Inventory of Payment Models that Promote Comprehensive Prevention Services: California School-Based Health Alliance

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Overview

This working document identifies payment reform strategies and initiatives that may inform the efforts of School Based Health Centers (SBHCs) in California to provide comprehensive prevention services.

This information is intended to be a reference for the California School-Based Health Alliance as they identify opportunities for increasing the incentive and resources for the services that SBHCs in California consider “unreimbursable.”

It is important to note that this inventory does not address the results and outcomes of the strategies and initiatives described. In many cases, the programs listed are just launching, and there is no (or insufficient) data to evaluate their effectiveness or impact.

Users Guide

The inventory is presented in a table format. Payment Reform strategies are categorized based on the title, type, summary description, relevance to SBHCs, target population, model, and other considerations. Models include:

- Fee-for-Service
- Primary Care Medical Home
- Bundled Payments
- Prospective Payment System
- Primary Care Capitated Payment
- Pay for Performance
- Global Payments
- Grants

Programs using similar approaches are categorized together to provide the user with a quick visual crosswalk of like programs.

Definitions of Payment Models

Fee-for-Service (FFS) Payments: Providers are paid established rates for rendering, for the most part, face-to-face health consultations and procedures for patients. This payment methodology has formed the basis of how Medicare, Medicaid and commercial health plans have historically paid most American primary care and specialty care providers. The financial incentive under this system is for providers to see more patient volume and to do more highly reimbursed procedures. There is no incentive to use high-value approaches or deliver on desired outcomes, although such incentives can be "layered onto" a FFS model.

Primary Care Medical Home (PCMH): This model is designed around patient needs and aims to improve access to care, increase care coordination and enhance overall quality, while simultaneously reducing costs. The medical home relies on a team of providers—such as physicians, nurses, nutritionists, pharmacists, and social workers—to meet a patient's primary health care needs and coordinate care among the various parts of the health care system. Studies have shown that the medical home model's attention to the whole person and coordination of all aspects of health care offer potential to improve physical health, behavioral health, access to community-based social services and management of chronic conditions. PCMH payments are most frequently paid as per-member-per-month (PMPM) supplemental payments for a practice to provide a bundle of PCMH services, such as care coordination and care management. Supplemental payment refers to payments being made "on top of" either fee-for-service or capitated payments for primary care services.

Bundled Payments: This model combines two key concepts: 1) episode-based payments and 2) bundled service payments. "Episode-based payments" are single payments designed to cover the cost of all services delivered across settings during a defined episode of care, usually defined by a diagnosis and a time period (e.g., beginning three days prior to a knee replacement surgery and extending 30 days past a patient's discharge from the hospital for this procedure). These payments are considered "bundled" since payments for services delivered by multiple providers can be combined into a single payment, which is then divided up between these providers as they see fit. Episode-based payments have held allure for hospitals wanting to drive surgical quality outcomes or reduce incentive for unnecessary yet costly imaging services. This is done by structuring episode-based payments to not cover surgical complications or to only estimate that a limited number of episodes will require imaging services. Despite their conceptual allure, most systems trying to experiment with episode-based payments have encountered multiple implementation challenges. Bundled service payments are a single payment for a collection of services. In Federally Qualified Health Centers (FQHC), Prospective Payment System (PPS) payments are bundled in the sense that the payment for each visit is designed to include both medical services and enabling services, such as language translation, transportation, and enrollment into public insurance programs. Both episode-based payments and bundled payments have been criticized for not decreasing the financial incentive to perform more episodes (ex. Knee surgeries) or bundled visits.

Primary Care Capitated Payment: This payment model is when a primary care provider accepts a fixed prospective PMPM payment for rendering all primary care and preventive services to an assigned member. Under capitated payments, providers are bearing financial risk because they are paid the same amount regardless of the amount of primary care services rendered. The cited benefits of capitation payment for providers are that it can provide some flexibility in services rendered and a predictable cash flow. A common critique of primary care capitation is that is can reduce the incentive for providers to see patients and thus capitation payments are often accompanied by access requirements and/or meeting quality thresholds.

