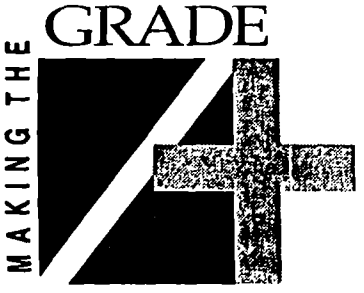
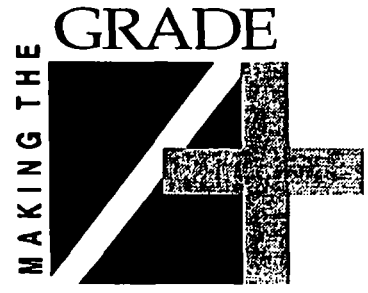


School-Based Health Centers: Comprehensive Health Care for Children and Youth

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.



WHY SCHOOL-BASED HEALTH CENTERS?

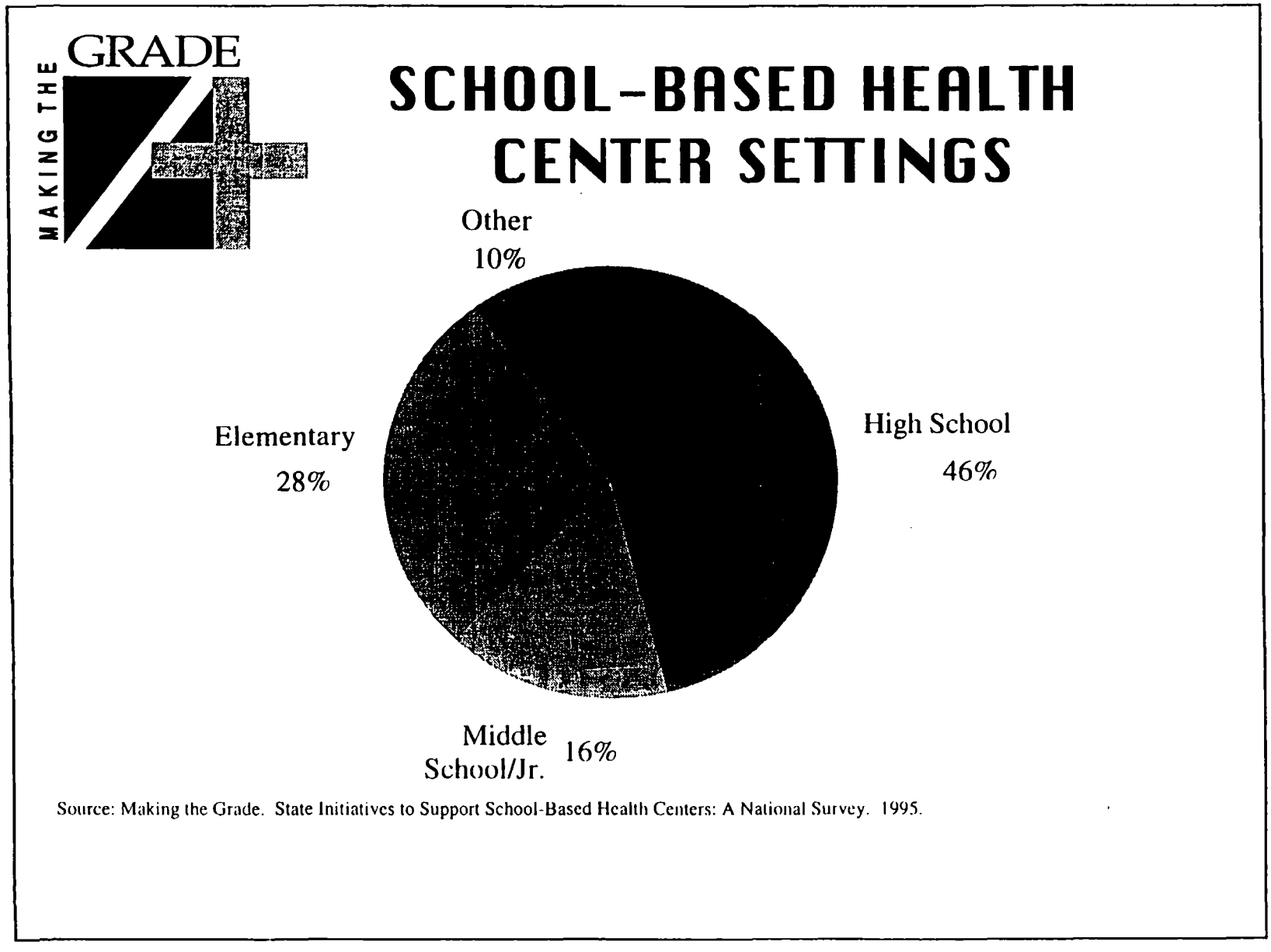
To deliver accessible primary physical and mental health services to students.

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.

DEFINING CHARACTERISTICS OF A SBHC

- On school site
- Comprehensive primary care including diagnosis and treatment
- Staffed by a multi-disciplinary team
- Parental consent policy
- School-community partnership
- Community advisory council

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.



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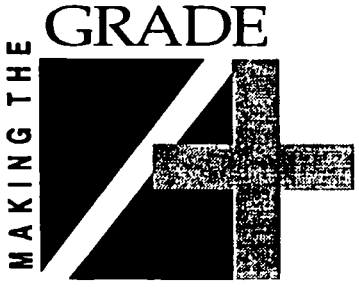

SBHC STAFFING

	Average FTE
Mid-level practitioner (NP/PA)	.81
Physician	.24
Registered nurse	.81
Mental health services providers	.89

Source: McKinney, DH and Peak, GL. (1995). Update 1994. Washington, DC: Advocates for Youth.

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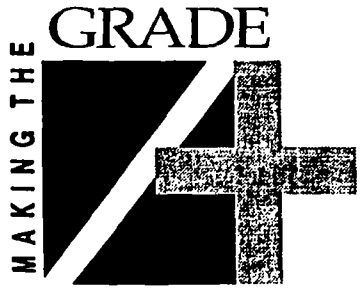

SERVICES PROVIDED AT SBHCs

Medical	%
Injury treatment	96
Physical examinations	90
Family planning counseling	86
Medication dispensed	83
Primary care	83
Prescriptions	83
Immunizations	83
Pregnancy testing	81
Laboratory testing	79
Chronic illness management	77
STD screening/treatment	71

Source: McKinney, DH and Peak, GL. (1995). Update 1994. Washington, DC: Advocates for Youth.

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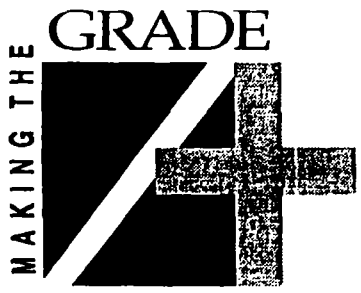

SERVICES PROVIDED AT SBHCs

Mental Health	%
Depression	92
Dysfunctional family	90
Suicide	89
Sexual orientation	88
Rage and anger	88
substance abuse	86

Source: McKinney, DH and Peak, GL. (1995). Update 1995. Washington, DC: Advocates for Youth.

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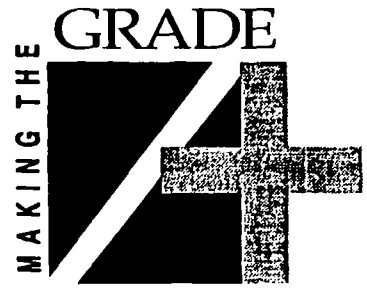

WHAT SERVICES ARE STUDENTS USING?

	%
Acute illness	28
Mental health	21
Physical exams	14
Reproductive health	14
Other incl. immunization, vision, hearing testing	8
Chronic conditions	8
Acne/other dermatology	4
Nutrition/eating disorders	2
Alcohol and other drug abuse	2
Dental	1

Source: The School-Based Adolescent Health Care Program, The George Washington University, Washington, DC, 1993.

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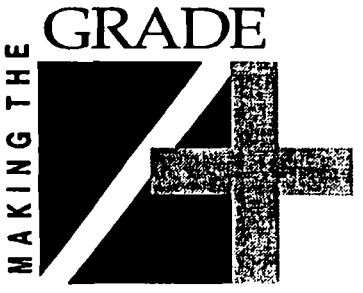


STUDENT ENROLLMENT AND VISITS

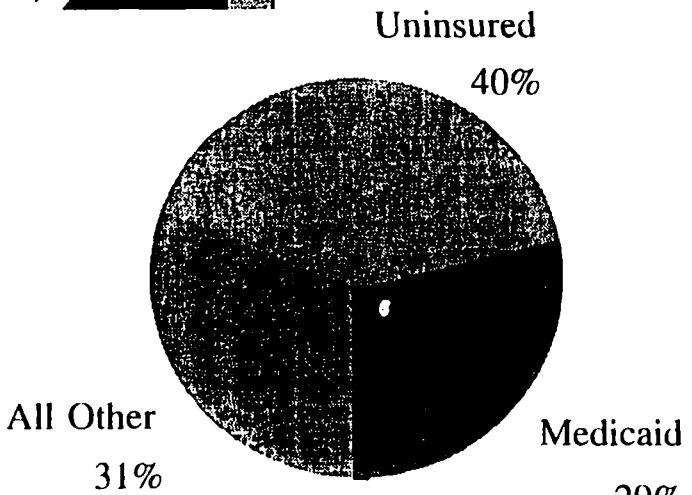
	CT	NY	NY	CO	OR
				2 sites	7 sites
Grade level:	K-8	6-8	9-12	9-12	9-12
# of students:	1200	1700	1700	3926	8858
# of SBHC enrollees:	968	688	1000	2595	4336
# of SBHC visits/year:	1927	2942	5214	7590	18,600

Source: The School Health Policy Initiative, Ingredients for Success. Comprehensive school-based health centers. Montefiore Medical Center, New York. 1995.

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.

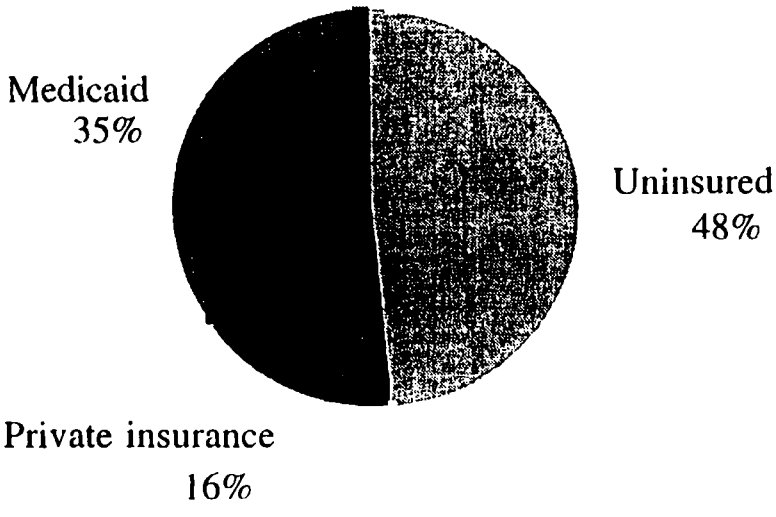
MAKING THE GRADE

INSURANCE STATUS OF SBHC USERS



N=206

Source: McKinney, DH and Peak, GL. (1995). Update 1994. Washington, DC: Advocates for Youth.



N=24

Source: The School-Based Adolescent Health Care Program, The George Washington University, Washington, DC, 1993.

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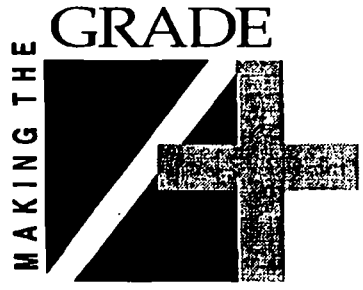

SCHOOL-BASED HEALTH CENTER SPONSORS

	%
Local public health department	26
Community health center	19
Hospital	13
School systems	11
Other	31

Source: McKinney, DH and Peak, GL. (1995). Update 1994. Washington, DC: Advocates for Youth.

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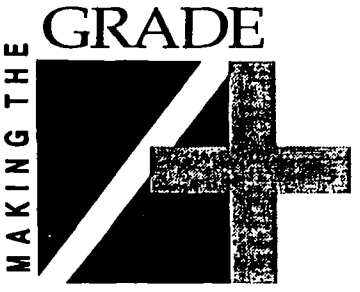
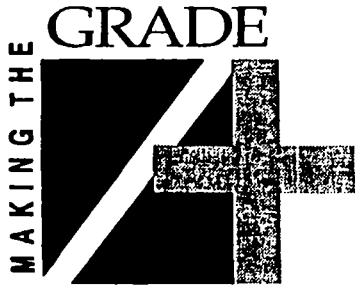


CURRENT FUNDING SOURCES FOR SBHCs

	%
State health departments	24
Private foundations	18
MCH block grant	17
Local government	12
School districts	8
Community health centers	7
State human services	3
Medicaid	2
Other	7

Source: Center for Population Options. School-based and school-linked clinics: Update 1991. Author: Washington DC

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.



