** All third party payers will specify what types of providers are eligible to provide services to their enrollees. These definitions often exclude visits provided by nurses and visits by certain mental health providers who are not able to practice independently. In addition, insurers will specify credentialing requirements for eligible providers. Finally, to be recognized as a primary care provider by any payer the provider must agree to assure a range of services, directly or through contract, that go beyond what can be provided within many school-based settings.
3. **Services.** SBHCs are generally competent at recording their services. However, many of the services provided in a school setting are not recognized as billable services by insurers. This is particularly true for preventative services, including services that prevent otherwise medically necessary and billable visits.

Revenue Cycle outputs are incongruent or difficult to manage in the SBHC environment:

- **Explanation of Benefits (EOB) sent to responsible parties.** While not an issue for Medicaid, commercial insurers are generally required to send an EOB to the responsible party. In the school setting, that is generally the parent or guardian. For some SBHC services the generation of an EOB to the student's home is not desirable and may in fact violate state requirements that certain services be provided confidentially to minors if so requested.
- **Accounting:** Claims result in full payment, as defined by the relationship to the insurer, partial payment, or no payment, as explained on a remittance advice from the insurer. Accounting and claims follow up work, or accounts receivable (A/R) management, is labor intensive and highly technical, and generally requires sophisticated medical practice management tools. In addition, successful A/R management is directly related to a provider's success in No. 1-3, above.
- **A conflict with the model of care:** A product of claims adjudication may be assignment of a financial obligation to the patient's guarantor. In executing provider agreements SBHC may create a contractual obligation, or in the case of Medicare legal obligation, to collect or attempt to collect on these assigned charges.
- **Coordination of benefits:** An important component of the payment cycle is coordination of benefits. Given the difficulties in the school setting in No. 1-3, above, gaining secondary insurance information is problematic. In addition SBHCs by policy will not assign residual balances to the student or the student's guarantor, thus compromising a 'normal' A/R management tool.

Other factors that influence revenue collection at SBHCs:

1. **Size of practice:** Individually, Oregon's 45 SBHCs are micro-practices. The State School-based Health Center Program reports that Oregon SBHCs served 20,177 clients in 63,863 visits in 2007. Measured by either visit volume or patient panel size and

averaged over 45 centers, the average school-based health center is 1/3 the size of a family medicine physician in solo private practice.

Though all SBHCs must meet minimum staffing for state certification, SBHCs have significant variation in staffing, particularly in support and hours of operation.

2. **Integration:** SBHCs are often not integrated into the community's general health care system, at the primary care provider (PCP), specialty, or hospital level.
3. **Prevention focus:** Much of the care provided in the school setting focuses on screening, prevention, and triage. Often these services are provided by a nurse. These services, core to school-based health care, are traditionally not reimbursed by insurers.
4. **Medical Sponsorship:**
 - a) **Sponsorship by Community Health Centers:** Half of Oregon's 45 SBHCs are affiliated with community health centers (CHC).

A CHC is required to manage the practice's revenue cycle as part of its contract with the Health Resources and Services Agency (HRSA). A school-based health center affiliated or owned by a CHC may locally be a micro-practice but it can take advantage of the parent agency's infrastructure.

- b) **Sponsorship by a local health department:** Many of the non-CHC sponsored SBHCs are sponsored by county health departments. Most local health departments in Oregon are not organized to manage a practice revenue cycle. Some non-CHC health centers, and some planning grant sites, are actively seeking affiliation with a CHC.

5. **Working with public entities:** Most Oregon SBHCs are affiliated with public entities. Many of these entities do not support or fully support the tools and business practices necessary to allow a practice to manage its revenue cycle or cost drivers. Even those entities that have invested in competent registration, scheduling, and billing systems (e.g., OCHIN clinics) have not necessarily invested in accounting systems that support real time A/R management.

