
HB 2445

School-Based Health Center Workgroup

Summary Report

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Prepared by
Oregon Health Authority
Public Health Division
SBHC State Program

Prepared for
Oregon State Legislature
per House Bill 2445

This report is available online at:

<http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Pages/Transformation.aspx>

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INTRODUCTION

School-Based Health Centers (SBHCs) have been operating in Oregon since 1986 and constitute a unique public-private partnership through collaborative relationships that include the local school district, county health departments, public and private practitioners, parents, students and the Oregon Public Health Division (PHD). SBHCs represent a distinctive health care model for comprehensive physical, mental, preventive and in some cases, dental health services provided to youth and adolescents in a school setting, regardless of their ability to pay. While each Oregon SBHC is uniquely situated to meet the needs of the youth in their community, all state certified SBHCs have common attributes. By nature, the SBHC model focuses on prevention activities such as well-child exams and health assessments that address key health promotion topics such as family support, healthy weight and development, nutrition and physical activity, mental health and substance abuse, healthy sexuality development, safety and injury prevention and oral health.

SBHCs are critical access points that support the health and academic achievement of Oregon youth. Having an SBHC in a school allows students to get back to the classroom faster, and has been shown to keep youth out of more costly care settings, such as urgent care and the emergency room. For more information about SBHCs in Oregon, visit the SBHC State Program Office website at www.healthoregon.org/sbhc

In 2013, the Oregon Legislature passed House Bill 2445 that mandated the Oregon Health Authority to convene a work group to develop recommendations for the effective and coordinated use of SBHCs for children who qualify for medical assistance. The workgroup was lead by staff from the Oregon Public Health Division, which convened on three occasions over a three month period. The workgroup consisted of coordinators and staff from SBHCs, representatives from medical sponsors of SBHCs, local public health authorities, schools utilizing school-based health centers, Coordinated Care Organizations (CCOs), the Oregon Health Authority, and other interested stakeholder groups. The workgroup included representation from both rural and urban counties. See Appendix A for a full list of attendees at each workgroup meeting. This document describes the workgroup goals, the process used, discussion topics, and final recommendations.

WORKGROUP GOALS

House Bill 2445 specifically tasked the work group with developing recommendations for:

- Optimizing the effective and efficient use of school-based health centers by coordinated care organizations, including effective coordination of care and reimbursement;
- Ensuring the coordination and disclosure of protected health information by school-based health centers in accordance with ORS 414.679 and
- Developing financial incentives to:
 - Increase the number of SBHCs certified as patient centered primary care homes (PCPCH) without requiring SBHCs to be certified as patient centered primary care homes;
 - Improve the coordination of the care of patients served by CCOs and SBHCs; and

- Improve the effectiveness of the delivery of health services through SBHCs to children who qualify for medical assistance.

WORKGROUP PROCESS

The SBHC model is built on addressing local needs through local partnerships. As such, there was a need to engage as many SBHCs, CCOs and community partners as possible to participate in the workgroup. Public Health Division (PHD) staff facilitated three work sessions with over 40 participants between the three meetings. Participants represented 35 SBHCs in nine counties and seven CCOs. Staff from the state Medical Assistance Program and Patient Centered Primary Care Home Program participated in the workgroup as well. Each meeting was open to the public and allowed for public comment.

PHD staff structured each session to include a framework for the discussion and following up with questions to the workgroup that created a foundational understanding for the group. Agendas and any documents for discussion were sent out prior to the meeting and posted on the SBHC State Program Office website. Summary notes were taken and posted on the website prior to the next meeting. The first meeting served as an organizational meeting to discuss the goals and intent of the workgroup and legislation. Participants were asked to share the current status of their SBHC/CCO relationship as it relates to the coordination of care, billing and reimbursement, and the role of PCPCH recognition. The second meeting was a work session to discuss current care coordination and reimbursement systems, and draft initial recommendations related to those areas. The third and final meeting revisited and finalized the recommendations from meeting two, discussed the relationship of SBHCs to PCPCH recognition, and developed recommendations on use of the incentive pool funds.

The draft report and recommendations were sent out to all workgroup participants for comments and feedback. The final recommendations were generally supported by the workgroup participants, however, noting that not all CCOs and SBHC were represented.

WORKGROUP RECOMMENDATIONS

The workgroup immediately recognized that the relationship between the CCOs and their regional SBHCs needed to be strengthened, specifically in the areas of communication and establishing foundational knowledge of the SBHC model. There was a shared understanding that SBHCs are a valuable model of care. However, the workgroup identified a need for some basic activities to support open communication between SBHCs and CCOs in order for SBHCs to function effectively and be sustainable in the transformative environment of health care delivery. The workgroup recommendations reflect relationship building activities and policies that support SBHCs to be effectively utilized as part of the CCO provider network.

The following recommendations are organized under an overarching goal that the workgroup identified as necessary steps in the pathway to reaching optimized use of SBHCs by CCOs. Along with each recommendation are suggested action items and timelines.

Goal: To have a shared understanding of respective roles and value of SBHCs among community providers and CCOs.

RECOMMENDATION #1

SBHCs to share information explaining the SBHC model, services offered, role in patient care, and the value of the SBHC to the CCO and community providers.

Suggested timeline: Summary reports for all SBHCs would be completed by September 1, 2014.

Background: A clear understanding of the local SBHC model is essential to care coordination efforts between SBHCs, CCOs and community providers. SBHCs meet a variety of needs for youth and community members that range from serving as a patient's primary care provider to providing occasional acute care services. See Appendix C: SBHC Care Coordination Framework that displays the SBHC PCP Framework. Workgroup participants felt there was a need for CCOs and community providers to have a better understanding of the local SBHC models in order to truly engage in care coordination and build collaborative relationships. This includes the recognition that SBHCs offer services beyond primary care, such as on-site mental health and oral health services.

- Action: SBHCs will provide a summary of their model including on-site services and information regarding the SBHC's "role" in the patient's care (i.e. primary care provider, non-primary care provider).
- Action: This document will be shared with their regional CCO(s). CCOs will communicate this information to their provider network.
- Action: SBHC State Program Office will provide SBHCs with an outline that sites can use as a template for their summary document.

RECOMMENDATION #2

CCOs (with SBHCs in their region) shall convene their provider network, including SBHCs, to discuss the role of the SBHCs in patient care and strategies to encourage coordination of care for SBHC patients.

Suggested timeline: Summary report of the meeting, including care coordination plan, shall be made publically available by January 1, 2015.

Background: The lack of open communication and trusting relationships between SBHCs and community providers is a barrier to effective care coordination strategies. Workgroup participants expressed the need to build trusting and collaborative relationships between SBHCs and community providers which would allow for more efficient referral processes and care coordination. SBHCs specifically requested CCOs to lead these efforts in order to achieve better provider-community support. The intent of this discussion would be to agree on ways to ensure efficient use of the SBHCs and reduce duplication of services between SBHCs and local community providers. Due to the nature of the meeting, the workgroup strongly recommends that clinic providers participate in the meeting, including mental and oral health providers, where applicable.

- Action: The workgroup noted that best way to move forward in this recommendation will be specific to each CCO/SBHC community. Therefore, the group proposed that each CCO and SBHC(s) within the region will create a plan on how to best move forward to meet this recommendation, ideally, with the CCO leading the discussion.

RECOMMENDATION #3

State Program Office will explore practical and evidence-based methods to collect and report SBHC data (including traditionally non-billable services)

Suggested timeline: A draft report will be made publically available by January 1, 2015.

Background: SBHCs are currently required to submit their medical encounter data to the State Program Office on a semi-annual basis. See www.healthoregon.org/sbhc for a complete list of data variables. However, in many instances the data available to SBHCs for reporting purposes is based on billing systems and the quality of these data are variable. Being able to report on SBHCs activities and data in a consistent manner across all SBHCs was identified by the workgroup as an important aspect in informing alternative payment methodology (APM) discussions and SBHC sustainability. There are many activities that happen in SBHCs that are not billable such as health education and case management services. Some activities take substantial time even before the actual billable portion of the visit occurs (e.g., check-ins and building relationships with students and school staff). These activities are necessary yet not reimbursable. In addition, there are opportunities to collect and report SBHC activities that may align with CCO incentive metrics. Some entities have started to look into the non-billable activities however, there is no consistency in how SBHCs collect and report on traditionally non-billable services.