STATES WITH COMPREHENSIVE GUIDELINES FOR SBHCs

- Colorado
- Connecticut
- Delaware
- Illinois
- Louisiana
- Maine
- Massachusetts
- New York
- North Carolina
- Oregon
- Pennsylvania
- Texas

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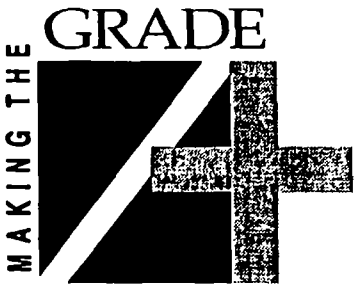


COMPONENTS OF STATES' GUIDELINES FOR SBHCs

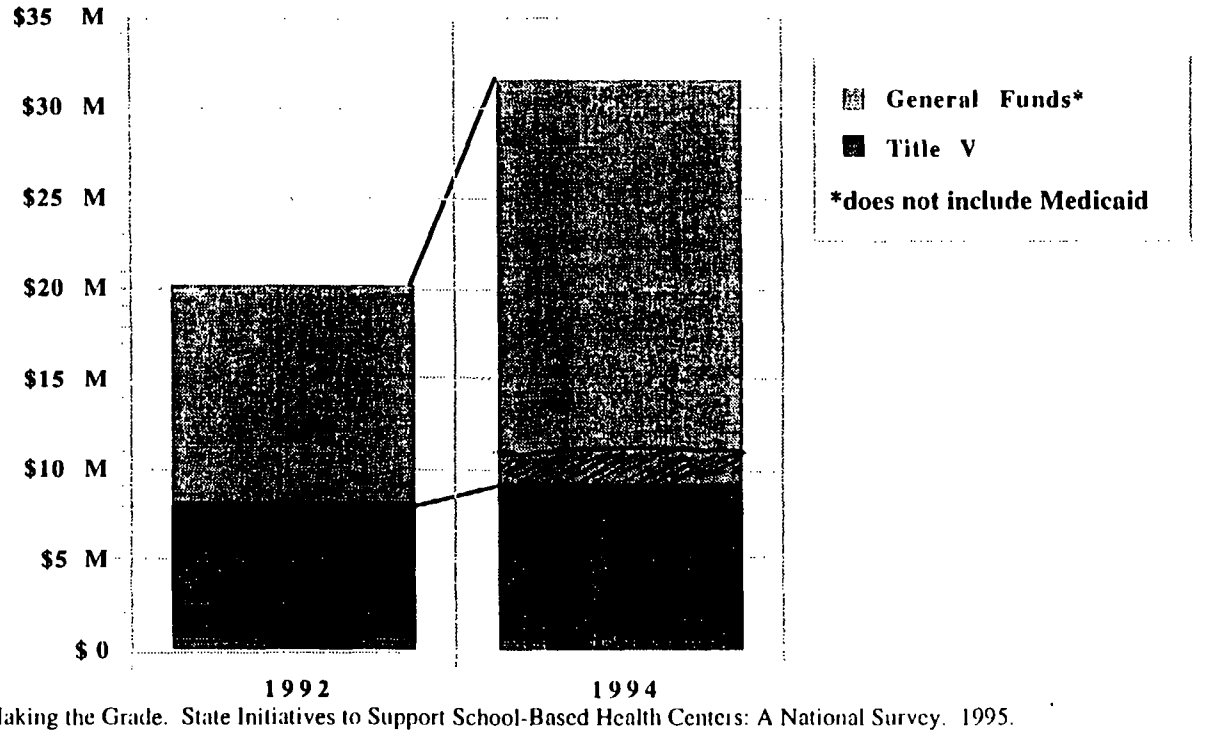
- Sponsoring agencies
- Staffing
- Site specifications
- Service standards
- Continuity of care
- Evaluation/ Quality assurance
- Parental consent
- Community participation
- Integration with existing school health programs

Source: Making the Grade. State Initiatives to Support School-Based Health Centers: A National Survey. 1995.

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.

MAKING THE GRADE

STATE GRANT FUNDING OF SCHOOL-BASED HEALTH CENTERS



Source: Making the Grade. State Initiatives to Support School-Based Health Centers: A National Survey. 1995.

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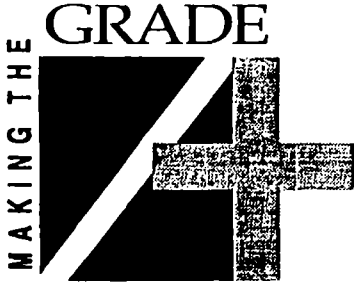

SBHC FINANCING: SEVEN COMMUNITY PROGRAMS

FY 1995

	Centers	Operating Budget	Per Center Average
Baltimore	10	$2,070,000	$207,000
Boston	8	1,244,000	155,500
Bridgeport	8	1,542,000	192,750
Memphis	2	331,000	165,500
Multnomah Co.	10	1,952,000	195,200
New Haven	10	1,291,000	129,000
St. Paul	7	997,500	142,500
TOTAL	55	$9,427,500	$171,400

Making the Grade (1996). School-based health centers and managed care: seven school-based health center programs negotiate a difficult fit.

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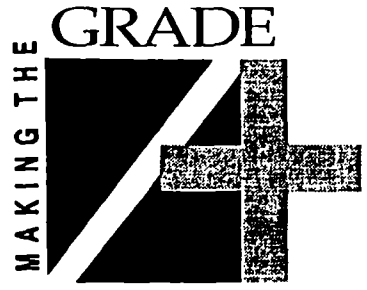

SBHC FINANCING: SEVEN COMMUNITY PROGRAMS

FY 1995

	County/City	State	Federal	Third Party	Other
	%	%	%	%	%
Baltimore	62	18	12	9	0
Boston	10	78	0	12	0
Bridgeport	38	52	0	0	10
Memphis	100	0	0	n/a	0
Multnomah Co.	73	6	14	7	0
New Haven	22	53	4	0	21
St. Paul	1	55	24	20	1

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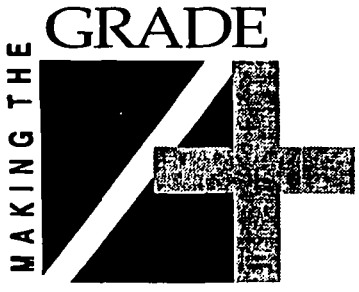

SBHC FINANCING: SEVEN COMMUNITY PROGRAMS

School-Age Medicaid Recipients

	as % of SBHC enrollees	% in managed care	% in Medicaid HMOs
Baltimore	52	99	30
Boston	30	85	33
Bridgeport	42	100	100
Memphis	80+	100	100
Multnomah Co.	18	100	100
New Haven	42	100	100
St. Paul	50	100	100

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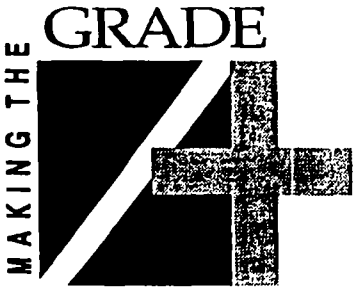
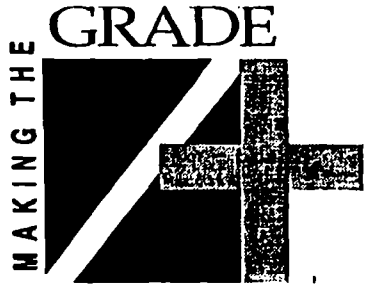


SBHC FINANCING

Denver School-Based Health Center Program
1991-1992
Three High Schools

Student body enrollment	Health center enrollment	Users	Visits
3,869	2,793 (72%)	1,595 (57%)	7,439

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.

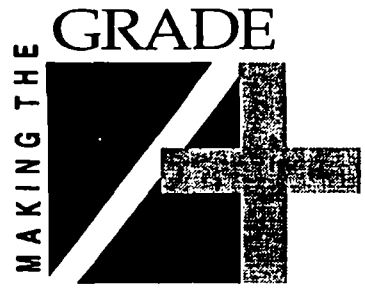


SBHC FINANCING

Denver School-Based Health Center Program
1991-1992
Three High Schools

Primary care service type	Total cost	# of visits	Cost per visit	# of enrolled students	Cost per enrolled student
Medical	$149,915	4,231	$35.43	2,793	$ 53.68
Mental health	92,232	2,105	43.82	2,793	33.02
Substance abuse	44,870	1,076	41.70	2,793	16.06
Total	$287,017	7,412	$38.72	2,793	$102.76

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.



SBHCs AND MANAGED CARE CONTRACTING: SEVEN COMMUNITY PROGRAMS

	# of MCPs	# of contracts	Type of Managed Care Contract: Primary care	Acute care	Other
Baltimore	4	1		1	
Boston	4	3	1	2	
Bridgeport	11	7	4	2	1 dental
Memphis	6	5	5		
Multnomah Co.	11	1	1		
New Haven	10	4	4		
St. Paul	5	5	5		

Making the Grade (1996). School-based health centers and managed care: seven school-based health center programs negotiate a difficult fit.

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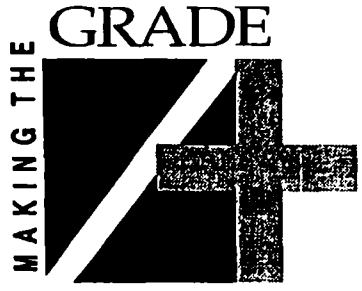

Memphis/Shelby County Medicaid Revenues
1994-96

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

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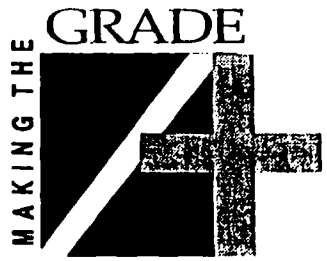


OPPORTUNITIES FOR STATE OFFICES TO SUPPORT SCHOOL-BASED HEALTH CENTERS IN LINKING WITH MANAGED CARE

Facilitate meetings between managed care plans and school-based health centers (Massachusetts)

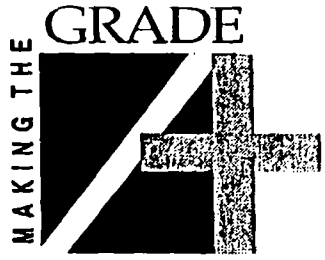
Establish capitation rate for adolescents that supports comprehensive care

Develop standards for school-based health centers consistent with Medicaid HEDIS (Colorado)

Managed care organizations encouraged to contract with safety net providers (Oregon)

Require managed care plans to contract with school-based health centers in their service areas (Connecticut, Delaware, New York)

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.



OPPORTUNITIES FOR MANAGED CARE PLANS TO WORK WITH SCHOOL-BASED HEALTH CENTERS

Invest the time necessary to learn about school-based health centers (Health Partners, MN)

Negotiate inclusive primary care contracts with school-based health centers that serve enrolled population (Health Partners, MN)

Collect data on services utilization (Kaiser Colorado)

Establish centers in schools attended by large numbers of enrollees (Total Health Care, MD)

Co-fund centers with other plans in schools that enroll large numbers of students from several plans (Saint Paul, MN)

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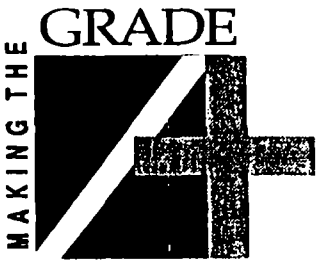

OPPORTUNITIES FOR SCHOOL-BASED HEALTH CENTERS AND THEIR SPONSORING PROVIDER ORGANIZATIONS

Understand the managed care perspective and be prepared to answer critical questions (Health Start, St. Paul, MN)

-- Are you a full service primary care provider?

-- Will you be a primary medical home?

-- How will you provide 24-hour, 365-day a year care?

-- How will the HMO obtain clinical information?

-- Can you meet standards and licensing requirements?

Market the strengths of the centers: access and primary prevention. (Gather data to document claims)

Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.

