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CHILD HEALTH INITIATIVES
Summary

Issue: Today, 10 million--14 percent--of children are uninsured. Many more children are underinsured, with limited access to critical preventive and primary care services. To expand health coverage for these children we propose a three-part strategy.

Work with states to continue to fulfill the promise of Medicaid for children who are already eligible under current law.

- Work with states and local communities to take additional steps to increase the enrollment in Medicaid of currently eligible children: (1) develop Federal-state partnerships to identify and enroll eligible children through outreach in schools, including special education providers, churches and other community service providers; (2) take additional steps to ensure that all federally supported programs meet specific goals of facilitating the enrollment of eligible children; (3) dedicate a portion of the additional $500 million for state administrative expenses associated with the welfare law based on state performance with respect to enrolling eligible individuals (e.g., children) in Medicaid; (4) develop a program to better market Medicaid enrollment to the public through partnerships among states, provider groups (e.g., American Academy of Pediatrics) and foundations to develop public service announcements and appropriate print media to encourage children and families to seek information about Medicaid eligibility, to enroll in Medicaid, and to utilize appropriate services; and (5) take steps to renew state interest in undertaking demonstrations and other activities that involve expansion of Medicaid coverage for children and working families.

Challenge the health care industry and health professional organizations to work with communities to improve integration of school-based and school-linked health centers and consolidated health centers into a community's health care delivery system.

- Encourage managed care organizations and health insurers to work with communities seeking to develop and implement health care delivery settings for children such as school-based/linked health centers. Managed care organizations could collaborate with community sponsors to create funding mechanisms in order to develop and operate school-based/linked health centers, and/or to designate school-based/linked health centers as a site for delivering primary care services.

- Work with managed care organizations and health insurers to devise a range of approaches for: (1) reimbursing school-based/linked health centers for the services they provide; (2) developing model billing systems that support these approaches.

Enhance funding for communities considering expanding access to health services by bringing school-based or school-linked health centers to their communities.

- Expand the **Healthy Schools, Healthy Communities** initiative. New school-based health centers funded under this initiative would: (1) have the option of expanding services to the parents and siblings of the school's students; (2) link to other appropriate programs, including Healthy Start, state Maternal and Child Health, Head Start, Community Schools, and Empowerment Zones/Enterprise Communities; (3) provide comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, health education and preventive dental care; (4) develop billing systems to enable center to participate in a community-wide health care delivery system. In addition this initiative would support school-linked health centers. School-based health centers may not be the right choice for every community. School-linked health centers can serve students from several schools in a particular catchment area and provide continuity of care as students are promoted to the next school. School-linked health centers provide services that might not be as comprehensive in scope as a school-based health center, but can be targeted to specific community needs. Other options are also possible.

- Expand funding for **Consolidated Health Centers** (CHCs) to work with communities to develop school-based or school-linked health programs to improve the health and school performance of children. Recognizing the benefits of interactions between education and health efforts, many communities have established links between schools serving low-income children and CHCs as a method of providing comprehensive health services to underserved children. This linkage provides children with preventive and primary care, links to an established health care system and access to reimbursement mechanisms for Medicaid and other third party payers. Approximately 250 CHCs have developed school-based or school-linked service programs. In addition, CHCs' expertise and participation in managed care would be a valuable resource to school health programs.

- Provide technical assistance to help school-based/linked health centers create effective linkages to Medicaid, managed care organizations, and other health insurers by: (1) identifying steps to facilitate Medicaid reimbursement for health services delivered in school-based/linked health centers; (2) using the Medicaid Maternal and Child Health Technical Advisory Group to improve communication between state Medicaid Directors and Maternal and Child Health Directors on incorporating school-based/linked health centers into Medicaid managed care and other payment arrangements; (3) using 1115 waiver authority to encourage states to use Medicaid to facilitate Medicaid managed care providers to reimburse school-based/linked health centers for services delivered; (4) distributing guidance to communities forming school-based/linked health centers on becoming Medicaid providers and establishing linkages with health insurance and managed care organizations to devise a system of reimbursement for health services provided to students; and (5) encouraging state Medicaid programs to provide outstationed eligibility workers to schools with health centers to enroll Medicaid eligible children into the program.

To: Hillary Rodham Clinton
From: Bill Curry
Re: School Based Health Clinics

Background

At least 11 million American children are without health insurance of any kind and this number is increasing. Millions more have only catastrophic or second rate primary coverage. The data tells us that in 1993 alone almost one million children lost insurance because Medicaid could no longer keep pace with the accelerating contraction of employer-based private insurance. Even children who have coverage are underserved because parents can not/will not attend to non emergency needs or because there is insufficient primary care available in their communities. Access to care is as important an issue as the ability to pay for it.

There exists today a network of 700 school based and community based health clinics that struggle to meet the needs of these children. There is strong evidence that these clinics - especially the school based centers - are far and away the best and most cost effective means of reaching underserved children. They offer a wide range of primary care services, including:

- physical exams
- immunizations
- blood tests
- laboratory screening
- eye exams
- acute care, especially respiratory ailments
- abuse and dependency treatment

The average Medicaid primary health care costs per child, without dental coverage, is around $560 per year; private HMOs are even higher. One program in New York provides this schedule as well as dental and mental health services, at a cost of $318 per student per year that is as much as 40% lower than Medicaid or even capitated HMO costs.

But school based clinics are just getting off the ground while community health clinics are taking a financial pounding from Medicaid's transition to managed care and from cuts in federal, state and local human service budgets. Typically, these clinics are not organized to discriminate between their insured and uninsured patients. Nor are they yet equipped to secure third party reimbursements for those who are insured. Thus major potential revenue streams are lost to them.

Proposal

School based health centers are the most immediate, achievable, and cost effective way to dramatically increase the quality and expand the availability of health care services to

America's children. The President and the First Lady have that rare opportunity to provide the right leadership at just the right moment -- and to nurture and grow a nascent idea into a vibrant healthy system capable of meeting a sacred obligation.

This can be done without massive spending, cumbersome bureaucracy or coercive regulation. We need only respond to the grassroots call of parents and communities who know what their children need and fix the system so that it supports what works. Here's how to begin:

1. **Issue a challenge** to all insurance and managed care companies to help devise a system to reimburse school and community based clinics for services rendered to their covered dependents. Some might wish to make an annual contribution in lieu of payments. Some might prefer capitation to other methods of reimbursement. But the industry must come together to meet the challenge. In so doing, they will help midwife a transition that in the long run will bring down costs and expand service, thus serving their own needs as well as the needs of others. A terrific example of the kind of partnership that needs to become more commonplace already exists between the Oxford Health Plan and the Sunset Park Neighborhood Health Center, which serves the needs of 11,000 children in Brooklyn.

2. **Get our own house in order** by making Medicaid reimbursement much easier than it is now. For example, the New York City program cited above bills Medicaid for about half of the population it serves. But that's the exception not the rule. A comparably large program in Denver that serves adolescents, many of whom are enrolled in Medicaid, found the reimbursement process too complicated, cumbersome, and expensive.

3. **Provide or identify funds** for the clinics to develop billing systems that enable them to participate in the marketplace. The Robert Woods Johnson Foundation was the first to recognize this need. RWJ currently funds offices in nine states that help SBHCs build relationships with HMOs, and trains both public purchasers and private providers to help school based clinics secure third party payments.

4. Make school construction funds ~~contingent on~~ at least the submission of a clinic plan.
→ consider clinic plan in evaluating school construction funds.

5. Consider freeing up other more narrowly programmed money to this broader purpose.

This is obviously a very brief and incomplete presentation of the issues that need to be addressed. I am of course available at any time to talk with anyone concerned about underlying issues, language, politics, etc.

Draft: 8/21/96

Expand Investment in School Health Programs to Serve the Health Needs of Children and Adolescents

Background

- The current generation of students often experience compromised access to health care services because of the combined barriers of poverty, a lack of health insurance and, in some areas, a lack of primary care providers.

- To address these problems, school health programs provide preventive, medical and mental health services to elementary, middle and high school students around the country. They currently operate in many states, with the majority in rural and inner city communities where there are many medically underserved and uninsured children.

- School health programs provide a wide range of services depending upon the needs of the communities, including primary care, physical examinations, injury treatment, immunizations, dental treatment, counseling, chronic illness management, substance abuse prevention, and health education.

- School health programs provide an opportunity for health care workers to be in frequent contact with students, allowing for ready access to health professionals, health information and clinical services. They also can provide an effective way for both educators and health care providers to reach hard-to-reach parents.

- School health centers serving adolescents allow students to exercise more control over their decisions to use health care services, unlike the use of community-based providers which may require direct parental involvement.

- Offering health services in schools can be an effective tool to bring Medicaid eligible children into preventive and appropriate follow-up care and to provide access to the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program.

- School health programs have the added benefit of helping to identify and support children with developmental delays.

- Support for school health programs may come from multiple sources, including HHS funding for the consolidated health centers program.

- School health programs provide a unique opportunity to improve the health status of young children and adolescents using one of two strategies: school-based or school linked health centers.

- **School-based health centers (SBHC)** are a cost effective means of providing health care services to students. The average annual operating budget for a school-based health center is estimated to be $180,000. The cost to operate a health center is $179 per year per student or $66 per student visit. There are estimated to be at least 650 school-based health centers out of approximately 80,000 schools.

- Nearly 40% of students using SBHCs are uninsured. Most SBHCs do not receive full Medicaid reimbursement.

- While adolescents traditionally underutilize health care services, a recent study found students using SBHCs had higher visitation rates for medical and health care than students using conventional health care sources. Adolescent SBHC users, in comparison to the general adolescent population, used medical, mental health and substance abuse services more often. Student visitation rates, for general medical services, were greater than the rate for adolescent visits to community-based medical providers.

- The use of SBHCs may also reduce the demand for costly emergency services. A recent study found that adolescents enrolled in managed care who had access to a SBHC had markedly fewer emergency visits. In addition, the study found that fewer students sought emergency services.

- **School-linked health centers** provide many of the same services as SBHCs. They provide medical, psychosocial and dental services through special arrangements between schools and other agencies. Such services are not necessarily located at the school and may be provided full or part time. While school-based services might not be appropriate for all communities, any site can develop and benefit from a school-linked program because of the flexibility they afford to target specific needs.

Proposal

- Expand the **Healthy Schools/Healthy Communities** initiative to improve the health of children in a school setting. Through this program now in its third year, school-based primary health care sites have been developed in 27 communities to provide services for 24,000 children who are at risk for poor health, school failure, homelessness and other consequences of poverty. The program has been funded at $16.8 million over a three year period. New funds would be targeted to organizations to establish new school-based health centers in communities with high rates of uninsurance. Current sites link to both Healthy Start and Head Start sites. SBHCs funded under the new initiative would:

- serve children of all ages from pre-kindergarten through grade twelve;
- have the option of expanding services to the parents and siblings of the school's students;
- link to other appropriate programs, including Healthy Start, Head Start, community schools, and EZ/ECs.
- provide comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, health education and preventive dental care;
- provide reproductive health services at the option of the community; and
- develop billing systems to enable center to participate in a community-wide health care delivery system.

- Expand the **Healthy Schools/Healthy Communities** initiative to support school-linked health centers. SBHCs may not be the right choice for every community. School-linked health centers can serve students from several schools in a particular catchment area. They also can provide continuity of care as students are promoted to the next school. Such centers provide an opportunity to target out of school youth and aid them in accessing health, psychosocial and other services that meet their basic needs. The location off school grounds allows greater flexibility for extending operating hours or operating during school vacations and the summer months. School-linked health centers can more easily avoid the community controversy associated with the delivery of particular services, such as family planning or reproductive health services, on the school site. School-linked health centers provide services that might not be as comprehensive in scope as a SBHC, but can be targeted to specific community needs such as screenings, health education or mental health services.

- Expand funding for **Consolidated Health Centers** (CHCs) to work with communities to develop school-based or school-linked health programs to improve the health and school performance of children. Recognizing the benefits of interactions between education and health efforts, many communities have established links between schools serving low-income children and CHCs as a method of providing comprehensive health services to underserved children. This linkage provides children with preventive and primary care, links to an established health care system and access to reimbursement mechanisms for Medicaid and other third party payers. Approximately 250 CHCs have developed school-based or school-linked service programs. In addition, CHCs' expertise and participation in managed care would be a valuable resource to school health programs.

- Encourage managed care organizations to work with communities to develop and implement school health programs. Managed care providers in several states authorize SBHCs to provide health care services, then bill Medicaid directly. Managed care organizations may collaborate with community sponsors to create funding mechanisms in order to develop and operate SBHC organizations that designate the SBHC as the primary care clinic. Under the terms of the contract, the managed care provider reimburses the SBHC using Medicaid reimbursement rates.

- Work with managed care organizations and fee-for-service health insurers to devise a range of approaches for reimbursing school health programs for the services they provide and develop model billing systems that support these approaches.

- In order to assure integration of school health programs into the broader health care delivery system, the Department will provide technical assistance to help school health programs create effective linkages to Medicaid, managed care organizations, and other insurers. The Department can:

  - identify steps the Department can take to facilitate Medicaid reimbursement for health services delivered in school health programs;

  - develop strategies to strengthen linkages between school health programs and health insurance and managed care organizations in both rural and urban settings;

  - use the Medicaid Maternal and Child Health Technical Advisory Group to improve communication between state Medicaid Directors and Maternal and Child Health Directors on incorporating school health programs into Medicaid managed care and other payment arrangements;

  - use the 1115 waiver authority in Medicaid to encourage states to mandate Medicaid managed care providers to reimburse school health programs for services delivered;

  - distribute guidance to communities forming school health programs on becoming Medicaid providers and establishing linkages with health insurance and managed care organizations to devise a system of reimbursement for health services provided to students; and

  - encourage state Medicaid programs to provide outstationed eligibility workers to schools with health programs to enroll Medicaid eligible children into the program.

- Encourage states to expand funding for school health programs through the **Maternal and Child Health (MCH) Block Grant**. In 1994, 25 states invested $12 million in MCH block grant dollars and $22.3 million in state general funds for school health programs. Further funding targeted to the development of school-based/linked health programs would directly benefit many of the children who lack adequate health insurance coverage or access to health care services. The MCH Block Grant provides maximum flexibility to states to design programs that are appropriate to their individual population needs.

- Use the Special Projects of Regional and National Significance (SPRANS) Maternal and Children Health Block Grant set-aside to encourage states to conduct demonstrations to develop effective models which build the relationship between managed care organizations (including Medicaid managed care providers) and schools to ensure access to health care services for children and adolescents.

