

Abstract

The value of school-based health centers (SBHCs) in supporting health, prevention and education for young people is well documented.¹ However, it is challenging to identify payment models that support the unique services and service delivery models employed by SBHCs. Establishing reliable funding from public and private sectors for comprehensive prevention services provided by California SBHCs is essential to the long-term sustainability of SBHCs, and for improving the health of the populations they serve. This issue brief explores innovative payment reform strategies and policy changes that could support California SBHC comprehensive prevention services. These strategies include:

- **Strategies for Maximizing Reimbursement through Risk-Bearing Entities (RBEs):**
 - Contracting for specific preventive services
 - Participating in a capitation arrangement
- **Strategies for Maximizing Reimbursement through Medi-Cal:**
 - Exploring opportunities to expand Federally Qualified Health Center (FQHC) SBHC Scope of Services
 - Contracting with Medi-Cal managed care organizations (MCOs) or MCOs' delegated behavioral health organization
 - Advocating for Medi-Cal coverage of preventive services delivered by Medi-Cal non-licensed providers under direction of a licensed provider
 - Advocating for Medi-Cal's MCOs reimbursement of SBHC services
 - Advocating for increased federal matching drawdown with education funds
- **Current Opportunities to Integrate Services into the Larger Health Care Landscape:**
 - Promoting the value of SBHCs in Accountable Care Communities (ACC)
 - Advocating for California's potential pursuit of a section 2703 Patient Centered Health Home (PCHH) State Plan Amendment (SPA) for new care coordination funds for eligible clients
 - Leveraging Affordable Care Act (ACA) Community Benefit Standards for Hospitals

The foundation for any successful strategy or policy is fully understanding and clearly articulating the value of SBHCs in helping health care payers meet their goals. This issue brief addresses the value of SBHCs to payers and describes next steps for SBHCs to consider as they move forward with the concepts presented.

- **Recommended Next Steps for SBHCs Include:**
 - Ensuring SBHC capacity to obtain data on the value of comprehensive prevention services to the broader health care system
 - Articulating SBHC value in addressing the social determinants of health
 - Preparing SBHC leaders to effectively communicate opportunities to increase payment for SBHC prevention services through payment and delivery reform
 - Identifying the capacities needed for SBHCs to engage in promising health care reforms that support preventive services
 - Conducting cost modeling of SBHC payment structures to sustain services
 - Pursuing FQHC payment reform to promote inclusion of social acuity factors and comprehensive prevention services

Introduction

In this era of health reform, the Triple Aim has emerged as a guiding framework for delivery system transformation. The Triple Aim focuses on improving the patient experience (quality of care and satisfaction), improving population health, and reducing per capita costs. As public and private sector entities transform to meet Triple Aim goals, there is a growing recognition that payment reform is a pivotal catalyst and critical element of a transformed health care system. As such, payment reform initiatives are emerging at an accelerating rate.

One overarching goal of most payment reform efforts is the transition from a system that pays for the volume of health services to one that rewards providing the best care and quality outcomes for a population at the lowest total cost. Delivery system reforms increasingly recognize the need to provide comprehensive prevention services, and to address social determinants of health. Reform efforts create opportunities for school-based health centers (SBHCs) to re-examine how services are delivered and reimbursed and to assess how the SBHC model fits into the broader health service delivery system.

SBHCs are directly impacted by payment and delivery system reforms through their operating organizations and funding sources. In California, there are currently 226 school health centers serving some of the state's most vulnerable children.ⁱⁱ The most common types of organizations that operate SBHCs in California are Federally Qualified Health Centers (FQHCs) and school districts. Other sponsoring organizations include county health departments, hospitals/medical centers, mental health agencies, nonprofit community-based organizations, and private physician groups.ⁱⁱⁱ California SBHC funding sources include: Medi-Cal, Family Planning, Access, Care, and Treatment (FamilyPACT) or Child Health and Disability Prevention Program (CHDP); county and school district funds; private and government grants; subsidies from the sponsoring organization and donations.^{iv} However, many of the comprehensive prevention services that SBHCs provide are not typically reimbursed by payers.

The California School Based Health Alliance identified an opportunity to better understand how emerging payment models might impact and support SBHCs. To build SBHC understanding of payment and delivery system reform opportunities, the California School Based Health Alliance, along with John Snow, Inc., a public health research and consulting organization with a focus on vulnerable populations, drafted an inventory of payment models that support comprehensive prevention services. The inventory is designed as a "living" document and will be updated as models and examples arise and evolve. This issue brief analyzes the major concepts captured in the inventory to date that could be leveraged to secure payment for California SBHC comprehensive prevention services, with consideration of California's current payment reform landscape.