REIMBURSEMENT FROM THE COLORADO MEDICAID PROGRAM FOR PRIMARY HEALTH CARE SERVICES PROVIDED TO MEDICAID-ENROLLED CHILDREN THROUGH SCHOOL-BASED HEALTH CENTERS:

ISSUES, OPPORTUNITIES AND RECOMMENDATIONS

PURPOSE OF THIS DOCUMENT

This document reviews barriers and opportunities for Colorado Medicaid Program dollars to support primary health and mental health care services provided to Medicaid recipients through school-based health centers (SBHC). Based upon this review, recommendations have been formulated which are designed to guide: 1) the organization of SBHCs; 2) targeting of resources for new SBHC programs; and 3) policy changes which may affect one or more of the state agencies involved in planning the Colorado School-Based Health Center Initiative (CSBHCI).

The analysis and recommendations contained in this document will be presented to the Colorado Department of Public Health and Environment (CDPHE), which manages the CSBHCI through a planning grant from the Robert Wood Johnson Foundation, and to the Department of Health Care Policy and Financing which houses the State Medicaid Program. These departments have been working together to plan for the establishment and financing of new SBHCs in the state. Complementary decisions will be made by the two departments regarding how the recommendations will be implemented to support SBHCs.

If these recommendations are implemented, it is expected that SBHCs will be enabled to: provide access to basic care for poor and vulnerable children and youth; receive compensation for care provided to Medicaid recipients; and be sustained in Colorado communities over the long term.

OVERVIEW

There are currently about 160,000 children in Colorado age 0-21 enrolled in Medicaid. Approximately 90,000 or 56 percent of these are school-age children. This represents about 14 percent of the total 650,000 children of school age in the state.

The cost of all health care services supported by the State Medicaid Program for the school-age population is expected to be $159,389,311 for the current fiscal year. The total cost for primary care services (including outpatient, physician, laboratory, pharmacy and X-ray services) is estimated to be about $50,531,334 for the current budget year.

Colorado's Primary Care Provider (PCP) Program: In 1982, Colorado's State Medicaid Program was approved for a 1915(b) waiver, limiting the freedom of provider choice for Medicaid

recipients. This waiver must be renewed every two years. Under the waiver, all enrolled recipients are required to choose a Primary Care Provider (PCP) who will serve as the gatekeeper for all the medical care services they receive. Approximately 50 percent of the state's school-age children have selected a Primary Care Provider (PCP), and their Medicaid card bears the name of the selected PCP. About half of the state's Medicaid-enrolled school-age children have not chosen a PCP. A Medicaid recipient without a PCP assigned can go to any provider they wish without authorization. There may be several possible reasons why a recipient has not chosen a PCP. A common problem found in some communities may be that local providers are not accepting Medicaid patients.

Most medical care received by the Medicaid recipient must be pre-authorized by the PCP to be eligible for Medicaid reimbursement. Services not requiring PCP referral include emergencies, family planning, and mental health visits. Children in foster care are not required to choose a PCP.

In selected geographic areas of the state, there is currently intense marketing efforts by the private managed care sector to enroll Medicaid recipients who have not selected a PCP. While Medicaid fee-for-service reimbursement and capitation rates often reflect less than usual and customary charges, the increasing size of the Medicaid population, coupled with excess capacity in many medical provider systems, make it necessary and profitable for them to serve Medicaid patients.

During the last two years, under authority of the 1915(b) waiver, when a Medicaid recipient fails to choose a PCP, he or she may be assigned to a local HMO or managed care organization.

Medicaid Eligibility: Colorado is implementing Federal OBRA 1989 guidelines for increasing the percentage of the Federal poverty index (FPI) that is used to determine eligibility for Medicaid benefits at the required rate. This means that by the year 2003, all children and adolescents under the age of 19 will be eligible for Medicaid at 100 percent of FPI. In 1994, Colorado children and adolescents over 11 years of age are currently eligible for Medicaid benefits if they meet AFDC guidelines, which are about 42 percent of FPI. Pregnant girls are eligible up to 133 percent of FPI.

Except for the long-term care program, the State Medicaid Program has not sought a Federal 1115 waiver from HCFA, which would permit large-scale changes of Federal Medicaid requirements. No additional waivers are proposed in Colorado at this time.

Financing Structure: About 89 percent of health care to the state's Medicaid recipients is now provided through fee-for-service arrangements. Currently, fee-for-service reimbursement

for services provided to Medicaid recipients cover an estimated 40% to 60% of usual and customary charges for physician office services.

The financing arrangement for the State Medicaid Program is transitioning to a capitated managed care system as new health plans become available and are approved by the Department of Health Care Policy and Financing. At the end of the current fiscal year, it is anticipated that 11 percent or about 9,900 of the State's school-age Medicaid recipients may be enrolled in a capitated managed care program. The move towards capitated managed care is part of an effort by State Medicaid Program officials to curb rising costs, and to increase access to medical services for recipients. State Medicaid officials estimate that 5 percent of total costs are saved in a capitated managed care arrangement over the traditional fee-for-service reimbursement structure.

In it's move towards capitated managed care, the State Medicaid Program is in step with the private sector. It is estimated that the percentage of the insured population in Colorado covered under a managed care organization or HMO is increasing by 6 to 8 percent per year (source - HMO Association of Colorado). Departmental policy gravitating towards capitated managed care contracts with the private health insurance sector will move the State Medicaid Program substantially into the private medical marketplace.

Authorized Primary Care Providers (PCPs), through their agreement with State Medicaid, perform a gate keeping function to manage health care. PCPs receive a monthly case management administration fee of $2.50 to $3.50 per recipient in exchange for assuming these responsibilities. The agreement requires the PCP to arrange for back-up coverage on a 24 hour daily basis. Quarterly utilization reports are provided to the PCP regarding all the health care the child received during the reporting period.

Calculation of capitation rates for Medicaid managed care is based upon the state's history of costs for care provided through the fee-for-service reimbursement system. In FY 1994-95, the monthly capitation rate for an AFDC child for all services (in-patient, out-patient, pharmaceutical and equipment) is about $80 to $85 in the metropolitan area. About 32 percent or $26 to $27 of this amount is estimated to be spent on primary care services. In rural areas of the state, the total monthly capitation rate is about $75 to $80.

REVIEW OF ISSUES AND OPPORTUNITIES

The structure of reimbursement for health care services provided to Medicaid-enrolled school-age children and youth provides a number of challenges to SBHC programs seeking financial support for services provided to children who are

Medicaid recipients. The most prominent challenges are reviewed below, and possible solutions are explored for overcoming them. Where examples of success in overcoming identified barriers exist, these are described.

Issue #1 - School-based health centers and coordination with the child's medical home or PCP: Depending upon how they are organized, SBHCs may or may not have the ability to serve as the PCP for Medicaid-enrolled children. Medicaid provider requirements include the ability to serve all the child's health needs, including inpatient, 24 hour care, laboratory, X-ray, durable medical equipment, and transportation. In cases where the SBHC is not the child's PCP, prior authorization is required in order for the care to be reimbursed on a fee-for-service basis by Medicaid.

SBHCs can provide an important access point for preventative primary care services. Even children with some health insurance coverage may under-utilize important preventive services. However, it is also important that the relationship of the child and his or her community provider be maintained and supported. When care is provided in a SBHC which is not serving as the child's PCP, it must be coordinated with the PCP to meet Medicaid provider requirements.

Possible Solutions - There are over 1,900 primary care physicians and provider organizations which meet Medicaid primary care provider requirements, and are eligible to be compensated for care through SBHCs. These include clinics, physicians, HMOs, and others. Organized under these entities, the SBHC service delivery model could provide an important access point for them to reach new patient populations, and to provide a value-added service to their customers.

One important example of such qualified providers are Community Health Centers. There are 16 of these in the state, forming a large network of care serving the health needs of Colorado's medially indigent. The primary care mission of these entities is closely aligned with that of SBHCs. CHCs are Federally Qualified Health Centers, and are able to bill and receive cost-based Medicaid reimbursement. These programs will be made stronger by the formation of Colorado Access, a new HMO composed of the Colorado Community Managed Care Network (a consortium of community health centers), The Children's Hospital, University Hospital, and University Physicians, Inc. This alliance was created to capture a portion of the medically indigent market in the state. Several of these organizations have had long-term involvement with school-based health centers.

The Medicaid Model Contract for HMOs could contain a standard clause requiring or encouraging an established working agreement between MCOs and SBHCs where these programs co-exist.

Whether the payment structure is fee-for-service, global

budget or capitated arrangement, coordination of health care is a crucial issue. It will be necessary to negotiate with individual Medicaid providers in each community. When fee-for-service reimbursement is the method of payment, it will be necessary to explore the PCP's willingness to pre-authorize the care provided to Medicaid-enrolled children. Protocols would need to be developed to assure communication and appropriate referrals to managed care providers.

The number of children in a given school site who are enrolled in Medicaid will be an important factor in determining the economic feasibility of supporting SBHC services with Medicaid revenues.

Issue #2 - Physicians and Mid-Level Practitioners as the Providers of Care: Medicaid is based on a classic medical model, and is dissimilar in important aspects from the psycho-social preventive model operating in most SBHCs. In contrast with the mid-level (nurse practitioner or physician assistant) provider model found in most SBHCs, the Medicaid provider is the physician, who is also the gatekeeper of care.

Under Federal guidelines, pediatric and family nurse practitioners are permitted to bill and be reimbursed directly for the provision of Medicaid services (see Federal Transmittal #3, April 1990). However, Colorado law enacted to implement this Federal requirement prohibits direct reimbursement unless the professional is functioning independently and not as part of any health care entity through salary or contract. There are few known providers in the State which are currently eligible for reimbursement under the Colorado law.

Medicaid physician PCPs may prefer to be the family's only provider of medical care, and may view the involvement of any other provider as a potential problem regarding continuity of care and relationships with family members. Some physicians may not feel comfortable with a SBHC nurse practitioner's recommendations regarding the health care of a child for whom they are the PCP. If the PCP is under capitated payment, the issue of reimbursement for services provided by another provider is even more complicated.

Possible Solutions - How the SBHC is organized will be an important factor in the degree to which this is a barrier to Medicaid financing of SBHC services. If the sponsoring agency has the capacity to serve as the child's PCP, or to enroll the family in it's managed care program, the problem may be alleviated.

One example exists of a nurse practitioner model set up to receive direct Medicaid reimbursement for SBHC services. A nurse practitioner from the University of Colorado Health Sciences Center, School of Nursing, formed her own corporation, and intends to practice independently to meet the above guidelines

for pediatric and family nurse practitioners. Colorado's liberal Nurse Practice Act will permit her to independently provide any medical service for which she has the training, knowledge, experience, skills and abilities. Her practice will be set up a part of the Sheridan School District's SBHC, which recently received funding through a Bureau of Primary Health Care "Healthy Schools, Healthy Communities" grant. Through this mechanism, this new program will attempt to bill the State Medicaid Program for the primary medical care services to be provided in the SBHC. The program will also serve as a faculty practice site for the School of Nursing.

Issue #3 - The Physician On-Site Rule: The Colorado Medicaid Program state rules require that a physician must be on-site at the time that a health service is provided by a non-physician practitioner for that service to qualify for reimbursement by Medicaid. This potentially limits reimbursement for services provided through SBHCs, as these programs typically rely on mid-level practitioners and often have limited physician back-up or supervision on site.

There are exceptions to the physician on-site rule in that these rules do not pertain to "clinic services" as defined in the Colorado Medical Assistance Act. This definition permits community health centers, certified rural health clinics, health departments, county nursing services, visiting nurse associations, and others to receive reimbursement for these services provided to Medicaid recipients without a physician on site.

Possible Solutions - Under Colorado revised statute, those provider organizations which are exempted from the physician on-site rule could receive reimbursement from Medicaid on a fee-for-service basis if other provider requirements are met. For example, a recently-opened elementary school-based health center in Lafayette is organized as part of a community health center. Assuming other requirements are met, the CHC would be able to receive reimbursement for services from Medicaid without a physician on site.

An HMO or Prepaid Health Plan licensed in the state of Colorado which has a capitated managed care contract with the State Medicaid Program is not subject to the physician on-site rule. A non-physician provider could provide care to Medicaid recipients in a school site, or the managed care organization (MCO) could contract with another service provider organization without being required to having a physician on site. Denver Health & Hospitals is the largest Medicaid managed care contractor in the state, and expects to have 16,000 enrollees by the end of FY 1994-95. DH&H could designate a proportion of its estimated revenues from the Medicaid managed care contract to support SBHCs, based upon the value of primary care services that

are delivered to Medicaid recipients through school sites.

There are two ways to make it possible for SBHCs, regardless of how they are organized, to be directly reimbursed for services provided to Medicaid recipients without a physician present on site.