HHS Accomplishments for Children

- In FY 1996, HHS is spending approximately $50 billion, or about a sixth of its total budget, to sustain its investments in our nation's children and young people. HHS especially serves children and teens who are disadvantaged.

- HHS programs for children in need serve about one in every five children in America.

- Secretary Shalala established an HHS **Governing Council for Children and Youth**, bringing together all parts of the Department to better serve children, youth and families.

Medicaid

- President Clinton firmly upheld his commitment to preserving the Medicaid entitlement as a sine qua non in the welfare reform negotiations. Medicaid covers *over 18 million children*, or roughly one in every five children in the U.S.

- Under health care reform waivers in 12 states, many previously uninsured children are eligible for Medicaid. Massachusetts and Florida alone expect to to cover some 670,000 new children (121,000 and 550,000 respectively) under Medicaid expansions.

Immunization

We are extremely happy with the progress we have made since the Clinton Administration took office 3 years ago. The Childhood Immunization Initiative (CII) is one of several factors contributing to this success:

- In 1994, 75 percent of the nation's two-year-olds received the full recommended series of vaccines -- the highest levels ever recorded. In addition, childhood vaccine-preventable diseases are now at record lows.

- Despite this success, about 25% of our toddlers – about 1 million children under age 2 -- lack one or more doses of the full series of vaccinations.

We now plan to reach our Year 2000 goals for children who are two years old in 1997--that is, 90% of all two year olds will be fully immunized in 1997. THIS WILL BE A GREAT ACCOMPLISHMENT!

Maternal and Child Health Block Grant

- HHS provides direct investment in State Health Departments through the Maternal and Child Health Block Grant. This funding is critical to ensuring that the most vulnerable children and their families receive needed health care and related services. In FY 1996 the Block Grant was funded for $678.2 million

Teenagers and Smoking

- In August 1995, the President announced the nation's first comprehensive campaign to limit both the access and the appeal of tobacco products to minors. Under proposed regulations by the FDA, children would not be able to buy cigarettes and smokeless tobacco products, and promotional and advertising gimmicks appealing to children would be limited.

Teenage Pregnancy Prevention

- The Administration's strategy to prevent teen pregnancy encourages abstinence and personal responsibility by young people, provides financial support to enhance access to health and family planning services, supports community efforts, and invests in research and evaluation to determine what approaches work.

  As part of this strategy, the President's FY 1997 budget request includes $30 million for HHS to launch a new Teen Pregnancy Prevention Initiative, to support prevention efforts in communities with high teen pregnancy rates.

Insurance Reform

- The limitations on pre-existing conditions exclusions are expected to protect many children who would otherwise lack access to needed coverage. There are an estimated 1 million children in families in which at least one individual faces an exclusion for a pre-existing condition.

Health Care for the Temporarily Uninsured

- The President's plan for the temporarily uninsured would extend transitional coverage to 3 million people, including 700,000 children.

SCHOOL-BASED/LINKED HEALTH CENTERS

Overview

Many children lack access to the routine health care needed to prevent disease, disability and unnecessary hospitalization. Children need access to regular health care services because many of the major health problems that face our country are preventable, acquired in youth and attributable to a few types of behavior, including those that lead to injury and poor nutrition. Adolescents experience unique problems and are confronted with a complex web of physical, emotional and social issues requiring more than simple medical care. To address these concerns, a small but growing number of communities are using an innovative approach to reach children with limited access to health services: School-Based/Linked Health Centers (SBHC).

SBHCs provide preventive, medical and mental health services to elementary, middle and high school students around the country. In 1994, 79% of SBHCs serviced high school students, 9% serviced primary school children (pre-K through 8) and 12% serviced a combination of high school and primary school students. Since the early 1980s, states and communities have established SBHCs in about 650 of the nation's 80,000 schools. SBHCs are financed primarily through state, local and private foundation funds. Federal programs, particularly Medicaid, CHCs and the MCH Block Grant, supplement these funds.

Where are SBHCs?

SBHCs operate in schools in many states. The majority of SBHCs developed in rural and inner city communities where there are many uninsured children and high rates of adolescent health conditions caused by high risk behaviors. For example, New York has 140 of the 650 SBHCs, 112 of which are in New York City. New Mexico and California also have many SBHCs with 29 and 26, respectively.

Who is Served by SBHCs?

SBHCs serve a wide range of students. The children and adolescents vary in age, from pre-K to 12th grade, and have diverse ethnic, geographic and economic backgrounds. While many different populations use these health centers, the majority of SBHCs target low-income or below poverty level children and adolescents. For example, according to the Office of Technology Assessment, many of the adolescents who use school-linked health centers (SLHCs) have no other health care source. Among the other populations which many SBHCs target are ethnic minorities and high risk groups, such as teen parents. Some clinics extend services to siblings and parents of students.

SBHCs in Elementary Schools

While SBHCs provide particular benefits to adolescents, they are also beneficial for elementary school children. A 1994 GAO report concluded that the monitoring and early treatment of chronic conditions (e.g., asthma) can prevent unnecessary hospitalization and deaths. In addition, the report concludes that mental health services are particularly effective at

this level when problems first appear because younger children are more malleable, feel less peer pressure and are more open to discussing their problems than adolescents. The GAO report also noted that elementary school students are more likely to use a SBHC than other health care facilities because parents and students are already familiar with the school and the SBHC is a part of the school. Parents feel a SBHC is a much friendlier place to receive care. Also, SBHCs in elementary schools involve parents more directly because providers need the younger children's medical records or must instruct parents on a child's medication regimen.

Average Costs for SBHCs

A recent study of SBHCs by the Health Resources and Services Administration (HRSA), reporting data through 1993, estimated annual clinic costs for 6 SBHCs in 5 different states. Several estimates were generated, including total annual costs, costs per registered student, cost per user and cost per visit. Costs per user ranged from $122 to $500, while cost per visit ranged from $29 to $90. These costs varied significantly for the schools for a variety of reasons and therefore should not be used for comparison. For example, the cost estimates were not always based on data from the same school year; the clinics offer a wide variety of differing services; some of the clinics did not account for the costs of all in-kind services they received; and not all of the clinics included administrative costs in their estimates.

Major Problems Facing SBHCs

- Many SBHCs lack stable sources of financing. Because SBHCs receive financial support from a patchwork of sources, SBHC funding is fragmented and often short-term. Contributions from Medicaid are not a certainty given the increasing number of low-income children enrolled in Medicaid managed care organizations. Reimbursement from other sources is also difficult because SBHCs often have limited administrative capacity to implement effective billing mechanisms to bill Medicaid and third party payers. Private foundations, which have played a prominent role in establishing SBHCs, generally cease contributing funds once their grants expire.

- Budget limitations have adverse effects on the provision of services by limiting their availability. For example, there is a large demand for mental health services from elementary and high school facilities. Both public and private health insurance coverage of mental health services tends to emphasize acute or emergency conditions, rather than ongoing care, which limits SBHC's ability to receive reimbursement for services their clients need. Dental care is also a problem. Few SBHCs give onsite dental care (13%) and such care is hard to obtain out in the community due to high costs, long waits and a lack of dentists.

Other Problems Confronting SBHCs

- The comprehensiveness of referral networks vary among SBHCs.
- Some students drop out of school or, for those under age 5, are not in the school system.
- SBHCs may not always be open, especially in the summer and during school vacations,

and often have limited hours when students are in school.

- SBHCs find it difficult to recruit, train and retain nurse practitioners and physician assistants, the key primary care providers at SBHCs.
- Outcomes research on the effectiveness of SBHCs is sparse.
- There is controversy in most communities over SBHCs providing reproductive health care services, e.g., counseling, gynecological exams, pregnancy testing, sexually transmitted disease diagnosis and treatment, prescription and distribution of contraceptives and prenatal care.

Types of Services Offered (See Attached List)

- The most commonly provided services at SBHCs are:
  - primary care
  - physical examinations
  - injury treatment

- But, specific services vary by location and include:
  - immunizations
  - counseling
  - laboratory tests
  - chronic illness management
  - health education
  - substance abuse treatment
  - reproductive health services

Support for SBHCs

SBHCs generally enjoy parental support because they offer easy access to health care by bringing providers to the children. This eliminates the need for parents to leave work or to provide transportation. SBHCs also facilitate follow-up, offer free or low cost services and provide services in an atmosphere of trust and confidentiality in a culturally sensitive manner. Many programs, especially in elementary schools, require parental consent forms indicating which services can be provided to a child.

Assessing SBHCs

Although there are no national, comprehensive evaluations of either school-linked or school-based health centers, informal assessments of particular programs have been done at the state and local levels. Most of the findings show positive behavior and health outcomes for clinic users. The following are examples from either school-linked health centers (SLHC) or school-based clinics (SBHC):

- An evaluation of 6 SBHCs noted that there was considerably lower alcohol consumption

in most of the schools evaluated in comparison to other schools. However, there were no significant differences in use of illegal drugs.

- That evaluation also found that only a SLHC with a full-time physician which required all new students to have physical examinations positively impacted the likelihood of students having seen a doctor recently. Among those impacts were:
  - An 11% increase in the number of students seeing a doctor within the past 12 months.
  - An increase in the number of students receiving a physical exam, blood test or urine test in the past two years or having seen a dentist recently.

- School-linked community health centers, serving pre K-12th grade in three New York cities, report that parents, when electing the level of care on enrollment forms, chose levels that provide more than usual school health services. Principals and teachers declare that the health centers' programs have had positive impacts on learning and school attendance.

- An evaluation of seven SBHCs collectively serving elementary, junior and high schools reveals that clinic users are less likely to drop out of school than regular students and that the dropout rate for the schools as a whole has declined.

- A demonstration SLHC which served junior and senior high school students reported that knowledge and use of contraceptives significantly increased for students using the center's services. Also, previously increasing pregnancy rates eventually stabilized and declined; within 28 months it declined by 30 percent.

Existing Government Efforts to Improve the Health of Children through SBHCs

The Health Resources and Services Administration's (HRSA) Healthy Schools, Healthy Communities initiative is one example of a government program to improve the health of the nation's children in a school setting. Through this program, school-based primary health care sites have been developed in 27 communities to provide services for 24,000 students who are at risk for poor health, school failure, homelessness and other consequences of poverty. The 27 centers provide comprehensive primary care services on site, including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services and preventive dental care. The programs are from 8 rural areas and 19 urban areas representing 20 states and the District of Columbia. Children of all ages from kindergarten through grade 12 are being served.

JOURNAL OF ADOLESCENT HEALTH 1995;17:68–76

SPECIAL REPORT

State Initiatives to Support School-Based Health Centers: A National Survey

JOHN J. SCHLITT, M.S.W., KAMALA D. RICKETT, M.H.S., LISA L. MONTGOMERY, M.P.A., AND JULIA G. LEAR, Ph.D.

In March 1993, the *Making the Grade* National Program Office and the Columbia University School Health Policy Initiative surveyed the 50 states, the District of Columbia, and Puerto Rico to determine how many state governments had launched initiatives to establish school-based health centers. With interest in school-based health centers continuing to grow and proposed federal legislation offering possibilities for new growth, *Making the Grade* returned to the states in the summer of 1994 to assess current support for school-based health centers as measured by:

(1) the number school-based health centers,
(2) state sponsored funding for school-based health centers,
(3) state enabling policies and technical assistance activities,
(4) Medicaid and Medicaid managed care arrangements with school-based health centers, and
(5) communications efforts to support school-based health centers.

The survey of state representatives revealed a substantial expansion in the number of school-based health centers and a significant increase in state funding for the centers in the 18 months since the initial survey of states. Although the degree of involvement varies, state governments have fast become leading players in the development of school-based health centers. With older state initiatives in school-based health centers expanding, and additional states piloting new efforts, state governments have undertaken the development of service standards, staffing guidelines, long-term financing strategies, and quality assurance guidelines. In addition, states have begun to invest in the development of state level offices to provide technical assistance to operating centers as well as support communities in conducting needs assessments and other planning activities. With the emerging role of the states, governors, legislators, and state agency officials have also emerged as key decision makers in program policy formation and development.

School-Based Health Centers in the United States—October 1994

The first comprehensive school-based health centers were established in the early 1970s in Dallas, Texas, and St. Paul, Minnesota. Increasingly, states and localities have looked to schools as reasonable and innovative sites for the expansion of health care for children and adolescents. By 1985, the Center for Population Options estimated that school-based health centers numbered 40; by 1989, 150; and by 1992, over 400. By fall 1994, the *Making the Grade* survey found school-based health centers had increased to 607 sites in 41 states and the District of Columbia. Nearly half of these facilities are located in high schools, and over one-quarter are located in elementary schools.

From Making the Grade: State and Local Partnerships to Establish School-Based Health Centers, a national program office of the Robert Wood Johnson Foundation, administered by The George Washington University, Washington, D.C.

Address reprint requests to: John J. Schlitt, Associate Director, Making the Grade National Program Office, 1350 Connecticut Avenue, N.W., Suite 505, Washington, D.C. 20036.

Manuscript accepted February 3, 1995.

1054-139X/95/$9.50
SSDI 1054-139X(95)00060-6

Published by Elsevier Science Inc., 655 Avenue of the Americas, New York, NY 10010

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MAKING THE GRADE

STATE AND LOCAL PARTNERSHIPS TO ESTABLISH

SCHOOL-BASED HEALTH CENTERS

School-Based Health Centers and Managed Care: Seven School-Based Health Center Programs Forge New Relationships

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Supported by the
Office of Adolescent Health
Maternal and Child Health Bureau
Health Resources and Services Administration
Public Health Service
U.S. Department of Health and Human Services

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Acknowledgement

This report was made possible through a contract with the Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services.

School-Based Health Centers and Managed Care: Seven School-Based Health Center Programs Forge New Relationships

In June 1995, the Making the Grade National Program Office at The George Washington University, with support from the DHHS Bureau of Maternal and Child Health, convened a meeting of representatives from federal and state governments as well as school-based health centers and managed care plans to identify some of the policy and programmatic issues that must be addressed in linking school-based centers with the evolving managed care system.[1] Comments from the June meeting were reported in a paper, "Medicaid, Managed Care, and School-Based Health Centers: Proceedings of a Meeting with Policy Makers and Providers," available from the Bureau of Maternal and Child Health and the Making the Grade National Program Office. The following paper continues the exploration of issues affecting the relationships between school-based health centers and managed care plans and focuses on the experiences of seven school-based health center programs that have negotiated contracts with plans. The paper also examines the role of state governments in facilitating these negotiations.