- Action: The State Program Office will explore reporting/tracking systems to capture SBHC-related data. State Program Office will take the lead on engaging stakeholders to address this recommendation.

<p>Goal: To effectively and efficiently provide quality care to SBHC patients through the collaboration with non-SBHC primary care providers (PCPs).</p>

RECOMMENDATION #4

CCO or its delegates will provide a point of contact to the SBHC to address care coordination questions or comments.

Suggested timeline: Contact person identified and shared with SBHCs by March 1, 2014.

Background: SBHCs are struggling with how to best communicate with CCOs when needing assistance with care coordination activities.

- Action: Point of contact will work with SBHC to negotiate and identify systems and methods of communication to enhance care coordination efforts.

RECOMMENDATION #5

Systems shall be developed between the SBHC and CCOs to better identify the SBHC patients' primary care providers (PCP).

Suggested timeline: A system would be in place that would allow for SBHCs to identify PCPs for their patients starting Sept 1, 2014.

Background: Workgroup participants recognized that youth access SBHCs for a variety of reasons (see SBHC PCP Framework). Some SBHC providers are the assigned PCP; there are other instances that the SBHC is the not assigned PCP and youth are choosing to access the SBHC services over their assigned PCP. Currently, there are some systems in place to allow

SBHCs to identify PCPs (i.e. patient portals), however, many SBHCs struggle with being able to identify the assigned PCPs of their patients to even attempt to coordinate care. This recommendation will allow SBHCs to identify a patient's assigned PCP and more effectively provide referrals, coordinate care and not duplicate services. Workgroup participants also recognized that EHR systems could be better utilized as an effective tool for health information exchange (HIE) between SBHCs and PCPs, including identification of assigned PCPs. Workgroup participants recommended CCO include SBHCs in their HIE discussions.

- Action: CCOs will provide a list of OHP patients assigned to SBHC providers as their PCP.
- Action: CCOs and SBHC will work together to create a simple systematic way to identify non-SBHC PCPs for those OHP patients utilizing the SBHC.

<p>Goal: Payment structures between SBHCs and CCOs will encourage and support financial sustainability of SBHCs.</p>

RECOMMENDATION #6

CCOs will consider SBHCs in discussions regarding alternative payment methodology in order to optimize the use of SBHCs in the provider network and contribute to financial sustainability.

Suggested timeline: Continuous

Background: Workgroup participants recognized that decisions for alternate payment methodologies (APM) have not been finalized, particularly in the area of preventive care. However, workgroup participants felt there is an opportunity for CCOs to better support the preventive work and sustainability of SBHCs through APMs. Some potential strategies that were discussed focused on reimbursement for traditionally non-billable services (i.e. health education, case management, prevention messaging) with the recognition that these are key components of the SBHC model and valuable services. Some hybrid payment strategies may include some fee-for-service reimbursement, case-rate payments and the possibility of wrap payment for non-FQHC SBHCs. CCOs could reimburse SBHCs as part of the medical neighborhood for a patient, even if the SBHC provider is not the assigned PCP.

- Action: CCOs will include SBHCs in their discussion of APMs. Additionally, work completed by the State Program Office under recommendation #3 will be made available to CCOs to help support APM discussions as they unfold.

<p>Goal: Communication and expectation around billing and reimbursement are clear and predictable.</p>

RECOMMENDATION #7

CCO or its delegates will provide a point of contact to the SBHC to address care billing and reimbursement questions or comments.

Suggested timeline: Contact person identified and shared with SBHCs by March 1, 2014.

Background: SBHCs are currently struggling with how to best communicate with CCOs when there are issues or questions around billing and reimbursement.

- Action: Point of contact will work with SBHC to establish a formal payment agreement and answer billing/reimbursement questions or concerns.

RECOMMENDATION #8

CCOs or its delegates and SBHC medical sponsors will create formal billing and reimbursement agreements.

Suggested timeline: Agreements will be formalized at the earliest practicable date, but no later than June 30, 2015.

Background: Not all SBHCs have formal payment agreements or contracts with CCOs. The lack of a formal agreement creates unease and unpredictable business planning and budgeting for SBHC medical sponsors. In addition, the lack of formal agreements does not validate the current work being done by SBHCs.

Action: If one is not in existence, CCOs or its delegates will work with SBHC medical sponsors to create formal billing and reimbursement agreements or contracts.

Goal: Ensure confidentiality of services in accordance with best practices for adolescent care.

RECOMMENDATION #9

CCO or its delegates and SBHC medical sponsors will consider patient confidentiality and privacy when developing plans and policies for both care coordination and billing and reimbursement processes.

Suggested timeline: Continuous

Background: Care coordination and communication plans should recognize the need to assure patient confidentiality and privacy. Confidentiality is a fundamental principle underlying the delivery of health care. Fear that services or information disclosed during a health care visit will not be kept confidential is an ongoing, major barrier to care, especially for young people. Confidential care is an important standard for adolescent health and key to successful adolescent care. State minor consent laws provide one layer of protection, but the law is not black and white and places most of the onus on individual providers. Inability to assure for confidential and private services not only affects the client’s willingness to seek services, but also the SBHCs credibility as a safe access point for youth.

- Action: CCOs or it delegates and SBHC medical sponsor create policies and procedures that assure patient confidentiality and privacy.

Goal: Support innovative projects and activities that advance local SBHC models within health system transformation.

RECOMMENDATION #10: (Use of incentive fund pool)

SBHC State Program Office will fund projects that focus on one more of the following goals:

- Increasing the number of SBHCs certified as patient centered primary care homes (PCPCH) without requiring SBHCs to be certified as patient centered primary care homes;
- Improving the coordination of the care of patients served by coordinated care organizations and SBHCs; and
- Improving the effectiveness of the delivery of health services through SBHCs to children who qualify for medical assistance.

Suggested Timeline: SBHC State Program Office to release a request for proposals in spring 2014

Background: The Legislature awarded approximately \$750,000 for the biennium to support the above mentioned goals. Workgroup participants discussed how the incentive funds should be prioritized and structured.

- Action: The State Program Office will release a request for proposals to support local innovation that address one or more of the three goals outlined by the legislation, as well as a mix of funding opportunities (large and small). To that end, funds will support larger projects that involve systems change and will provide lessons learned that can be shared with the entire SBHC community. In addition, some funds will support more targeted activities, with the possibility of helping meet specific recommendations. Projects must focus on one or more of the targeted outcomes listed above.
- Eligible Applicants: CCOs, medical sponsors, or a joint application. Application must show evidence of support from the other entity if it is not a joint application.
- Additional considerations: Funding should support projects in geographically diverse locations.

Goal: Advance the SBHC model through lessons learned from recommendations and incentive funding projects.

RECOMMENDATION #11

The SBHC State Program Office will provide an update on the progress of work conducted to meet the proposed recommendations and use of the incentive funds. Evaluative information will be made available to workgroup committee members and posted on the program website.

Suggested timeline: no later than May 2015

Background: Workgroup participants expressed the need for oversight and accountability. Progress on the recommendations and use of incentive funds will also help inform use of incentive funding in future biennia.

- Action: SBHC State Program Office to track progress of recommendations and incentive funds projects.

CONCLUSION

The health reform efforts underway in Oregon and have created both opportunities and challenges for the SBHC model. SBHCs are a crucial component of the overall health care delivery system by providing high quality patient-centered care in an accessible location. They serve vulnerable populations and are at times the only effective access point for many youth. In a changing health care environment, effective and efficient partnerships between CCOs, community providers and SBHCs are critical to support the SBHC model and ensuring healthy, productive futures for Oregon's youth.

APPENDICES

Appendix A: Workgroup Participants

The following list includes the HB2445/SBHC workgroup participants and their represented organizations. Each of the members participated in at least one of the three workgroup meetings. Individual participation does not constitute full endorsement of the recommendations by the represented organization.