First, the State Medical Services Board could adopt a rule change permitting non-physicians to be directly reimbursed without a physician on-site. This process requires a number of steps. The program area in the Department of Health Care Policy and Financing would draft the proposed rule change. A fiscal assessment would be done, a justification written, and a legal review would be performed. A hearing by the Board would be scheduled, and this would be published widely to providers and the public at large. If approved at a hearing by the Board, the rule would become effective in 30 days. Such a rule change would involve many different providers, and could potentially have a large fiscal impact.

Second, the appropriate section of the State Medical Assistance Act could be amended through legislation to include SBHCs under the "clinic services" classification, and thereby exempted from the physician on-site rule. This would require an assessment of the fiscal impact of such a change, and all the complexities involved in working with the legislature to achieve the passage of a bill. However, an amendment to the Medical Assistance Act would have the advantage of involving the exemption of only one provider type, and would potentially have less of a fiscal impact than would a rule change as described in the paragraph above. Should an amendment pass, SBHC facilities could require to be licensed or certified by the Health Facilities Division at the CDPHE.

Enthusiasm for proposing changes in State Medicaid rules or amending the Medical Assistance Act must be tempered by an current assessment of the financing arrangements that are being increasing employed by the State Medicaid Program. Assuming that the state continues to move towards capitated managed care arrangements, the utility of these strategies may be limited.

Another proposal could increase Federal Medicaid resources for school-based health services. There is currently an initiative led by the Colorado-based Piton Foundation to increase the State's Federal Medicaid match by documenting state and local dollars used to fund school health services and associated administrative costs for Medicaid recipients. In Colorado, legislative action will be necessary to implement this initiative. The draft legislation, which is to be introduced in January of 1995, includes services which are provided through contractual arrangements as eligible for Federal Medicaid match. The draft bill amends the Colorado Medical Assistance Act to include participating school districts as Medicaid "clinic services" providers, which exempts them from the physician on-

site rule. The draft legislation requires that any new Medicaid revenues that result from this strategy are to be used to enhance school-based health services, including SBHCs. If the legislation passes, organizing SBHCs through school districts could become a viable option. The proposal has the strong support of school districts and their associated member organizations.

Currently, there are 3 SBHCs in the state (Commerce City, Lafayette, and the San Luis Valley) which are billing or plan to bill Medicaid on a fee-for-service basis for medical services provided to Medicaid recipients through SBHCs. Commerce City is organized as a free-standing 501(C)(3), and is currently billing only for Medicaid-eligible services when the physician is on site. The programs in Lafayette and the San Luis Valley, as community health centers are exempt from the physician on-site rule. They also have the ability to serve as the child's PCP, and can be reimbursed for 100% of established costs.

Under current conditions, organizing SBHCs under community health centers may have important advantages. However, it is important to account for the fact that the environment in which decisions regarding health care financing are being made is in a great deal of flux. In particular, it is not clear how long FQHCs will enjoy cost-based reimbursement. Therefore, it may be prudent to try various provider models for organizing these services, including private physicians and hospitals.

There are no known Colorado SBHCs which have contractual arrangements with private Medicaid managed care organizations.

Issue #4 - Medicaid as Payer of Last Resort: Federal guidelines require that providers must seek payment from all other sources before seeking payment for services from Medicaid. Such other sources include private health insurance plans and patients. By Federal law, Medicaid cannot be charged for services if the service is otherwise free to non-Medicaid recipients. This implies that a test of means and a fee schedule must be established which assesses uniform charges for all patients. Within a school setting, fee schedules and billing systems are difficult and costly to administer and maintain.

Possible Solutions - SBHCs could seek Title V Maternal and Child Health funding support. Under Federal guidelines, programs utilizing funds from Title V are not required to seek other third party reimbursement or co-payments from Medicaid recipients. The program must be receiving and using Title V dollars in order to be eligible for this exception. The program must also meet the Colorado Medical Assistance Act definition of an eligible provider, according to administrative rules in Volume VIII.

In Colorado, the Title V Maternal and Child Health Block grant is allocated through a competitive application process. There are currently three SBHCs in the state receiving a total of

$175,000 from the Title V Block. Other programs wishing to receive Title V dollars would be required to compete through the established application process. Or the CDPHE could address the funding of additional SBHC programs as a broader policy decision to increase financial support through the State Medicaid Program.

Under Federal requirements, programs receiving Title V funds must provide services free of charge to families with incomes below 100 percent of the Federal Poverty Index.

One creative solution has been developed in the state to permit schools to bill Medicaid for developmental evaluations needed by children birth through 21 to determine their educational needs, while avoiding the necessity of billing parents (which is not permitted under educational guidelines). Under this agreement (currently in draft form) between the State Departments of Health, Education, and Social Services, a number of sources may support the cost of a developmental evaluation for a child, including: Part B of IDEA; private health insurance (families have the option not to use their private insurance); local in-kind resources, such as BOCES, mental health, social services, etc.; and maternal and child health block grant funds. While parents in theory could still be assessed a fee, there are a number of funding sources which are designed to provide payment for the services. This assures that federal Medicaid guidelines regarding payer of last resort are met, and the service is never provided for free.

A SBHC could be set up on a similar premise. Services could be supported from a number of payment sources. As part of the program's business plan, a "super bill" could be created which tracks the nature of the services delivered, the usual and customary charges, and tracks the payment source for the service.

To help them address the complexities involved in setting up a billing system, SBHCs might contract with a private billing firm, one of the state's Community Health Centers, or a health alliance. A regional billing system for the more sparsely-populated areas of the state and might be less costly.

Issue #5 - Capitated Managed Care: Private managed care organizations which have Medicaid contracts may perceive little benefit in sub-contracting with SBHCs. While SBHCs may be able to provide services for a relatively low cost per visit, they are designed to increase appropriate access to care, and are therefore likely to be a cost additive. Where there is a lack of formal relationships between MCOs and SBHCs, duplication of payment and fairness will be issues. SBHCs will essentially subsidize private MCOs by providing needed primary health care services to their enrollees.

It may be argued that because school-age children and teenagers tend to under-utilize primary preventive medical services, managed care contracts which are based upon the history

of fee-for-service utilization for these age groups are under-funded. However, these arguments are unlikely to impact capitation rates without overall state health care reform initiatives.

Mental health services, an important service in most SBHCs, are not currently part of Medicaid managed care contracts.

Possible Solutions - In the current Colorado political environment, it is unlikely that MCOs will be required to contract with SBHCs. This means that the relationships between SBHCs and MCOs will be slow to develop, and must be based upon mutual trust and the ability of SBHCs to add value to the services provided by managed care organizations. State Medicaid Program could provide encouragement or incentives through their Model Contract to work with SBHCs.

The success in developing relationships between private Medicaid managed care contractors and SBHCs will depend upon a number of factors: careful study of the totality of care a child receives (including that provided by school- and community-based sources); the numbers of students enrolled in specific health plans (market share) in specific schools; the ability of SBHCs to comply with data and accountability requirements (such as HEDIS and NCQA); and the marketability of SBHCs to parents. While it will be necessary to pursue them, the development of formal relationships with MCOs that result in actual dollar support for SBHC services may be slow to evolve.

Issue #6 - Mental Health Services: Mental health services comprise an important part of the core services provided in SBHCs.

In Colorado, a large proportion of mental health services are provided to Medicaid-enrolled children through programs organized as comprehensive community mental health centers (CCMHC). They are licensed by the Colorado Department of Public Health and Environment under mental health regulations, and are assigned a Medicaid provider number by the State Medicaid Program. A total of $39 million is expected to be spent on mental health services provided through CCMHCs this year. It is expected that $8 to $11 million will be spent on mental health services for those under 21 years of age.

The arrangement for reimbursement of mental health services provided to Medicaid recipients by CCMHCs differs from other providers of such care. Each year, the Department of Human Services (DHS) which houses the Division of Mental Health, receives a general fund appropriation for mental health services from the Colorado Legislature, and these dollars in turn generate a Federal Medicaid matching amount. DHS then negotiates with each of the 22 comprehensive CCMHCs a maximum amount or "cap" for which each individual agency may bill for services provided to Medicaid recipients during the fiscal year. CCMHCs submit cost

reports using a limited number of procedure codes (based upon Medicare reasonable costs). The reimbursement amount per Medicaid visit by CCMHCs is generally higher than fee-for-service rates captured by private providers. For example, Pikes Peak CCMHC receives about $90 per Medicaid visit, compared with just over $50 for a visit provided by a private practice psychiatrist.

Mental health centers are exempted from the physician on-site rule as they are granted "rehab option" status as defined in the Medical Assistance Act. They are not bound by PCP pre-authorization rules. However, Medicaid remains the payor of last resort, which requires that CCMHCs bill other payment sources where they exist, and set a fee with the family.

The State is currently working on a pilot capitated managed care arrangement for the provision of mental health services. The contractor for the pilot has not yet been selected, and could be a CCMHC or a private provider of care. If the model is successful in enhancing access to care and reducing costs, the pilot could be expanded to other selected areas of the state where they can work out local politics. If the pilot or subsequent replication of the program were located in the same geographic area as a SBHC, similar problems would arise as with the co-existence of managed care organizations and SBHCs.

Some mental health services are also provided on a fee-for-service basis by physicians and licensed psychologists. Psychologists are exempted from the physician on-site rule. Social workers in private practice may also receive reimbursement, under a physician's on-site supervision. Reimbursement amounts vary by profession. Psychiatrists receive about $50 per visit, psychologists receive about $42, and social workers about $17 for the same procedure code.

Possible Solutions - Under the Medical Assistance Act and current state Medicaid rules, CCMHCs should be able to receive reimbursement for mental health services provided to Medicaid recipients in school sites. Adequate numbers of students who are eligible for Medicaid must be available for this a to be desirable and economically feasible strategy.

Several comprehensive community mental health centers are successfully billing Medicaid for mental health services provided in school sites (Denver County, Jefferson County, Roaring Fork and Aurora, among others). All referrals are screened by the mental health worker to determine a source of payment, and a sliding scale is used to set a fee or co-payment with the family.

Most CCMHCs, as permitted by Colorado statute, will permit minors over the age of 15 to consent for their own mental health care.

Should Medicaid managed care contract be located in the same community with a SBHC, contractors could be encouraged to reimburse or provide mental health care delivered through SBHCs where they co-exist.

There are no known examples of private providers successfully sustaining a school-based mental health practice with reimbursement from the Medicaid program.

Issue #7 - Substance Abuse Intervention Services: Currently, substance abuse treatment is not a Medicaid fee-for-service benefit, except for services provided to pregnant women.

Issue #8 - Preventive Dental Services: Dental health is the most common health problem among school-age children. A statewide study recently completed of 1,300 records through the School of Dentistry, University of Colorado Health Sciences Center reports some startling findings. An estimated 50% of all the state's children received no dental care during the previous year. At the same time, children with permanent teeth had an average 1.9 decayed teeth (significantly above the national average of 1.6 decayed teeth).

Most any needed dental care is a covered service for children who are Medicaid recipients. The preventive dental services identified by the CDPHE as most important for children to receive through SBHCs include screening, cleaning, dental sealants, fluoride treatments, and referral for restorative care. These are all relatively inexpensive services, and under current state law these may be provided by a dental hygienist.

However, dental care may be among the most difficult of health services for medically indigent families to access. Of all children who are Medicaid recipients, only 24% utilized dental services of any kind during the last year. There may be several reasons for this. The State Medicaid Program reimburses only about 30% of usual and customary charges for dental services. As a result, providers are scarce. It is estimated that the State Medicaid program has lost about 200 dentists from the program over the last 2 years.

The ability of SBHCs to utilize dental hygienists as providers of preventive care is limited under current state rules. State Medicaid doesn't recognize dental hygienists as providers, although Colorado's Dental Practice Act is the only state which permits dental hygienists to practice independently. Similar to other medical services, a dentist must be on site at the time any service is provided to be reimburse by Medicaid.

Possible Solutions - Solutions for problems in receiving reimbursement for preventive dental services provided in SBHCs are similar to those listed under Issues #2, #3 and #4 above.

Issue #9 - Family Planning: Under Federal guidelines, the State Medicaid Program must allow Medicaid recipients to receive family planning services from any enrolled provider they choose. The usual pre-authorization from the PCP is not required. Where these services are included in a capitated managed care

arrangement, other qualified providers may be reimbursed directly for them on a fee-for-service basis.

Possible Solutions - Teenagers may choose to seek family planning services from a SBHC which provides them, rather than receiving them through their HMO or PCP. If otherwise eligible to receive such reimbursement, SBHCs could bill for family planning services provided to Medicaid recipients. It should be noted that family planning services are not provided in all SBHCs, but are an optional service that may be selected through a local planning process.

RECOMMENDATIONS

Based upon the above analysis, eight interrelated recommendations have been formulated. These are considered to be the most feasible strategies for assuring that SBHCs benefit from Medicaid dollars to support basic primary health care services that are provided to the Medicaid-enrolled school-age population.