A growing number of school-based health center programs have entered into relationships with managed care plans. These pioneer programs are providing early lessons about the benefits and challenges of linking school-based health centers to the clinical and financial systems of managed care. They also are providing insights into the special issues affecting health programs that provide a safety net to underserved, poor communities. Seven school-based health center programs were surveyed concerning their negotiations with managed care plans. While the centers are optimistic that linkages with managed care will strengthen services available to their patients, they report that creating these relationships has been challenging. In some locations, managed care plans that enroll a large number of health center patients have refused to negotiate agreements; others have agreed to negotiate but define the relationships narrowly. Still others have embraced school-based health centers as partners in providing primary care. Although survey respondents characterize these new relationships as "works-in-progress," they are concerned about the future. This paper presents the results of the survey, describes the role of state governments in facilitating negotiations, and integrates relevant commentary and discussion from a June conference on Medicaid, managed care, and school-based health centers organized by the George Washington University.

Background

Since their beginnings in the early 1970s, school-based health centers typically have been isolated from the organizational and financial arrangements that characterize the rest of the health care system. School-based health centers, for the most part, have not been linked closely with other community providers or participated in mainstream financing mechanisms.

[1]Making the Grade: State and Local Partnerships to Establish School-Based Health Centers is a multi-grant program of The Robert Wood Johnson Foundation involving nine states in an initiative to develop policy environments supportive of school-based health centers as well as to fund at least four local school-based health centers in each participating state.

Their driving purpose has been to make health care readily available to adolescents. In the early years, the centers were supported by private foundations, local health departments, and Maternal and Child Health (MCH) block grants. Third-party payments were not sought. Only recently have many centers begun billing public and private insurers for care provided to beneficiaries. Reflecting the limited role of patient fees, the financial reports of the seven school-based health center programs indicate that third party revenues represented eight percent of the 1994/95 operating budgets. See Table 1, page 4. Data from other studies suggest that this experience is typical.[2]

Historically, school-based health centers have confronted a number of barriers to securing patient care revenues. Limited Medicaid coverage for adolescents, exclusion of preventive services from many private insurance plans, and administrative costs associated with billing have all constrained billing efforts. Moreover, a portion of services commonly provided by the centers -- for example, group counseling and classroom-based health education -- are not covered by medical insurance.

Despite barriers to billing, organizations that sponsor school-based health centers increasingly have determined that maximizing patient care revenues will be essential to future financial viability.[3] The pursuit of patient care dollars, however, places school-based health centers in a difficult dilemma. Traditional private health insurance and state Medicaid programs as well as fee-for-service payments by managed care plans primarily have reimbursed for medical treatments; support for mental health and health education has been more limited. School-based health centers, which have emphasized preventive services, health promotional activities, and mental health care, risk compromising their comprehensive approach to patient care if they seek to maximize revenue by focusing on reimburseable medical services.

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[2] Lear JG, Montgomery LL, Schlitt JJ and Rickett KD. Key issues affecting school-based health centers and medicaid. *J of Sch Health*. 1996:66(3):83-88. A 1989 Center for Population Options survey found that Medicaid contributed between two and four percent of the operating costs of the reporting school-based health centers. Center for Population Options. School-based clinics enter the '90s: Update, evaluation and future challenges. Author. Washington, DC. 1990. A report from Perino and Brindis stated that seven California clinics had received three percent of their operating costs from Medicaid during FY 1990/91. Perino J and Brindis C. Payment for services rendered: Expanding the revenue base of school-based clinics. Center for Reproductive Health Policy Research, University of California, San Francisco. Report to the Stuart Foundations, 1994. In FY 1992/93, 23 school-based health centers funded under a Robert Wood Johnson Foundation initiative reported to the Foundation and the School-Based Adolescent Health Care Program National Program Office that 13 percent of the health center operating budgets were supported by patient care revenue.

[3] Workshop presentations and comments by conference participants at the first meeting of the National Assembly on School-Based Health Care in Washington, DC, June 23-25, 1995, indicated a widely shared understanding that securing third-party payment for patient care and developing a defined relationship to the larger health care system would be essential to financing school-based health centers in the future.

Table 1. Financing seven school-based health center programs, FY 1995

Program	# sites	Total Operating Budget	County/City		State Grants		Federal Grants[a]		Third Party		Other	
Baltimore City Health Dept.	10	$2,069,837	$1,288,510	62%	$346,050	18%	$251,726	12%	$183,551[b]	9%	$0	0
Boston Dept. of Health & Hospitals[c]	8	1,243,964[d]	126,200	10%	971,409[e]	78%	0	0	146,355[f]	12%	0	0
Bridgeport Health Dept.	8	1,541,691	583,070	38%	807,621	52%	0	0	1,000	0	150,000	10%
Memphis/Shelby Co. Health Dept.	2	331,000	270,000	82%	0	0	0	0	61,000[g]	18	0	0
Multnomah County Health Dept.	10	1,952,000	1,432,000	73%	110,000	6%	270,000	14%	140,000	7%	0	0
New Haven Public Schools	10	1,291,238	288,875	22%	683,900	53%	50,000	4%	0		268,463	21%
Health Start, Inc. St. Paul, MN	7	997,478	10,000	1%	545,431	55%	237,170	24%	194,877[h]	20%	10,000	1%
TOTAL	55	$9,427,208	$3,998,655	42%	$3,464,411	37%	$808,896	9%	$726,783	8%	$428,463	5%

[a] Federal grant support appears in three categories: Federal grants, Maternal Child Health (MCH) block grant funds allocated by state government, and MCH block grant funds allocated by local government. Federal Medicaid support appears in the Third Party column.

[b] Includes $123,324 in patient care revenues from health-related special education services and $60,227 in attributed Medicaid payments.

[c] Includes 5 full time and 3 part-time sites; in FY96, there will be 6 full time and 2 part-time sites.

[d] Reflects a phased-in budget. FY95 full budget is closer to $1,500,000, an amount not including in-kind support from other agencies.

[e] $780,809 of this amount is a one-time state contribution that will be replaced by city dollars.

[f] An estimate by BDHH: reimbursement flows directly to the city's general fund and not to the program.

[g] Revenues generated by three capitation contracts for students who have selected the centers as their primary care provider, and by two fee-for-service contracts with managed care plans.

[h] Includes $115,000 in Medicaid payments and $79,877 in commercial insurance; most payments are made through contracts with HMOs.

While discussions about the appropriate "fit" of school-based health centers with mainstream health care and managed care plans, in particular, continue the number of centers seeking relationships with the plans is increasing. The rapid growth of managed care and anticipated reductions in federal and state grant dollars available to the centers have provided a powerful incentive for the school-based health centers and their sponsors to undertake major changes in the way they are financed as well as the ways they relate to the larger health care system. While negotiations with managed care plans may begin with the goal of securing payment for revenues for patient care, under the best circumstances they lead to a process that places the centers squarely within the provider networks whose responsibility is meeting the comprehensive care needs of children.

Initial agreements between school-based health centers and managed care: Defining the scope of services and financial arrangements

Representatives from seven school-based health center programs were surveyed to gain insight into their relationships with managed care. Survey participants included Baltimore City Health Department, Bridgeport Health Department, Boston Department of Health and Hospitals, Health Start, Inc. in St. Paul, Memphis/Shelby County Health Department, Multnomah County Health Department, and New Haven Public Schools. As noted in Table 2 on page 6, these school-based health center programs are operating in mandated Medicaid managed care environments, assuring that at least some of their patients will be enrolled in managed care. The proportion of school-based health center patients who are Medicaid beneficiaries ranges from 18 percent in Multnomah County, Oregon, to 80 percent in Memphis/Shelby County, Tennessee. The seven programs all operate multiple sites that provide comprehensive primary medical and mental health care. Five of the seven programs are sponsored by city or county health departments. Their experiences with managed care contract negotiations range from six months to several years. All but one have concluded written agreements with managed care, or are part of an agreement negotiated by their sponsor organization. Baltimore operates under a verbal agreement with a plan. Survey responses describe a total of 26 contracts.

The survey respondents are not the only multi-site school-based health center programs that have developed contracts with managed care plans. Established programs in New York City and Philadelphia have developed contracts; programs in Dallas, Houston, Los Angeles, Pittsburgh, and San Francisco are considering such arrangements. The seven programs participating in the survey were selected because they were established programs that had operated at least five years;

2. Medicaid Environment for Seven School-Based Health Center Programs

Community	State Medicaid Waiver[a]	Medicaid Recipients Enrolled in SBHCs				State SBHC/Medicaid Managed Care Policy
		as % of total SBHC enrollment	% in managed care	of students in managed care		
				% in HMOs	% in PCCM[b] program	
Bridgeport/ New Haven, CT	1915(b) Goal: 70% enrollment by 1/97	42%	100%	100%	n/a	Managed care plans are required to contract with SBHCs in service area (State Request for Proposals for managed care plans)
Baltimore City, MD	1915(b); 1115 Submitted to state legislature	52%	99%	30%	70%	SBHCs can enroll as PCCMs; proposed 1115 waiver requires HMOs to contract with SBHCs; proposed 1115 waiver requires plans to reimburse for SBHC services and allow adolescents to self-refer to SBHCs
Boston, MA	1915(b) Implemented in 1992 1115 approved 4/95	30%	85%	33%	66%	HMOs, but not PCCMs, are required to "coordinate" with SBHCs and develop a work plan for improving access to preventive and confidential services to adolescents
St. Paul, MN	1915(b) Implemented beginning in 1975 1115 Approved 4/95	50%	100%	100%	n/a	Managed care plans required to offer contracts to public health departments and community clinics that serve Medicaid clients; plans also required to develop action plans for adolescents; no specific reference to SBHCs
Multnomah County, OR	1115 Implemented 2/94	18%	100%	100%	n/a	Managed care organizations encouraged to contract with traditional public health providers; no specific reference to SBHCs
Memphis/ Shelby County, TN	1115 Implemented 1/94	80%+	100%	100%	n/a	MCOs required to coordinate with traditional public health providers; no specific reference to SBHCs

[a] The 1915(b) waiver gives states flexibility in defining eligible providers and payment mechanisms for categorically and medically needy Medicaid recipients; the 1115 waiver, in addition to provider and payment flexibility, allows the state to define eligible populations and services.

[b] Primary Care Case Management (PCCM) is a "managed care" system that pays primary care providers to provide "gate-keeping" services. The primary care case manager is paid a special fee or an enhanced primary care rate to supervise specialty referrals and hospitalizations for their patients. The PCCM does not bear risk for patient use of services. Maryland and Massachusetts provide both HMO and PCCM options for Medicaid enrollees. Boston and Baltimore school-based health centers (through their sponsor agencies) can serve as PCCMs provided they or their sponsoring agency meet 24-hour care coverage requirements. Under the Maryland PCCM plan, providers are paid an enhanced primary care rate; in Massachusetts, the PCCMs receive a monthly case management fee.

they provide comprehensive services and do business in a geographic area with a high penetration of managed care in the public health services market. Moreover, they were headed by directors willing to make the substantial time investment required to gather and analyze data concerning their managed care arrangements.

The school-based health center programs were asked to describe the following elements of their contracts or agreements: scope of services, payment mechanisms, pre-authorization requirements, and service coordination and information exchange policies. Survey responses, summarized in Table 3 on pages 8 and 9, indicate that negotiations with the managed care plans have resulted in a diverse set of agreements. The differences among them reflect alternative approaches to two main issues: the scope of services provided by the school-based health centers to plan members, and arrangements by which the centers are paid for their services.

Scope of services. Twenty of the 26 contracts authorize school-based health centers to serve as "secondary" primary care providers. As defined in these agreements, the health centers provide a specific set of services -- typically well child visits and acute, episodic sick care -- to the plans' beneficiaries without pre-authorization by the plan. The centers do not serve as a medical home in that they do not manage referral and hospitalization services.

In Memphis/Shelby County, the Health Department contracts with five managed care plans to participate as a member of their provider networks. For those families that select the Health Department as their primary care provider, the school-based health centers may serve as the medical home for enrolled students who attend the two high schools with school-based health centers. The health centers are authorized to provide all services defined in the managed care contract, including medical services, mental health services (up to 45 visits per year), and preventive services. Substance abuse treatment is not included. In addition, the centers, through the Health Department, are responsible for providing 24-hour coverage and managing specialty and hospitalization care.

A few contracts define a narrow service package: one provides for comprehensive dental screening and treatment; another authorizes the screening component of the EPSDT examination; and three others authorize urgent or acute medical care only. The Bridgeport, Connecticut dental contract takes advantage of the full-time dentist and the dental operatories located in four of the Bridgeport school-based health centers. Services covered include diagnostic exams, prophylaxis, fluoride and sealant treatments, fillings, and emergency care.

Table 3. School-Based Health Centers and Managed Care Plan (MCP) Agreements

SBHC sponsor *# of SBHCs* *# of Managed Care Plans in Service Area*	# MCP	Scope of SBHC services provided under agreement	Financial arrangements PM/PM = per member/per month FFS = fee-for-service	Pre-authorization requirements	Service coordination/ information exchange policy	SBHC services not covered by agreement
Baltimore City Dept. of Health *10 SBHCs* *4 MCPs*	1	EPSDT screenings and immunizations	FFS based on health department fee schedule	For all services including EPSDT screenings and immunizations	Copy of record is sent to HMO	Mental health, acute care
Boston Department of Health & Hospitals *8 SBHCs* *4 MCPs*	1	Primary physical care services	Global visit rate	None required for services specified in contract	Coordination of care form sent to plan	Mental health
	1	Acute medical care/ minor medical problems, case management	Annual payment based on on historical use and service pattern			
	1	Urgent care only	FFS rates negotiated with managed care plans			Preventive primary and mental health care
Bridgeport Health Department[a] *8 SBHCs* *11 MCPs*	1	Primary physical and mental health care including group counseling	FFS based on Medicaid CPT codes	None required for services specified in contract	Records maintained by SBHCs; available for audit by plan	None
	1	Primary physical health care; dental and mental health provided through sub-contract				Group health education and group counseling
	1	Primary physical and mental health care; dental care				
	1	Primary physical and mental health care; lab services	Global visit fee			
	1	Medical treatment-related services	FFS based on Medicaid schedule			Preventive primary and mental health care

[a] Some of these contracts are not final. Contract details are subject to change.