Prospective Payment System: A Prospective Payment System (PPS) is a method of reimbursement in which Medicare or Medicaid payment is made based on a predetermined, fixed amount paid to a provider for a service or bundle of services. The payment amount for a particular service can be derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services). Centers for Medicare and Medicaid Services (CMS) uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. State Medicaid departments are required to pay some providers, including FQHC and Rural Health Clinics (RHCs), through a PPS methodology.

Pay for Performance (P4P): Pay for performance rewards providers for meeting or exceeding pre-established benchmarks for care processes and/or patient health outcomes. Similarly, hospitals that score well on quality-of-care measures such as surgical complications or mortality may receive financial rewards. While P4P has traditionally been focused on quality and patient experience metrics, it is now being expanded to include "value measures" or "Triple Aim measures," such as inpatient utilization, emergency department utilization, and total cost of care.

Global Payments: These payments (sometimes called "global capitation") are usually paid to a single risk-bearing entity or health care organization, and are designed to cover a complete array of services for a population of patients over a defined period of time (for example, all of a population of patients' health care needs over the course of a year, instead of only the services associated with a given condition or procedure). Global payments are currently used by private managed care organizations (MCOs), including publicly financed products like Medicare Advantage plans and Medicaid managed care plans. Increasingly, accountable care organizations (ACOs) are accepting global capitation for assigned patients. Under global capitation, if services rendered to assigned patients across the health system cost less than the amount paid to the MCO or ACO the organization keeps the leftover funds as profit. To ensure providers or MCOs do not withhold needed care, globally capitation of plans and providers is accompanied by requirements to report on quality and utilization measures, which can be linked to performance bonuses or publicly reported. The amount of a global payment can be based on normative standards (e.g., the average risk-adjusted payment for the population in the community) or based on historical spending for the population cared for by the capitated organization, trended forward. Global capitation can allow for significant flexibility in how health funds are spent. However, globally capitated entities still have to make decisions about how they are going to pay individual providers (e.g., partial capitation, FFS, episode-based payment, P4P, PCMH supplemental or some combination).

California School-Based Health Alliance Payment Reform Models and Opportunities

Two tables are included in the following inventory. The first table summarizes payment models that could potentially be employed by California SBHCs to increase incentives and resources for traditionally "unreimbursable" services, such as (but not limited to) counseling, case management, health education, group sessions or group health promotion in the school district. The second table summarizes possible opportunities that California SBHCs may pursue as they plan for the future.

Table I. Payment Reform Models					
Title	**Type**	**Description**	**Relevance to SBHCs**	**Target Pop.**	**Covered Services**
FQHC Scope of Services Change See the Bureau of Primary Health Care website	Prospective Payment System	Change in the scope of services is a mechanism for adjusting the Medicaid reimbursement rate of a FQHC due to "a change in the type, intensity, duration and /or amount of services." A HRSA approved change in scope modifies the services or sites in the grantee's scope of project for the section 330 grant. It does not approve a "change in the scope of services" for State Medicaid reimbursement purposes. A "change in the scope of services" is defined differently in each State's Medicaid Plan. The State Medicaid Agency must be contacted if a change in scope of services is being requested by a health center. State approved "change in the scope of service" can result in an increase or decrease in FQHC Medicaid reimbursement.	For SBHCs that are FQHCs or look-alikes, they can submit a change in scope of services, following CA guidelines, which allow for preventive services, prevention guidance and treatment and reimbursement of doctors and registered dieticians for their services.	Medi-Cal	Primary Care and Enabling Services (i.e. case manage-ment)
Michigan Initiative See Michigan Initiative website.	Enhanced Capitation Payments	To ensure funding for outreach and education services to the Medicaid population by school-based health centers, the Michigan Initiative maximized the federal matching dollars by leveraging appropriated state K-12 budget dollars (combining the funds appropriated for SBHCs and the funds appropriated for the State health education curriculum), with the additional funds going to increase the capitated payment to Medicaid managed care plans (which required a comprehensive managed	The Michigan initiative, which involves enhanced capitation payments to MCOs for SBHC outreach and education, is a promising model.	Medicaid	Outreach and Health Education