Recommendation #1: Target SBHCs in high need communities, and in schools which have high numbers of Medicaid-eligible students attending. Research and experience indicate that economically disadvantaged populations are more likely to experience significant barriers to accessing health care, and to be at risk for the "new morbidities," including violence, depression and suicide, smoking, alcohol and other drug abuse, unintended pregnancy, sexually transmitted diseases including HIV infection, and nutritional and weight concerns.

Recommendation #2: Encourage and select programs which are organized under entities which already have received Medicaid provider status. Give strong consideration to including some programs organized by providers which are exempted from the physician on-site rule, such as Community Health Centers and health departments. Because the health care financing environment is changing and uncertain, consider including a diversity of provider types, including private physicians and hospitals.

Recommendation #3: Explore the impact of Title V funding on the ability of agencies that organize SBHCs to bill Medicaid without having to establish a fee structure with all families. Such a fee structure may serve as a barrier to access to care for indigent children and youth. Advocate that the State Title V agency provide ongoing Maternal and Child Health funding to SBHCs certified by the CDPHE.

Recommendation #4: Support the Medicaid Refinancing bill, initiated by a group formed through The Piton Foundation, which could provide school districts and their communities with a pool

of funds to support school-based health services, including SBHCs.

Recommendation #5: Continue to work with private health insurance companies which have Medicaid managed care contacts to develop strategies for them to work with SBHCs in the delivery of primary health care services to the school-age population.

Recommendation #6: Advocate for the addition of language to the standard Medicaid managed care contract that encourages and provides incentives for Medicaid contractors to negotiate service and financing arrangements with SBHCs in communities where they exist.

Recommendation #7: Assist communities developing SBHCs in negotiating referral, care coordination and payment arrangements with private managed care organizations.

Recommendation #8: Initiate a bill to the legislature to include SBHCs under the "clinic services" definition exempting them from the physician on-site requirement. This would permit entities organizing SBHCs to capture Medicaid dollars while employing a low-cost, mid-level driven service delivery model.

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School Age Medicaid Enrollee's As Of 7/16/94

	Age 0-3 Years			Age 4-11 Years			Age 12-18 Years			Total
Eligibility Category	Number of Enrollees	**Pre Member/ Month	*** Colorado Popula-tion	Number of Enrollees	Per Member/ Month	*** Colorado Popula-tion	Number of Enrollees	Per Member/ Month	*** Colorado Popula-tion	
04 - AFDC	51,381	81.03		47,295	81.03		19,763	81.03		118,439
05 - AND/AB	1,016	400.19		3,249	400.19		3,011	400.19		7,276
10,11,13,23,70-FC*	1,105	256.73		2,122	256.73		3,052	256.73		6,279
144 - CRISP	25	142.79								25
TOTAL MEDICAID	53,527			52,666			25,826			132,019
TOTAL COLORADO			217,049			425,134			357,269	999,452

Footnotes:

TOTAL SCHOOL AGE MEDICAID POPULATION (4-18) = 78,492

TOTAL SCHOOL AGE COLORADO POPULATION (4-18) = 782,403

* Foster Care includes subsidized adoption: AFDC/SSI Foster Care

** Per Member Per/Month
Colorado Medicaid Prepaid Capitated Health Plan rates for 7/1/94 to 6/30/95. These are Statewide rates and would vary somewhat depending on whether they are paid in or outside the Denver Metro Area. Rates are inclusive of all Medicaid Services except Nursing Home Care.

*** Colorado Population (per Reid Reynolds 7/26/94)
- 65% have Employer Based Health Care coverage
- 5% have Federal coverage through Medicare or CHAMPUS, or Private Non-Group coverage
- 30% may be Medicaid, Indigent, Self Pay

The number of Medicaid enrollees is extracted from the Medicaid Eligibility Summary report by Aid category and zip code as of 7/16/94 (EBHBU2A)

HEALTHY CARING

A Process Evaluation of the Robert Wood Johnson Foundation's School-Based Adolescent Health Care Program

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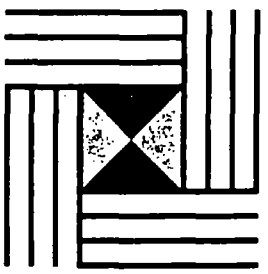
Chapter 7

Costs and Revenues



This chapter examines the costs and revenues associated with operating a school-based health center. Not surprisingly, the bulk of expenses has been for personnel; thus, the costs incurred by SBHCs vary according to the amount of staff time purchased. After a discussion of the types of expenses involved in running an SBHC, we address specific costs and revenues. The next section describes problems sites have encountered in attempting to generate revenues through insurer reimbursement. As we will explain, existing accounting systems do not provide comprehensive information on costs and revenues. Because it is important to describe finances as accurately as possible, we collected extensive data from three sites and use them as examples throughout this chapter to overcome shortcomings in existing budget reports.

Expenses for a School-Based Health Center

Sites incurred substantial costs before opening their doors to deliver services. In addition to the time individuals spent planning SBHC operations (most of which was donated), money was spent on equipment, supplies, and renovations to the space that would house the SBHC. Because the Foundation prohibited the use of grant funds for renovation, school districts generally provided and paid for any necessary construction, which ranged in cost from $20,000 to $60,000 per site. Equipment costs were substantial, an estimated $10,000 to $15,000 per site. A site typically purchased two or more exam tables, file cabinets, a computer, a microscope, a photocopying machine, desks, a refrigerator, a scale, and other assorted items. Some sites were able to scavenge equipment from the medical sponsor, the school district, or other organizations; at one site, a hospital that was closing donated most of the needed equipment. To start delivering services, each site spent about $5,000 to $10,000 for supplies ranging from folders for medical charts to tongue depressors.

Since the SBHCs began serving students, the largest budget expenditure has been for personnel, constituting 80 percent or more of the annual total. The health centers incur no out-of-pocket costs for rent or utilities, because both have been in-kind contributions from school systems. Other basic operating expenditures include laboratory work, medical supplies, office supplies, telephone, professional insurance, printing and duplication, postage, equipment maintenance, medical devices, drugs, and travel to the annual meeting hosted by the Foundation's program office.

Case Examples

To overcome shortcomings in the budget figures reported by sites and to provide more detail on specific costs and revenues, we selected three SBHCs for in-depth analysis. Although they are not statistically representative of all SBHCs in this study, they provide information about expenses and income and were chosen to reflect major differences in medical sponsorship and staffing arrangements among sites. We used fiscal reports prepared by each site, compared them with staff allocation data collected during our site visits, reviewed questions with SBHC staff, and rectified oversights.[42] Although the figures lack accounting perfection, they are as accurate as possible given existing budget reporting systems.[43]

42. For example, we removed charges for staff who no longer work at one school-based health center. For two SBHCs, we identified staff time donated by other agencies, obtained salary and benefits amounts, and calculated the dollar contribution these other organizations made to SBHC operations.

43. For example, the only administrative time Site #3 reported is for two health aides who act as SBHC receptionists, yet we know that several medical staff members spend some time managing the health center. Because we were unable to obtain precise estimates of the amount of this time, we did not attempt to adjust the budget to reflect differences between the work they perform as managers and the work they perform as medical professionals.

Site #1 is sponsored by a public health department. The school housing Site #1 enrolled about 750 students, all of them African American, in fall 1991. The school is in a low-income neighborhood where substantial numbers of residents live in public housing or run-down single-family units. The SBHC does not have a large staff. A registered nurse, social worker, and receptionist work full-time (the receptionist's duties include issuing WIC vouchers). A nurse practitioner works four days per week, a nutritionist is present for one day per week, and a physician is available three hours per week. Most of the physician's time is spent on the telephone with SBHC staff; he does not regularly see students. A staff member from the health department spends, on average, one day per week administering SBHC operations.

A nonprofit agency sponsors **Site #2** (plus several other SBHCs in the area), which is located in a school that enrolled more than 1,600 students in fall 1991. The surrounding neighborhood is experiencing some changes. Although it has traditionally been a safe, working-class neighborhood, drugs and associated crime are appearing in one sector. Compared to all SBHCs, its staff levels are moderate. The only full-time SBHC worker is the medical assistant, who also serves as a receptionist. The site has one nurse practitioner who works four days per week; it also purchases an additional half day per week from a nurse practitioner employed by the school district. Two social workers are based in the SBHC, for a total of 0.8 FTE. A nutritionist works one day, two health educators each work one-half day, and a physician is present for four hours weekly. The school has a full-time nurse whose office is in the SBHC's suite.[44]

The largest budget expenditure has been for personnel, constituting 80 percent or more of the annual total.

A university hospital sponsors **Site #3**, which is in a school that enrolled more than 1,700 students in fall 1991. The neighborhood is composed of low-income and working-class families. Of all the sites in this study, this SBHC has the largest complement of staff. Full-time workers include two nurse practitioners and a social worker (contributed by a public agency). Two health aides funded by the school system each work 30 hours weekly. A psychology intern works in the SBHC 10 hours per week; two physicians are each present for at least two half days per week. A data clerk works on SBHC matters for six hours weekly. In addition, a number of physician residents rotate through the SBHC, with one (or more) usually working a four-hour session each week. Students training to be nurse practitioners also join the staff from time to time. Staff from the public health department's dental service spend one-third of the school year in a mobile unit parked outside the building.

Costs Incurred in Operating School-Based Health Centers

According to reports all SBHCs submitted, total operating expenses in 1991 ranged from $70,000 to $360,000, with

44. Costs for the salary and related expenses of the school nurse were not available, so they have not been included in the figures reported in this chapter. However, her work and the patients she sees are largely separate from the SBHC, so the missing figures are not problematic

an average of $297,977. Costs per patient visit ranged from $18 to $161, with an average of $77 (Lear, 1992b). These figures must be treated with extreme caution because some reported costs (especially administrative ones) are almost certainly inflated, and most individuals preparing reports have no system to verify staff time charges.

Total costs during the 1991-1992 school year for the three sample SBHCs described here were $145,610, $162,102, and $339,026 (Table 3). Personnel costs accounted for 83 percent of Site #1's budget, 76 percent of Site #2's budget, and 90 percent of Site #3's budget. Within the category of personnel costs, charges for medical staff were at least twice as much as those for psychosocial or administrative staff (Figure 10).

Using data sites reported on the number of students using SBHCs,[45] we calculated the cost per patient visit. Each visit cost, on average, $58.62 at Site #1, $62.68 at Site #2, and $71.09 at Site #3. We also calculated the cost per student enrolled in the school as of October 1991.[46] Having a school-based health center cost, per student, $193.12 at Site #1, $98.18 at Site #2, and $194.06 at Site #3 (Table 4).

Some variation is due to labor market conditions and cost-of-living differences. Annual salaries for nurse practitioners, for example, are around $33,000 at Site #1, $46,000 at Site #2, and $53,000 at Site #3. Another difference in the range of costs per patient visit results from the number of staff at each site. The data also imply: (1) some minimum threshold of costs for school-based health centers, somewhere around $50 per patient visit; and (2) some economies of scale that can be achieved in schools with larger student enrollments.

TABLE 3
ANNUAL COSTS FOR THREE SELECTED SCHOOL-BASED HEALTH CENTERS

CATEGORY OF EXPENSES	SITE #1	SITE #2	SITE #3
Personnel			
Medical staff	$ 63,279	$ 81,724	$165,639
Psychosocial staff	$ 24,719	$ 20,315	$ 43,726
Administrative staff	$ 15,456	$ 9,602	$ 33,500
Fringe benefits	$ 16,686	$ 11,770	$ 60,986
Subtotal	**$120,140**	**$123,411**	**$303,851**
Other Direct Costs			
Lab, x-rays, medical supplies, drugs	$ 4,111	$ 8,508	$ 15,446
Office supplies, telephone	$ 1,172	$ 4,986	$ 5,167
Space	$ 10,418	$ 18,348	$ 12,500
Other	$ 9,769	$ 6,849	$ 2,062
Subtotal	**$ 25,470**	**$ 38,691**	**$ 35,175**
Total Costs[a]	**$145,610**	**$162,102**	**$339,026**

[a]The cost totals include in-kind contributions, such as rent and utilities. Their dollar amount was determined by the school systems or medical sponsors. The cost totals also include salaries and benefits for staff donated by other agencies.

REVENUES

Overall, sites in this study obtain most of their revenues from their medical sponsors and the Robert Wood Johnson Foundation grant. School systems contribute about 10 percent of the sites' budgets, usually in the form of space and utilities. Ten school systems have stationed health services personnel (school health nurses or health aides) at the school-based health

45. As noted in Chapter 3, sites do not always submit reliable data. We believe, however, that the information submitted by these three sites is of high quality and can be used with confidence.