SBHC sponsor *# of SBHCs* *# of Managed Care Plans in Service Area*	# MCP	Scope of SBHC services provided under agreement	Financial arrangements PM/PM = per member/per month FFS = fee-for-service	Pre-authorization requirements	Service coordination/ information exchange policy	SBHC services not covered by agreement
Bridgeport Health Department *(cont'd)*	1	Medical treatment-related services; lab services; medically necessary mental health and substance abuse services up to two visits	Global visit rate + lab fees	None required for services specified in contract	Records maintained by SBHCs; available for audit by plan	Preventive primary care; mental health and substance abuse services beyond two visits
	1	Dental services including diagnostic exams and prophylaxis, fillings, emergency care	PM/PM capitation			All but dental care
Health Start, Inc, St. Paul *7 SBHCs* *5 MCPs*	5	Primary physical and mental health care; EPSDT services	FFS rates negotiated with each plan	None required for services specified in contract	Information on patient visits fowarded to medical home; emergency visit data exchanged	Health education programs, outreach, social services
Memphis/ Shelby County Health Department *2 SBHCs* *6 MCPs*	3	Primary physical and mental health care and case management	PM/PM capitation for members who select health department as primary care provider; FFS rates for all others	For care to plan members that have not selected health department as primary care provider	Exchanged as needed for claim processing and auditing	Substance abuse services, group health education, group counseling
	2	Primary physical and mental health care and case management	FFS rates negotiated with each plan	None required for services specified in contract		
Multnomah County Health Department, Oregon *10 SBHCs* *11 MCPs*	1[b]	Primary physical and mental health care; gate keeping and case management for specialty care	PM/PM for enrollees who designate county health department as primary provider	For care to plan members that have not selected health department as primary care provider	Encounter form is electronically transferred to health department which is then forwarded to plan	PM/PM payment does not cover cost of providing all services
New Haven, Connecticut Public Schools *10 SBHCs* *10 MCPs*	3	Primary physical health care	FFS based on Medicaid schedule	None required for services specified in contract	Preliminary stages of development	Group health education, mental health and substance abuse services
	1	Primary physical and mental health care	FFS based on Medicaid schedule			Group health education, group counseling

[b] Care Oregon is a joint venture of the Multnomah County Health Department and the Oregon Health Sciences University.

Generally, the most significant uncovered service in the managed care contracts is mental health care. Frequently mental health comprises between 25 - 50 percent of the services utilized by SBHC enrollees. According to the survey, 16 of the 26 contracts authorize the centers to provide mental health assessment and treatment services to plan enrollees. Several of these, however, do not cover group counseling, an approach frequently used by school-based health centers. One barrier to inclusion of mental health services is the limited mental health care authorized by many state Medicaid plans. With limited financial support for sub-acute mental health services, managed care plans may consider these to be potentially high-risk or high-use services that must be closely monitored. Sub-contracting for mental health may also be difficult in states that carve out services for the seriously mental ill as a separate program requiring a unique provider network and separate service agreements.

Health education, group counseling, and outreach are not routinely included in the contracts. Of 26 contracts, 7 provide for these services. The inclusion of health education and outreach in the service package may become more likely as the plans become more comfortable with the health centers and more oriented to early intervention efforts.

Financial arrangements. Fee-for-service reimbursement is the most common means by which the plans pay school-based health centers for services. Payment rates are based on a variety of factors including Medicaid and EPSDT fee schedules, fixed global visit rates, or a service-specific rate negotiated by the school-based health center and the plan. While fee schedules are frequently treated as proprietary information unavailable to the public, several centers reported receiving global visit rates of approximately $50.00 per visit.

Under two pre-paid arrangements, Multnomah and Memphis/Shelby County health departments allocate to the school-based health centers a portion of the per member/per month capitation fee for those students whose families select the sponsoring health department as their primary care provider. The financial risks associated with a prospective payment system are assumed by the sponsoring health departments. Health department representatives report, however, that although parents may designate the school-based health center as their child's primary care provider, this has not occurred frequently. Parents may not be aware of the school-based health center option for their school-age children or may desire a provider who is accessible to the entire family.

The Bridgeport Health Department has contracted to provide services to participants in a local Medicaid dental plan. This plan, which receives a sub-capitation payment from five of the eleven Medicaid managed care plans in Bridgeport, has contracted with the Health Department for its school-based health centers to provide a full range of primary dental care, including assessments and fillings. For those eligible students who elect to receive their dental care at school, the dental plan will pay the health department $2.80 per member per month. While Bridgeport Health Department representative Kristine Hazzard acknowledges that the rate may not cover the cost of care, she notes that, "Two years ago we were providing the very same dental services as a public health service with limited-to-no reimbursement. At a minimum, this contract provides for financial remuneration that we've never had."

Sub-capitation agreements present two financial challenges to school-based health centers. First, the initial contract between the sponsoring agency and the plan must provide for a payment that covers the cost of comprehensive services to school-age children. If the initial contract does not cover the cost of that care, neither will the sub-contract. Secondly, the school-based health center program must negotiate with the sponsoring agency to determine how much of the original capitation should be passed on to the centers. The process for negotiating sub-capitation payments requires on-going discussions and data gathering.

Managed care-sponsored school-based health centers. A new approach in managed care-sponsored school-based health centers is emerging in regions where Medicaid managed care penetration is high. A small number of HMOs that function both as managed care plans and community health centers have established centers in schools attended by large numbers of their enrollees. In Baltimore, Maryland, for example, Total Health Care has organized school-based health centers in three elementary schools. The centers provide triage for all students in the school regardless of their plan enrollment status, and offer full services to students affiliated with Total Health Care.

Few of the surveyed programs are recovering significant revenues under managed care agreements, and some report that Medicaid revenues have fallen sharply. The Memphis/ Shelby County Health Department has experienced a dramatic decline in Medicaid support since the introduction of TennCare, the state's mandatory Medicaid managed care program. At present, six managed care plans are enrolling TennCare beneficiaries in Memphis, five of which have made agreements with the Health Department. With only a small number of enrollees selecting the Health Department as their primary care provider, most Medicaid revenues result from fee-for-service payments for specified services rather than capitation fees. Table 4, page 12, documents the decline in Medicaid payments for school-based health center services in Memphis over the past two years.

Table 4. Memphis/Shelby County School-Based Health Centers, Billing/Reimbursement Activity, 1993-95

	1993 Medicaid	1994 TennCare	1995 TennCare [a]
SBHC Services Billed	78%	60%	45%[b]
Billed Services Paid	60%	40%	32%
Total Services Paid	47%	24%	15%

[a]1995 "Services paid" category may be underestimated because it does not include anticipated revenues for services billed in the last quarter.

[b]Excludes self-pay, unallowed and denied claims, sliding adjustments, and capped fees for health department designated-managed care enrollees.

The Multnomah County Health Department, which sponsors 10 school-based health centers, has secured a contract with only one of the eleven managed care plans serving Medicaid recipients. The Health Department is a member of that plan. The loss of fee-for-service payments by Medicaid and the limited number of students or their families who select the Health Department as their primary care provider are expected to result in an 86 percent decrease in Medicaid income for the school-based health centers, down from $188,000 in school year 1994/95 to $26,000 in 1996/97.

In Minnesota, Health Start, Inc. successfully negotiated comprehensive fee-for-service contracts with all plans serving Medicaid recipients in its service area and is also contracting with two plans for commercial enrollees. As a result, Health Start has strengthened its linkages to its patients' other care providers and has been able to sustain its pre-managed care patient services revenues. This income, however, represents only 20 percent of the combined operating budget for seven centers.

Many in the school-based health care field express concern that the focus on managed care contracting may lead to a false impression that school-based health centers could become self-supporting through either prepayment or fee-for-service patient care revenues. According to Karen Hacker, director of adolescent and school health for Boston Department of Health and Hospitals, "School-based health centers will never be fully reimbursable through insurance alone. Not only are many students uninsured but much of what the centers do is *not* reimbursable through either traditional medical insurance plans or managed care contracts." Bernice Rosenthal with Baltimore City Health Department agrees: "Because school-based health centers have a public health perspective, they will always need other dollars to exist."

As the St. Paul experience suggests, even the most optimal conditions will not solve the fundamental challenge: paying for care to uninsured students and providing all students with a range of services not generally included in traditional health care arrangements.

To illustrate the additional difficulties of trying to marry a comprehensive health care model to a traditional medical insurance approach, health finance consultant Steve Rosenberg offers the neighborhood health center model as a case in point. After five years of grant support, the federal government attempted to secure funding for these "Great Society" anti-poverty programs by re-shaping them to fit within a Medicaid reimbursement structure.

> Around 1972, the United States stopped looking at neighborhood health centers as a social model of health care and started looking at them as a medical model. This change was made so that the health centers could bill Medicaid. We made the change by having the predecessor of the Bureau of Primary Health Care define the Bureau Common Reporting Requirements (BCRR). The BCRR set the standards for health centers in such areas as scope of service, budget allocations, productivity, and how services are delivered. These rules essentially defined a medical model and did not support a broader social approach to care. Now, can we write similar rules for school-based health centers? Can we secure federal and state reimbursement dollars without narrowing the model so drastically that we take away the easy access, range of services, and all the other reasons that gave rise to these centers in the first place?[4]

Other contract provisions

Pre-authorizations. Most fee-for-service contracts do not require pre-authorization by the plans to provide services described in the contract. Pre-authorization is necessary, however, if centers want to be reimbursed for services outside the scope of the contract. Baltimore City Health Department is the exception to this rule. The managed care plan with which it has an agreement requires the school-based health centers to seek pre-authorization for *all* services rendered to its enrollees. School-based health centers operated by the Boston Department of Health and Hospitals may or may not need to obtain pre-authorization, depending on *which* contract is involved and *what* service is provided. Under the primary care capitation sub-contracts in Memphis/Shelby and Multnomah counties, care is compensated under the sub-capitation and does not require pre-authorization if the sponsoring health departments are the designated primary care provider. If the student is enrolled with a different provider, pre-authorization for all services from that provider is required. Health Start contracts do not require pre-authorization for any of the physical and mental health services provided in the school-based health centers.

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[4] Making the Grade National Program Office, "Medicaid, managed care and school-based health centers: Proceedings of a meeting with policy makers and providers." June 26, 1995, Washington, DC.

Pre-authorization policies are difficult for many centers, not only because pre-authorization requires maintaining accurate information on students' plan enrollment and contact numbers, but also because pre-authorizations frequently must be secured while students wait to be served. In general, school-based health centers have hired few support staff. A single front-desk aide may be responsible for pulling medical charts, sending appointment reminders to students in classes, writing student passes to return to class, setting up new appointments, and maintaining order in the waiting room. Busy clinics will have difficulty meeting the administrative requirements of their managed care contracts without adding to operating costs and creating barriers to care for their patients.

The pre-authorization policy also has posed new questions for school-based health center providers. Does the commitment to increase students' access to care require the center to treat students enrolled in managed care plans that have not negotiated agreements or that refuse to authorize service? Should the health center support a plan's request to refer its enrollees back to their medical home and hope that the young people will follow through? Should the centers spend limited resources caring for students whose care is already paid for and organized by a plan? Some of the providers feel strongly that the pre-authorization policy is contrary to their mission of expanding access to care. Consequently, pre-authorization policies are not always heeded, the care is provided -- although not compensated -- and other public health resources fill in where managed care will not.

Service coordination and information exchange. Managed care plans, particularly those operating under a Medicaid contract, have data reporting obligations to the state Medicaid agency. The precise nature of those data requirements are still being developed. The seven respondents all report that they provide information on patient visits to the managed care plans, primarily for claims processing. In Massachusetts, a common reporting form has been developed for school-based health centers to use with all managed care partners. Although most of the information flows from the school-based health centers to the managed care plans, Health Start in St. Paul can access information on emergency room utilization by their patients. Health Start also agrees to communicate with clinics in the health plan's network. To protect their adolescent patients' confidentiality, Health Start negotiated with the plans to assure that information on legally protected confidential services (contraceptive care, mental health services, and substance abuse treatment) would not be forwarded by the plan to the home.

Three Lessons Learned

For school-based health centers, negotiating with managed care plans has been hard work. Based on their experiences, the school-based health center programs offer three guidelines to building successful partnerships with managed care plans.

Understand the managed care perspective. Key to building a successful partnership is understanding the potential partner's perspective. Representatives from the managed care industry note that plans, even those organized by non-profit entities, approach partnerships with school-based health centers as business ventures.[5] It is important, therefore, to understand the organization and financing of managed care and how school-based health centers might fit within this model. What might compel managed care plans to collaborate with providers such as school-based health centers? Some of the more obvious reasons include: the ability of school-based health centers to help the plans meet certain state requirements (e.g. providing EPSDT exams to a specified percentage of their Medicaid enrollees); the easier access school-based health centers provide for adolescents; the greater likelihood that early intervention services may be provided; and the desirability of center sponsorship as a marketing strategy for the community.

As pointed out by Donna Zimmerman, many plans may resist relationships with school-based health centers because they do not have sufficient information about the centers. Educating the medical leadership and contract administrators about school-based health centers -- what they do and how they are staffed -- is an essential first step in building the relationship. Clinic tours, written materials (for example, protocols, parent permission forms, and clinic formulary lists), and meetings can help plans understand how school-based health centers function.[6]

Market the Strengths of the Centers Some plans view school-based health centers as an opportunity to invest in primary prevention and are willing to explore the possibility that increasing access to care will improve the quality of care for school-age children -- without triggering a cost explosion. According to Zimmerman, "We were successful with the managed care plans because we went in and said, 'Look at the utilization of adolescents. They aren't likely to go to your providers for care.' And the plans agreed with us." Today, Health Start has primary care contracts with all of the county's managed care plans that serve Medicaid

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[5] Presentations by Sandra Maislen and Valerie Whittlesey at the Healthy Schools, Healthy Communities Grantee Conference, Washington, DC, January 25, 1996.

[6] Zimmerman DJ and Reif CJ. School-based health centers and manged care health plans: Partners in primary care. *J Public Health Management Practice*, 1995 *1(1)*: 33-39.

recipients as well as contracts for commercial enrollees. Although the administrative tasks associated with multiple contracts are complex, the impact has been largely positive, according to Zimmerman: "Our net receipts from Medicaid have been maintained, we've established open lines of communications with the plans, and have been able to tap into the plans' resources for operational management and staff development needs.[7]

A Managed Care Perspective

Sandra Maislen, Vice President of Professional Affairs with Neighborhood Health Plan (NHP), a managed care organization serving Massachusetts Medicaid recipients, offers critical questions that managed care plans like NHP are asking school-based health centers:

- Are you a full service primary care provider?
- What level of risk can you accept?
- Will you be the primary medical home?
- How will you manage 24-hour coverage?
- How will coverage be provided 365 days a year?
- Are your providers board-certified in pediatric/adolescent medicine?
- If nurse practitioners are delivering care, where is the attending level oversight?
- How will the HMO obtain clinical information?
- How should the HMO pay for these services?
- Does the HMO need to pay for these services?
- What is the school-based health center product?
- Can it meet standards and licensing requirements?
- Has the HMO already paid another provider for these services?