Organization	Name
Bethel SD/Cascade MS SBHC	Annemarie Hirsch
Bethel SD/Cascade MS SBHC	Wendy Lang
CareOregon	Denise Johnson
Cascade Health Alliance	Scott Munson
Cascade Health Alliance	Angela Leach
CHC Jackson County	Melissa Klegseth
Clackamas County PH	Jamie Zentner
Clackamas County PH	Janelle McCleod
Columbia County	Sherrie Ford
Deschutes County PH	Kate Moore
Deschutes County PH	Linda Webb
FamilyCare CCO	Carol Burgdorf-Lackes
FamilyCare CCO	Brett Hamilton
HealthShare CCO	Ashlen Strong
Kaiser Permanente	Catherine Potter
Kaiser Permanente	Jean Reister
Kaiser Permanente	Tracy Dannon-Grace
Klamath Open Door Family Practice	Kim Petersen
Milwaukie HS	Michael Ralls
Multnomah County Health Dept	Jill Daniels
Multnomah County Health Dept	Sami Jarrah
Oregon Primary Care Association	Sarah Dryfoos
Oregon School Based Health Care Network	Doug Riggs
Outside In	John Duke
Outside In	Lori Kelley
PacificSource CCO	Kate Wells
Rep. Nathanson's Office	Adam Renon
Trillium CCO	Debi Farr
Union County Public Health/ Center for Human Development Inc	Carrie Brogiotti
Virginia Garcia Memorial Center	Araceli Gayton
Virginia Garcia Memorial Center	Charles Ashou
Wash. Co. Health and Human Services	Bill Thomas
Oregon Health Authority/Medical Assistance Program	Don Ross

Oregon Health Authority/Medical Assistance Program	Linda Williams
Oregon Health Authority/Office of Health Policy and Research	Nicole Merrithew
Oregon Health Authority/Office of Health Policy and Research	Brian Nieubuurt
Oregon Health Authority/Public Health Division	Rosalyn Liu
Oregon Health Authority/Public Health Division	Liz Thorne
Oregon Health Authority/Public Health Division	Sarah Ramowski
Oregon Health Authority/Public Health Division	Cara Biddlecom
Oregon Health Authority/Public Health Division	Stefanie Murray
Oregon Health Authority/Public Health Division	Bob Nystrom
Oregon Health Authority/Public Health Division	Michael Tynin

Appendix B: 9/23/13 Workgroup Meeting Summary Notes

SBHC HB2445 Workgroup

Meeting # 1

Sept 23, 2013

Attendees by represented organization: OHA Public Health Division, OHA Medical Assistance Programs, OHA Oregon Health Policy and Research, Bethel School District, Virginia Garcia Health Center, Health Share CCO, Washington County Health and Human Services, FamilyCare CCO, Union County Public Health, Trillium CCO, Clackamas County Public Health, Multnomah County Health Dept, Outside In, Deschutes County Public Health, Pacific Source CCO, CHC Jackson County, Milwaukie HS, Columbia County Public Health, Klamath Open Door Family Practice, Oregon State Board of Nursing, Oregon School-Based Health Care Network, Komen Latina Initiative, Cascade Health Alliance.

Overview

Workgroup was convened to focus on the 3 areas regarding the relationship between SBHCs and CCOs. Workgroup will meet from now until the end of December, as a report needs to be generated to legislature by Dec 31st. Goals of the first meeting include discussion of: 1) coordination of care, 2) billing and reimbursement, 3) incentive funds.

Participant Documents: 1) Agenda 2) HB 2445 3) List of SBHC and medical sponsor (medical sponsor is entity that operates SBHCs and liability and owns medical records) 4) Fact sheet.

Discussion and Recurrent Themes

SBHC Role and Function:

- Our mission is to create system of care that supports school aged children; SBHCs are seen as part of the safety-net system as they serve many Medicaid children.
- We have certification standards for SBHCs that demonstrate an expectation around care coordination; SBHCs need to have referrals and a follow-up system, but details are fleshed out at the local level.
- SBHCs not required to become PCPCH recognized, but it is recommended that they align with PCPCH standards.
- SBHCs have different capabilities at the moment in regards to PCPCH recognition, and there is technical assistance incorporated into the new law to help them to become more standardized.
- The model has focus a of primary care services; many SBHCs are playing role of primary care provider for youth. Many times, there are youth choosing SBHC as primary care even if they have another provider.

Current status

- There is a lot of variety in the relationship between CCOs and SBHCs. Some of this is a product of the diversity in how CCOs are set up.
 - Some CCOs contract with different insurance entities that contract with providers
 - CCOs may or may not recognize SBHCs as primary care providers (PCPs).
 - This could be tied to communication, a lack of understanding on what SBHCs provide, or on the PCPCH status of the SBHCs
- There is a lack of capacity in billing and electronic health record (EHR)
- There may be provider competition for clients
- Metrics for CCOs should be more specific to population; SBHCs serve adolescents and there are few metrics for that population.
- SBHCs can help CCOs optimize PC from a systems standpoint. When there is a well-child screening at SBHC and screening indicates further care may be needed, CCO can strengthen communication and referral between PCP so that SBHCs are trusted to help get patients in so they can have their needs met.
- Can be siloed based on their medical sponsor.

Like relationship to be

- SBHCs recognized as valuable as youth medical homes.
- SBHCs not to be siloed and instead working with CCOs and community to make sure there is continuity of care.
- If a youth comes in and identifies SBHC as primary care provider, would like to see the SBHC reimbursed as PCP. Reimbursement is an issue.
- From a CCO standpoint, making sure that the medical sponsor is truly responsible for SBHC and is doing all the billing would be helpful.
- CCOs act more like sponsors for SBHCs. CCOs may be interested in collecting encounter data, that may be easier if it's a sponsorship relationship.
- Work towards the relationship focus being on coordination of care, and using the right person to provide that care.
- Not having care or reimbursement tied to the NP model.
- Clear role of SBHCs in community, which could change based on community needs.
- More communication between CCOs and providers.
- Coordination and information-sharing between CCOs and SBHCs
- Standardization of SBHCs
- Build trust between SBHCs and CCOs

Challenges or Barriers

- Huge variation across the state in SBHC and CCO relationships, SBHC PCPCH recognition, and contract relationships. Variation along with the lack of a concrete statewide policy makes it difficult for a State Program Office to move the model forward.
- Communication between CCOs and SBHCs has been lacking on SBHC needs.
- SBHCs need help determining how to categorize their care, e.g. who the SBHC is a PCP for, ancillary provider for, and who is carved out for confidential services.
- How to demonstrate role SBHC is playing in multiple children's lives.
- Creating a system that allows for billing and accounting for folks.
- Relationship between primary care providers in the community and SBHCs can be rocky, as there can be a perceived competition for clients.
- Varied capacity for billing and EHR, which impacts sustainability of the model, and ability for SBHC to meet PCPCH standards.
- SBHC may be recognized as a PCPCH but the provider within the SBHC may not be recognized as the PCP by a CCO. This may get in the way of patient care.
- Mixed understanding or misperceptions about quality of care in SBHCs, or that SBHCs are duplicating PCP services.
- Unclear benefits for SBHCs to become PCPCH.
- Unclear capacity of SBHCs to address mental health issues.

Next Steps and Next Meetings

Looking forward, there will be two more meetings. Theme of next meeting: coordination of care. There will be substantial time set aside to decide on incentive funds.

Appendix C: SBHC Quick Facts

School-Based Health Centers: Quick Facts

The School-Based Health Center (SBHC) model is nationally recognized and provides school-aged youth with comprehensive physical, mental, and preventive health services delivered by qualified medical providers in a school setting.

During the 2013-2014 school year, there will be **65 certified SBHCs** in operation.



Current Operations

Electronic Health Records

- 51 sites use OCHIN Epic
- 60 sites use some type of EHR

PCPCH status

- 12 sites have Tier 3 recognition
- 17 sites have Tier 2 recognition
- 39 sites are not certified

Who did Oregon school-based health centers serve last year (2012-2013)?