46. We would have preferred calculating the costs per student with parental consent to use the SBHC, but this was not possible given the way health centers organize their records. See the discussion in Chapter 2.

centers, but the extent of work they do as part of the SBHCs varies greatly. Similarly, four sites have school system social workers at the SBHC. Almost half the sites receive some staff time donated by community agencies or public organizations.[47] Remaining costs are covered by patient revenues (discussed in the following section) and grants from local foundations or corporations.

The three SBHC examples obtain differential portions of their revenues from various sources (Table 5). The medical sponsor of Site #1 contributes 14 percent. Because of students' concerns about confidentiality, this site only recently began billing Medicaid but is encouraged by the amount of reimbursements received thus far. More than 20 percent of the patient visits at this SBHC are for infants and toddlers from the school's on-site day care center. Because most of these children are Medicaid recipients, much of their SBHC medical care is reimbursed. The school system contributes only the space the health center occupies.

Three-fourths of Site #2's revenues comes from the Foundation and the medical sponsor. Many students enrolled in this SBHC are also enrolled in health maintenance organizations (HMOs) that have declined to reimburse the health center for services delivered. The patient revenues it receives are primarily from Medicaid, with a small amount from private insurance carriers. The school system donates space and utilities. The medical sponsor has been successful in procuring some small grants for SBHC operations.

The revenue sources for Site #3 are more diversified than those for the other two. One-third of this site's revenue comes from the medical sponsor and about one-fourth from the Foundation. In-kind contributions from the school system and staff contributed from other agencies constitute nearly one-third of the SBHC's income. The SBHC has two grants: one from the state and another from a medical school that pays for its residents to work in the health center and be supervised by its staff. Patient revenues comprise a small percentage of the total.

FIGURE 10
PERSONNEL COSTS IN THREE SCHOOL-BASED HEALTH CENTERS

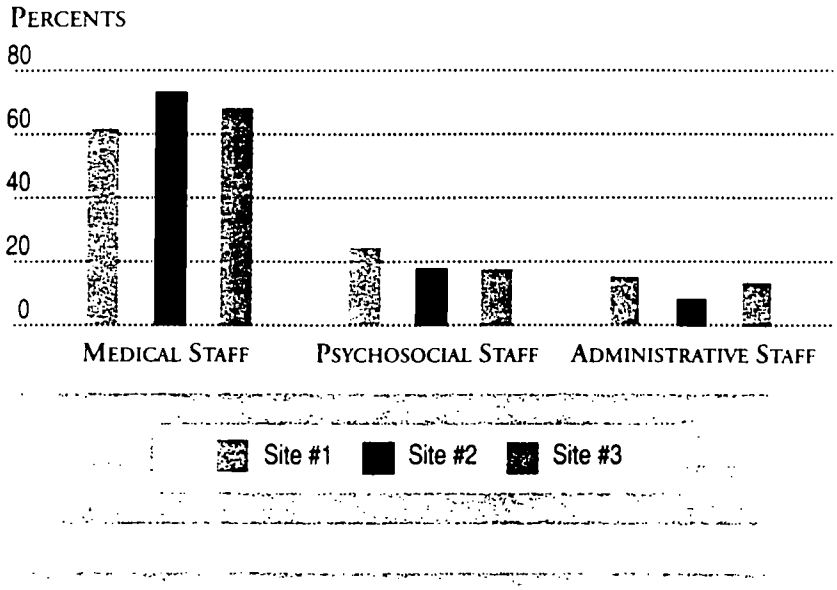


TABLE 4
COST PER PATIENT VISIT AND PER ENROLLED STUDENT AT THREE SELECTED SCHOOL-BASED HEALTH CENTERS

ITEM	SITE #1	SITE #2	SITE #3
Total budget	$145,610	$162,102	$339,026
Number of patient visits	2,484	2,586	4,769
Cost per patient visit	$ 58.62	$ 62.68	$ 71.09
October 1991 enrollment	754	1,651	1,747
Cost per enrolled student	$ 193.12	$ 98.18	$ 194.06

47. This figure excludes staff donated by the school system and interns.

The Reimbursement Problem

The SBHCs have not recovered significant portions of their operating expenditures from third-party insurers. According to reports SBHCs prepared for the 1990–1991 school year (the most recent data available), the site recovering the highest proportion from patient revenues claimed that one-fourth of its expenses were reimbursed by Medicaid and private insurers. Fully half of the 24 SBHCs recovered one percent or less (Lear, n.d.).

Table 5
Revenue Sources and Amounts for Three Selected School-Based Health Centers

	Site #1		Site #2		Site #3	
Revenue Source	Amount	% of Total Budget	Amount	% of Total Budget	Amount	% of Total Budget
RWJ Foundation	$ 85,000	58	$100,000	62	$ 95,000	28
Medical sponsor	$ 19,914	14	$ 20,867	13	$116,245	34
School system	$ 10,418	7	$ 17,179	11	$ 56,050[a]	17
Grants	—	—	$ 10,700	7	$ 8,500	3
Contributed staff	—	—	—	—	$ 43,008	13
Patient revenues	$ 30,278	21	$ 13,356	8	$ 20,223	6
Total	**$145,610**		**$162,102**		**$339,026**	

[a]Includes two health aides.

Several SBHCs decided *not* to seek reimbursement. Most of their reasons are practical ones:

- The school board in one community with several SBHCs has, in effect, prohibited the health centers from submitting requests for private insurer reimbursement. As mentioned earlier, a member of that board who is married to a physician thinks the SBHCs could adversely affect doctors' revenues. Although no specific policy bans billing, SBHC staff are unwilling to risk incurring the board member's wrath.

- Staff at several sites believe that efforts to obtain reimbursements would not be cost-effective, and one SBHC's experience validates this opinion. At one time, this site had a full-time employee responsible for billing. The most the SBHC ever recovered was less than half this person's salary.

- Billing practices could threaten confidentiality. Medicaid or private insurers can routinely notify a beneficiary or policyholder when a payment has been made. Staff are concerned that parents might question their children about matters they are not eager to discuss. One said, "A lot of these kids are in here because their parents are drinking or doing dope. What are they going to say when mom or dad asks what this is all about?"

Managers at two SBHCs mentioned another problem that discourages them from reimbursements: "losing" money in the medical sponsor's accounting system. One was unwilling to submit claims until she found a division at the sponsor willing to process claims and apply reimbursements to SBHC services. Another is mystified as to why the actual reimbursement rate the SBHC receives is less than one-third of the amount billed. Both are convinced that patient revenues are absorbed into the medical sponsor's larger operation. "Losing" money in this fashion is important when the SBHC is considered a separate division of the sponsor and is expected to cover substantial portions of its costs.

Although Medicaid is a potential revenue source, its contributions may remain limited. One state in this sample sets eligibility at 16 percent of the poverty

rate, thus excluding all but the poorest from coverage.[48] Several schools in this study enroll large numbers of immigrants, many of whose parents are undocumented workers and thus ineligible for Medicaid. Even if these children were entitled to Medicaid benefits (as pregnant girls would be), they are often unwilling to risk exposing their families' residency status in return for medical coverage. The age of SBHC patients also militates against obtaining Medicaid reimbursement because insured parents' cooperation must sometimes be obtained, which is not always easy. Unless they are emancipated minors or meet other specific conditions, adolescents cannot sign up for Medicaid on their own.

In most SBHCs, few students are covered under private insurance plans; their parents are unemployed or not offered coverage by their employers. Some staff think those with private insurance are somewhat less likely to use the SBHC because they usually have an alternate source of medical care. Sites have been successful at billing private insurers for covered SBHC patients, however.

Some sites are located in areas served by HMOs, but getting reimbursement from them is not easy. HMOs have few incentives to share enrollment fees with SBHCs for services delivered. Four health centers estimated that at least one-third of their patients were enrolled in HMOs. Two have been unable to negotiate agreements to bill HMOs at all. Another has recovered only a trivial amount. The fourth has a reimbursement agreement with only one of three HMOs that enroll students attending this school; last year, of 636 patient visits by HMO-covered students, remuneration was obtained for only 208.

Conclusions

Given the large psychosocial services component and the low-income areas served at most sites, the school-based health centers in this program are not financially attractive for private health providers, regardless of their value to the adolescents served and the community as a whole. The issue for the program sites is how to survive after Foundation funding ends.

The SBHCs have not recovered significant portions of their operating expenses from third-party insurers.

The sites have benefited from Foundation grant funds, running about $100,000 per year. As the end of the grant period approaches, they are beginning to face the reality of finding alternate sources of revenue or cutting back services. Those treated as outposts of the medical sponsor are fairly optimistic about their continuation. In these places, where the sponsor is usually a public health department, the SBHCs are considered an integral part of the medical sponsor's services. The other SBHCs are being scrutinized as the medical sponsors determine whether to continue their investment at the current level or reduce or raise it.

It is significant that even after years of delivering services successfully, the

48. The state does, however, provide Congressionally mandated services for certain categories of beneficiaries (e.g., pregnant women whose income is 150 percent or less of the poverty level).

Foundation-supported sites are uncertain about their financial futures. They are fragile organizations whose survival is subject to the fiscal conditions of their medical sponsors. Some fear their services will be curtailed severely or eliminated altogether after the Foundation grant ends. Others are more confident about their continuation, believing that medical sponsors are committed to school-based health centers or that enough funds can be scraped together to cover operating costs.

The pressure to contain total Medicaid budgets through options such as mandatory managed care plans can damage SBHC reimbursements unless special procedures are established.

Some sites are considering cost-cutting strategies, such as the use of more part-time personnel, staff donated by multiple agencies, or interns. These may be a resourceful way of maintaining or increasing services but are not without drawbacks. Sites pursuing these strategies must recognize that a successful program depends on conscientious efforts to address lines of accountability and supervision, continuity of care, performance standards, coordination of schedules, assorted benefits packages, and team building.

Sites are beginning to pursue revenue-enhancing strategies, especially more aggressive efforts to obtain reimbursement for services rendered. One has posted a part-time billing clerk at the SBHC to conduct interviews with students and their parents and provide information about low-cost insurance packages. Another has approached its state Medicaid agency with ideas about different ways of billing for services that would result in more income. Three are located in a state that just increased the amount SBHCs can bill Medicaid for services, in part because of lobbying efforts of those involved with school-based health centers.

Attempts to increase Medicaid reimbursements face formidable obstacles unless special efforts are made. The pressure to contain total Medicaid budgets through options such as mandatory managed care plans can damage SBHC reimbursements unless special procedures are established. To avoid financially harming SBHCs, state and local policymakers will need to include special provisions for school-based services as they develop managed care arrangements.

Key Issues Affecting School-Based Health Centers and Medicaid

Julia Graham Lear, Lisa L. Montgomery, John J. Schlitt, Kamala D. Rickett

ABSTRACT: *Public support for establishing school-based health centers has outstripped understanding of how to pay for them in the long term. As a result, a large number of school-based health centers have been started without a clear notion of how they will be sustained. Since 1990, the number of school-based health centers has grown from an estimated 200 to almost 700. A substantial portion of these centers face staffing and service cuts if stable funding mechanisms to support school-based health centers are not put into place. This article addresses issues raised as state governments and the centers consider the possibility of patient care revenue as a component of a long-term funding strategy.* (J Sch Health. 1996;66(3):83-88)

The first school-based health centers were established about 25 years ago. The twin themes of increasing access to care for adolescents and reducing teen pregnancy appear early in discussions of school-based health 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 access to health care for low-income students.[1]

As described in an Office of Technology Assessment (OTA) report,[2] barriers to adolescents' access include a high rate of uninsurance and other financial problems; difficulties private physicians may have in identifying and treating behavioral, emotional, and substance abuse problems; and concerns some adolescents have about confidentiality from traditional office practices. While the first school-based health centers were established primarily in high schools, increasingly state initiatives and community programs have developed centers in elementary and middle schools. The 1994 Making the Grade Survey found that 46% of school-based health centers were located in high schools, 28% in elementary schools, 16% in middle or junior high schools, and 10% in alternative or K-12 schools. While state and local government support for school-based health centers increased sharply, the number of centers grew from about 50 in the mid-1980s to almost 700 by the end of 1995.

In late 1995, the U.S. Congress considered legislation creating a new federal grant program (Medigrant) to help states pay for health care to the poor. This legislation terminates open-ended Medicaid support for health care for the poor and replaces it with a fixed-sum grant program. State funding levels are tied to previous federal payments, with some minor adjustments related to demographic changes. This legislation reduces federal program requirements and permits state flexibility in determining who will be eligible for services, what services will be covered, and what standards for service delivery will be enforced. Ultimately, the impact of these changes may be great, but current arrangements will influence the shape of state programs for several years. Thus, the relationships that school-based health centers have developed with their Medicaid agencies will serve as the foundation for future developments.