Collect, Analyze and Use Data. While the St. Paul experience has been a model for many school-based health centers around the country, Zimmerman is quick to acknowledge that, in addition to the historical presence of managed health care in Ramsey County, Health Start has benefited from two decades of delivering care in schools and four years of billing Medicaid and other insurers for services to their beneficiaries. That experience meant Health Start knew the insurance status of its students, had excellent data on services provided, and could give managed care plans a record of care provided that had been deemed reimbursable under fee-for-service arrangements.

Sandra Maislen, Vice President of Professional Affairs for Neighborhood Health Plan of Massaschusetts (see box, left), represents a plan that is investing in school-based health centers. Twenty-one of the 31 school-based health centers in Massachusetts are sponsored by community health centers that participate in the Neighborhood Health Plan (NHP) primary care provider network. Because the school-based health centers have long been a part of their network, Maislen and NHP created an internal carve out from reserve funds for the school-based health centers. The strategy, according to Maislen, is to collect utilization and encounter data as evidence that the Massachusetts capitation rate for school-age children does not cover costs.

[7] Making the Grade National Program Office, "Medicaid, managed care and school-based health centers."

States as midwives and matchmakers: Facilitating partnerships between school-based health centers and managed care plans

The surveyed programs indicate that beyond the details of specific negotiations, the major challenge to developing relationships with managed care has been the unwillingness of some plans to come to the bargaining table. With the exception of Health Start, directors of the other six programs have been unable to secure contracts with all the managed care organizations that enroll Medicaid beneficiaries in their service area. While a number of factors may account for this reluctance on the part of the plans, the perception of the health centers is that the plans are not eager to share control of patient care utilization and resources with providers external to their networks. A critical role for state government has been to facilitate or encourage negotiations between the plans and the school-based health centers. Without state involvement, six of the seven program directors believe that school-based health centers will have difficulty initiating discussions with the plans and that the plans may remain unaware of the opportunities that school-based health centers represent.

State governments that have been most active in facilitating partnerships between the health centers and the plans historically have invested federal and state dollars in school-based health centers. As suggested in Table 2, the momentum of the Medicaid managed care movement has prompted state health departments and local providers to explore how they can encourage managed care to link with the centers. With the help of state health care financing agencies, states are attempting to develop supportive state policies, provide technical assistance, or utilize a combination of both to sustain the ability of school-based health centers to care for underserved students.

One state strategy for supporting school-based health centers in a managed care environment is to confer a preferential status on the centers through a carve out arrangement. The issue of carve outs or special treatment for provider types, services, or categories of beneficiaries deeply divides managed care plans and public health advocates and is a recurring theme in discussions concerning the role of safety net providers within managed care networks. The plans argue that management of costs and quality requires full authority to control service utilization. Public health advocates and safety net providers maintain that certain services such as family planning, or vulnerable populations such as the elderly or adolescents, may not be attended to adequately unless special provisions are made. To protect these services and populations, some states have carved out select categories and made them eligible for favorable treatment. In various states, these protected categories have included

special needs children, the chronically mentally ill, and the aged. Service carve outs have included family planning, sexually transmitted diseases, mental health, and substance abuse services. Not all states implementing Medicaid managed care programs, however, have agreed to a carve out strategy and there is considerable variability among the states on the subject of carve outs.

Four states -- Connecticut, Massachusetts, Delaware, and New York -- while avoiding any explicit guarantees to school-based health centers, have used the state contracting process to require managed care plans serving Medicaid beneficiaries to link with school-based health centers. Through the Medicaid managed care Request For Proposals (RFP) process, these states obligate managed care plans to contract with the school-based health centers located in their service area. The specifics of the relationship -- scope of services, authorization, financial reimbursement, information coordination -- are not defined in the RFP but are left to the negotiations between the plans and the school-based health centers. To assist in the negotiation process, New York and Connecticut have developed model contracts. They have also devised service and staffing standards for school-based health centers as a way of assuring plans about the quality and content of care delivered at the centers.

For Boston Department of Health and Hospital's Karen Hacker, the role of the Massachusetts Department of Public Health has been critical. "Without state pressure for change we would not be doing anything," admitted Hacker. "When the state Medical Assistance office mandated linkages between managed care and school-based health centers as part of its contracting policy, it meant there was an open road ahead of us -- not an easy one, but an open one."[8]

In Maryland, the Governor's Office has drafted Medicaid reform legislation that would permit school-age plan members to seek health care from school-based health centers without pre-authorization. The students' Medicaid managed care plan would be responsible for reimbursing care rendered by a school-based health center provider.

Other states, such as Colorado, have avoided even limited mandates, preferring to bring managed care plans and school-based health centers together voluntarily to explore the benefits of partnership. The state's strategy is to demonstrate to the managed care plans and other insurers that school-based health centers can help plans meet quality and access standards to which they ultimately will be held accountable. A public-private task force on school-based

[8] Making the Grade National Program Office, "Medicaid, managed care and school-based health centers," p.4.

health center policies and financing has provided technical assistance and written materials for insurance companies and managed care plans. The written documents include: a school-based health center benefits package; a cost analysis of school-based health center services; a set of accountability measures drafted as a requirement for contractual arrangements with insurers; and a two-county market share analysis using school enrollment data matched with Medicaid and selected managed care organizations.

The West Virginia Department of Health and Human Resources, in its Request for Applications (RFA) to its 1915(b) managed care program, established a financial incentive of up to two percent in additional capitation for plans to contract with public health care providers, including school-based health centers.

Minnesota has not adopted measures directed at linking school-based health centers with managed care. The state code, however, requires all managed care plans to develop action plans for addressing the health care needs of adolescent enrollees. In addition, under the prepaid Medicaid program, health plans must offer contracts to community clinics. According to Zimmerman, these requirements were helpful to Health Start. It marketed its school-based health services to the managed care plans as an opportunity for the plans to effectively meet the state directives. In the future, Health Start may use its association with Neighborhood Health Care Network, a consortium of Twin Cities community clinics, to negotiate larger contracts, including risk-sharing, with the health plans. Massachusetts, in a similar vein, requires its Medicaid health maintenance organizations to develop a plan for improving access to preventive and confidential services for adolescents. Because this requirement does not apply to the more than 1,300 primary care case management physicians who enroll 75 percent of Medicaid managed care beneficiaries, the reach of this requirement is limited.

Into the Future

Despite the challenges school-based health center programs and managed care plans have faced in negotiating mutually satisfactory agreements, these relationships represent a critical step forward for all involved. In agreeing to open their networks to school-based health centers, the managed care plans have acknowledged existing barriers to care, especially for adolescents, and the opportunities presented by the centers to overcome those barriers. School-based health centers, in responding to the challenges posed by the plans regarding their quality of care and accountability, are developing new skills and expertise that promise to strengthen school-based health care.

Perhaps critical to the future of these partnerships will be the ability of states to play a facilitative role, whether through encouragement or regulatory means, in brokering relationships between school-based health centers and managed care plans. As these relationships continue to evolve and mature, state oversight will likely be critical in identifying emerging clinical, financial, and administrative issues.

The continued development of outcomes measures or accountability efforts by managed care plans, major health care purchasers and state offices offer a particular opportunity for school-based health centers to demonstrate how they can assist the plans meet quality-related requirements. A shared commitment to patient care outcomes, as the St. Paul experience attests, eases the negotiations between the plans and the school-based health centers. As the seven school-based health center administrators report, however, negotiating these contracts can be a complex and demanding process. The challenge for the future will be the development of contractual relationships that, through the defined scope of services and payment structure, recognize the mix of medical and psycho-social services provided at the centers and support the continued availability of comprehensive care to school-age children.

Social Policies for Children

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The Brookings Institution
Washington, D.C.

1996

Contents

Chapter 6

Health Care Goes to School: An Untidy Strategy to Improve the Well-Being of School-Age Children

Julia Graham Lear

TWO CONTENDING forces in the field of public policy have created a difficult terrain on which to build social policies that support poor children. On the one hand, there is widespread concern that any new government program, even those targeted on the youngest and most vulnerable members of society, will increase the federal debt or press states beyond their fiscal capacity. On the other, despite concerns about public spending and persistent antigovernment rhetoric, there has been sustained political willingness to consider the needs of poor children. These needs, documented in recent years by nearly a dozen reports sponsored by various bipartisan or independent bodies, appear to reinforce a national interest in "doing" something for poor children, particularly if the "doing" can be cost contained and targeted on those most in need.[1]

One intervention on behalf of poor children that meets the criteria of targeted and limited spending is the school health center.[2] Over the past twenty years, these centers have demonstrated potential for responding to the persistent health problems and limited access to care affecting low-income students. School health centers, usually sited in communities where child and adolescent health professionals are few and needs are great, have increased availability of physical and mental health services for school-age children. While the future of all children's health care has been clouded by the failure to achieve universal health insurance, recent experience suggests that broad repli-

ıtion of these centers can help children and their families overcome arriers to needed health services.

Recapping the Need

While most children are in excellent health and receive adequate are, too many children in the United States neither see a physician at ecommended intervals nor receive treatment for episodic or chronic roblems.[3] The difficulties confronting these mostly low-income chil-dren are compounded by the higher rates of health problems associ-ated with poverty and the greater barriers poor children experience in securing care.

Health Problems of School-Age Children

The most common complaints of school-age children include injuries, chronic conditions, and mental health problems. Injuries kill more than eight thousand children age fifteen and younger annually. Chronic conditions limit the routine activity of between 2 and 6 million children ages eighteen and younger.[4] Mental health problems affect even larger numbers. The National Institute of Mental Health estimates that 7.5 million young people (12 percent of our children) have at least one diagnosable disorder. Half of these children are said to have seriously handicapping conditions.[5] Problems affecting adolescents, including violent death, pregnancy, and substance abuse, have stirred continuing worries about behaviors that compromise individual and societal well-being.[6]

Poverty in the United States increases the number of health problems affecting children. Poor children, reported in 1993 to number 15.7 million (22.7 percent of the total under-eighteen population), have a frequency rate for many medical problems that is double to triple the norm. Child deaths due to disease are triple to quadruple those of other children and deaths due to accidents are double to triple those of other children.[7]

Barriers to Health Services

The primary reason children are unable to secure timely and appropriate care for their health problems is financial. In 1991, more

than eight million children under age eighteen had no health insurance. These children were less likely to receive preventive or early intervention care.[8] Eliminating financial barriers by guaranteeing universal health insurance coverage remains the most essential step toward ensuring health care for low-income children.

Health insurance alone, however, will not solve all problems. Unequal distribution of physicians and other health professionals across the United States, inadequate transportation services, cultural barriers, and institutional practices all impede access to care. In Chicago, for example, the child-to-pediatrician ratio in poor neighborhoods is 5,887:1, in contrast to a national average of about 1,000:1.[9] Even when physicians are present in a community, they may refuse to see medicaid-enrolled children. In some instances, medicaid rules get in the way of service. For example, nearly half the state medicaid programs do not reimburse for mental health services provided by psychologists or clinical social workers, even when they are supervised by psychiatrists.[10]

Adolescents face additional barriers to care. Adolescents are more likely than other age groups to be uninsured. About 15 percent have no health insurance.[11] Many, despite legal protections, are also unable to secure confidential services related to sexuality, substance abuse, or emotional problems. And all adolescents confront a shortage of physicians or other health professionals trained in adolescent health care.

If poor children do not receive adequate health care, does it make a difference? Health economist Victor Fuchs has written that in rich nations health services do not ensure better health for any age group: genetics, income, and behavior are more important in determining health status.[12] Most who have studied the matter agree, while emphasizing that health care plays a variable role, depending on patient age, health problem, and other factors. Barbara Bergmann suggests elsewhere in this volume that in the United States as in other wealthy countries, quite apart from questions of efficacy, health care is considered a "merit good"; that is, most people believe that a decent society makes health care available to everyone, regardless of other factors. While the congressional impasse on health care reform suggests something less than a national consensus on universal access to care, support for children's health services appears to continue in the face of federal and state budget cutting.[13]

Launching a School Health Center Initiative

Building on continued public support for programs directed toward children's well-being, this chapter proposes meeting the health care needs of a large number of unserved and underserved school-age children by establishing comprehensive school health centers in up to 7,500 elementary and secondary schools across the United States. The centers would provide a broad range of physical and mental health services as well as preventive care and health-promoting activities. The eligible schools would be elementary and secondary schools with student populations exceeding 500 and in which 50 percent or more of the students are entitled to participate in the free or reduced-price lunch program. The centers would link existing efforts in primary care, public health, school health, and health education with emerging systems of managed health care to ensure that the health care requirements of the neediest children are met.

HOW MANY CENTERS? While poor children can be found in nearly every public school, those in greatest need and with the fewest resources are most frequently found in schools with the highest concentrations of poverty. The Department of Education estimates that approximately 20,000 elementary schools and 5,000 secondary schools have enrollments in which more than 50 percent of the students are poor. However, many elementary schools have enrollments too small to sustain a full-time school-based health center. There are 8,300 elementary schools in which 50 percent of students are from poor families and which also have enrollments in excess of 500.[14] Those schools, plus an estimated 2,000 very poor secondary schools, would be eligible for school health centers.

It is unlikely that all 10,300 schools would be interested in participating in the program. First, while poor communities are most likely to have large numbers of children with significant untreated health problems, this is not always the case. Therefore, a few low-income schools would not have students with compelling unmet health care needs.[15] In other communities, space limitations within the school; labor market constraints; opposition from community members, school faculty, administration, or school board; competing priorities (for example, establishing recreation programs or family resource centers); or an absence of a sponsoring medical organization may also deter a school or a school district from participating in a health center initiative. A reasonable guess might be that 7,500 of the eligible schools would ultimately seek to establish centers if they were financially viable.

HOW MUCH WOULD IT COST? If 7,500 public elementary and secondary schools were supported to establish and operate comprehensive school health centers, the total cost would be $1.5 billion annually (at an average cost per center of $200,000).[16]

WHO SHOULD PAY? The answer to this question is everyone, and hence this strategy is untidy. There would be no single source of dollars, no czar or czarina for school-based health care. Some central standard setting would exist because health care, especially health care for the poor, is homogenized to some degree by the role of the federal government in medicaid and, potentially, by the role of the federal government in health care reform. But schools are a matter of local and state control, and health care itself is organized and staffed in quite different ways across the country. A patchwork of funding sources and participating partners seems appropriate to the health and education systems that would be involved in the new strategy.