Oregon SBHCs had 65,705 visits, serving:

- 22,408 total patients
- 19,344 patients between 5-21 years
- 6,906 patients with 3 or more visits

Demographics for patients are shown below:

Demographic	% of All Visits	% of Patients (all)	% of Patients (5-21 yrs)
Male	39.5%	43.0%	41.3%
Female	60.5%	57.0%	58.7%
Hispanic	23.8%	21.9%	20.3%
Non-English Speaking	15.4%	14.2%	12.5%
White, Non-Hispanic	55.4%	52.1%	52.4%
Medicaid	42.3%	40.8%	38.2%
Privately Insured	13.8%	19.2%	20.3%

What services did SBHCs provide?

- 13% of visits had an **immunization** component
- 13% of visits were related to **reproductive health**
- 18% of visits were related to **mental health**
- 10% of visits contained a **well visit** (as defined by CCO metric)

How are SBHCs helping Oregon meet the adolescent well visit benchmark?

- SBHCs served **5,678** adolescent Medicaid patients (between the ages of 12-21)
 - Of those, **1,826** received an adolescent well visit (32.2%)
- SBHCs served **2,352** established adolescent Medicaid patients (3 or more visits to the SBHC)
 - Of those, **791** received an adolescent well visit (31.9%)

Adolescent well visits by CCO catchment area are shown below. (Note: data comes from the 2012-13 Encounter Data submitted by SBHCs to the State Program Office; numbers are not pulled from official Medicaid or CCO data.)

CCO	Number of SBHCs	Number of Medicaid Adolescent Patients Seen (ages 12-21)	Number of Medicaid Adolescent Patients given a Well Visit	Percentage of Medicaid Adolescent Patients given a Well Visit
Umpqua	2	135	26	19.3%
Western OR	3	110	18	16.4%
Family Care / HealthShare	21	2874	1150	40.0%
Intercommunity Health Network	6	389	101	26.0%
Trillium	6	576	155	27.0%
AllCare	13	679	53	7.8%
PacificSource (Central OR)	7	517	169	32.7%
Columbia Pacific	3	155	62	40.0%
Jackson CareConnect	9	385	48	12.5%
PrimaryHealth	3	263	3	1.1%
Eastern OR	2	116	38	32.8%
Yamhill	3	132	55	41.7%

Appendix D: 10/29/13 Workgroup Meeting Summary Notes

SBHC HB 2445 Workgroup Meeting #2: October 29, 2013 Summary Notes

Attendees by represented organization: OHA Public Health Division, OHA Medical Assistance Programs, OHA Oregon Healthy Policy and Research, Bethel School District, CareOregon, Cascade Health Alliance CCO, Clackamas County Health Department, Community Health Center Jackson County, Deschutes County Health Department, Estacada School District, FamilyCare CCO, Health Share, Kaiser Permanente, MedImmune, Multnomah County Health Department, OutsideIn, Pac/West, Trillium CCO, Washington County Department of Health and Human Services, Union County Health Department. Yamhill County Health Department.

Introductions

- This is the second meeting of the workgroup. There will be a total of three meetings.

Recap – Workgroup Goals and Previous Meeting

- Workgroup mandated by HB 2445. The purpose of the workgroup to develop recommendations for SBHCs related to billing and reimbursement, PCPCH certification, and care coordination.
- First meeting laid foundation for workgroup and helped participants understand current state of SBHC/CCO relationships, specifically regarding PCPCH and coordinated care. Summary notes are available on the SBHC State Program Office website. www.healthoregon.org/sbhc
- Goal of second meeting: Develop recommendations for the effective and efficient sure of SBHCs by CCO focused on care coordination and reimbursement. Opportunity for participants to share what's happening and understand problems/systems to help SBHCs be used more effectively.

Review of materials

SBHC Care Coordination Framework

- Core components of care coordination: Core elements identified in handout
- CCO Provider Network: SBHCs are part of this network; within SBHCs, different levels of PCPCH recognition. At minimum, all SBHCs must meet SPO certification requirements
- Common SBHC/Primary care provider utilization scenarios. Four main buckets for how students use SBHCs (not exclusive) and coordination of care is important in all scenarios. This is what is really happening at SBHCs. Scenarios do not necessarily apply for every kid utilizing SBHC and all scenarios could be happening at one SBHC. Any scenario could be happening at any PCPCH recognition levels, as well.

- The piece absent from framework is other network providers the student may be seeing for service. Because SBHCs provide easy access (and sometimes fragmented care), it is critical for SBHC providers to know where else child receives care and how to coordinate services.

Coordination of Care Discussion

What's working:

CCO relationships: Many report strong CCO/SBHC relationship. CCOs appreciate what SBHCs can contribute to health system in terms of primary care, prevention, insurance enrollment, high-risk client engagement. CCOs “get” public health; they are population-focused. Some SBHCs are included in CCO communications.

SBHC model: Works for “high risk,” frequent flier families and youth. SBHCs provide key preventative services for these populations. Aligns with CCO metrics and goals. Rural SBHCs fill gaps for patients who can't travel 50 miles for care.

Federally-qualified health centers (FQHCs): They seem well-positioned with care coordination; often have multiple PCPs in network - sometimes same PCPs in SBHCs and community clinics. SBHCs that are sponsored by FQHCs seem to have an easier time getting reimbursed for primary care services. FQHCs can transfer care in the summer to other clinics; some SBHCs become community clinics after school hours.

Communication with community providers: Some local providers know what SBHCs are, but relationships/role definition requires time to develop, especially if SBHCs acting as PCPs. Some SBHCs are able to fax client info to local providers to ensure care coordination.

EHR: Some CCOs use EPIC, so Care Everywhere helps coordinates care.

Challenges/barriers:

Relationship with local provider community:

- Some community providers often feel SBHCs are unnecessary to system. Providers have local political clout and some have pushed back against SBHCs seeking PCPCH certification and reimbursement.
- Local providers don't see value of SBHCs.
- SBHCs communicate with providers by faxing client information, but providers often don't know what to do with that information. Helpful to develop cover letter explaining reason for faxing patient information. SBHCs sometimes get info back.
- Local providers feel they “own” patients and SBHCs are competition for care reimbursement.

Role definition: Some SBHCs report lack of understanding of role that SBHC plays. Model varies according to location – some SBHCs only provide safety net services, while other SBHCs provide PCP, wrap around services. SBHCs, CCOs, and local providers all need to be clear about these roles and how everyone can work together.

EHR: Many SBHCs are on EPIC through OCHIN, but community providers are on many different EHR systems. Not sure how else to communicate with providers (except via fax). Need alignment of EHR systems among CCOs, SBHCs, and local providers.

Medical sponsorship: SBHC medical sponsor varies among the centers. Often difficult to secure SBHC medical sponsor. Non-FQHCs at disadvantage, especially when medical sponsor unable to provide extensive support. Some non-FQHCs would like CCO support in gaining FQHC status.

Populations served: SBHC clients are more high risk and often move around. Youth may not want to visit outside community providers if referred or assigned to them as PCP.

Identifying PCP:

- SBHCs often don't know who is assigned PCP; Patients also often don't know who is assigned PCP (students don't carry their insurance information).
- Assigned PCP in EHR may be different from in MMIS. Need to work with CCOs to make sure everyone knows who real PCP is. Rubber hits the road when it comes to reimbursement. When you have to look at two systems to find out the PCP, you're going to have some problems.
- SBHCs must look up assigned PCP for individual students, which is an inefficient method for identifying PCP. Would be better to receive list from CCO showing which students are assigned to SBHC as PCP, and list of community PCPs for their SBHC students.
- SBHCs play PCP role for many patients, even if not assigned as official PCP.
- Families should choose PCP themselves. Need to be intentional as far as role of SBHC for students. Process of changing PCP is inefficient for many families (two-step process).

Care coordination: If SBHC is PCP, the SBHC needs to be responsible for providing/coordinating care. If SBHC is not the PCP then the SBHC needs to be intentional about coordinating back with the PCP as far as the care the SBHC is providing for the student. No solid system yet for care coordination with network providers.