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FUNDING HISTORY OF SCHOOL-BASED HEALTH CENTERS

In 1994, 25 states allocated $12 million of their Title V (Maternal and Child Health) block grant funds to school-based health centers, a 45% increase over the 1992 allocation of $8.1 million. In 1994, 25 states also appropriated $22.3 million in state general funds for school-based health centers, a 140% increase over the $9.2 million appropriated in 1992. Less easily documented, but nonetheless important, has been support from local governments. Community support has played a critical role in financing school-based health centers. As indicated in Table 1, 11 urban areas that organized multi-site health center programs during the past decade are supporting 46% of the total budget from local resources.

Historically, school-based health centers were started and sustained with public and private grants. A 1990 survey[3] reported that: state health departments provided 24% of funding for centers, private foundations 18%, Maternal and Child Health block grants 17%, local governments 12%, schools 8%, community health centers 7%, Medicaid 2%, and private payers less than 1%.

Funds from patient care reimbursement, whether from private insurance or Medicaid, only recently have contributed significantly to the operating costs of school-based health centers. For the 1992-1993 school year, 24

school-based health centers funded under a Robert Wood Johnson Foundation initiative reported that 13% of their operating budgets were supported by patient care revenue, most of which was for services to Medicaid-insured students.[4] The 11 urban centers reported that third party payments accounted for 8% of their operating budgets. Based on comments by representatives from 24 school-based health centers and by representatives from 12 state governments, the limited support from patient care revenues and Medicaid is ascribed to several factors:

- State officials perceived the school-based health centers as experimental projects that more appropriately were funded by private and public grant dollars.
- In the past, relatively few privately insured students have attended schools with health centers. Even if students have private insurance, that insurance might not cover preventive health services and might require large out-of-pocket payments.[5]

Table 1
Funding 11 Multi-Site School-Based Health Center Programs in Urban Settings, Fiscal Year 1995

City	# Sites	Total Operating Budget	County/City	%	State Grants	%	Federal Grants[1]	%	Third Party	%	Other	%
Baltimore City	10	$ 2,069,837	$ 1,288,510	62	$ 346,050	18	$ 251,726	12	$ 183,551[2]	9		
Baltimore County[3]	15	963,179	400,000	42	123,179	13			440,000	46		
Boston[4]	8	1,243,964[5]	126,200	10	190,600	15			146,355[6]	12	$ 780,809[7]	63
Bridgeport, Conn.	8	1,541,691	583,070	38	807,621	52			1,000		150,000	10
Dallas[8]	9	3,178,646	1,999,662	62			24,984	(1)			1,154,000	36
Denver	5	1,043,930	287,176	28	116,000	11	163,000	16			477,754	46
Multnomah County, Ore.	10	1,952,000	1,432,000	73	110,000	6	270,000	14	140,000	7		
New Haven, Conn.	10	1,291,238	288,875	22	683,900	53	50,000	4			268,463	21
St. Paul, Minn	7	997,478	10,000	1	545,431	55	237,170	24	194,877[9]	20	10,000	1
San Jose, Calif.[10]	8	962,801	8,070	1	22,295	2			154,231	5	778,205[11]	47
Seattle/King County, Wash	8	1,165,571[12]	1,163,571	100					2,000	(1)		
Total	98	$ 16,410,335	$ 7,587,134	46	$ 2,945,076	18	$ 996,880	6	$ 1,262,014	8	$3,619,231	22

[1] *Federal grant supports appears in three categories: Federalg rants, Maternal and 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.*

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

[3] *Baltimore County opened four new sites in January. All sites are part-time. The health department, school system, and university support and maintain these center programs. Billing takes place at all sites. The program also has begun to negotiate contracts with managed care plans.*

[4] *Eight of Boston's 13 school-based health centers are sponsored by the Boston Dept. of Health and Hospitals. In fiscal year 1995, there were five full-time and three part-time sites. In fiscal year 1996, there will be six full-time and two part-time sites.*

[5] *Reflects a phased-in budget. The fiscal year 1995 budget is closer to $1.5 million, an amount not including in-kind support from other agencies.*

[6] *Rough estimate. Because the Boston Dept. of Health and Hospitals is a city agency, reimbursement flows directly to the general fund and not to the program.*

[7] *A one-time external (state) source of funds. In fiscal year 1996, program will be shifted partially to city dollars.*

[8] *Dallas figures reflect the 1995-1996 budget which will support nine comprehensive Youth and Family Centers located in high schools but serving clusters of schools including elementary and middle schools.*

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

[10] *In 1993-1994, two full-time and six part-time sites which were open two-four days a week.*

[11] *Support includes $593,382 from medical sponsor, Good Samaritan Healthy System, $159,106 from the Good Samaritan Charitable Foundation, and $25,717 from grants/donations.*

[12] *In-kind contributions as well as dollar support from non-health department sponsoring health care institutions are not included. Seattle tax levey specifically to fund programs for school-age children contributed $540,000 for program budgets in 1994-1995. Tax levy legislation will expire in 1997.*

Information provided by school-based health center program directors in Baltimore, Baltimore County, Boston, Bridgeprt, Dallas, Denver, Multnomah County, New Haven, St. Paul, San Jose, and Seattle/King County.

• Poor adolescents are less likely than their younger counterparts to have Medicaid coverage and, as a result, school-based health centers located in high schools frequently have high rates of uninsured patients.

• Not all services provided to Medicaid-insured students are reimbursable due to state-specific Medicaid plan limitations or exclusions. Some states refuse reimbursement to nurse practitioners unless a physician is on-site when care is rendered, and nearly half of the states prohibit reimbursement for mental health services delivered by a clinical social worker.

• Due to the projected limited revenue potential and the administrative burden associated with billing, some school-based health centers have chosen not to bill either patients or their insurers for services provided. These school-based health centers and their sponsoring organizations have concluded that the cost of billing would exceed the revenues generated.

Despite barriers to billing, organizations that sponsor school-based health centers increasingly find that patient care-related revenues are an essential component to funding these services. The Clinton Health Security Act, in attempting to finance school-based health centers by integrating them into the proposed regional and corporate health plans, contributed to a perception that all personal health services — even those targeted to low-income students — ultimately will be financed through a patient care funding mechanism. Moreover, since school-based health centers commonly report more than 30% of their patients as uninsured, there is a growing sense that available grant dollars should be used to cover the cost of serving those patients.[4,5] Interest in third party payment also accelerated as the numbers of school-based health centers increased and uncertainties about federal funding through block grants and Medicaid grew.

Greater reliance on patient care revenues is not endorsed by all school-based health centers or their supporters. Critics emphasize the large number of uninsured students using the centers and the importance of public health dollars in funding care for the uninsured. Others suggest that a financing strategy that requires school-based centers to fit within a traditional medical services model may undercut the unique blend of social, mental health, and medical services that have been the hallmark of many comprehensive school-based health centers. Health center staff undertake a number of activities, such as classroom health education and work with school faculty and parents, that are not billable. To tie the work of the center to a reimbursement structure that does not recognize these services appears to some to threaten what is most valuable about school-based health centers.[6]

MEDICAID PARTICIPATION IN SCHOOL-BASED HEALTH SERVICES

Until recently, most health services delivered at the school site were not reimbursed by Medicaid. In general, state Medicaid officials maintained that health services provided at schools either were not included in the defined list of services eligible for Medicaid reimbursement, were not provided by eligible providers, or already were paid for by local and state dollars used to employ or pay for the school health providers. Changes in the Medicaid program under the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), as well as federal support for health-related services for disabled children have created opportunities for state Medicaid plans to pay school systems or providers based in schools for specifically defined health services delivered at the school site.

Early Periodic Screening, Diagnosis, and Treatment

OBRA 89 expanded the number of women and children eligible for Medicaid and its related component, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program is intended to make preventive and comprehensive health services available to Medicaid beneficiaries younger than age 21. Because beneficiary participation in EPSDT had been less than many child health advocates had hoped, OBRA 89 encouraged states to implement the EPSDT expansions by directing the U.S Dept. of Health and Human Services to set state-specific annual EPSDT participation goals. The Health Care Financing Administration (HCFA), acting on behalf of the Secretary of the U.S. Dept. of Health and Human Services, set goals designed to attain EPSDT participations of 80% or more by 1995. In 1990, after consultation with the states, HCFA added an instruction to the *State Medicaid Manual* regarding the goals. With that prodding, a number of states have looked to schools, with their proximity to children and adolescents, for help in attaining these goals.[7]

Health Services for Disabled Children

Simultaneously with development of Medicaid funding for in-school EPSDT services has been increasing support for in-school health care for children with disabilities. Special education services were mandated for handicapped children through the Education for the Handicapped Act in 1975. Medicaid reimbursement for the health-related services required to educate disabled children was not available until the late 1980s. However, a court decision in 1987 and Congressional action in 1988 opened the door to federal support for medically necessary services for Medicaid beneficiaries.[8] Congress declared, as part of the Medicare Catastrophic Coverage Act of 1988, that Medicaid funds *were* available to pay for health-related services. Specifically, Congress stated that nothing under the Medicaid statute should be interpreted to prohibit HCFA from paying for services provided under a state Medicaid plan simply because the services were provided as part of an Individualized Education Plan (IEP).

The extent to which the provisions of health-related services have transformed the health service mix in the schools is demonstrated by data from New York City. In fiscal year 1992, the New York City Health Dept., the official provider of school health services, budgeted $8.18 million for school health services. In the same year, the city Dept. of Mental Health, Mental Retardation, and Alcoholism Services spent $5.6 million on school-based mental health services. Two years earlier (the most recent data available at the time), the New York City Public Schools spent $41.7 million on health education and related services, and $65.9 million for therapeutic services for special education services.[9] In terms of resource utilization, health-related services provided to special education students has come to represent the greatest part of health care in schools and growth in this area has led states to press for Medicaid reimbursement for services to its

beneficiaries.

Varied State Experiences

By 1992, it was reported that 28 states had authorized schools to bill Medicaid for at least some services rendered to its beneficiaries. Of the 28 states that had chosen to use school-based providers, 11 indicated they were considering reimbursing for care provided by schools.[7] While state interest in Medicaid participation in school-based services has grown, states differ greatly in levels of financial support, administrative structures, billing procedures, provider credentials, and how federal revenues received as a result of billing are used, according to a December 13, 1994 memorandum from Sally Bachman, The MEDSTAT Group, to Julia Paradise, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services.

One challenge school-based health centers confront in securing Medicaid support for care provided to its beneficiaries has been Medicaid officials' unfamiliarity with the content of health care offered by the centers. As noted, Medicaid involvement with schools is a recent phenomenon. It mostly has involved reimbursement for EPSDT examinations, outreach activities to support the EPSDT program, and provision of health-related services for the Medicaid-insured special education students. Most state Medicaid officials are unfamiliar with school-based health centers and do not known how they differ from traditional school health services. In early 1994, the Health Care Financing Administration began an inquiry into the role of Medicaid plans in the delivery of school-based health services. A workgroup was convened, the so-called Camden Yards Work Group on School-Based Health Care, chaired by Donna Checkett, Missouri Medicaid Director. A report from the workgroup, which was expected in late 1994, has been delayed. Moreover, HCFA and state Medicaid officials express concern that schools may misunderstand basic Medicaid requirements. In a December 22, 1993 memorandum to all regional Medicaid officers, the Medicaid Director commented:

> *"...for any service to be covered under the Medicaid State plan, it must be included among those listed in section 1905(a) of the Social Security Act (the Act). There is no benefit category in the Act titled "school-based services." Consequently, the State must describe its school-based services in terms of the specific 1905(a) services which will be provided..."*

The variety of state-supported school health services complicates the policy making on reimbursement for Medicaid officials. For example, the Connecticut Public Health Dept. defines several different types of health services in schools including basic school health services, enhanced clinical services, part-time school-based health centers (for schools with less than 500 students), and full-time comprehensive centers. The latter two models provide on-site primary care, function as a medical home, and are organized by a mainstream health care organization which provides 24-hour back-up as well as weekend and vacation coverage. However, when the Dept. of Public Health and Addiction Services sought reimbursement under Medicaid for its school-based health center services, the state Medicaid officials neither understood that the centers truly were providing primary care, nor that state grants to support the centers were paying only a portion of the cost. Thus, health department officials spent more than three years discussing the issue of reimbursement with the state Medicaid officials before approval for Medicaid reimbursement was granted.

The Connecticut Medicaid program is not the only one to question payment for health services delivered to beneficiaries at a school-based health center. Delaware has chosen not to reimburse for services provided at its school-based health centers. In this case, the school-based health center services primarily are grant-funded by the state and the Medicaid office has argued successfully that to reimburse for services through Medicaid would constitute duplication of payment. The health care organizations that sponsor the school-based health centers have countered, unsuccessfully, that the state grants provide only partial support to the centers.