The degree to which various levels of government and private agencies would contribute would depend, in part, on whether the federal or state governments expand health insurance coverage for all children and on the degree to which school health centers are included in the changing structures of health care financing. Specific measures at the federal and state level would be essential to assist school health centers either to receive adequate grant support to sustain the centers or to recover a significant portion of their operating costs through payment for patient services. Currently most school health centers are paid little for patient care due to the large number of uninsured students they care for, the poor coverage for primary and preventive care offered by many private health insurance plans, and a variety of regulations that limit medicaid participation.

The Federal Role

The collapse of health care reform in 1994 and election of a Congress that is not eager to resume the health care debate create a

challenge to crafting a federal role to support school health centers. Despite bipartisan approval of funding for school health services during the health reform discussions, current anti-Washington rhetoric and Republican presidential politics likely preclude the possibility of a major federal initiative as was envisioned in the Clinton proposal.[17]

The new Republican-led Congress, however, creates both opportunity and necessity for rethinking the federal role in improving health care for poor children in a period of retrenchment. Two useful possibilities present themselves: providing vision and leadership on the continued importance of child health services and offering a small, well-constructed grant initiative that models the delivery of effective health services.

VISION AND LEADERSHIP. In the midst of post–health care reform angst, political leaders and federal officials urgently need to remind the nation of its obligation to continue to build the network of services for children. Creating a vision of a health care system that serves all children and defining the role of school health centers within that system is particularly beneficial when the health care system is changing radically. Poor children face uncertain treatment in the emerging health care systems that are dominated by integrated service networks, complex managed care programs, and Wall Street–oriented financing plans.

THE GRANT INITIATIVE. A federal grant program could build on recent work by the Department of Health and Human Services and link with state-led initiatives to develop school health centers as part of a multifaceted effort to improve health care for unserved and underserved school-age children.

At present direct federal support for school health centers is small indeed. Despite support within the Clinton administration, less than $6 million is designated for school health centers by the Department of Health and Human Services.[18] An expanded but politically viable federal initiative might underwrite the establishment of 350 school health centers, a number slightly less than 5 percent of the target 7,500 but large enough to increase significantly the number of poor children served and the number of viable models in every interested state. A reasonable schedule for development of 350 excellent, standard-setting centers might be 50 in fiscal year (FY)96, 75 in FY97, 100 in FY98, and 125 in FY99. The numbers in table 6-1 demonstrate how this strategy might work.

TABLE 6-1. *Funding Required to Support New School-Based Health Centers, Fiscal Years 1996–99*

Millions of dollars

Fiscal year	Number of new sites	Start-up funds	Continuation support	Total
1996	50	7.5	—	7.5
1997	75	11.3	5.0	16.3
1998	100	15.0	10.0	25.0
1999	125	18.6	12.5	31.1

Source: Author's calculations.

The average cost per center would be $200,000, and the federal government would provide 75 percent of that cost in the start-up year and 50 percent in succeeding years. Determining factors in selecting sites would be willingness of health care organizations and school systems to redeploy some of their personnel and redirect some of their funding to support the centers. For example, a city mayor might choose to use some Office of Substance Abuse Prevention funds to support the mental health professionals at the center. The state mental health system might also encourage community mental health centers to place staff within the health centers. Schools might choose to use chapter 1 education funds or funding for health-related services for special education students to contribute to the functioning of the center. Schools with pupil-support personnel, such as social workers, counselors, nurses, or psychologists, could link their staff with the new centers.

Continuation support would not exceed 50 percent of the average cost of the center because the centers would increasingly be woven into the mechanisms that fund clinical care. Schools with a mostly insured population might eventually secure up to 50 percent of the operating cost of the centers. Schools with large numbers of uninsured students would face a greater challenge to survive.

To set a school health center initiative in motion, the Congress and the executive branch need to appropriate funds to finance the start-

up of new school-based health centers and set aside additional dollars to support the nonreimbursable services and activities provided by the school health centers. Federal agencies that might participate in a school health center initiative include the Bureau of Maternal and Child Health, the Bureau of Primary Health Care, the Center for Mental Health Services, and the Center for Substance Abuse Prevention.

The State Role

One significant result of the collapse of national health care reform is that state governments are assuming major responsibility for nurturing and sustaining service initiatives such as school health centers. Many states are already investing heavily in the centers. In 1994 thirty-two states reported allocating an estimated $38.8 million to local governments or health institutions to provide comprehensive primary care services in schools. California, Delaware, and Massachusetts are all supporting more than 20 centers; Connecticut has made grants to 50; and New York State is supporting nearly 150.[19]

There is growing awareness, however, that the shrinking public health dollar and the emergence of managed care require a thoughtful and intentional state policy to encourage the participation of both private and public funds to support the health centers if established centers are to survive and if new centers are to open.

The first step states must take to facilitate the development of school-based health centers is to identify the barriers to school health centers and construct public policies that remove or reduce them. The primary barrier to the creation of school health centers is financial. The fundamental question is how to fund additional primary care for poor children while public grants are not expanding and threatening to shrink. Paradoxically, the rapid expansion in managed care—particularly medicaid managed care—creates an opportunity for states to move aggressively to develop school health centers.

Managed care has grown dramatically in the past few years, and medicaid managed care has grown even more dramatically. Between 1991 and 1993, the number of medicaid beneficiaries enrolled in managed care plans increased from 8.1 million to 33.6 million. Since 1993 seven waiver applications have been approved by the federal Health Care Financing Administration that will allow states to bring

all medicaid enrollees under a state-funded managed care initiative, the medicaid Section 1115 demonstration waivers. Applications from eight more states are under review in Washington, while at least ten additional states are in the process of developing applications.[20]

One characteristic of the waiver request—and the aspect that creates the most opportunity for school-based health centers—is that although the initial impetus for the waiver has been to contain health care costs, waivers are also used as vehicles to expand insurance for the uninsured, coordinate care for the enrollees, and ensure that quality standards are met. Thus the 1115 waiver application process creates a powerful opportunity to reassess the health care needs of poor children, rethink the adequacy of primary care services, and adopt strategies that support the development of additional primary care delivery sites. And these sites might include school-based health centers.[21]

Within the 1115 waiver, there are three primary strategies a state can pursue to make sure that the new medicaid managed care system makes a school-based health center strategy viable: a regulatory approach, a market model, or a pooled funding approach. Each has some strengths and weaknesses; none is likely to be adopted in its purest form. All have the advantage of helping state officials think about what is required to establish a financing system for a new health care delivery mechanism.[22]

REGULATORY APPROACH. Under this approach, the state medicaid office—either in its 1115 waiver application or in its contract with the managed care plans—specifies that the plans must contract with and reimburse school health centers for care provided to their enrollees. The state might designate cost-based reimbursement or it might require that the plans reimburse the centers at the market rate, with the state providing additional dollars for the uncompensated health education and classroom services frequently provided by school health centers. While this approach provides certainty of participation in the managed care network for the centers, it burdens the managed care plans by insisting they contract with school health centers that might not meet a plan's standard of care. It also burdens the school health centers, which would likely be required to negotiate contracts and undertake complex billing and accounting procedures with a large number of managed care plans.

MARKET-BASED MODEL. In a privatized approach the state might determine that managed care plans should reimburse for school-based health services of a specified type. Regulations would define the services and conditions under which certain health care services should be provided at a school. For example, regulations might state that if 20 percent or more of a school's population belonged to a plan, then the plan must offer certain services at schools with specific characteristics. How the plans would organize to deliver those services would be left to the market. If a health center were located in a school, then plans might choose to contract with the center. The plans also might choose to contract with school nurses or other health personnel. As with the regulatory approach, this strategy places a heavy administrative burden on the school health center staff and may be difficult to implement in health markets with a large number of plans enrolling medicaid children.

POOLED FUNDING APPROACH. Under this strategy, the state defines the eligible populations to be served and the services to be funded with state dollars. The state may then inform the managed care plans that if they want to participate in the state's 1115 waiver program, the plans pay a tax to the state, perhaps a set amount per adolescent per month, which would then be placed in a state pool that could include MCH block grant funds, chapter 1 funds, juvenile justice funds, and other categorical funds. The state funds could then be used to draw down the federal match under medicaid and enlarge the pool further. The state would then have an expanded pool of funds to support local school health centers. The benefit of this approach is that it relieves individual school health centers from a billing and accounting burden. The disadvantage is that at the clinic level it reduces the connection between service volume and revenues and, at the state level, increases the state agency's obligation to monitor and tend to productivity as well as other standards.

A New Approach to Children's Health Care

The first school health centers were established about twenty-five years ago. The twin themes of increasing access to care for adolescents and reducing teen pregnancy appear early in discussions of the centers. Their expansion, however, has been fueled primarily by concern that adolescents in general have not been well served by the traditional health care delivery system and a desire in particular to increase health care for low-income students. The first health centers were established primarily in high schools, but increasingly state initiatives and community programs have developed centers in elementary and middle schools.

In the past ten years, the number of school health centers increased from about fifty to more than six hundred. This expansion was fueled primarily by state support. In 1994, states allocated $12 million of their Title V (maternal and child health) block grant funds and $22.3 million in general funds to support the centers.[23]

The school health centers blend medical care with preventive and psychosocial services; they also organize broader school-based and community-based health promotion efforts. How this is done varies from school to school, community to community, but is suggested by the four examples below.

New York City

At Far Rockaway High School, located on the isolated Far Rockaway peninsula in Queens, almost one-third of the 2,000 students had no regular source of health care before the school clinic opened. Finding health care was a particular challenge for these students because one-quarter had recently immigrated to the United States and one-half were foreign born. Only one-quarter were living with both parents, and one-third were enrolled in special programs for academically at-risk students or had repeated a grade.[24]

In 1987, the Adolescent Division of North Shore University Hospital and the Far Rockaway High School staff organized a school health center, to be open year-round, five days a week, 8:00 A.M.–4:00 P.M., with weekend coverage by the nearby St. John's Episcopal Hospital emergency department. The center is staffed by two nurse practitioners, a clinical social worker, part-time physicians, and trainees in the fields of medicine, nursing, and psychology. During the 1992–93 school year, 1,015 (of 1,600) students made 4,722 visits to the health center. Twenty-five percent of visits were for acute medical problems; 21 percent were for mental health issues; 14 percent were for job, sports, or routine physical examination; 13 percent were for gynecological problems; 12 percent were immunizations; and 6 percent were for chronic conditions.

Although the visit categories sound routine, the time devoted to these visits suggests the intensity of need. Only 19 percent of visits lasted less than ten minutes; 38 percent lasted from ten to twenty minutes and 43 percent lasted longer than twenty minutes. In addition to clinical services, the health center staff organized educational sessions and special events for students, faculty, parents, and the community.[25]

Denver

Denver's first three school-based health centers have acquired a slightly different focus. While the clinics at Lincoln, East, and Manual high schools also enroll about 70 percent of the school population and provide a similar set of physical and mental health services, the school population is more diverse, including more Asian and white students as well as students from families above the poverty line but below the median community income. These students are also more likely to have community-based health providers. Despite their better access to community resources, the students keep the Denver clinics busy: 1,480 students made a total of 7,598 visits during the 1992–93 school year. The medical director thinks that students use the clinic because they believe the services are more likely to be confidential than those provided by private physicians or HMOs.

The health centers also deliver a high volume of mental health and alcohol and drug treatment services. Mental health and substance abuse services constitute about half the total, with medical services about 45 percent and a special violence prevention program 3 percent. Close links to school staff promote the use of these services. Under agreement with the school system, students caught using drugs or alcohol are given the option of staying in school if they agree to attend a prescribed number of sessions with the substance abuse counselors. Similarly students involved in violence or abusive relationships are referred by school administrators as well as the courts to the clinics' specialized violence prevention and intervention counseling services.[26]

Bridgeport, Connecticut

At Blackham Elementary and Middle School in Bridgeport, Connecticut, the health center serves an ethnically diverse mix of the

very poor, not so poor, and the simply poorly insured. At Blackham, the health team is joined by a dentist. The volume of dental work in the city's four school-based dental suites is such that a full-time dentist stays busy spending one day a week at each school health center and allocating the fifth day to the school with the longest waiting list.

When asked to compare her elementary school and high school health centers, the clinic director notes that for about 75 percent of the care, the content—acute care, chronic care, and mental health—is relatively similar. But at the elementary school an outreach worker has been hired to make home visits and to assist families to secure social services.

The health center serves as a base on which to build a variety of support and social services for students and their families. For example, a large number of boys from the sixth, seventh, and eighth grades have been referred to the male outreach worker due to concerns about gang involvement, truancy, and school performance. The outreach worker has formed a "men's group" to create a network of support for young boys headed for trouble.[27]

Portland, Oregon

For the Multnomah County Health Department, school health centers are an intervention to address the problem of teen pregnancy. When the health department opened its first center at Roosevelt High School in 1986, the site was selected not only because a large number of students had no health insurance, but also because the school's neighborhood had a high teen pregnancy rate.[28] The seven Multnomah County school health centers provide comprehensive physical and mental health services; they also offer a full range of family planning services, including dispensing condoms and prescribing other contraceptives. Family planning represented 40 percent of the care provided during the 1992–93 school year.

In 1992 the state of Oregon adopted its Benchmarks process to guide funding decisions. Reducing teen pregnancy and teen drug abuse were established as two urgent benchmarks. Based on the results of a study comparing student behaviors at schools with health centers and schools without health centers over a two-year period, the state has expanded its funding for the health centers. The Oregon

Health Department has noted the positive impact the health centers had on targeted behaviors: students in clinic schools were more likely to see a health provider in the previous year than students in nonclinic schools; students in clinic schools were less likely to report having sex in the month before the survey than students in nonclinic schools; and students in clinic schools reported less binge drinking than students in nonclinic schools. According to the Oregon Health Department, "In each of these selected survey questions, the students in the Clinic Schools demonstrated improvements in health related behaviors compared to Control Schools."[29]

Arguments in Support of a School Health Center Strategy

Despite the failure of Clinton health care reform, the potential for expanded health insurance coverage for children and adolescents continues as states use managed care initiatives to insure a greater number of poor and near-poor children.[30] Therefore, the question remains, How do we make this potential access to care a reality? School health centers, which represent a dollar-limited, population-specific strategy involving both the federal and state governments, are a realistic approach in the current fiscal and political environment.