Referrals: Some SBHCs are acting as PCP, but not recognized as such, so its difficult to refer (requires prior authorization). Some patients come to SBHC exclusively, but majority have other PCP assigned by CCO. When a specialist is needed, patient must go back to PCP for a referral. Doesn't provide coordinated care and inefficient; slows everything down.

Integration of primary care and other specialty services: Different mental and dental health records and reimbursement systems.

How CCOs can help:

Educating community providers: CCO can help communicate the services SBHCs offer to community providers. CCOs could communicate that SBHCs are not duplicating services, but providing complimentary services. Include information on SBHC staffing pattern, services, and the population of students they are seeing, etc. CCOs could also delineate roles so that

providers are all on the same page. Having CCOs help communicate with community providers could be more effective than the SBHCs reaching out.

PCP assignment: CCOs and SBHCs need to communicate about which patients assigned to SBHC as PCP. SBHCs also need to know who patients' assigned PCP is, in order to properly communicate care. Potential to develop identifier to let CCO know that the provider also provides care at the SBHC? Because many providers provide care at SBHC and community clinics, CCO could send list of patients assigned PCP by provider name, so FQHCs can track assigned patients within clinic system.

Other areas of assistance: CCOs could assist SBHCs and community providers with EHR alignment and exchange of information. CCO could help SBHCs link with local providers to provide care outside of normal clinic hours.

Additional Comments:

Incentive funding could help CCOs and SBHCs meet recommendations. All recommendations should be representative of various SBHC systems and allow flexibility for regional variation, particularly in rural/frontier counties.

Possible Recommendations – Care Coordination

In order to optimize the effective and efficient use of SBHC by CCOs in the area of care coordination, the following recommendations and actions were identified.

Goal #1: To have a shared understanding of respective roles and value of SBHCs with community providers and CCOs.

- Information needs to be shared that explains the SBHC model, services offered, role in patients care, and the value of the SBHC to the CCO and community providers.

Action:

- SBHCs will provide a summary of their model including services as defined by their role in the patient's care and share the document with their regional CCO(s). CCOs will communicate this information to their provider network.
 - See State Program Office care coordination framework for potential roles in relation to PCPs.
 - The document should emphasize the core elements of the SBHC model including preventive services, accessibility and youth-focused elements of the model.
- SBHCs will provide data to the CCO that supports the prevention-based model of care.
 - Start with incentive metrics, such as Adolescent Well Visit.
- CCOs will convene/engage their provider network, including SBHCs, to discuss the role of the SBHCs in patient's care.

- The intent of this discussion would be to agree on ways to ensure efficient use of the SBHC and reduce duplication of services between SBHCs and community providers.
- The discussion is also intended to help build trusting and collaborative relationships across the CCO provider network that will allow for a more efficient referral processes.

Goal #2: SBHCs know the assigned primary care providers (PCPs) for their patients.

- In order to effectively and efficiently provide quality care to their patients, SBHCs need to communicate with the patient's PCP and vice versa.

Action

- CCOs will assist SBHCs in identifying who the PCPs are for the SBHC patients.
 - CCOs will provide a list of patients assigned to SBHC providers as their PCP. SBHC will provide list to CCO of their Medicaid patients to help identify non-SBHC PCPs for SBHC patients.
 - The intent is for the SBHCs, CCOs and other community providers to have a clear understanding of who is the patients' assigned PCP
 - ** need to assure confidentiality of care when information is shared between PCP and SBHC. What if youth does not want the assigned PCP to know they use the SBHC? Does a youth's right to confidentiality supersede the expectations around care coordination? Create system that allows for this?
 - **SBHC will need to send provider list to CCO and CCO send patients assigned to those providers as PCPs back to SBHC.
 - **Need timeline for how often reports will be sent.
 - CCOs will include SBHCs in health information exchange discussions to better utilize EHR in care coordination of patients.

Goal #3: Recognize there are specific services, mental, dental and specialty services that need to be specifically addressed regarding coordination of care between SBHCs and other community providers.

- SBHCs and CCOs need to include mental, dental and specialty services when talking about care coordination.

Reimbursement Discussion

How are SBHCs being reimbursed?

Fee-for-service: Majority of SBHCs are being reimbursed via traditional FFS model, including preventative health services.

Alternative payment methods: Some SBHCs in talks with MCOs to develop capitation payments (i.e. SBHC receives lump sum for patient's care, regardless of type of service) for private insurance patients. OHP patients on MCO plan will continue to be FFS. CCOs are continuing to work out new payment methodologies for all patients (not just SBHCs).

PCP designation: For most part, PCP status doesn't impact how centers are reimbursed, although may be an issue at a few sites. SBHCs must communicate with PCP or other providers to ensure services not duplicated (and therefore not reimbursable).

CCO contract: Some SBHC are operating under contracts with CCO, others not; Contracts vary according to medical sponsor, FQHC status, etc.

There are was discussion around the possibility of incentive funds being used to bring SBHCs on to EHR systems.

Barriers:

Prevention/non-traditional services: There are many activities that happen in an SBHC that are not billable, including those that happen even before the actual billable portion of the visit occurs (e.g., check-ins, relationship development). SBHC needs other funding sources to cover the time and work that is non-billable.

Primary care services:

- Some centers are unable to meet patient-centered primary care home (PCPCH) standards due to funding or resource constraints.
- Centers may not receive full reimbursement because they not able to be recognized as PCP.
- Annual PCP services: Can only be reimbursed once annually for certain services (well-child, immunizations, etc.). Must communicate with other local providers (if SBHC is not PCP) to ensure services not being duplicated; This can be time-consuming. CCOs are working on building care coordination platforms to prevent service duplication, but it will take awhile.

Communication:

- Some SBHC are unclear on who to communicate with in the CCO regarding how coding/billing concerns.
- DMAP clarified difference between 03 placement (schools in public education) and 11 (medical office code). Working with CMS to determine SBHC-specific code.

Referrals: Some SBHCs can not refer to specialist. Patients often go to urgent care or must receive duplicative primary care visits in order to receive referral.

FQHC status: Wrap around payment is critical to sustaining SBHC under FFS model, but requires capacity to provide full services. FQHC medical sponsorship allows for the enhanced rate.

Confidentiality and billing: Information flows back unpredictably to patient's family because of external service providers (lab, etc.) and there is concern around maintaining confidentiality of services. Some SBHCs are not billing due to confidentiality concerns.

EHR: Some sites without EHR systems have reported billing issues.

Areas for improvement:

Alternative payment methodologies: Traditional FFS model doesn't capture time SBHC staff spend on non-traditional/preventative health services. Proposed models could include flexible benefits/payments system or hybrid FFS/capitation payments. SBHCs should be included in APMs with their CCOs?

Predictability: Whatever payment structure is adopted, there must be some level of predictability to help SBHCs plan annual budgets. Knowing which health plans students are on should help predict budget for each year and plan for the future. CCO contracts should be in place to provide security.

Community Health Improvement Plans: CHIPs offer partnership opportunity for SBHCs and CCOs. SB 436 encourages CCOs to work with their community partners around health and education, specifically looking at the effective use of SBHCs.

Communication: SBHC need to know who to contact at the CCO for billing questions. DMAP, CCOs, and SBHCs need to communicate/clarify place of service codes. SBHCs need to be notified of changes immediately to reduce billing issues

Telemedicine: There are some limitations on billing for referrals that should be addressed.

Confidentiality: Need to ensure that billing/reimbursement protects confidentiality, especially if services provided by other community provider (lab, etc.).

Language for Recommendations – Reimbursement

In order to optimize the effective and efficient use of SBHC by CCOs in the area of reimbursement, the following recommendations and actions were identified.

Goal #1 Payment structures between SBHCs and CCOs should encourage financial sustainability of the SBHC.