SBHCs employing public employees experience barriers to staffing and work hour flexibility, provider reimbursement, employment conditional on credentialing, etc., that increase costs and add complexity to the revenue cycle. Even when local efforts are successful there is little sharing of best practices in resource management across public entities.

6. **Centrality of the model of care:** The child centered, prevention focused model of school-based health care should not be compromised to enable increased revenues. This finding applies universally to both CHC and non-CHC affiliated SBHCs.

Revenue Cycle Goals

- Improve school-based health center's ability to relate to any and all subsequent reimbursement mechanisms – fee for service, capitation, and grant based
- Move billing activities out of individual sites in order to find economy of scale sufficient to support a competent system for managing the revenue cycle
- Work with other allied stakeholders to define how the State of Oregon and private insurers should relate to school-based and other safety net providers

Revenue Cycle Recommendations

- 1. Primary recommendation: Improve information collection practices related to the revenue cycle. Identify and disseminate across all health centers best practices in:**
 - a) Patient registration including consent forms and insurance information coordinated with student registration
 - b) Staff training in collecting demographics, identifiers, and insurance information
 - c) This effort should be made independent of whether or not a bill is generated, and should integrate into existing billing systems, if any.
- 2. Borrow or Build a system to manage the revenue cycle of SBHCs not currently part of an existing community health center.**
 - a) **Borrow:** Implement a system-to-system collaboration with Oregon's community health centers. Approaches might include:
 - i) Explore various affiliation options up to and including change of ownership
 - ii) Explore establishing a local health department / school district 'best practice' of FQHC sponsorship of the medical practice
 - Establish a school district / local health department 'incubator' role if necessary

Benefits of the "Borrow" approach might include:

- i) Allow SBHCs to take advantage of the community health center's infrastructure and benefits, such as
 - 24/7 coverage and link to comprehensive primary care home
 - Greater capacity to manage insurance contracts, manage A/R staff, create and manage financial and accounting systems and secure cost-based reimbursement and other Medicaid and HRSA benefits, such as FTCA and HRSA sponsored providers
- ii) Reduced use of community resources for overhead and duplicated services

- iii) Create opportunities to support school-based health care with HRSA expanded medical capacity grants
- iv) Allow providers to focus on core competencies
- b) **Build:** Seek or establish a shared revenue cycle management service that relieves clinic coordinators and managers of this technical responsibility. Coordinate, share or create these functions:
 - i) provider credentialing and re-credentialing
 - ii) commercial contract negotiation
 - iii) assist with setting charges
 - iv) insurance and coding training for providers and support staff, to support effective central billing
 - v) check all students with visits against the on-line Medicaid database
 - vi) claims submission to third party payers
 - vii) payment receipting, funds transfer and patient account management, including writing offs
 - viii) follow up billing
 - ix) A/R management reporting and performance measures

Potential strategies for building capacity to support multiple clinics include:

- i) Use an established A/R management firm
- ii) Identify a best practice health center related to revenue cycle management and growing that practice to provide service through agreement with other SBHCs
- iii) Create a joint venture, following the best practice business plan employed by the Michigan School Base Alliance (including their funding strategy reliant on foundation and other support for system development)

Revenue Cycle Conclusions:

Although most SBHCs bill for their services, the school-based health care model challenges revenue generation. These micro practices often lack the staffing and scale necessary to efficiently generate revenue. Even when they are sponsored by a larger CHC, SBHCs prevention focus means that many services provided are not billable.

Improvements in information collection can be made within the existing sites that will expand revenue. Sites that are not affiliated with a CHC can also join with other sites to build or borrow revenue management services.