Comprehensive Prevention Services are provided to individuals to prevent the onset of a targeted condition including counseling, health education, group sessions, and health screenings.

To determine the most appropriate strategy, SBHCs must consider 1) the type of comprehensive prevention services offered and how they are delivered; 2) the payer source for the service (public or private); 3) whether the service is a Medi-Cal covered benefit and 4) how the services will be funded.

Strategies for Maximizing Reimbursement through Risk-Bearing Entities (RBEs)

Regardless of payer source, SBHCs must identify the benefit to the payer of the comprehensive prevention service provided. This may include demonstrated positive health outcomes, cost savings or cost-neutrality for the payer source, and/or access to a hard-to-reach population served through SBHCs. Once these benefits are identified, SBHCs could sustain comprehensive prevention services through either commercial payers or Medi-Cal through one or more of the following strategies.

Execute contractual agreements for specific preventive services. SBHCs can demonstrate to RBEs, such as managed care organizations (MCOs) and commercial Accountable Care Organizations (ACOs), how school-based preventive services help meet goals of access to quality care and reduction of avoidable or preventable utilization. SBHCs could identify specific chronic diseases or issues where SBHC services are associated with high-quality, cost-effective outcomes. Such areas might include: asthma prevention/treatment, teen pregnancy prevention, diabetes prevention, behavioral health concerns and access to care for high-risk populations. RBEs could use the flexibility of global or capitated payments to fund SBHC services that align with the RBEs access and utilization goals.

One example of contractual financing for preventive services through commercial plans is in The Alliance for a Healthier Generation's Benefit. The Alliance for a Healthier Generation is a national organization addressing childhood obesity by creating a payment mechanism to reimburse providers for comprehensive obesity prevention and treatment services. The Alliance persuades insurers (primarily commercial) and employers to offer a specific benefit package of comprehensive obesity and treatment services for children and families. Two key factors help convince insurers and employers to include the benefit in covered services: 1) expert guidance on the number of visits with providers (primary care physician and registered dietician) and 2) actuarial analysis demonstrating cost neutrality. Participating insurers and employers not only agree to add/pay for the covered services but also periodically market the benefit to their plan's beneficiaries.

The partnership between Aetna and the Child Health Investment Partnership (CHIP) of the Roanoke Valley in Virginia demonstrates reimbursement of comprehensive preventive services through a contract with a Medicaid ACO. Aetna contracts with the CHIP of Roanoke Valley Virginia to provide home visits focused on its highest health care utilizers, paid on a per member per month basis, similar to an ACO arrangement. Set services include oral health, asthma management, prenatal care and behavioral health. This partnership emphasizes collection of client data on quality indicators (Health Care Effectiveness Data and Information Set (HEDIS) measures, health outcomes and reduced costs). The CHIP of Roanoke Valley example highlights the importance of SBHCs articulating their ability to address and improve HEDIS scores, which health plans are held accountable for addressing for quality. In order to pursue such a model, SBHCs would need to negotiate a clear set of services (such as asthma management or oral health), demonstrate their ability to provide these set services, and hold themselves accountable for meeting quality standards.

Participate in a Capitation Arrangement. In addition to establishing contracts with RBEs for specific services, it is important for SBHCs to consider how they would be paid to provide comprehensive preventive services. Capitated payment arrangements are a type of payment mechanism that offer greater flexibility in funding services through a fixed prospective per-member-per-month (PMPM) payments for rendering all primary care and preventive services to an assigned member. Compared to fee-for-service (FFS) reimbursement, a capitated payment not only allows for greater flexibility in the services a provider can render but a predictable cash flow. Under capitated payments, providers are bearing financial risk because they are paid the same amount regardless of the amount of primary care services rendered. SBHCs might benefit from the flexibility to use capitation payments for preventive services.

By contracting with RBEs such as an MCO or ACO, as discussed above, that is receiving capitated payments, the RBE's could use the flexibility of their capitated payments to fund SBHC comprehensive prevention services. The pediatric ACO, Partners for Kids, a part of the Nationwide Children's Hospital in Columbus, Ohio, provides an example of how the flexibility of capitated payments could benefit SBHCs and of the critical components to support this type of payment arrangement. The pediatric ACO, part of a physician's health organization, contracts with and receives capitated payments from all five Medicaid MCOs. The ACO is responsible for all Medicaid managed care children in 34 counties and bears all financial and clinical risk.