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		care waiver from the CMS). The increase in payment for Medicaid managed care providers required came from federal coffers but most was turned over by the managed care plans to SBHCs for the purposes of delivering health education and outreach to Medicaid-eligible or Medicaid-enrolled students. Michigan's Medicaid office wrote a concept paper followed by a formal request to CMS that emphasized the goals of the model, which included reporting requirements for SBHCs to track health education and outreach.			
Alliance for a Healthier Generation- **Healthier Generations Benefit** See website	Health Plan Benefit	A national organization, the Alliance for a Healthier Generation, offers the Healthier Generation Benefit which is designed to provide comprehensive services to prevent and treat childhood obesity. Participating insurers and employers commit to offering the benefit as part of their medical benefits. The benefit includes at least four annual visits with his/her primary care provider and four visits with a registered dietician for children regardless of weight or to children with BMI's at or above the 85th percentile. The benefit is available for three years and potentially longer depending on evaluation results. Participating providers offer services as part of the benefit and have access to tools and resources and free CME credit webinars.	Insurers/employers can add the Healthier Generations Benefit to their medical benefits. The Alliance convinces insurer/employers to add the benefit by 1) demonstrating cost-neutrality through actuarial analysis and 2) providing expert guidance on appropriate number of visits with specified providers. Provider reimbursement is determined by the insurer. The Alliance engages local providers to participate by working with the local chapters of the American Academy of Pediatrics and working with local providers to educate about the benefit. The benefit is primarily offered through commercial and individual plan. At this point, only a few insurers	Youth (3-18 years old)	Obesity prevention

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			offer the benefit to their Medicaid beneficiaries, likely due to risk of modifying their Medicaid rate with the state.		
Collaboration between risk-bearing entity (MCO) and SBHCs to avoid high-cost events	ACO	In Virginia, Aetna contracts with Child Health Investment Partnership of the Roanoke Valley to provide home visiting with a health focus to its highest utilizers. The contract is paid per member per month. There is also an emphasis on collecting data in the client's home on quality indicators (HEDIS measures, health outcomes, reduced costs). Services provided include oral health, asthma management, prenatal care, and behavioral health. Partner for Kids, an Ohio-based pediatric ACO, uses excess funds from capitated payments to invest in preventative services that help reduce their downside risk for high cost patients. ACO contracts with all 5 Medicaid MCO and is responsible for all Medicaid managed care children in 34 counties including financial and clinical risk. School-based preventative services that the ACO invests in include: teen pregnancy prevention (Safe Choices program); asthma therapy (Medicaid coverage of two inhalers, one is kept and routinely accessed at school) and behavioral health (pilot of Good Behavior game for positive social-behavior). Key factors to ACO investment include: data analysis on quality and utilization, financial risk, incremental approach and stakeholder engagement/shared resources.	Since CA does not have ACOs, this model would need to be proposed in MCO system. SBHCs could replicate the model by advocating to a Medi-Cal MCO to fund certain types of prevention activities, such as teen pregnancy prevention or access to second prescribed inhaler at school, based on SBHC access to certain populations served by MCO and potential to reduce MCO costs. Emphasis on data collection, quality and utilization outcomes, and financial risk in both models.	Medi-Cal	Health education