Public and private payers need to examine whether continued reliance on the normal revenue cycle is in the best interest of school-base health centers, the students, the students guarantors, or the insured themselves. The Oregon School-Based Health Care Network is

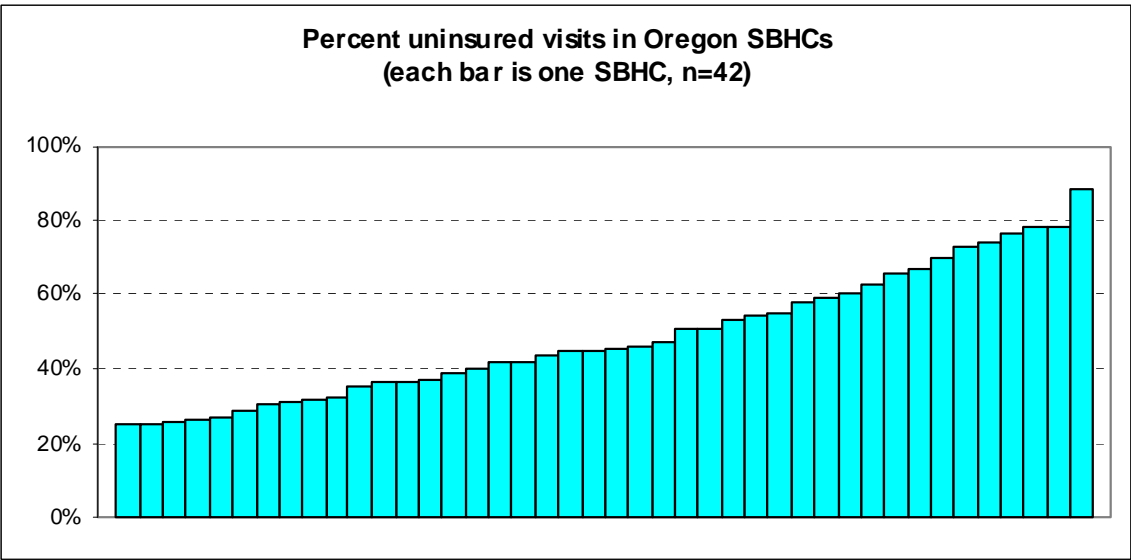
exploring this issue and will work with stakeholders to examine how to best generate revenue that sustains this unique delivery model.

BACKGROUND AND RECOMMENDATIONS BY PAYMENT TYPE

Many of the comments and recommendations that follow are internally inconsistent. Some relate to better management of the revenue cycle, assuming that the reimbursement environment that surrounds the revenue cycle will remain relatively constant. Other recommendations relate to changing the reimbursement environment itself related to services and providers at SBHCs.

COMMERCIAL INSURANCE

Commercial insurance billing represents less than 5% of school-based health center revenue yet consumes a large amount of stakeholder, staff, and insurer effort.



Source: State of Oregon, Public Health Division, Adolescent Health Section, SBHCs Program, "An overview of costs and revenues of Oregon's SBHCs" 2007.

The 2006 Oregon Population Survey found 13% of Oregon's children had no health insurance, private or public. However, the Overview reports 49% of school-based visits had no associated coverage. It is generally accepted that the 49% figure is composed of two components: students who are uninsured, and students where the center is unable to determine insurance coverage, with most of the latter group commercially insured.

Commercial insurers, particularly indemnity plans, offer the least flexibility in their business model as it relates to physician practices. They are heavily regulated at the national and state level and through their contracts with purchasers (employers).

The school-based health care policy and practice environment will continue to present barriers to effective commercial billing (see Revenue Cycle Conclusions).

There's general agreement by school-based practitioners, advocates, and insurers that forcing SBHCs to take the steps necessary to become effective at generating operating revenue from commercial insurers may not be in any stakeholder's or the public's best interest.