Action:

- As CCOs are developing their alternative payment methodology they should consider payment/reimbursement for non-billable services (preventative, cost-saving care that is “effective and efficient use” of services) and recognize that this is key component of SBHC model.
- CCO should consider a hybrid payment strategy that includes some fee-for-service reimbursement and the possibility of wrap payment for non FQHC SBHCs.
- CCO should explore the role of SBHCs as part of the medical home for a patient, even if the SBHC provider is not the assigned PCP.

Goal #2: Communication and expectation around billing and reimbursement are clear and predictable.

Action:

- CCOs and SBHCs develop a formal contract that includes a payment plan.
- CCO identify a point of contact within the CCO to address billing and reimbursement questions related to the SBHC.

Goal #3 Ensure confidentiality of services when requested and appropriate.

Action:

- SBHC billing and CCO reimbursement processes should allow for confidential services,.

Closing Comments and Next Steps

- Any recommendations that are proposed should recognize and consider the differences between our SBHCs based on regions (rural, urban, frontier).
- Summary notes, including proposed recommendations, will be sent to all workgroup participants in the next couple weeks.
- The State Program Office will review recommendations and bring suggested edits to the next meeting for discussion to finalize the proposed recommendation.
- There is potential that not everyone will be fully supportive of all the proposed recommendations. A possible way to represent the recommendations would be to have workgroup members rank their level of support of each of the proposed recommendations. This will need to be discussed at the last meeting.
- Next meeting: **November 2^{5th} (1p-5p)**. Final meeting.
 - Summary recommendations. Incentive payments specifically linked to PCPCH recognition/efficient & effective use of SBHCs.
 - Report to legislature due at end of December. Will communicate drafts of this report via email.

Appendix E: SBHC Care Coordination Framework

SBHC Care Coordination Framework

Core Components of Care Coordination (adapted from NIH definition)

1. Numerous providers involved
2. Coordination is necessary to carry out disparate activities in patient's care
3. Providers need knowledge about their own and others' roles, and available resources
4. Providers rely on exchange of information
5. Integration of activities has the goal of facilitating appropriate delivery services



CCO Provider Network

SBHCs

- SBHC/ no recognition
- SBHC/ Tier 1 PCPCH
- SBHC/ Tier 2 PCPCH
- SBHC/ Tier 3 PCPCH

COMMON SBHC/PCP UTILIZATION

Scenario A

Scenario B

Scenario C

Scenario D

COMMON SBHC/PCP UTILIZATION SCENARIOS

- A. Student receives primary care svcs from non-SBHC assigned PCP; visits SBHC for periodic acute care/required immunizations only.
- B. Student receives some primary care svcs from non-SBHC assigned PCP; visits SBHC for specific types of services (e.g., family planning, mental health, dental, confidential services) + periodic acute care.
- C. Student has non-SBHC assigned PCP, but gets all services from SBHC.
- D. Student is assigned to SBHC provider as PCP and gets all services there.

Appendix F: 11/25/13 Workgroup Meeting Summary Notes & First Draft Recommendations

SBHC HB 2445 Workgroup Meeting #3: November 25, 2013 Summary Notes

Attendees by represented organization: OHA Public Health Division, OHA Medical Assistance Programs, OHA Oregon Healthy Policy and Research, Center for Human Development (Union County), Clackamas County Health Department, Deschutes County Health Department, Health Share CCO, Kaiser Permanente, The Lund Report, Multnomah County Health Department, Northwest Grassroots and Communications, Outside In, Pacific Source, PacWest, Public Health Foundation of Columbia County, Trillium CCO, Washington County Health and Human Services

Introductions

- This is the third and final meeting of the workgroup.

Recap – Workgroup Goals and Previous Meeting

- Workgroup mandated by HB 2445. The purpose of the workgroup is to develop recommendations for SBHCs related to billing and reimbursement, PCPCH certification, and care coordination.
- First meeting laid foundation for workgroup and helped participants understand current state of SBHC/CCO relationships, specifically regarding PCPCH and coordinated care.
- Second meeting's focus was to develop recommendations for the effective and efficient use of SBHCs by CCO, focused on care coordination and reimbursement. Opportunity for participants to share what's happening and understand problems/systems to help SBHCs be used more effectively. Summary notes for first and second meetings are available on the SBHC State Program Office website. www.healthoregon.org/sbhc
- Goal of third meeting: Finalize proposed workgroup recommendations and develop recommendations for incentive payments referenced in HB 2445.

Review of materials

Proposed Recommendations document

- Proposed recommendations sent out prior to meeting, as well as previous meeting minutes. Recommendation language intended to be starting point for discussion today.
- Intention of care coordination recommendations are to recognize increasing role of SBHCs within health system. Systems issues need to be addressed, gaps filled to integrate SBHCs within system. Recommendations are a starting point for future work; reports from CCOs/SBHCs can provide feedback on process and help us dive deeper moving forward.

- Oregon School-Based Health Alliance (OSBHA) will be contracted to provide technical assistance to help SBHCs/CCOs meet certain recommendations, specifically those related to care coordination, communication, and billing.

Care Coordination: Recommendations & Discussion

Goal 1: To have a shared understanding of respective roles and value of SBHCs with community providers and CCOs.

Recommendation A: SBHCs to share information explaining the SBHC model, services offered, role in patient care, and value of the SBHC to CCO and community partners.

Suggested timeline: July 1, 2014

- Derived from last workgroup discussion, re: communication issues among providers, SBHCs, and CCOs and need to clarify SBHC model among these stakeholders.
- SBHC State Program Office (SPO) could provide template to allow SBHC to fill in information on their model (populations served, age groups, etc.). SPO would provide state-level data; SBHC/LPHA could also include some local-level data points (PCPCH status, payor mix, etc.)
- Goal of template to provide macro-level view of SBHC role in service provision. Could ultimately help reduce duplication of services.
- CCO method of sharing template can vary according to ways in which CCOs currently communicating with provider network: could coincide with CCO convening of provider network (Recommendation B) or via CCO clinical advisory panel. Ultimately a local decision.
- Concern expressed regarding having sufficient data to include in CCO report. Although SPO requiring mid-year data reports this year, may not accurately reflect new payor mixes (data available mid-July 2014).
- **Recommended change: Extend information sharing deadline until September/October 2014.**

Recommendation B: CCOs to convene/engage their provider network, including SBHCs, to discuss the role of the SBHCs in patient's care and strategies to encourage coordination of care for SBHC patients.

Suggested timeline: January 1, 2015

- Derived from last workgroup discussion, re: efficient use of SBHCs, need to reduce duplication of services, and need to build trusting and collaborative relationships.
- Intention to provide opportunity to discuss what communications among these partners could look like, with goal of providing best coordinated care
- SB 436 also focused on building integration of health and education and asking CCOs to look at partnerships. Convening could help meet these goals.
 - *Note:* Intent of SB 436 also to convene conversations in areas without SBHCs and discuss model's potential in CCO region. Therefore, not necessary to delineate "in counties with SBHCs" in recommendation language.
- **Recommended change: Meetings should be provider-based (not just administrative staff) and have clinical representation, including mental and oral health.**

- **Recommended change: Require CCOs or other participating entity to report out on substance of convening.**

Recommendation C: SPO to explore how best to measure, collect and report SBHC data (including traditionally non-billable services).

Suggested timeline: January 1, 2015

- Derived from last workgroup discussion, re: sustainability of SBHC model and fee-for-service (FFS) billing.
- Potential need for another workgroup to explore data issues. However, need to explore what's already being done, how SBHCs can fit into new models, and how SBHCs need to adapt. SPO responsible for bringing information together prior to potential workgroup formation.

Goal 2: To effectively and efficiently provide quality care to SBHC patients through the collaboration with non-SBHC primary care providers.

Recommendation D: Systems will be developed between the SBHC and CCOs to better identify the SBHC patient's primary care provider (PCP).

Suggested timeline: September 1, 2014

- Derived from last workgroup discussion, re: reported difficulties of SBHCs finding out client's assigned PCP. Discussed SBHCs/CCOs sharing client lists, but in practice would be difficult. CCOs/SBHCs could negotiate what kind of information sharing system is in place (e.g., provider portal, EHR). Intent of recommendation that SBHCs need to know who assigned PCP is.
- Issues remain with defining provider role, i.e., "assigned" PCP vs. "acting" as PCP, as discussed last workgroup. Speaks to need to collect more data on what is happening on the ground before we can begin to explore this grey area.