Other states have taken a different position. New Jersey and North Carolina treat school-based health centers sponsored by health care organizations as satellite facilities and reimburse as if the services were delivered at the main site of the sponsoring agency. As a result, in New Jersey, health centers at Jersey City's Snyder High School and Dickinson High School sponsored by the Jersey City Family Health Center, a federally funded community health center, generated $150,000 in revenues during the 1992-1993 school year for care provided by a Federally Qualified Health Center (FQHC). Patient visits by Medicaid enrollees, like visits to the Family Health Center itself, were reimbursed on a cost basis. In North Carolina, a county health department-sponsored school-based health center in Greensboro, generated $20,000 in the 1993-1994 school year, with North Carolina Medicaid using a fee schedule to reimburse the health center. In New York, the state offers school-based health centers two reimbursement options. Sponsoring hospitals or diagnosis and treatment centers can bring their school-based health centers under their state-issued operating certificates, which allow the centers to bill at the sponsoring facility's all inclusive Medicaid rate, or the centers can bill under a state-established fee schedule for school-based health centers.

The dramatic growth of managed care in the past several years complicates the entry of school-based health centers into the health care financing mainstream. In 1993, private managed care plans were found in 46 states and the District of Columbia.[10] For Medicaid beneficiaries, some form of managed care was available in 45 states and the District of Columbia.[11] In 1991, 2.6 million of the 28.3 million Medicaid beneficiaries were enrolled in managed care plans; three years later, 8.1 million of 33.6 million Medicaid beneficiaries were enrolled. This change represented a 189% increase compared to a 18.9% increase in the total number of Medicaid beneficiaries during the same period, according to personal communication with the U.S. Dept. of Health and Human Services, Health Care Financing Administration, Medicaid Managed Care Office, June 30, 1994.

While coordination of school-based health centers and Medicaid managed care initiatives is in its infancy, states such as Massachusetts, Rhode Island, Oregon, and Connecticut are taking steps to link school-based health centers and managed care organizations. Other states such as California and Maryland are facilitating local agree-

ments between managed care plans and school-based health centers. However, a far greater number of states have done little to develop relationships between these two entities.[1] To encourage coordination between managed care organizations and school-based health centers, in June 1995 the Director of the Health Care Financing Administration Medicaid Managed Care Team sent a memorandum to the state Medicaid directors providing a list of state contacts knowledgeable about school-based health centers and noting explicitly that "...We at the Health Care Financing Administration believe such linkages are important..."

ISSUES IN LINKING SCHOOL-BASED HEALTH CENTERS AND MEDICAID

The need for school-based health centers to develop relationships with Medicaid and managed care plans presents an imposing challenge. Many individual school-based health centers have not worked with either private or public health insurers and are unfamiliar with the language and requirements of organizations that purchase health care. State offices that administer school-based health center programs generally have focused exclusively on grants strategies for funding the centers and equally are unfamiliar with health care financing issues. However, state Medicaid programs, which have little experience with school-based health centers, increasingly have become involved with other kinds of health services in school and have some knowledge to contribute to the discussion. As described below, specific issues must be addressed for Medicaid policymakers and school-based health centers to negotiate a better fit between these different approaches to organizing better health care for low-income children.

Duplication of Payment

One of the most pressing issues from a Medicaid perspective is assuring that its reimbursement for school-based health care does not result in duplication of payment. Such concerns have deterred several states from reimbursing care for Medicaid-enrolled students. In these states, Medicaid officials have taken the position that state or other grants to support the centers already were paying for the care of Medicaid enrollees. The task for school-based health centers and public health officials has been to document that grant support is not paying the entire cost of care and Medicaid is not being asked to pay for care funded under other arrangements.

Medicaid managed care programs present other concerns. Fees are paid to managed care plans 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. At the same time, some school-based health centers seek permission to bill Medicaid separately for services rendered to its beneficiaries. As a result, there exists the potential for states to pay twice for services provided to Medicaid children and adolescents. A solution to this problem may involve "carving out" funds for services provided by the school-based health centers from the state centers (similar to arrangements made in Maryland and New York for family planning services) or using either the state contracts with the managed care plans or the local plan contracts with health care providers to assure that school-based health centers are included in managed care networks.

A related issue is the development of an adequate capitation rate for adolescent health care. If the capitation rate is based on the historic patterns of under-utilization of health services by adolescents, the capitation rate has the potential for locking in the pattern of underservice. An inadequate capitation rate guarantees insufficient funds to expand the service system sufficiently to offer adolescents an appropriate level of care.

Free Care

An obstacle to arranging for Medicaid reimbursement of services provided in schools has been a statutory prohibition against Medicaid reimbursement for services provided free of charge to non-Medicaid patients. This provision, however, does not apply to services provided under the Individuals with Disabilities Act (IDEA) or to Title V grantees and providers. With Title V providing funds to a substantial number of sponsors of school-based health centers, the Title V exclusion may eliminate the free care barrier for many school-based health centers, according to a March 10, 1994 memorandum from Linda Sizelove, Health Care Financing Administration Medicaid Bureau, to Camden Yards Work Group on School Health.

Quality Assurance

State Medicaid plans have addressed quality assurance, in part, by specifying the provider qualifications required for participation in the medical assistance program. Under Medicaid managed care programs, the state Medicaid plans are giving more intense attention to quality of care measures and plans administering Medicaid managed care initiatives will be required to document the degree to which they meet certain quality goals. In this area, there is a good fit between managed care and school-based health centers. Nearly half the states have outlined quality assurance activities for the school-based health centers. These activities take one of three forms: the state requires a school-based health center to participate in the quality assurance programs of an external organization such as the medical facility with which the center is affiliated; the state provides guidelines to school-based health centers outlining ways in which quality assurance activities should be conducted; or the state administers a quality assurance program which may include site visits, chart reviews, grievance process reviews, and quarterly reports. Most comprehensive school-based health centers are using computer-based registration and encounter systems that permit reporting the kinds of data likely to be required by the managed care plans.

Some managed care plans have been reluctant to establish formal relationships with school-based health centers due to the plans' uncertainty about quality of the services being provided. A precondition to negotiating a contract between a school-based health center and a managed care organization is assuring that the medical director of the managed care organization is comfortable with the care provided by the school-based health centers. Reaching 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, Minn., which operates seven 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% of Health Start's patients expected to be enrolled in managed care by the end of 1994, successful negotiations were essential to survival of school-based health centers.[12]

School-Based Health Center Services and Provider Teams

One approach to addressing concerns about the content of care is to define clearly the service package and describe the providers who offer that package. An increasing number of states either mandate or recommend a specific model for school-based health centers.[1] At present, 22 states have developed guidelines, with some 12 described as comprehensive.

While product standardization is an essential component of quality control and linkage of school-based health centers to managed care systems, the drive toward standards creates tension with one of the strengths of school-based health centers — community control. A long-standing tenet of school-based 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 flexibility at the local level while recognizing the importance of defining a set of care services is one of the key challenges of the next several years.

A Single Unified Medical Record

Development of a single, unified record for each patient is the embodiment of the medical home concept and the foundation on which managing patient care rests. Information exchanges between school-based health centers and managed care plans have been limited, making the establishment of a unified medical record difficult at best. Yet the managed care provider may have accepted contractual responsibility for complete case management of its enrolled patients. In many cases, lack of patient information sharing is the result of the two providers not having established a formal relationship. The provider's desire to honor patient confidentiality and to devote limited time to patient care rather than to administrative tasks also may contribute to the difficulty of finding a quick solution. In Massachusetts, the state Medical Assistance Division (Medicaid) has facilitated a solution to this problem by convening a work group of managed care plans that has developed a universal communication form to be used for exchanging data between the school-based health centers and a child's medical home. In St. Paul, Health Start and RamseyCare included requirements on medical record information exchange in their contractual agreement.[10]

TOWARD THE FUTURE

The last half-decade of the 20th century offers both opportunity and peril for school-based health centers. In recent years, states expanded the number of children covered by Medicaid and are implementing Medicaid managed care with the purpose, in many states, of continuing to increase state capacity to guarantee care for low-income children. These developments may create an opportunity for school-based health centers to become part of a comprehensive service network for children. In this approach, school-based services could be supported partially through part of the capitation rate or through separate state funds.

The growth of managed care, especially the growth of Medicaid managed care, however, also could limit the replication and sustainability of school-based health centers. There may be financial incentives for managed care plans to exclude school-based health centers from the provider networks. There may be administrative complexities that deter contractual relationships between insurers and school-based health centers. Although managed care and the school-based health centers share the goal of improving access to primary preventive care, competition for scarce primary care dollars to fund those services, may impede school-based health center participation in the new health care system.

For school-based health centers to secure their role as part of a network of accessible services for school-aged children, state and local sponsors must pay particular attention to documenting service delivery gaps for children, identifying the services the school-based centers provide to fill those gaps, and monitoring the political and policy discussions that attend the development of managed care initiatives. Inclusion of school-based centers in the publicly supported system of care for Medicaid beneficiaries will depend on the long-term presence of school-based health center representatives at the bargaining table as future arrangements for primary care are hammered out. ■

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SCHOOL-BASED AND SCHOOL-LINKED HEALTH CENTERS

Update 1994

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Budget and Funding Sources

Most SBHCs/SLHCs operate with a combination of in-kind contributions and cash from various sources. Because the type of sponsoring agency, size of the staff, services offered, location and number of clients served have an impact on budget, budgets reported have a broad range. Survey results indicate that in the 1992-93 school year, the median cash operating budget per SBHC/SLHC was $125,000 (n=177); the mean budget was $147,951 (n=177). Respondents further estimated the median value of in-kind contributions to be another $30,500 (n=128).

Table 21 summarizes the median cash operating budget for SBHCs/SLHCs by service model, locale, grade levels served and years in operation; Figure 8 shows mean budget for the various types of sponsoring agencies.

Table 21--Median Cash Operating Budget by Service Model, Geographic Location, Grade Level and Center Age

SBHCs/SLHCs Characteristics	n	Median Budget in Dollars	Budget Range in Dollars
Service Model:			
School-Based	103	$100,000	1,500 - 436,896
Campus-Linked	55	147,000	8,000 - 875,000
School-Linked	14	214,582	83,700 - 800,000
Geographic Location:			
Rural	53	67,164	6,000 - 436,896
Suburban	19	170,000	2,500 - 800,000
Urban	104	160,000	1,500 - 875,000
Grade Level of School(s):			
Primary	28	67,194	1,500 - 200,000
Secondary	128	143,500	2,500 - 800,000
Combined	16	125,978	6,000 - 600,000
Center Age:			
Mature	17	108,500	27,470 - 800,000
Established	50	170,270	5,710 - 600,000
Young	103	101,300	4,250 - 875,000

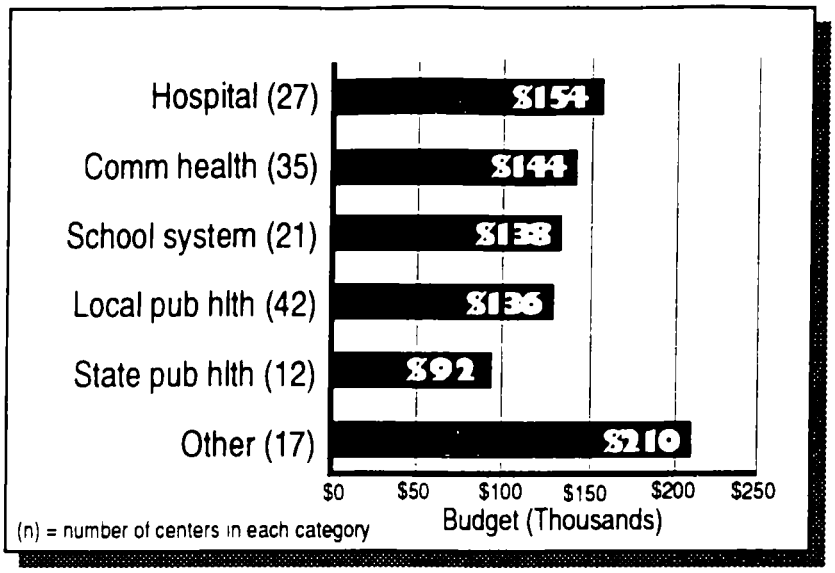

Figure 8—Mean cash operating budget of SBHCs/SLHCs by sponsoring agency (n = 138).

Cost per Student

SBHCs/SLHCs responding to the 1992-93 survey indicated that the median cash cost to operate the center was $163 per enrolled student or $64 per student visit. Table 22 shows how budget per enrolled student and budget per student visit change across service model, location, grade level and center age categories.