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Title	**Type**	**Description**	**Relevance to SBHCs**	**Target Pop.**	**Covered Services**
Oregon Coordinated Care Organizations (CCO) See School Based Health Alliance for more information.	Global Payment Grants	State legislation encourages Oregon's CCOs (regional ACO-like entities), under a global budget, to: 1) integrate school-based physical, behavioral, and oral health care into their networks; and 2) identify improvements in school-based health care systems. State law also authorizes the Oregon Health Authority to provide incentive grants to CCOs to help facilitate integration of school health providers and services across the networks. Proposed regulations regarding these incentive funds are in the public comment stage. Oregon's SBHC State Program Office strongly encourages all SBHCs to become state-recognized Patient Centered Primary Care Homes (PCPCHs). CCOs are required to include recognized primary care homes in their networks of care to the maximum extent feasible.	In Oregon, the SBHC model has been incorporated in the framework for CCOs both statewide and locally. For example, Multnomah County in Oregon secured contracts with their local CCOs to reimburse SBHCs for services provided to the networks' school-age enrollees. The county's SBHCs are all certified PCPCHs. The CCOs are required to report these and 16 other quality health metrics to document care improvement. Based on their overall performance on these measures, the CCOs may receive financial incentives – or penalties – from the Oregon Health Authority. The Oregon Health Authority has set Triple AIM goals under health reform and each center must provide primary care screening and patient education to maintain its certification. Is payment authorized for patients for whom the	Medicaid	All Physical health services (including Primary Care) Behavioral Health Oral Health
Accountable Care Communities (ACC)	Community-focused, ACO-like	One of four proposed initiatives in the California State Innovations Model grant (CalSIM), ACCs incorporate a community focus and are designed to include multiple stakeholders to improve geographically-designed population health. A newer concept, ACCs expand on core delivery system reform to prevention and population-based health methods in the broader community. A broad collaborative	SBHCs could engage in the proposed CA ACC initiative to be an active participant. Demonstration funding in California could be used to build on ACCs and extend their reach to provide a comprehensive, yet contained, vehicle to test payment reform options that incentivize prevention and	Population health, community-based (counties)	Broad population health focus-dependent on community focus

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		of community stakeholders (e.g., traditional health providers, social services, local government, CBOs, employers, faith-based organizations, and others) together set the goals for population health in the specific community and mobilize resources, finances and activities. Austen BioInnovation Institute (ABIA) in Akron, Ohio led the ACC movement which leverages resources from multiple diverse community sectors to integrate services across the continuum of care to impact a range of social determinants of health.	population health. For example, in Ohio the Akron ACC began with three major focuses, one being activities to reduce the risk of diabetes through weight loss and exercise programs. In its first 18 months, the initiative saw positive results in terms of weight loss, a ten percent reduction in the average cost per month of care for persons with diabetes, and a drop in emergency department visits associated with the condition. Another focus included health education and screening for underserved populations through partnerships with the faith-based community.		
Primary Care Capitated Payment See JSI's Report Building the Foundation for Payment Reform for Community Health Centersin California	Primary Care Capitated Payment	Health centers may advocate for primary care capitation payment that takes enabling services into account, that is higher for more acute populations, that increases with a realistic inflation factor and is adjusted upwards based on social acuity factors. Co-morbid behavioral health diagnosis would be one factor used for capitation adjustment. Health centers can begin the process for identifying a handful of other social acuity factors, piloting studies to confirm their influence and then developing systems to expand data collection.	By following these steps, FQHCs (including SBHCs) will be able to argue for data-driven adjustment of capitation p ayments based on the psychosocial complexities of the populations they serve.	Acute popula-tions	Enabling services

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Title	**Type**	**Description**	**Relevance to SBHCs**	**Target Pop.**	**Covered Services**
Conversion of California FQHC PPS rate to a capitated equivalent	Capitated Payments	Under federal law, states may provide an alternative to PPS by submitting a State Plan Amendment (SPA) for an APM to the Centers for Medicare and Medicaid Services (CMS).The California Primary Care Association (CPCA) and California Association of Public Hospitals (CAPH) submitted a proposal to California Department of Health Care Services (DHCS) to convert the existing FQHC PPS rate to a capitated equivalent under an Alternative Payment Methodology (APM).	If submitted to CMS and approved, there would be an opportunity for SBHCs associated with participating pilot FQHCs and serving as the assigned PCP for some of their patients to use PPS funds more flexibly to deliver services.	Medi-Cal FQHCs	To be determined
Iora Health See Iora website	IPA (Health Plan Substitute)	Iora Health is a disruptive innovation in the primary care marketplace that accepts a flat higher- than-average primary care fee to focus on the patient's overall health, without doing any traditional billing. Patients are not charged a co-pay fee for provider contacts, and providers are encouraged to use creativity in addressing health issues and reducing overall health system costs. Iora is (currently) serving patient populations associated with self-insured organizations, such as Dartmouth College. Iora provides technology infrastructure to primary care health practices to facilitate a wide range of services all aimed at producing health outcomes for patient populations and cost savings to the self-insured organization. While Iora would like to expand its model of care delivery to Medicare and Medicaid, they have not yet been able to navigate around federal requirements for actuarial soundness and the need to document utilization, not just outcomes. The fact that Iora works with self-insured employers who pay their employees'	SBHCs, or a contracting entity, could consider contracting with Iora to establish a primary care prevention-focused health service option and negotiate a monthly fee for each patient in the limited but growing geographies where Iora operates in conjunction with self-insured entities (Las Vegas-Casino Workers' Union, Dorchester Carpenter's Union, New Hampshire-Dartmouth College, Brooklyn-Freelance writers' union). Iora is not currently in the CA market and may not enter it, due to strong Kaiser presence. Iora is different from Kaiser or ACOs in that they do not accept any payments from government health programs or private insurers. Like Kaiser, Iora uses a team-based approach to care yet Iora uses a nurse or NP to oversee the care management, not a physician.	All	Primary Care Behavioral Health