Commercial Insurance Goal

Working with major commercial insurers move grant or population based reimbursement models for school-based health center services

Commercial Insurance Recommendation

Policy strategy – Engage with commercial insurers to complete the discussion from 2005.

a) Tactics:

- i) Request that CareOregon, (or LIPA or other MCO or other) assume a convener role
- ii) Request that Regence (or other) assume a sponsor role
- iii) Establish amongst school-based providers and advocates a preferred outcome to negotiate from
- iv) Establish a clear agenda to produce agreements
 - Try to achieve consensus among key stakeholders that application of the physician billing expectations is not a preferred option
 - Create an expectation of action
- v) Bring clear provider, client, and service information
 - Understand and be able to describe how school base differs from a physician practice
 - Describe the positive effects of school-based health care on utilization of physician and hospital services
 - Describe the economic value – educational outcomes, parental time, school staff time

MEDICAID

Most of the above findings, conclusions and recommendations regarding the revenue cycle apply to Medicaid.

Medicaid in Oregon is paid directly through the State (also known as fee for service – FFS or open card) or through managed medical (fully capitated health plan, or FCHP), dental care organizations (DCO), or mental health organizations (MHO). The State decides county by county based on managed care plan capacity whether or not to require managed care enrollment.

Medicaid will likely grow as an opportunity for school-based services, as the legislature considers strategies to cover more of Oregon's uninsured children.

School-based and Medicaid

The Overview reports that Medicaid is an important revenue source for CHC affiliated health centers, just behind FPEP. Medicaid provides little revenue to non-CHC centers.

The FQHC affiliated centers are able to bill Medicaid, either directly (open card) or after the fact (managed care) up to the prospective payment rates (PPS) established for their parent health center on an agency basis. This leads to a highly enhanced revenue stream:

- Under FQHC payment rules, the average FQHC reimbursement in Oregon may be up to three times the Medicaid (or prevailing MCO) payment rates to other Medicaid providers
- In addition accounting treatment of Medicaid payments may also contribute to the difference between CHC and non-CHC affiliated health centers. Under Medicaid rules, a school encounter is billed and paid at the same rate as any other medical encounter generated by the FQHC. When billed out, most providers will book revenue to their school-based health center based on the expected collection, rather than on what the school-based encounter contributes to the blended rate. Since school-based encounters are generally less expensive than encounters provided in a full primary care setting, this treatment can result in school-based encounters being overvalued relative to cost, even if the agency in total is neutral.

Three Approaches

In a managed care environment there are three general payment approaches that could be used to reimburse SBHCs:

- 1. The 'carve out' approach:** Oregon Medicaid (DMAP) would carve out school-based health services from existing contracts with managed care plans, and reimburse school-based providers directly, with the payment mechanism to be defined
- 2. SBHCs relate as a provider** to the Medicaid managed care plan
 - a) The center may join the managed care plan's panel of providers (e.g., centers in Oregon who have contracted relationships with plans through their parent FQHC).

This could be mandatory (state requirement of managed care plans to accept SBHCs that approach the plan). At this time it is 'encouraged'.

- b) The center may be considered a non-network provider and the State would require their managed care contractors to pay without prior authorization (e.g., Oregon's treatment of communicable disease services provided by local health departments)

3. The school-based health center contracts with a primary care provider who is already in the managed care plan's network, with services and reimbursement detailed in the contract.

In all states but Oregon there is a federal mandate that Medicaid through its managed care contractors assure access to FQHC services. This mandate has been waived in Oregon since 1994. While in other states the burden lies with the managed care plan to seek out and contract with the FQHC, in Oregon the FQHC must seek out the plans and convince them to establish a contract.

Recently OSBHCN engaged in conversations involving a possible statutory mandate related to the interim session, but joined with others to seek an administrative solution. There is a high degree of current anticipation and willingness to continue this conversation across stakeholders.

While there's no mandate for managed care plans to contract with school-based or other providers there's some local interest in doing so. Several medical plans have established contracts or are attempting to establish contracts within their respective business models.

While on their long term work plan, the Oregon Primary Care Association has not succeeded in regaining the FQHC mandate.

The situation with DCO and MHO contractors is less optimistic, with many barriers reported by SBHCs in gaining contracts for preventative dental or mental health screening and treatment services.