Recommendation E: A point of contact is identified within the CCO for the SBHC to address care coordination questions or comments.

Suggested timeline: February 1, 2014

- Derived from last workgroup discussion, re: care coordination and communication issues. Intention of recommendation to clarify communication points and assign responsibility.
- **Recommended change: Language should be adjusted to say "within the CCO or its delegates."**
- **Recommended change: CCO and SBHC will negotiate and identify method of communication for coordination of care.**

Reimbursement: Recommendations & Discussion

Goal 3: Payment structures between SBHCs and CCOs should encourage financial sustainability of the SBHC.

Recommendation F: CCOs will consider SBHCs in discussions regarding alternative payment methodology in order to optimize the use of SBHCs in the provider network and support financial sustainability.

Suggested timeline: Ongoing

- Derived from last workgroup discussion, re: current payment structure (fee-for-service) and sustainability. Alternative payment methodologies (APM) still in formation; critical to include SBHCs in these discussions. SBHCs need to be considered a unique entity, given activities (“touches”) integral to SBHC model – relates to Recommendation C (“non-billable services”), so new reimbursement strategies need to be developed for SBHCs, such as hybrid payment strategy and exploring role of SBHCs as part of medical neighborhood. Timeline “ongoing” because SBHC-specific discussion can only progress as fast as broader APM discussion moves forward.
- Discussion that some entities currently experimenting with new ways to document and bill for traditionally non-billable services (including capitation rate). Key element of health system transformation (cost reduction, patient engagement).
- Recommendations focus specifically on Medicaid because HB 2445 relates to CCOs and Medicaid recipients. Most centers currently bill Medicaid – will be SBHC certification requirement in 2014. This is baseline to help SBHCs move towards billing private insurance, which is difficult given number of private plans.
- Goal to eventually be able to report on and bill for all services being delivered, to both Medicaid and private insurers.
- **Recommended change: Insert “in their case rate” in second bullet point.**

Goal 4: Communication and expectation around billing and reimbursement is clear and predictable.

Recommendation G: Create or amend formal contract that includes SBHC and CCO billing relationship and plan.

Suggested timeline: June 30, 2015

- Derived from last workgroup discussion, re: not all SBHCs have formal contracts and/or billing arrangements with their CCOs. SBHC reimbursement/funding is unpredictable.
- Intention that every SBHC system has ability and mechanism to bill CCO for services. Contract specified to provide formal relationship related to payment. Could increase reimbursement predictability. Systems that currently have agreement in place would not be required to duplicate these efforts.
- Discussion that HB 2445 does not provide enforcement or reporting mechanism. Encourage partners to discuss methods for formalizing relationship and OSBHA can provide technical assistance to facilitate these conversations.
- Discussion that some, especially larger CCO systems, contract with medical sponsors, so need clarity recommendations not require individual contracts among SBHCs/CCOs.
- **Recommended change: Clarify parties required to participate in contract process.**
- **Recommended change: Reconsider specifying “contract” in recommendation language**

Recommendation H: A point of contact is identified within the CCO for the SBHC to address billing and reimbursement questions or comments.

Suggested timeline: February 1, 2014

- Relates to Recommendation E: Opening up and clarifying lines of communication among SBHCs and CCOs. This could be a starting place for some SBHCs.

Goal #5: Ensure confidentiality of services in accordance with best practices for adolescent care.

Recommendation I: SBHC billing and CCO reimbursement processes for all confidential services.

Suggested timeline: Ongoing

- Derived from last workgroup discussion, re: confidentiality concerns related to billing and reluctance to bill for certain services if confidentiality could be compromised. Issue transcends health system transformation as far as EHR and health info sharing.
- Goal to ensure that confidentiality remains part of the dialogue as we move towards formalizing billing arrangements. Recognition that confidentiality not just a billing issue, but should be in back of our mind. For example, if sharing information with PCP, confidentiality should be considered as part of that process.
- **Recommended change: Consider applying confidentiality concerns to care coordination recommendations.**

Recommendation Summary

- Reimbursement language is vague (“could” or “might”) and does not offer specific guidance, re: billing. Recommendations written to allow for local flexibility for payment strategies. Previous workgroup sessions did not provide enough detail to deliver clear, overarching recommendations related to billing. Intent to set a clear baseline with current recommendations, open lines of conversation, push work at local level, use incentive funds to explore potential solutions, come back next biennium to look at next steps.
- **Recommended change: Employ stronger language (e.g., “will”) in recommendations, while simultaneously allowing for the precise method of meeting recommendations to be flexible.**
- Concern expressed that work not going to last without oversight. Need to incentivize discussions/partnerships and create new solutions.
- **Recommended change: Formation of new workgroup to continue to facilitate the recommendation achievement process.**
- Concern that mandate for workgroup not limited to primary care, but recommendations do not specifically call out mental health, dental care, etc. Directive to move towards integrated care, which is key aspect of SBHC model.
- **Recommended change: Highlight integration of services (as unique aspect of SBHC model) in final workgroup report.**

PCPCH Model and SBHCs Discussion

- Discussion of PCPCH recognition: the incentive for SBHCs to meet PCPCH standards (financial reimbursement) and barriers to achieving recognition (e.g., 24/7 care, care coordination, staffing capacity, data tracking). Intent of PCPCH is to provide coordinated care, foster relationships with other providers.
- Legislation/workgroup goal to help SBHCs achieve quality care guidelines underlying PCPCH standards. Intent of incentive funds is to encourage SBHCs to think about priorities and value of PCPCH model; potentially move towards recognition, while making room for local-level needs and constraints. Potential movement towards “medical neighborhood” concept: patients coming to SBHCs regardless of PCP assignment and ensuring care coordination and quality care.
- Update on PCPCH incentive funding from OHA/OHPR: ACA Medicaid supplemental payments to PCPCH-certified homes for patients with certain chronic conditions ended September 30, 2013. Some CCOs are developing mechanisms for special payment arrangements for recognized PCPCHs (varies by locality). Center for Evidence-Based Policy now using PCPCH standards as common measure of “medical home-ness;” this creates some alignment in PCPs standards among payors. Payor would make some sort of variable payment based upon level of meeting PCP standards (will vary according to payor). Each PCP should contact payors they are involved with to see what opportunities are available.

Financial Incentive Funds Discussion

- Review of HB 2445 bill language regarding incentive funds (Section 2(4)(c)(A-C)). Incentive funds offered to help meet PCPCH standards (without requiring PCPCH certification); to improve coordination of care, and to improve effectiveness of health service delivery. Amount of money is approximately \$750,000 for biennium. Language suggests that dollars are continuous.
- Legislation requires rules to be written to determine criteria for incentive funds. After recommendation language finalized, SPO will also be drafting rules to determine criteria for receipt of incentive funds.
- Two key questions: (1) What are priority recommendation activities to incentivize?; (2) What mechanism should be developed to enable work to move forward?
 - E.g., payment for completing recommendation activities vs. a pilot project in which entity provides information or workplan around specified activities that the workgroup identifies and money is used to enable that work/testing.

Priority Areas for Incentive Funds

- Discussion of eligibility for funds. Some recommendations cannot be achieved by SBHC alone. Potential to incentivize partnerships to meet goals. Could allow medical sponsors or CCOs to apply, but partnership could be required for application.
- Discussion of possibility to financially award SBHC that have already met certain recommendations and could share model with others. Funds could be awarded to bring others up to standards, or to encourage learning collaborative.