SCHOOL HEALTH CENTERS INCREASE ACCESS TO CARE. The fundamental reason to support a school health center strategy is that these centers will increase access to health care for low-income, school-age children. Data from a large number of school-based health centers, summarized in table 6-2, confirm the potential of health centers for increasing access to care.[31]

Students use the health centers frequently, as demonstrated by the number of enrollees, total visits, the number of visits per user, and the ratio of repeat to new visits. Analysis of a particularly busy health center indicated that the most frequent clinic users were students with more high-risk behaviors, lower grade point averages, and a greater self-identified need for mental health services than the average users.[32]

In a study of twenty-four school-based health centers, the centers were found to provide care to a large number of students who had not had care recently, did not report a regular source of care, and did not have health insurance. Twenty-four percent of the new students

TABLE 6-2. *Frequency of Diagnostic Categories in Selected School-Based Health Centers with Comprehensive Capacity*

Percent unless otherwise specified

Item	Connecticut elementary school	New York middle school	New York high school	Colorado high schools (2)	Oregon high schools (7)
Grade level	K–8	6–8	9–12	9–12	9–12
Students in school	1,200	1,700	1,700	3,926	8,858
Enrollees in SBHC	968	668	1,000	2,595	4,336
SBHC visits per year	1,927	2,942	5,214	7,590	18,600
Diagnoses per year	2,253	2,942	5,942	7,590	23,343
Diagnostic categories					
Well child/adolescent	8	15	19	14	12
Gynecology/sexually related	4	4	24	9	42
Mental health/social work	33	26	16	42	16
Injury/orthopedic	5	6	6	6	5
Neuro/ophthalmology	10	8	3	2	<1
Cardio/respiratory	8	4	4	2	3
Dermatology	6	3	3	3	4
Hematology	<1	2	3	<1	1
Gastroenterology	3	4	5	1	1
Dental	9	15	8	<1	<1
Ear/nose/throat	9	3	3	2	5
Infections	3	6	6	6	4
Drug and alcohol services	—	—	—	14	1
Other[a]	<1	<6	<3	<3	<5
Total	100	100	100	100	100

Source: Columbia University School Health Policy Initiative, "National Work Groups Define School-Based Health Center Services," ACCESS to Comprehensive School-Based Health Services for Children (Columbia University School of Public Health, 1994), p. 3.

a. Includes endocrine/obesity, urologic, allergic, and unspecified services.

who enrolled in the health centers during the 1992–93 school year stated they had not received medical care in more than two years, 35 percent said they did not have a regular source of care, and 47 percent stated they did not have health insurance.

SCHOOL HEALTH CENTERS FIT WITHIN A STATE-DRIVEN HEALTH POLICY ENVIRONMENT. While consensus on health care reform currently eludes Congress, health care policy continues to be high on state legislative agendas. School health centers are congruent with the purposes of health care reform, whether that reform is driven by the federal or state governments.

States are essential partners in a school health center initiative. They make the laws regulating health professionals, write the medicaid rules regarding which providers shall be reimbursed, fund public health measures, and allocate a variety of federal block grant funds. Reallocation of federal dollars in the health and education arenas frequently requires the participation of state governments. States also support the training programs that affect the supply and quality of health professionals available to the centers. As noted previously, with many states moving medicaid recipients into managed care plans, the main engine for financing school-based health centers will become medicaid managed care.[33]

Many states are attempting to shift emphasis and spending from specialty care to primary care by expanding medicaid benefits to more low-income residents. If the school-based health centers can persuade state governments or the organizers of health services that they offer cost-effective ways to increase access to primary care for underserved young people, states with larger numbers of poor and uninsured children may take the lead in establishing more school health centers.

SCHOOL HEALTH CENTERS FOCUS PUBLIC FUNDING ON THE "DESERVING POOR." A children-focused policy may have particular political appeal in a climate hostile to providing services and income to poor adults. An initiative that benefits children directly and adults only indirectly sidesteps opposition generated by programs that are perceived as benefiting the "undeserving" poor. The continued expansions of medicaid coverage for children during the Reagan years and the willingness of states to implement some of the more generous federal options suggest that, even in a harsh political climate, there remains support for policies that respond directly to children's needs.

SCHOOL HEALTH CENTER STRATEGY BUILDS ON RECENT WORK. A fairly solid base for reform has been laid not only by the stream of reports over the past ten years but also by small-scale demonstrations of school-based health centers in a number of cities and states. As noted at the beginning of this discussion, foundation studies, federal agency papers, commissions staffed by Democrats and Republicans, calls for action issued by corporate leadership, and state governments have all affirmed the need to alter the conditions and opportunities for children. Local and state initiatives supporting school health care have created a cadre of seasoned clinicians, political leaders, parents, students, and community advocates who can both demonstrate how to make such an initiative work and testify to the impact of the centers.

Arguments against a School Health Center Intervention

As school-based health centers have become increasingly popular, policy analysts have begun to look more carefully at this new primary care delivery mechanism and have raised at least four substantive objections.

SCHOOL HEALTH CENTERS WILL BE DUPLICATIVE AND UNNECESSARY. Perhaps the most powerful argument against a national strategy to expand school health centers is that they are redundant in a system that provides all poor families with medical care. This argument maintains that when families have financial access to services through health care reform, they will seek care from office-based physicians along with middle- and upper-income Americans. School health centers will then constitute an expensive duplicative effort. A corollary to this argument is that programs for poor people provide poor care. Since school health centers are mostly located in poor communities, school health centers, like other institutional providers—outpatient departments, emergency rooms, and community health centers—are likely to provide inferior-quality care.

Running counter to this argument is widespread agreement that we not only need to squeeze dollars from the overdeveloped acute care component of our health care system, but we need to direct those dollars into capacity expansion at the primary care level. The experi-

ence of the past decade is that a laissez-faire approach is unlikely to increase primary care capacity in poor urban neighborhoods or remote rural areas. As noted, the number of children's physicians increased sharply over the past ten years, but these physicians did not locate in the poorest neighborhoods. Issues such as race and class bias further constrain the operation of supply and demand forces. The medical marketplace is unlikely to allocate the needed share of health care resources to the poor.

Two additional factors argue against the proposition that universal health insurance will suffice to secure access to primary care for all school-age children. These are the shortage of personnel trained in adolescent health care and the social and economic changes that make it difficult for even more affluent parents to use the current primary care system for their children. Personnel shortages decrease the likelihood that even well-insured students, ages ten to seventeen, will find health care that is attuned to their needs. More broadly, a recent study found that employees of a large company whose health benefits included immunization for their children had not immunized their children according to recommended schedules and that substantial numbers of children were unnecessarily vulnerable to preventable diseases. Nearly all parents said they had a physician or clinic where they could take their children for sick and well child care, but difficulties in getting off work, long waiting times to see a physician, and concerns about out-of-pocket costs, inconvenient office hours, and difficulty in securing appointments deterred them from making timely appointments for their children.[34]

SCHOOL HEALTH CENTERS HAVE NOT ALLEVIATED ADOLESCENTS' PROBLEMS. One of the great confusions surrounding school health centers is the notion that a health center established in a school constitutes an intervention that can, by its existence, alter health-compromising and socially destructive behaviors. In many cases this confusion has been encouraged by health center advocates, who have maintained that school health centers are a panacea for teen pregnancy, alcohol abuse, dropping out of school, and violence. For those who anticipated this cascade of benefits, there has been great disappointment.[35]

The disappointment is misplaced. School health centers are beneficial because they increase access to care for that part of the population

that has been least served. They have overcome traditional barriers to medical care and they have expanded access to mental health services by bringing these services into a multidisciplinary model. Moreover, because they are organized and staffed in ways that make health professional training programs possible, the school health centers have the potential to expand the supply of health care professionals trained to care for school-age children.

This is not to say that school health centers cannot assist in intervening in problematic behaviors. By expanding the care system for children and adolescents and, in particular, by creating a health service in which adolescents feel comfortable and trusting, the opportunity is created for interventions that can affect a large number of young people.[36]

SCHOOL HEALTH CENTERS SERVE THE WRONG POPULATIONS. School health centers, this argument contends, are not the most important thing we can do to improve child health. Other measures would improve child health more: implementing universal health insurance, immunizing more children, attracting more women into earlier prenatal care, initiating aggressive community programs to reduce childhood injuries, increasing training programs for child and adolescent mental health professionals, and expanding preventive and primary care services for high-risk, underserved populations. While there is consensus that universal insurance is essential to overcome the highest barriers to health care, there is no consensus regarding priorities among these other needs. Children's health also would benefit from a long list of interventions, most of which have little to do directly with health care: for example, reducing the rate of child poverty or raising the taxes on beer and cigarettes. School health centers make sense in a time of fiscal constraint because they can be targeted to needy communities; they provide a range of services that respond to the unmet needs of a particular population, and they link children to the continuum of care offered by the health care system.

Critics also point out, correctly, that school health centers will not care for children who are not enrolled in school. While school health centers in elementary schools may serve family members or community residents as part of their outreach efforts, high school centers especially are unlikely to serve young people not enrolled in school. Principals in poor communities are security conscious and do not

allow strangers in their buildings. Only clinics that have separate entrances to their facilities are likely to receive permission to serve outsiders, and that permission may be granted only after the school administration has come to trust the staff.

To reach out-of-school and incarcerated young people and others who are at highest risk, there must be multiple sites committed to treating patients the health care system has been least anxious to serve.

Barriers to Implementation

While sustained concern about children's well-being and rapid changes in state financing of health services for children create opportunities to increase access to health care through school health centers, political, legal, and technical obstacles must be overcome.

Political Opposition

In some communities, two religious groups—the Christian Coalition and members of the Roman Catholic Church hierarchy—have organized substantial opposition to school health centers. Opponents of school health centers maintain that the centers encourage teen sex and, by permitting patient confidentiality, come between parents and their children. In response, parents and students, the most compelling proponents of the centers, argue that the centers fill an unmet need and are supported by families who use the local schools. Supporters also point out that parental consent requirements give parents the final say in whether their children use the health centers.

The willingness of conservative church groups to influence the school health center debate at the national level is unclear. Conservative Protestant groups have made outcomes-based education and sex education their priority issues at the local level, and nationally their political agenda has focused on abortion. Not all diocesan leaders within the American Catholic Church oppose the health centers or are willing to stop others from establishing them. Throughout congressional consideration of health care reform there was no evidence of a concerted effort to strip the proposed legislation of its language supporting school-related health services. Indeed, in the last congressional vote on the school health services portion of

health care reform legislation, the Senate Labor and Human Resources Committee voted 17–0 to support the section of the bill allocating funding for school-related health services. However, the important role of the Christian Coalition in the Republican victory in the 1994 congressional elections suggests that the GOP may be drawn to a more conservative position than it took during the earlier health care discussions.

Caps on Federal Discretionary Spending

In addition to potential political opposition, a federal initiative to support school health centers must clear barriers posed by the Budget Enforcement Act of 1990 (BEA). The BEA requires that increased discretionary funding in one area must be offset by reductions in other programs. Given the structure of the congressional appropriations committees, this requirement means, in practice, that an increase in one discretionary health program requires a reduction in another health program. This effectively sets one discretionary program against another and weakens the ability of school health centers to secure support from organizations whose own line items may be threatened by the creation of a school-based health center category.

While budget caps make it inevitable that a federal grant program may support only a fraction of the centers needed, there are opportunities in current federal programs to fund additional school health centers. For example, in FY1995 the Department of Health and Human Services budgeted $65 million for substance abuse prevention demonstrations for high-risk youth and $22.5 million for substance abuse prevention demonstrations for pregnant women and infants. Moreover, traditional providers of some services to poor children were scheduled to receive substantial funds: community health centers ($616 million) and maternal and child health block grant programs ($684 million). In the Department of Education, four programs might support health-related services: compensatory (chapter 1) education—$6.7 billion, Individuals with Disabilities Act special education grants to states (IDEA, part B)—$2.3 billion, Drug-Free and Safe Schools programs—$466 million, and Goals 2000, a new federal initiative to support school reform—$372 million. Funds from these programs could be teamed with a school health center initiative to reduce the need for new money.[37]

A Difficult Fit

Negotiating the fit between the health centers and medicaid (or medicaid managed care) requires resolving issues that have limited medicaid support for school health centers in the past.

One barrier to arranging for medicaid reimbursement of services provided in schools has been a statutory prohibition against medicaid reimbursement for services provided free to nonmedicaid patients. Historically, school health centers have chosen to increase access to care by not billing patients or their families. Medicaid officials have frequently been unwilling to be the sole payer for care. The "no free care" prohibition, however, does not apply to services given under the Individuals with Disabilities Act or to Title V grantees and providers. With Title V providing funds to many sponsors of school health centers, the Title V exclusion will make it possible for a number of school health centers to participate in medicaid.[38]

Medicaid officials have also argued that they will not pay twice for care. That is, if care is already paid for by other sources, such as state or federal grants, then medicaid will not reimburse for services. In the past, medicaid programs have refused to pay for care to medicaid-enrolled students at school health centers on the grounds that state or other grant support has already paid for their care. Documenting the health centers' total operating costs and demonstrating that grants are not paying the full cost of care is a partial response to these concerns.

Medicaid managed care programs have been confronted with similar concerns regarding duplication of payment. Capitation payments to managed care plans are based on an estimate of what the state would pay for an actuarially equivalent group of people under a fee-for-service arrangement for a given time period, usually a year. Thus, capitation payments are calculated to cover the cost of all identified care. School health centers, which may not be included in a student's managed care network, may seek to bill medicaid separately for services rendered. One solution to this problem may involve "carving out" funds for services provided by the school-based health centers from the medicaid managed care monies and continuing to pay fee for service to school health centers (similar to arrangements in Maryland and New York for family-planning services). Alternatively, medicaid may mandate that managed care plans include school health centers in their provider networks and reimburse the centers for care out of the plan's capitation payment.

Finally, some managed care plans have been reluctant to establish relationships with school health centers due to uncertainty about the quality of their care. A precondition to negotiating a contract between a school health center and a managed care organization is ensuring that the medical director of the managed care organization is comfortable with the care provided by the school health center. In the limited number of contracts negotiated between school health centers and managed care plans, this goal has required health centers to host site visits, share clinical data, permit review of medical records, and respond to questions concerning operating procedures, productivity and provider training. Health Start, a nonprofit corporation in St. Paul, Minnesota, which operates six school-based health centers as well as several community clinics, successfully undertook all these steps to reach a contract with RamseyCare, the largest medicaid managed care provider in Ramsey County. With 75 percent of Health Start's patients estimated to be enrolled in managed care by the end of 1994, successful negotiations were essential to survival of its health centers.[39]

Standardizing the Package

Product standardization is an essential component of quality control and linkage of school health centers to managed care systems. At present twenty-two states either mandate or recommend a specific model of services and staffing for school health centers.[40] However, the drive toward standards creates tensions with one of the strengths of school health centers—community control. A long-standing tenet of school health centers is that they are overseen by a community advisory committee and that key policies and program direction are defined at the local level. Accommodating the need for localities to have flexibility in the development of school health centers while recognizing the importance of defining a set of core services is one of the key challenges of the next several years.