Kellogg Study, April 2006

In 2006 Kellogg sponsored a review of the Oregon environment and identification of options relative to school-based and Medicaid. Those options included:

1. Convert some or all of current State general fund support for SBHCs into a component of the Medicaid program, thus drawing down federal match funds. Medicaid could increase capitation payments to the MCOs for enrolled school aged children. A sample system is in place in Michigan.
2. Establish an optional 'global' cost-of-service reconciliation program for counties, where counties would be allowed to invoice the State for the difference between all Medicaid payments (mental health, medical, Medicaid administration, dental) and the full cost of providing those services. It is assumed participating counties would provide the non-federal match. A sample system is in place in California. Proposed rules from CMS on limiting payments to governments would support this approach.

3. Convert current State general fund support to match federal Medicaid payments to fund increased disproportionate share hospital (DSH) payments to one or more DSH hospital; require the hospital to contract with SBHCs for services to low income / uninsured children

Those options were presented to the State, including the governor's office, in March 2006 by Eileen Ellis (of HMA) and Elli Hall (Health Policy and Management Consulting). State staff committed to explore these options, a work team was convened, and recommended actions were identified and forwarded through DHS. However, at this time the State has not acted on these options.

Since the Kellogg report in 2006 federal rules affecting these options have changed or are changing, and will generally make realizing any gain from these options more complicated or difficult.

Sidebar: CHC and Medicaid

State Medicaid programs are required to reimburse for services provided by a CHC under a payment system known as the prospective payment system (PPS). This requirement applies to DMAP.

PPS

Each CHC establishes a PPS rate with DMAP. Rates are individual and generally health center wide. For some CHC this rate was established in 2001 based on their reported 1999-2000 costs. For a newer CHC the rate is established at start-up. The PPS rate, once established, is adjusted annually based on a component of the Medicare Economic Index (MEI).

While PPS is related to cost when initially set, it loses its direct relationship to cost over time as it's adjusted by the MEI. Therefore, it's not accurate to equate PPS with cost based reimbursement.

Most states follow the basic approach described above in setting and adjusting PPS rates. States have the option to adopt alternatives to PPS, by amending their State Medicaid Plan. Alternatives do not have to be universally applied. Alternatives cannot produce a result worse than the basic approach described in statute.

What is Eligible?

Like Medicaid generally, the patient has to be a Medicaid enrollee. The service has to be included in the State Medicaid Plan. PPS applies fully to medical, mental health, and dental services.

In addition, the service has to be provided by a CHC. In its contract with HRSA a CHC describes the portion of its corporate body that will fall under the CHC designation. This is called 'scope'. Scope is approved by HRSA. For a non-profit CHC the entire corporation is generally included in scope.

For a governmental CHC the entire corporation is not included in scope. It's common to include primary care including dental, but public health clinics, jail health, and non-health programs are not generally included. County mental health programs in Oregon are increasingly included in scope.

PPS Payments

Once a CHC has established its PPS rate DMAP will reimburse the PPS rate for open card (non-managed care) visits. In Oregon this rate averages between 200% and 300% of normal DMAP fee for service payments. This payment is relatively automatic and timely, and relies on the Medicaid claims system to verify patient, service, and provider eligibility.

For managed care visits the CHC bills the plan (MCO, MHO, or DCO) and receives a payment. The CHC can later bill DMAP for the difference between this payment from the plan and the PPS rate. When this payment is made by DMAP it is called the **wrap payment**. DMAP relies on the plan's claims system to verify patient, service and provider eligibility. Generally, if a CHC does not have a contract with a plan a claim will be rejected, and the opportunity for a subsequent wrap payment is lost.

In managed care counties the wrap payment represents the majority of CHC Medicaid revenue. Wrap payments lag behind service date for up to a year or even longer, as DMAP requires full claims adjudication with the managed care plan before they'll accept a request for a wrap payment.