- Priority to apply incentive funds to effect systems change, as opposed to funding services that would require ongoing funding.
- Priority to incentivize system to identify PCP, especially for SBHCs/CCOs without provider portals. Foundational piece for SBHC to understand what role they play for patient and who is assigned PCP.
- Discussion of funding FTE to help meet recommendations, such as funding time for CCO staff to serve as point of contact for SBHCs, especially for large systems.
- Priority to pilot and test APM around care coordination. Relates to larger workgroup focus on supporting traditionally non-billable services at SBHCs and finding ways to bill that are sustainable via Medicaid, etc. CCOs already piloting with other priority populations.
- Priority to develop EHR systems, but concern related to magnitude of cost/sustainability. Potential to use funding to develop/leverage relationships to move towards EHR system implementation. Concern raised that focus should be broader than just information sharing via EHR, but on larger care coordination systems/communication or to build capacity for PCPCH.
- Priority to develop local relationships among CCOs and provider network. Laying relationship groundwork time-/resource-intensive, so might be helpful to fund FTE to support intensive relationship-building process.
- Priority to improve effectiveness of care for Medicaid, related to integration of services. Potential for SBHCs to be integration innovators. Pilot projects could explore this and help SBHCs and CCOs learn to work together.

Summary of priority areas for incentive funds:

- Encourage partnership: CCOs/SBHCs/LPHA
 - Potential to require partnerships to apply
- Building capacity around PCPCH: moving towards PCPCH standards and model by completing certain activities *without* requiring certification
 - PCP identification: “lean” the process; identify and address technology and communications issues
 - Develop plan to enhance care coordination capacity
- Pilot project/learning collaborative:
 - Demonstrate completion of some recommendations/help others meet recommendations
 - Alternative Payment Methodology pilots
 - Proof of concept of care coordination as billable service; Add to State Medicaid Plan.
 - Integration strategies around mental/oral services at SBHC
 - Evaluation of pilot projects to inform SBHC process of moving towards PCPCH recommendations
- FTE:
 - Fund time for a “SBHC expert” at CCO
 - Capacity building for CCO/SBHC conversations

Incentive Mechanisms

- Pilots: Bigger pilot projects with competitive RFA process; Balance with need to reach smaller centers with greatest need (not just bigger systems); Potential to structure RFQ to reach smaller systems. Frame to allow for innovative thinking within RFQ parameters. Because the funding is intended to be continuous, there is potential to reach all systems over multiple years.
 - Considerations: Raising bar for advanced systems vs. increasing capacity of smaller systems. Larger system pilot (e.g., APMs) could benefit all SBHCs, but smaller systems need to develop capacity. Also potential for multiple (smaller) systems to participate in larger pilot.
- Mini-grants: Set aside a small portion of money to meet some of the other recommendations. Short term funding needed for projects in which not a lot of money can make a big difference, such as PCP identification. May allow more SBHCs to meet workgroup recommendations/address systems issues.
- Other structure: Potential to identify key priority areas (as outlined in HB 2445); preference given to projects that address multiple areas. Allows for innovative thinking within legislation parameters.
- Project “mix”: Mini-grants to address low-hanging fruit, combined with robust dollars to focus on pilot projects (APMs, care coordination).
- Recipient(s) of funds: Original discussion that work sits with CCOs and SBHCs, so funding should be directed towards engaging these principle partners.
 - Refine language to include CCO “or its delegate” or “participating entity” to include CCO contractors.
- Joint application: Potential for joint application from CCOs/SBHCs/LPHAs, but need to guard against placing additional barriers for SBHCs without working relationship in place.

Closing Comments and Next Steps

- Summary notes, including proposed recommendations, will be sent to all workgroup participants in the next couple weeks.
- Timeline: Funding must be spent by end of biennium. Report must be submitted to legislature December 31, 2013. Will receive feedback when it goes to committee and then will move forward with RFQ. Potentially in spring 2013.
- Rosalyn will draft report that will include workgroup work, recommendation language, incentive fund recommendations. Will send out draft by mid-December. Workgroup members will have one week to submit recommendations (will give deadline date). Will incorporate recommendations and then move forward on final report.

DRAFT RECOMMENDATIONS: Updated by State Program Office

Proposed Recommendations – CARE COORDINATION

In order to optimize the effective and efficient use of SBHC by CCOs in the area of care coordination, the following recommendations and actions were identified.

Goal #1: To have a shared understanding of respective roles and value of SBHCs with community providers and CCOs.

Recommendation A

SBHCs to share information explaining the SBHC model, services offered, role in patients care, and the value of the SBHC to the CCO and community providers.

- SBHCs will provide a summary of their model including on-site services offered as defined by their role in the patient's care. This document will be shared with their regional CCO(s). CCOs will communicate this information to their provider network.
 - SBHCs have different levels of capacity to analyze and report their data. SBHC State Program Office can provide SBHCs with an outline that sites can use as a template for their summary document.
- Suggested timeline: Summary reports for all SBHCs would be completed by July1, 2014.

Recommendation B

CCOs to convene/engage their provider network, including SBHCs, to discuss the role of the SBHCs in patient's care and strategies to encourage coordination of care for SBHC patients.

- The intent of this discussion would be to agree on ways to ensure efficient use of the SBHCs and reduce duplication of services between SBHCs and local community providers.
- The discussion is also intended to help build trusting and collaborative relationships across the CCO provider network that will allow for a more efficient referral processes.
- The Oregon School-Based Health Care Alliance will be contracted with the State Program Office to help facilitate these discussions, as needed. .
- Suggested timeline: Meeting to be convened with a summary of the meeting publically available by January 1, 2015.

Recommendation C

State Program Office to explore how best to measure, collect and report SBHC data (including traditionally non-billable services)

- There is no consistency in how to collect and report on traditionally non-billable services among SBHCs.
- Suggested timeline: A draft report publically available by January 1, 2015.

Goal #2: To effectively and efficiently provide quality care to SBHC patients through the collaboration with non-SBHC primary care providers (PCPs).

Recommendation D

Systems will be developed between the SBHC and CCOs to better identify the SBHC patients' primary care providers.

- CCO will provide list of patients assigned to SBHC providers at their PCP.
- CCO and SBHC will work together to create simple systematic way to identify non-SBHC PCPs for those patients utilizing the SBHC.
- CCOs will include SBHCs in health information exchange discussions to better utilize EHR in care coordination of patients.
- Suggested timeline: A system would be in place that would allow for SBHCs to identify PCPs for their patients starting Sept 1, 2014.

Recommendation E

A point of contact is identified within the CCO for the SBHC to address care coordination questions or comments.

- Suggested timeline: Contact person identified and shared with SBHCs by February 1, 2014.

Proposed Recommendations – REIMBURSEMENT

In order to optimize the effective and efficient use of SBHC by CCOs in the area of reimbursement, the following recommendations and actions were identified.

Goal #3 Payment structures between SBHCs and CCOs should encourage financial sustainability of the SBHC.

Recommendation F

CCOs will consider SBHCs in discussions regarding alternative payment methodology in order to optimize the use of SBHCs in the provider network and support financial sustainability.

- As CCOs are developing their alternative payment methodology they should consider strategies that look at payment/reimbursement for non-billable services (preventative, cost-saving care that is “effective and efficient use” of services) and recognize that this is key component of SBHC model.
- CCO could consider a hybrid payment strategy that includes some fee-for-service reimbursement and the possibility of wrap payment for non FQHC SBHCs.
- CCO could explore the role of SBHCs as part of the medical neighborhood for a patient, even if the SBHC provider is not the assigned PCP.

- This recommendation will be linked to work done in Recommendation C; how best to measure and report on the work done in the SBHCs that represents the value of SBHCs. (includes non-billable services and billable services)
- Suggested timeline: Continuous

Goal #4: Communication and expectation around billing and reimbursement are clear and predictable.

Recommendation G

Create or amend formal contracts that include SBHC and CCO billing relationship and plan.

- Suggested timeline: Contract will be formalize at the earliest practicable date, but no later then June 30, 2015.

Recommendation H

A point of contact is identified within the CCO for the SBHC to address billing and reimbursement questions or comments.

- Suggested timeline: Contact person identified and shared with SBHCs by February 1, 2014.

Goal #5 Ensure confidentiality of services in accordance with best practices for adolescent care.

Recommendation I

SBHC billing and CCO reimbursement processes all for confidential services.

- Recognize that ensuring confidentiality should not be limited to billing practices and is not a concern within only SBHCs.
- Suggested timeline: Continuous