The ACO uses flexibility of capitation to invest in preventive services such as teen pregnancy prevention, asthma therapy and behavioral health prevention, which result in reduced health care costs and thus savings to the ACO. Common themes among the preventive services funded by the ACO include: use of evidence-based practices, analysis of quality and utilization metrics important to the payer (e.g., HEDIS measures), level of financial risk to ACO, incremental approach to preventive service projects (e.g., pilots) and multiple stakeholder participation, including shared resources. It is important to note that the pediatric ACO's high financial risk supports a willingness to identify, fund, and assess investment in preventive services that reduce their downside costs. This level of investment may not occur when the MCOs only have a fraction of the risk (and thus limited ability to capture resulting savings) because there are multiple MCOs in the service area. One solution would be to convene a community coalition, including local payer sources, which could agree upon, and mutually benefit from, shared investment in specific preventive services.

Strategies for Maximizing Reimbursement through Medi-Cal

Medi-Cal is a primary payer source for SBHC services. In assessing which strategy SBHCs should employ to sustain comprehensive preventive services, SBHCs must determine whether the service is an allowed benefit through federal regulation and California's Medi-Cal program.

Medi-Cal Covered Services

If the preventive service is a Medi-Cal covered service, the SBHC must determine why they are not reimbursed for the service. Reasons may include an FQHC-operated SBHC has not included the service in their scope; the SBHC is not recognized as the patient's Primary Care Physician; or there is a lack of information on the required protocol allowing the service to be billable. Specific strategies for SBHCs to consider are presented below.

Explore Opportunities to Expand FQHC SBHC Scope of Services. California SBHCs that are FQHCs or look-alikes receive a bundled per-visit payment for all qualifying visits under the PPS. While PPS rates can include the cost of delivering preventive services, prevention guidance and treatment, and physician, nurse practitioner and registered dietitian services, a health center can only bill a PPS rate when a patient sees a provider face-to-face. Nevertheless, the PPS rate offers one opportunity for FQHC SBHCs to use part of the revenue generated from visit-based bundled payments to deliver ongoing preventive services. For FQHC SBHCs wanting to expand preventive services, it is possible for a health center to submit a change in scope of services due to "a change in the type, intensity, duration, or amount of services" while following California guidelines.^v A scope change results in the health center receiving a new PPS rate that incorporates the costs of the expanded scope of services.^{vi} If the increased cost for delivering expanded school-based preventive services does not meet the 1.75 overall cost increase threshold for a scope change, the FQHC could include, or "piggy-back," the expansion of certain school-based preventive services into another scope of service change request, such as implementation of Electronic Health Records.

Scope change as a strategy for increasing a PPS rate of an FQHC SBHC should be approached with some caution. Given current California State Medi-Cal practice of applying a productivity screen during scope changes, some health centers have found that despite offering additional services, their new rate is less than their previous rate. The California Primary Care Association (CPCA) has challenged the legality of the productivity screen practice and is expecting a response to the legal challenge in the near future.

Contract with Medi-Cal MCOs or MCOs' delegated behavioral health organization to provide mental health services to youth. A recent California regulation requires Medi-Cal managed care plans to cover mild to moderate mental health services, most frequently reimbursed on a FFS basis. These newly covered services include individual and group mental health evaluation and treatment (psychotherapy). MCOs are currently building their behavioral health networks to provide this expanded benefit, presenting an

opportunity for SBHCs that provide mental health services to participate in these networks. SBHCs offer an ideal setting to reach adolescents, whose behavioral health issues often meet the mild to moderate criteria.

Advocate for policy change allowing Medi-Cal preventive services delivered by Medi-Cal non-licensed providers under direction of a licensed provider. A recent rule change by the Centers for Medicare and Medicaid Services (CMS) clarifies that states can reimburse for preventive services *recommended* by a physician or other licensed practitioner as long as the services remain within the scope of their practice under State law.^{vii} This clarification is a marked difference from previous guidance that States could only cover preventive services *provided* by a licensed practitioner. This change expands the types of health professionals who can provide reimbursable preventive services. It also expands the potential list of reimbursable services typically provided by non-licensed providers many of which are typically unreimbursed services provided by SBHCs. These could potentially include care coordination, home visits, group health education (providing the Medicaid enrollee has some one-on-one contact with a counselor) and services provided by Community Health Workers (CHWs).^{viii}

While an ideal opportunity to fund SBHC preventive services, this policy change would require an investment from the state to submit a State Plan Amendment (SPA) detailing the covered services, providers, training/credentialing, reimbursement process, and implementation and monitoring of the new policy. In California, such a change is aligned with the Let's Get Healthy California framework and California State Innovation Model (CalSIM) proposal, which both reflect an interest in supporting use of non-licensed providers, such as CHWs. SBHCs could leverage this interest to advocate for policy changes allowing non-licensed providers, such as CHWs, to be reimbursed for certain preventive services.