Specific Comments for School Based

To be eligible for PPS payments the school based health center must be 'in scope' of the CHC. Eligible visits at the school based health center are paid by DMAP, directly or through wrap payments, at the overall agency PPS rate. The CHC decides how to account for the revenue once it's received.

Medicaid Goals

1. Target fair and full reimbursement for school-based health center services from Medicaid (direct and through managed care contractors)
2. Establish a grant or population basis payment system that covers the cost of providing care to Medicaid clients
3. Evaluate the cost / benefit of converting State general fund support to fund improved Medicaid reimbursement
4. Achieve full recognition by Medicaid contractors, including mental health organizations

Medicaid Recommendations

1. Revisit the Kellogg Study recommendations from 2006

- a) Contact the Oregon Public Health Division, Office of Health Planning, to determine the status of the State's response to the Kellogg recommendations
- b) Assure this process has a policy home at DHS (e.g., Local – State Federal Partnerships Work Team, LGAC)
- c) Engage formally with the Office of Health Planning to energize this process as necessary
- d) Evaluate the Kellogg strategies, modified for changing federal rules, for difficulty and benefit
- e) Identify and evaluate related or new options suggested by the Kellogg report
- f) Consider working towards designation as a separate Medicaid provider type, with separate reimbursement
- g) Participate, monitor and champion; hold stakeholders accountable for fulfilling agreements

2. Managed care contracting with safety net providers

- a) From the three managed care mechanisms described above, or combinations of the three, OSBHCN needs to establish a strategy map advised by the cost / benefit / feasibility of each approach
 - i) detailed at the FCHP and MHO level
 - ii) detailed at the FQHC / non-FQHC level
 - iii) consider both where the money flows (DMAP vs. managed care plan vs. PCP) and how payment is made to the school-based health center (grant, fee for service, capitation)
- b) Fully Capitated Health Plans
 - i) Connect with CareOregon.

- (1) CareOregon has confirmed its willingness to be a leader in this effort, to fulfill its commitment made during the emergency session
 - ii) clarify and establish shared goal: on an administrative alternative to a statutory mandate for Medicaid managed care contracting
 - iii) include exploration of alternative payment mechanisms
 - iv) work with CareOregon, OPCA, other stakeholders to form a work plan with timelines and milestones
- c) MHO
 - i) Identify natural allies within MHO stakeholders
 - (1) Mental health directors with Lane, Benton, Multnomah and Lincoln Counties
 - (2) State Integrated Behavioral Health work team
 - ii) clarify and establish shared goal: on an administrative alternative to a statutory mandate for Medicaid managed care contracting
 - iii) include exploration of alternative payment mechanisms
 - iv) consider partnering with OPCA due to general MHO / FQHC contracting issues
 - v) consider partnering with the State Integrated Behavioral Health work team
 - vi) work with stakeholders to form a work plan with timelines and milestones

3. Restoration of FQHC as a type of required Medicaid service and as a mandated provider type in Oregon

- a) Connect with OPCA to determine the status of this issue
 - i) determine OPCA interest and approach to pursuing this issue in the short to intermediate term

4. Individual school-based health center strategy – use of on-line eligibility tools

- a) Focus on all SBHCs
- b) Survey relative to current use of DMAP on-line OHP enrollment tool
- c) Assure full enrollment and training, possibly relying on peer trainers
- d) Target 100% query of all school-based encounters

5. “Incident to” and behavioral health visits

- a) Work directly with OPCA to determine generally accepted operating definition / communicate best practice around nursing visits provided incident to a physicians care
 - i) Share across all SBHCs affiliated with a CHC
- b) Work directly with OPCA to communicate the definition and best practice of behavioral health codes
 - i) Share across all SBHCs
 - ii) Work with OPCA to develop a QA activity to measure use of BH codes across health centers including SBHCs; Develop remediation plan

