

Creative Practices from the Field: Managing Resources in Difficult Times

Tuesday, April 15, 2008
2 p.m. to 4 p.m.



Participants: Rhoda Jantzi, Judy Cleave, Bryan McNutt, Kim Epps, Janine Warner, Steve Bardi, Cindy Shaw, Traci Fossen, Maxine Proskurowski, Rosalyn Liu, Loretta Gallant, Carol Ohpkins, Eve Golden, Sandy Adams, Zack Goldman, Jackie Rose, Liz Smith Currie, Paula Moore, Betse Thielman

The Network is a membership organization whose mission is to advance access to health care for Oregon's youth. Part of what we do is to provide opportunities for sites to learn from each other's experiences. Today we want to share some practices from our field on how some sites are dealing with budget cuts and limited resources.

Strategies for Managing Limited Resources

Traci Fossen, Medford

Traci is the director of Kids Health Connection in Medford. Medford has had an issue with retaining providers and with making sure that providers are using all of their skills when they are focused on just a student-based population. To address those issues, KHC is rotating their FNP from their medical sponsor, La Clinica so that she is in the clinic two days a week for up to five hours each day and the rest of the week at La Clinica. The RN model changed to doing more triage and case management. The pros of this strategy are: families that don't have PCPs can access the FNP at La Clinica when school is closed (continuity of care). Also, it is a less expensive model. The NP is now seeing an average of 8 to 12 students a day. The cons are that access has decreased because there are fewer provider hours at the clinic. The students get referred and that creates barriers to access for families that have difficulty accessing La Clinica (impact on the model).

For more information on what KHC is doing in Medford, contact Traci Fossen at: 541-842-3106

Rhoda Jantzi, Judy Cleave Salem

Rhoda and Judy work with Hoover Elementary School in Salem. Hoover is a newer site and has just recently contracted with the school district to provide care to uninsured special education kids with R13 forms. In the last several months, they have provided 20 R13 assessments and are reimbursed at \$90-100 per exam.

For more information on how Hoover is making this program work, contact Rhoda Jantzi at 501-581-1713

Steve Bardi, Portland

Steve works for Multnomah County, which operates 12 SBHCs. Funding cuts have meant that the county has had to reduce their budget by about \$1 million. They have reduced administrative staff, are staffing their NPs at .8 FTE each, are sharing staff between sites. Front desk staff aggressively ask for insurance information and refer for OHP screening resulting in more than 100 families qualifying for OHP since Sept. RNs used to do

independent visits and case management but with staffing cuts were doing more NP support and not working to their skill level so they are now moving their RNs in high schools into other areas in the county and are replacing them with MAs.

For more information on what Multnomah County is doing, contact Steve Bardi at 503-988-4424 x29756

Cindy Shaw, Pendleton

Cindy is the SBHC Coordinator and RN at two sites in Pendleton. Pendleton recently was able to work with Family Care, the major Managed Care Organization in their community to begin the process of empanelling their NP and to allow reimbursements for care for children they see who are covered by Family Care. Family Care will no longer require that students get a referral to allow Pendleton SBHC to get reimbursement. Family Care had seen an increase in hospital use of its youth members and wants to work with the SBHC to address the causes of that increase. Pendleton is currently engaged in efforts to obtain a financial contribution from the School District to prevent loss of the Mental Health provider position. St Anthony's Hospital contributes \$52,000 per year to cover costs for the NP. They are also exploring the possibility of a relationship with Blue Mountain Community College to provide student health services to the CC students.

For more information on what Pendleton is doing, call Cindy at 541-966-3877 (M, W, F)

Other strategies from the field discussed:

Zachary: New Urban HS (planning grant site) is exploring options for OHSU to subsidize the cost of the MD provider of services through their mobile medical van.

Betse: Sacagawea (St Helen's) is exploring DHS paying the SBHC to provide screenings that are required within 24 hours of a child's entering the state welfare system.

Network update on the Billing and Reimbursement Project

Liz reviewed some of the highlights of recommendations around billing and reimbursements from a study we commissioned that is still in the **draft phase**. Below are recommendations that are listed for informational purposes only. The Network has not taken an official position on any recommendations. During the call, sites noted interest in further discussing finding reimbursements for nurse case management

Revenue Cycle Recommendations:

- I. Improve information collection related to the revenue cycle (regardless of whether a bill goes out)
 - a. Patient registration, including consent forms and insurance information coordination with student registration
 - b. Staff training in collecting demographics, identifiers, and insurance information
- II. Managing the revenue cycle: For centers currently not part of an existing community health center
 - a. **Borrow:** Implement a system to system collaboration with Oregon's community health centers..
 - i. Explore various affiliations 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
 - I. establish a school district/local health department incubator role if necessary
 - iii. Allow SBHCs to take advantage of CHC's infrastructure. Benefits include 24/7 coverage and link to comprehensive primary care home; greater capacity to manage insurance contracts and A/R; reduced use of community resources, opportunities to support SBHC with HRSA expanded medical capacity grants; Allow providers to focus on core competencies
 - b. **Build:** Seek or establish a shared revenue cycle management services, 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

Build Strategies:

Use and established A/R management firm

Identify a best practice health center related to revenue cycle management and grow that practice
Create a joint venture (Michigan example)

Recommendations Commercial Insurance:

Background: Commercial insurance represents less than 5% of SBHC revenue, but consumes a large amount of stakeholder, staff and insurer effort. They have the least flexibility in their business model and SBHCs are not well suited to commercial billing as described above.

Policy strategy:

Work with major commercial insurers to reimburse school based health center services on a grant or population basis

Recommendations

- I. Policy strategy – Engage with commercial insurers to complete the discussion from 2005.
 - a) Request that CareOregon or LIPA or other group assume a convener role
 - b) Request that Regence or other assume a sponsor role
 - c) Establish amongst school based providers and advocates a preferred outcome to negotiate from
 - d) Establish a clear agenda to produce agreements
 - i) Try to achieve consensus among key stakeholders that application of the physician billing expectations is not a preferred option
 - ii) Create an expectation of action
 - e) Bring clear provider, client, and service information
 - i) Understand and be able to describe how school base differs from a physician practice
 - ii) Describe the positive effects of school based health care on utilization of physician and hospital services
 - iii) Describe the economic value – educational outcomes, parental time, school staff time

Medicaid

There are three general payment approaches that could be used to reimburse school based health centers:

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. School based health centers 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 school based health centers 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 on their long-term work plan, the Oregon Primary Care Association has not succeeded in regaining the FQHC mandate.

Goals

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

Recommendations on Medicaid

1. Policy strategy 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. Policy strategy 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) FCHP
 - i) Connect with CareOregon.
 - (I) 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. Policy strategy 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 school based health centers
 - 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 school based health centers affiliated with a CHC
 - b) Work directly with OPCA to communicate the definition and best practice of behavioral health codes
 - i) Share across all school based health centers
 - ii) Work with OPCA to develop a QA activity to measure use of BH codes across health centers including school based health centers
 - (1) Develop remediation plan

FAMILY PLANNING EXPANSION PROJECT (FPEP)

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

FPEP – Recommendations

Goals

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

Recommendations

- I. 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 school based health centers