Service Not Covered by Medi-Cal

If the preventive service is not a Medi-Cal covered service, the SBHC could consider the approaches presented below.

Advocate for Medi-Cal's MCOs reimbursement of SBHC services. SBHCs could advocate for certain SBHC services to be included in the contracts that MCOs issue to providers indicating which services the MCO will cover. While Medi-Cal MCOs have the flexibility to offer services outside of Medi-Cal covered benefits, MCOs run the risk of reducing their Medi-Cal rate in future years if services provided are not included when rates are revised. To overcome this challenge, SBHC could advocate that DHCS clarify that certain SBHC services would be counted in actuarial rate setting for health plans and require MCOs to reimburse for these services as Medi-Cal-covered services.

Advocate for Increase Federal Matching Drawdown with Education Funds. Identifying funding to support the addition of SBHC services in Medi-Cal managed care is critical, and some states are exploring strategies of bringing together education and health funding to support SBHC services. For example, Michigan used K-12 funds appropriated for SBHCs to leverage federal Medicaid matching funds to support SBHC outreach and education services. The Michigan Medicaid Matching Initiative provides enhanced capitation payments to MCOs in which the additional funds must support SBHC outreach and education.

California SBHCs could identify unmatched expenditures from counties or local education agencies (e.g., school districts or county offices of education) that are eligible for a federal Medicaid match through an Intergovernmental Transfer. One option to explore is current school expenditures for mental health services that are now covered under Medi-Cal's mild to moderate mental health services.

Current Opportunities for Integrating Services into the Larger Health Care Landscape

There are emerging opportunities and policy changes that SBHCs can address to support funding for comprehensive preventive services. These opportunities are described below.

Promote Value of SBHCs within Accountable Care Communities (ACCs). SBHC prevention services have a potential role in California's proposed ACCs. The CalSIM grant to be submitted to the Centers for Medicare and Medicaid Innovation in 2014 includes an initiative to launch 2-3 ACC pilots. ACCs incorporate a community focus and are designed to include multiple stakeholders to improve geographically-defined population health. The ACC pilots will be funded through wellness trusts, which are board/coalition-managed public health funds used to support population-focused prevention and wellness services.^{ix} Wellness trusts pool, leverage and distribute funding to support prevention and wellness services and programs. SBHCs could position themselves as an essential participant in ACC pilot communities.

Advocate for California's potential pursuit of a section 2703 Patient Centered Health Home (PCHH) SPA for new care coordination funds for eligible clients. Under Section 2703 of the Affordable Care Act (ACA), States are given the option to offer health home services, including case management and care coordination, to individuals with chronic conditions. Section 2703 offers states the opportunity to fund health home services with a 90/10 federal match for eight calendar quarters. California is currently considering a 2703 SPA submission but has not determined the population focus. Pairing 2703 supplemental PMPM payments with the CalSIM resources for training in complex case management could offer additional resources for care coordination. In other words, Medi-Cal providers may be able to receive new funding for delivering case management/care coordination for individuals with chronic conditions that qualify under a 2703 benefit. SBHCs could advocate for a broader health home model that includes child-centered health homes for specific Medi-Cal enrollees, including children with special health care needs and foster youth, as a strategy for obtaining 2703 funding for SBHC patients.

Leverage ACA Community Benefit Standards for Hospitals. SBHCs could secure funds for preventive services by leveraging ACA's Community Benefit standards for hospitals. In addition to requiring non-profit hospitals to invest a certain percentage of their revenue in the community, new Community Benefit standards implemented through the ACA require non-profit hospitals to conduct a community health needs assessment and develop an implementation strategy every three years. SBHCs could work to establish long-term contracts with hospitals with Community Benefit obligations to address local health needs identified in the health needs assessment. SBHCs could also help with the community needs assessment process and advocate for a focus on prevention needs as well as acute health issues.

Secure Official Patient-Centered Medical Home (PCMH)/PCHH Recognition. SBHCs can capitalize on the increased emphasis placed on PCMH/PCHH recognition in a wide array of payment and service delivery reform models. SBHCs have long provided PCMH/PCHHs services for young people and their families, such as care coordination and integrated behavioral health counseling services as well as health services to students and their families.^x Formal recognition as a PCMH/PCHH will allow SBHCs to participate in initiatives such as 2703, and can lead to enhanced reimbursement by private insurers and in arenas outside of 2703, such as designation as providers of choice.