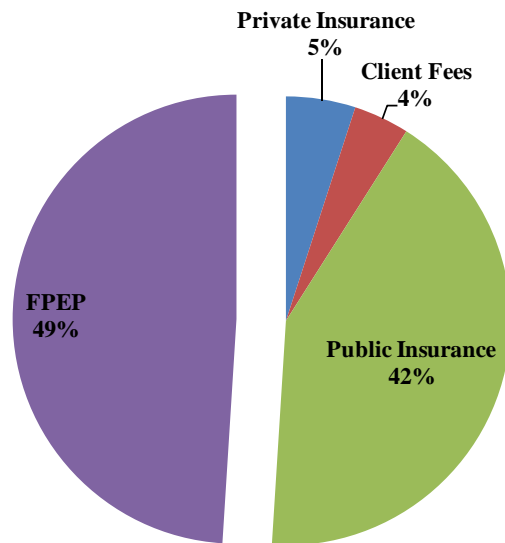
FAMILY PLANNING EXPANSION PROJECT (FPEP)

Most general revenue cycle findings, conclusions and recommendations apply to FPEP.

The Overview reports that 70% of community health center affiliated (FQHC) and 16% of non-FQHC affiliated SBHCs billed FPEP. For FQHC sites FPEP constituted 49% of all billing revenue. The report clarifies that this variation is not tied to school type (high school, middle, elementary).

Across the State FPEP visits are delivered through Planned Parenthood agencies (53%), public health agencies (36%) and FQHC providers (11%) *State Family Planning Office, CY 2005 data.*

Sources of Billing Revenue for SBHC under FQHCs, by Insurance Type
(n = 23)



Source: State of Oregon, Public Health Division, Adolescent Health Section, SBHCs Program, "An overview of costs and revenues of Oregon's SBHCs" 2007.

Early in 2007 the State implemented new FPEP reimbursement rules. Two unrelated changes were included:

- The State was required to comply with Medicaid integrity measures (assuring citizenship) as a condition of renewal of the federal FPEP waiver. The requirement to obtain positive proof of residency was extended to all FPEP providers (public health departments, Planned Parenthood, FQHC).
- The rate of payment had been \$105 per encounter (plus supplies, est. at \$19 / encounter) for non-FQHC providers, with FQHC providers billing at their prospective payment rates (without supplies). A single rate was established at \$140 plus supplies, and FQHC providers could no longer bill at their PPS rate.

Before the 2007 program changes FPEP billing revenue represented 22% of all revenue for FQHC affiliated health centers, with notable concentration in a small number of sites. These sites enjoyed high PPS rates, high school locations, and robust family planning services. These sites will see reductions of 50 – 80% of their FPEP revenue in 2007-08.

For other community health center affiliated sites the reduction in FPEP revenue will be smaller but significant as the reduction will be driven by proving eligibility rather than lower per-visit reimbursement.

The Medicaid integrity requirements are largely beyond the State’s control, and the State will work with any provider to satisfy these requirements. The State family planning office is also struggling with this issue as they observe the drop in FPEP claims (data not yet available).

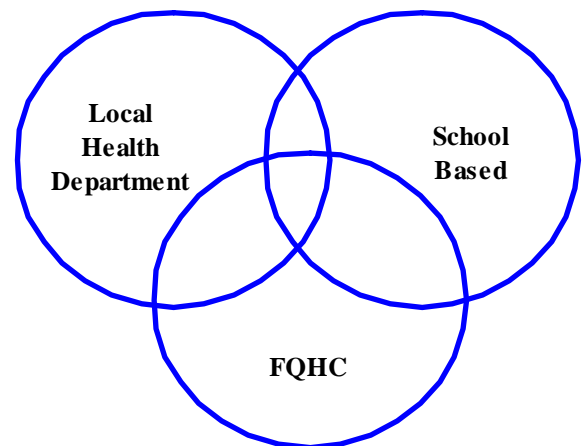
Provider reimbursement is largely a State issue, governed by federal protocols designed to assure that Medicaid reimbursement does not exceed reasonable cost or accrue to services provided to patients not specifically covered. Like other family planning services reimbursed through Medicaid, the federal government pays 90% of the cost and the State pays 10% of the costs. This very high federal matching rate should provide a strong incentive for the State to structure reimbursement to cover the true costs of family planning services.