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		health costs directly, not through an insurer, is what makes the model unique.	In scanning internet sources, Iora appears to be a trend among self-insured employers and direct primary care providers, however not specifically in California.		

Table II. Opportunities for California SBHCs to increase incentives and resources for traditionally "unreimbursable" services					
Title	**Type**	**Opportunity Description**	**Relevance to SBHCs**	**Target Population**	**Covered Services**
2703 Supplemental Payments (with CalSIM)	Primary Care Health Home	Section 2703 of the Affordable Care Act offers an opportunity to draw down a 90/10 federal match for health home services for individuals with chronic conditions. Pairing both Cal SIM resources to provide training in complex case management with 2703 supplemental payments, Medi-Cal providers may be able to deliver the case management/care coordination for individuals with chronic conditions that would qualify under a 2703 benefit.	The Children's Now project is advocating for CA to build a health home model via the 2703 supplemental payments that includes child-centered health homes for specific MediCal enrollees, including children with special health care needs, high-risk infants, and foster youth. They include optional payment policies that leverage funds (blended funding) and incentivize providers (ie. SBHC use health and education funds).	Medi-Cal	Case Mgmt Care Coord.
Incorporating social determinants of health into capitated payments	Capitated Payments	A new National Association of Community Health Centers (NACHC) and the Oregon Primary Care Association (ORPCA) project, funded by Kellogg, focuses on incorporating social determinants of health into risk adjustment for future capitation– resulting in reimbursement for low-income populations at higher rates because of social determinants of health (and the case management required to address social determinants).	Although a future looking project that is in its early stages, it would be an opportunity for SBHCs, which would require grant funding.	Medi-Cal FQHCs	Medi-Cal approved services

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Title	**Type**	**Opportunity Description**	**Relevance to SBHCs**	**Target Population**	**Covered Services**
Enabling Services Accountability Project Funding from the Office of Minority Health and the California Health Foundation See California AAPCHO website	Grant	California-based Asian American & Native Hawaiian and Other Pacific Islanders (AA&NHOPI) Association's Enabling Services Accountability Project increased Electronic Medical Record (EMR) data collection on enabling services and studied the impact of these services on health care access and outcomes. Overall, the project illustrated the role enabling services play in increasing access and quality of health care for medically underserved communities of color, providing compelling data to adequately compensate health centers for delivering these services.	SBHCs could pursue similar grant funding to support enabling services and document their benefits to health outcomes, laying the groundwork for future reimbursement of those services.	AA&NHOPI and FQHCs	Enabling Services
South Carolina CMS Innovations Grant	Grant	Eau Claire Cooperative Health Centers, Inc. in partnership with the Select Health Managed Care Organization received a CMS Innovations Grant for a project aimed at improving health outcomes for populations in underserved, low-income areas in Columbia, South Carolina. Eau Claire will use health care teams of nurse practitioners, registered nurses and community health workers affiliated with the health center to provide patient education, home visits and care coordination. Payers have agreed to share a portion of the cost savings from improved self-care, decreased hospitalizations and emergency department visits. The three-year project will create 22 health care jobs for peer health workers, nurses, community organizers, project directors.	This project will be complete in 2015. Results from this model inspire future funding for collaborations that offer reimbursement for health education and care coordination	Under-served popula-tions	Health education, Care Coordinati on, Home visiting