Next Steps

The following section provides recommendations for California School Based Health Alliance members to consider as they move forward with any of the specific concepts presented in this issue brief. Regardless of the approach(es) California SBHCs employ to increase funding for preventive services, there are fundamental strategies that will build a solid foundation for payment reform that benefit SBHCs.

- **Develop a strategy to use data to analyze and demonstrate value of SBHC prevention services:** It is important that California SBHCs apply data-driven strategies moving forward. SBHCs must be able to demonstrate empirically that they can help meet Triple Aim outcomes in order to communicate the value of SBHCs and negotiate with payers to provide compensation for SBHC services.
- **Emphasize SBHC ability to address social determinants of health:** As health systems struggle to reduce costs and improve quality, service delivery models are increasingly exploring how to address social determinants of health within a system that historically has focused on treating illness rather than promoting wellness. The movement in this direction offers promising opportunities for SBHCs to provide, and be compensated for, comprehensive prevention services that address social determinants. Identifying the specific elements of the SBHC model that address social determinants of health will help promote SBHC services in these models as they arise.
- **Educate SBHC leaders on payment reform concepts:** Leaders in the SBHC movement must identify and communicate effectively the value of SBHC preventive services to stakeholders. Providing educational opportunities for these leaders to better understand payment reform concepts in the changing healthcare landscape will provide them with additional tools to further articulate and pursue emerging opportunities.
- **Determine key characteristics/capacities for SBHCs to implement payment reform efforts:** Determining how SBHCs should move forward on payment reform opportunities is a critical next step. The various approaches presented in this issue brief will impact SBHCs differently due to the diversity of SBHC structure, funding and services. An analysis of key SBHC characteristics and/or capacities needed to engage in promising models will provide a reality-check to guide future work on payment reform. For example, formal recognition as PCMH will allow SBHCs to participate in initiatives such as 2703, and better position them for involvement in other efforts. In addition, providing support for lower capacity SBHC sites will need to be available to help sites identify a model(s) that work(s) depending on their diverse needs.
- **Conduct cost modeling to sustain services:** It will be important for California SBHCs to conduct cost modeling to identify whether specific changes in payment can generate the revenue that will be needed to incorporate and sustain the services.
- **Be actively involved in FQHC payment reform to promote inclusion of social acuity factors and comprehensive prevention services:** Over the longer term, if FQHC payment transforms into a PMPM reimbursement, California SBHCs that are FQHCs should advocate for such payments to take enabling services into account, to increase with a realistic inflation factor, and to be adjusted based on social acuity factors in addition to medical diagnoses. Identifying social acuity factors, piloting studies to confirm their influence, and then developing systems to expand data collection will enable California SBHCs (that are FQHCs) to argue for data-driven adjustment of health plan capitation payments and FQHC payments based on the social acuity complexities of the populations they serve.

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- ⁱⁱ California School Based Health Alliance, About School Based Health Centers: Locations. Accessed on June 9, 2014 <http://www.schoolhealthcenters.org/school-health-centers-in-ca/locations/>
- ⁱⁱⁱ California School Based Health Alliance, About School Based Health Centers Factsheet. *Overview of School Based Health Centers with Map, December 2013*. Accessed April 2, 2014 <http://cshca.wpengine.netdna-cdn.com/wp-content/uploads/2014/04/CA-SBHCs-Map-Overview-2014.pdf>
- ^{iv} Ibid.
- ^v Article 4, The Medi-Cal Benefits Program. (14131 – 14138) Scope Change and Federally Qualified Health Center Prospective Payment System Rate Setting and Payment. 14132.100.
- ^{vi} Ibid.
- ^{vii} Centers for Medicare and Medicaid Services. (2013). *Update on Preventative Services Initiative*. Informational Bulletin. Accessed April 24, 2013 at <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-11-27-2013-Prevention.pdf>.
- ^{viii} Trust for America's Health and Nemours. Medicaid Reimbursement for Community-Based Prevention. Based on a convening held October 31, 2013.
- ^{ix} Davis, A. & Long, P. (2013). *Multi-Stakeholder Health Care Payment Reform in California*. Prepared for the California Health and Human Services Agency.
- ^x Agency for Healthcare Research and Quality (AHRQ). What is the PCMH? AHRQ's definition of the medical home.2011. [page/what-pcmh](http://www.ahrq.gov/patientsandfamilies/what-pcmh). Accessed April 14, 2014