Three Interrelated Policy Stakeholders

Most local public health departments do not operate a FQHC are generally positively impacted by the FPEP reimbursement change. The Council of Local Health Officials was originally supportive of the reimbursement change.

SBHCs have not been a direct participant in this conversation.

FQHC involvement is mixed. When the rule change was announced in late 2006 FQHC providers, through the Oregon Primary Care Association (OPCA), have explored possible reimbursement strategies designed to more fully cover the cost of providing a FPEP visit by a FQHC. While the reimbursement discussion with the State has not concluded it is not moving forward with certainty.



FPEP – Goals

- Restore some portion of lost FPEP revenue while preserving revenue gains for providers who realizing per-visit payment increases

FPEP - Recommendations

1. **At the OSBHCN level join with OPCA in the FPEP reimbursement discussion**, specifically creation of a cost based reimbursement mechanism for FPEP services provided by FQHC providers. While most of the benefit (restoring lost revenue) will accrue to a small number of health centers, specifically the Multnomah system, the dollar volume is considerable.

- a) While affected FQHC / SBHC counties are likely to be involved through OPCA, OSBHCN could have a positive impact by adding its voice and raising the profile of this effort
- b) Work with OPCA to reach out to the Conference of Local Health Officials to achieve policy alignment
- c) As a natural ally, reach out to Multnomah County as a leader with all three stakeholder groups to form a coordinated strategy providers. While most of the benefit (restoring lost revenue) will accrue to a small number of health centers, specifically Multnomah, Clackamas, Benton and Lane health centers, the dollar volume is considerable

2. Individual school-based health center strategy – work with the State Family Planning office to survey health center coordinators

- a) Focus on non-FQHC centers
- b) Survey relative to FPEP service requirements – determine which centers are providing services compliant or close to compliant with requirements
- c) Determine ability to verify client eligibility
- d) Work with State FP office to conduct an intensive client reception training program to bring best practices to these SBHCs

CONCLUSIONS

Some interventions may produce local improvements in operating revenues generated out of patient care for school-based health services. However, the cost relative to benefit of these improvements will be relatively high, unless some success is achieved in creating sufficient economy of scale across health centers.

A range of system interventions offer greater opportunity. Specifically, achieving full affiliation with Oregon's resident community health centers would allow for extension of FQHC benefits to all SBHCs while leveraging existing investments in administrative capacity.

Medicaid will continue to be a significant insurer of health services to school aged residents. SBHCs need to examine the lost opportunity costs and benefits of the current practice of allocating state general funds directly to Local Public Health Authorities outside of the Medicaid program.

Finally, public and private payers need to examine whether continued reliance on the 'normal' revenue cycle is in the best interest of SBHCs, the students, the student's guarantors, or the insurers themselves. Significant potential exists amongst key environmental stakeholders to push this conversation, including the examination of non-traditional reimbursement systems providing better fit with school-based health center's unique delivery model.

INTERVIEWS

Vanetta Abdellatif, Multnomah County Health Department
Katy Bloch, Lane Community Health Center
Debbie Brinson, School-Community Health Alliance of Michigan
Sherlyn Dahl, Benton Community Health Center
Jill Daniels, Multnomah County Health Department
Stephanie Dreyfus, Provider Relations, Regence Oregon
Tom Eversole, Benton County Health Department
Dave Ford, CareOregon
Elli Hall, Health Care Consultant
Pam Mariea-Nason, CareOregon
Mike Martin, Clackamas County Health Department
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