Preserving the Integrity of the Model

Assuming that federal and state support for school health centers can be secured, an equally challenging task is ensuring that the funds

are used as intended. Recent experiences both within the federal health reform discussions and state initiatives in school health care suggest substantial ambivalence regarding the importance of a comprehensive school health center model. The two most common objections are that a comprehensive school health center model is too prescriptive and cannot be adapted to local needs and that rural areas may have difficulty recruiting a multidisciplinary staff and should not be penalized because of the geographical maldistribution of health professionals.

These arguments bring to mind a passage from Lisbeth Schorr's book, *Within Our Reach*, in which she discusses why so many health and social service demonstration programs have failed when they "went to scale."[41] Chief among the culprits has been the tendency to dilute the model. Sometimes dilution occurs because politicians want more sites than available monies permit and the model cannot be sustained at half the original cost. But just as likely to diminish the program are actions that dilute and modify the model. The enthusiasm for school health centers has come from their demonstrated effectiveness in bringing a range of medical and mental health services to children in need. Although one can sympathize with the desire to respond to local priorities or not penalize communities that suffer from health professional shortages, as Schorr reminds us, not replicating the model leads to disappointing results. Moreover, not tending to the model will make it unlikely that the centers will be incorporated into the evolving managed care health system. Negotiating contracts between school health centers and managed care plans and planning state-level support for the centers requires knowing precisely what core services will be provided. Without assurance of a core service package, policymakers at the state level are less likely to feel compelled to assure the centers' participation in the service network for low-income children.

The Future for a School-Based Health Center Initiative

The time is right for a school health center initiative. Concern about the declining well-being of poor children has created an impetus for change. The experience of the past twenty years has developed a model of health care delivery responsive to the needs of school-age children and an appropriate vehicle through which the nation can increase its investment in poor children. A school health center initiative has the potential to draw on the strengths of our multiple layers of government and their diverse sources of funding and leadership.

But those who remember the promise of health care reform in the 1970s, who have been encouraged by the popular support for Head Start, or who dare to hope that the relentless decline in the well-being of poor children may trigger a renewed commitment to their care will remain cautious. Cultural conservatives worry deeply about what programs should be permitted in schools. "Natural" allies of school health centers strategize to make sure that a new initiative does not undercut funding for already established health programs in schools. And the strongest supporters of school health centers have operated most effectively at the community level, frequently within the friendly confines of public health departments. It remains to be seen whether this new vehicle for comprehensive care for low-income children, lacking established friends in medicaid or well-organized lobbyists in the state legislatures, can survive the tumultuous change in the health care economy and negotiate the rough politics of redividing a shrinking public pie.

Notes

1. Committee for Economic Development, *Children in Need: Investment Strategies for the Educationally Disadvantaged: A Statement* (New York and Washington, 1987); William T. Grant Foundation Commission on Work, Family and Citizenship, *The Forgotten Half: Pathways to Success for America's Youth and Young Families* (Washington, 1988); Carnegie Council on Adolescent Development, *Turning Points: Preparing American Youth for the 21st Century* (New York: Carnegie Corp., 1989); U.S. Department of Health and Human Services, *Healthy People 2000* (1991); Office of Technology Assessment, *Adolescent Health*, 3 vols. (1991); Advisory Council Commission on Social Security, *Commitment to Change: Foundation for Reform* (1991); National Commission on Children (U.S.), *Beyond Rhetoric: A New American Agenda for Children and Families: Final Report of the National Commission on Children* (1991); Annie E. Casey Foundation, *Kids Count Data Book: State Profiles of Child Well-Being* (Baltimore, Md.: annual, 1990–95); and David A. Hamburg, *Today's Children: Creating a Future for a Generation in Crisis* (Random House, 1992).

2. School health centers are variously known as school-based health centers, school-based clinics, and school-linked clinics. This chapter uses the term *school health centers* to refer to integrated health services located on a

school campus, which provide primary medical and mental health care and are sponsored by mainstream medical organizations.

3. Barbara Starfield, "Child and Adolescent Health Status Measures," *The Future of Children: U.S. Health Care for Children*, vol. 2 (Winter 1992), pp. 25–39.

4. Children's Safety Network, *A Data Book of Child and Adolescent Injury* (Washington: National Center for Education in Maternal and Child Health, 1991), pp. 9–11. Paul Newacheck and William Taylor, "Childhood Chronic Illness: Prevalence, Severity, and Impact," *American Journal of Public Health*, vol. 82 (March 1992), p. 369. In analyzing a special questionnaire on chronic illness that was included in the National Health Information Survey for children in 1988, the authors estimate that 31 percent of children under eighteen, or almost 20 million children, have one or more chronic conditions. In this study chronic conditions did not include cancers or mental health problems that did not have a physical manifestation.

5. National Institute of Mental Health, *National Plan for Research on Child and Adolescent Mental Disorders, a Report Requested by the U.S. Congress*, submitted by the National Advisory Mental Health Council (Department of Health and Human Services, 1990). Estimates of children experiencing mental health problems overlap to an uncertain degree with estimates of children suffering from chronic conditions.

6. Phyllis Ellickson and others, *Forgotten Ages, Forgotten Problems: Adolescents' Health* (Santa Monica, Calif.: RAND, 1993). See also Alan Guttmacher Institute, *Sex and America's Teenagers* (New York and Washington, 1994).

7. Bureau of the Census, "Income, Poverty, and Valuation of Non-Cash Benefits," Current Population Reports, Series P-60, no. 188 (Department of Commerce, 1992), p. 22, table 8; and Starfield, "Child and Adolescent Health Status Measures," p. 33. See also Paul W. Newacheck and Barbara Starfield, "Morbidity and Use of Ambulatory Care Services among Poor and Nonpoor Children," *American Journal of Public Health*, vol. 78 (August 1988), pp. 927–33.

8. Robert F. St. Peter, Paul W. Newacheck, and Neal Halfon, "Access to Care for Poor Children: Separate and Unequal?" *Journal of the American Medical Association*, vol. 267, no. 20 (May 27, 1992), p. 2760.

9. Janet D. Perloff, "Health Care Resources for Children and Pregnant Women," *The Future of Children: U.S. Health Care for Children*, vol. 2 (Winter 1992), p. 84.

10. Ellickson and others, *Forgotten Ages, Forgotten Problems*, p. 21.

11. Paul W. Newacheck, Margaret A. McManus, and Joann Gephart, "Health Insurance Coverage of Adolescents: A Current Profile and Assessment of Trend," *Pediatrics*, vol. 90 (October 1992), p. 589. While medicaid expansions are increasing the number of insured adolescents, the federal mandatory phase-in of adolescents living in families with incomes up to 100 percent of the federal poverty line will not be complete until 2001. For those privately insured, exclusions for preventive and primary care as well as substantial deductibles curtail adolescents' access to care.

12. Victor Fuchs, *Who Shall Live? Health, Economics, and Social Choice* (Basic Books, 1974); and Victor Fuchs, "National Health Insurance Revisited," *Health Affairs*, vol. 10, no. 4 (Winter 1991), p. 13.

13. Eugene M. Lewit and others, David and Lucile Packard Foundation, "Analysis," *The Future of Children: U.S. Health Care for Children*, vol. 2 (Winter 1992), pp. 7–24. While political fallout from November 1994 is still evolving, to date, budget-trimming proposals at the state and federal level have not directly targeted children's programs. In New York State, for example, Governor George Pataki's proposed budget sharply cut state-funded health services for adults while preserving funding for most children's programs, including school health centers.

14. Personal communication with Judy Wertzel, special assistant to the assistant secretary for elementary and secondary education, Department of Education, April 28, 1994.

15. Documenting need for new services requires careful data collection and analysis. In addition to asking if families have regular sources of care for their children, it is necessary to ask where the children received care during their last several episodes of illness or who provided a physical examination and how recently.

16. Since personnel costs account for approximately 80 to 85 percent of the health center budgets, the total cost is a function of staff size. Staff size, in turn, should depend on the number of students enrolled at the host school and the level of their health care needs.

The average cost of seven school health centers in Multnomah County (Portland), Oregon, was $185,000 in 1991–92. Diane Ruminski and Howard Klink, "School-Based Health Centers: A Model for Delivery of Adolescent Health Care in Portland, Oregon," *Journal of Ambulatory Care Management*, vol. 16 (January 1993), pp. 29–41. The average cost of three full-time centers in Baltimore County during their start-up year, 1992–93, was $225,000. Personal communication with Judi Wallace, Baltimore County Third Party Payment Project, jointly sponsored by Baltimore County schools and health department.

17. Rosenberg and Associates, "Financing Adolescent School-Related Health Centers under the Proposed National Health Security Act," January 1994. Available from Making the Grade, George Washington University, 1350 Connecticut Avenue, N.W., Suite 505, Washington, D.C. 20036. Title III (Subtitle G, Part 5) of the administration's Health Security Act called for investment of $100 million in FY1996 in school-related health services, growing to $400 million in FY1999 and FY2000, with support totaling $1.5 billion over five years. The Education and Labor Committee of the House of Representatives reported out its version of health care reform with a similar level of support for school health services. In its version of Title III, the Senate Labor and Human Resources Committee increased support for school-related health services to $2.35 billion over six years. The Senate committee unanimously approved this section of health care reform legislation.

18. See *Federal Register*, vol. 59, no. 89 (May 10, 1994), pp. 24171–74.

19. John J. Schlitt and others, "State Initiatives to Support School-Based

Health Centers: A National Survey," *Journal of Adolescent Health*, vol. 17, no. 2 (August 1995), pp. 68–76.

20. "Where They Stand, Part II: 1115 Waivers Dot the Landscape," *State Health Notes*, vol. 16, January 23, 1995, p. 1.

21. Because the federal ERISA statute exempts employer-based self-insured programs from state regulation, states cannot mandate private plan participation in school health centers. The private market can be tapped to contribute to school health centers only through a voluntary approach.

22. Rosenberg and Associates, "State-Sponsored School-Based Health Center Programs: Issues for Long-Term Financing." Available from Making the Grade, George Washington University, 1350 Connecticut Avenue, N.W., Suite 505, Washington, D.C. 20036.

23. Schlitt and others, "State Initiatives to Support School-Based Health Centers."

24. Martin Fisher and others, "School-Based Adolescent Health Care: Review of a Clinical Service," *American Journal of the Diseases of Children*, vol. 146 (May 1992), pp. 615–21.

25. Martin Fisher and Linda Juszczak, "Final Report for the Far Rockaway High School Clinic," to the Robert Wood Johnson Foundation, August 13, 1993.

26. Bruce Guernsey, "The Denver School-Based Clinics: Annual Report for the 1992–93 School Year." See also David Hill, "The Doctor Is In," *Teacher Magazine* (February 1994), pp. 18–25.

27. Personal communication with Kristine Hazzard, MSW, supervisor, School-Based Health Centers, Department of Health, Bridgeport, Conn., July 15, 1994.

28. Ruminski and Klink, "School-Based Health Centers," p. 31.

29. Oregon Department of Human Resources—Health Division, "School-Based Clinics Helping Keep Oregon's Teens Healthy," February 1993.

30. During 1993 and 1994, states appeared to be anticipating health care reform by covering more children under medicaid. In North Carolina, for example, the state legislature approved expanding medicaid coverage to all adolescents age nineteen or younger who are below the federal poverty line. This measure took effect October 1, 1994. The impact of the proposed Medigrant program is not certain but threatens expanded coverage for low-income Americans.

31. Columbia University School Health Policy Initiative, "National Work Groups Define School-Based Health Center Services," *ACCESS to Comprehensive School-Based Health Services for Children* (Summer 1994), p. 3. See also Fisher and others, "School-Based Adolescent Health Care," pp. 615–21; and Ellen L. Marks and Carolyn H. Marzke, *Healthy Caring: A Process Evaluation of the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program* (Princeton, N.J.: MathTech Inc., 1993).

32. Larry I. Wolk and David W. Kaplan, "Frequent School-Based Clinic Utilization: A Comparative Profile of Problems and Service Needs," *Journal of Adolescent Health*, vol. 14, no. 6 (September 1993), pp. 458–63.

33. Harriette B. Fox and Lori B. Wicks, *Background Report on Adolescents and Medicaid Managed Care*. Available from National Academy for State Health Policy, 50 Monument Square, Suite 502, Portland, Maine 04101.

34. Jonathan E. Fielding, William G. Cumberland, and Lynn Petitt, "Immunization Status of Children of Employees in a Large Corporation," *Journal of the American Medical Association*, vol. 271, no. 7 (February 16, 1994), pp. 525–30.

35. A troubling aspect of the disappointment in school health centers is an unstated suggestion that it is not sufficient for health centers to assure adolescents access to health care. Rather, the argument seems to be that only if the health centers reduce poor children's bad behaviors and their health consequences should we concern ourselves with whether those children and youth receive help for their multiple, untreated problems.

36. The absence of a provider network in which adolescents trust creates difficulties in initiating programs designed to combine service delivery with behavior-changing interventions. The first requirement for launching an intervention is that the target population be willing to come to a particular location. Persuading young people to attend community-based services or programs is difficult. See Julia G. Lear, Henry W. Foster Jr., and Jennifer A. Baratz, "The High-Risk Young People's Program: A Summing Up, "*The Journal of Adolescent Health Care*, vol. 10, no. 3 (May 1989) pp. 224–30.

37. Personal communication, Committee on Appropriations, House of Representatives, July 18, 1995.

38. Memorandum from Linda Sizelove, HCFA Medicaid Bureau, to Camden Yards Work Group on School Health, March 10, 1994.

39. Donna J. Zimmerman and Christopher J. Reif, "School-Based Health Centers and Managed Care Health Plans: Partners in Primary Care," *Journal of Public Health Management Practice*, vol. 1, no. 1 (January 1995), pp. 33–39; and Office of Inspector General, School-Based Health Centers and Managed Care: Examples of Coordination (Department of Health and Human Services, 1993), p. 6.

40. Schlitt and others, "State Initiatives to Support School-Based Health Centers."

41. Lisbeth B. Schorr, *Within Our Reach: Breaking the Cycle of Disadvantage* (Doubleday, 1988).