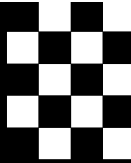


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**Center for
Health Services
Research and Policy**

School of Public Health and Health Services

**School-Based Health Centers And
Managed Care Arrangements: A
Review Of State Models And
Implementation Issues**

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SCHOOL-BASED HEALTH CENTERS AND MANAGED CARE ARRANGEMENTS: A REVIEW OF STATE MODELS AND IMPLEMENTATION ISSUES

Overview of Project

In this report, the George Washington University Center for Health Services Research and Policy (CHSRP), under a contract with the Department of Health and Human Services' Health Resources and Services Administration (HRSA), identifies methods by which states have included school-based health centers (SBHCs) in Medicaid managed care arrangements. This report provides a detailed description of SBHCs, their traditional funding streams and issues related to their inclusion in Medicaid managed care arrangements. In particular, the report details three Medicaid managed care reimbursement models for SBHCs. This report also serves as a companion piece to CHSRP's *Optional Purchasing Specifications: Delivery of School-Based Health Center (SBHC) Services Through Medicaid or SCHIP Managed Care*, a technical assistance document on managed care purchasing for school-based health center services.¹

HRSA asked CHSRP to explore existing reimbursement models states have implemented to fund SBHCs: the *carve-out*, *self-referral*, and *contract requirement* models. These models were identified through discussions with informants who had extensive knowledge of the SBHC environment. The SBHC *carve-out* model enables SBHCs licensed by the state to be reimbursed for Medicaid reimbursable services regardless of a patient's managed care status. The SBHC may receive reimbursement for the provided service to the managed care enrollee even if the SBHC is not in the MCOs' provider network. Carved-out services are reimbursed on a fee-for-service (FFS) basis. The second delivery approach, the *self-referral* model, allows adolescents to self-refer to the SBHC for a prescribed set of acute care and follow-up visits. The chief objective of this model is to keep the primary care functions (and its reimbursement) within the medical home and allow the SBHC to serve as an acute care provider. Similar to the carve-out approach, SBHCs are reimbursed by the health plans on a FFS basis.² In the *contract requirement* model, Medicaid managed care organizations are required to contract with SBHCs so that an individual SBHC can be reimbursed for services delivered to the MCOs' enrollees.

Our research on SBHC reimbursement models included several components. We conducted an in-depth analysis of Medicaid managed care contracts and interviewed numerous key informants involved with the development and implementation of SBHCs in Medicaid managed care arrangements. We also identified at least one state using one of the reimbursement models described above and conducted interviews with program experts. Connecticut, Illinois, Maryland, and New York are the selected states profiled in this report. Other states' approaches are mentioned briefly throughout the report.

Another component of our research was a review of published and unpublished materials on managed care arrangements with school-based health centers. Our literature review included peer-

¹ The specifications are available at www.gwhealthpolicy.org; click on "managed care contracting."

² Medicaid Managed Care and School-Based Health Centers. HRSA and NASBHC sponsored meeting on Medicaid managed care and school-based health centers. Summary of the days discussions. June 12, 2000. Contact: Making the Grade (202) 466-3396.

reviewed literature, other published resources and reference materials. See Appendix A for a complete bibliography. The documents for review were identified by Internet, Medline and Lexis-Nexis searches and key informants. The literature review revealed a myriad of issues confronting states endeavoring to include school-based health centers in mainstream healthcare financing mechanisms. The literature also revealed the many challenges SBHCs face as they struggle for sustainability in a changing healthcare environment. Findings from the literature are cited throughout this report.

We present our research findings in three separate sections of this report:

- Part I: Background and Overview of SBHCs;
- Part II: Service Delivery and Reimbursement Methods; and
- Part III: Models of Managed Care Contracting.

Part I contains a detailed discussion of SBHCs in the United States, including definitions of SBHCs and their evolution; the various service delivery types adopted by SBHCs; the role SBHCs play in increasing access to care for underserved populations; the patient population; scope of services; and provider issues. Part II focuses on SBHC inclusion in Medicaid managed care arrangements. We describe the relationship between MCOs and SBHCs, as well as an in-depth discussion on managed care implementation issues including quality assurance, confidentiality and informational exchange. Part III contains a detailed description of three Medicaid managed care reimbursement models. In this section, we profile three managed care contracting arrangements states may utilize to reimburse SBHCs.

PART I: BACKGROUND AND OVERVIEW OF SCHOOL-BASED HEALTH CARE IN THE UNITED STATES

Over the past 10 years there has been tremendous growth in the number of SBHCs in the United States. A 1998 survey revealed that 1,157 SBHCs located in 45 states and the District of Columbia served an estimated 1.1 million students.³ Although SBHCs are distributed throughout the nation, sixty percent are located in 11 states: New York, Arizona, Texas, California, Florida, Connecticut, Maryland, Michigan, New Mexico, Oregon, and North Carolina.⁴ Over 50 percent of SBHCs are located in urban areas, 30 percent in rural areas and 14 percent suburban areas.⁵

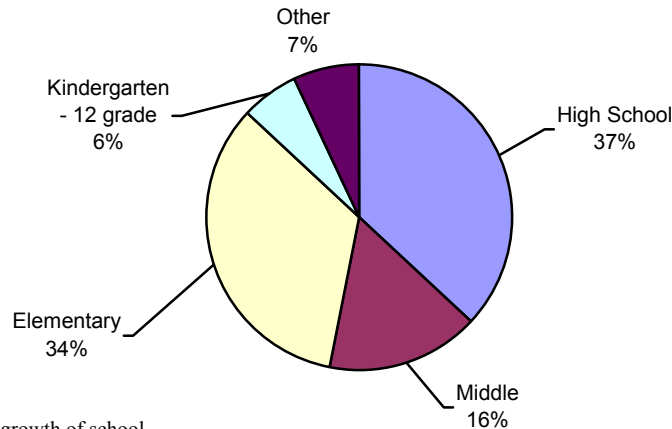
SBHCs originally began in the 1970s and continued to evolve in the 1980s. Because SBHCs were originally intended to increase health care access for adolescents and reduce teen pregnancy, a majority of them were located in high schools. Although the SBHC mission has been modified to facilitate a more comprehensive health care approach for all school-aged children, a large number of SBHCs are still located in high schools. However, an increasing number of SBHCs operate in elementary and middle schools. Figure 1 below illustrates SBHC distribution by school type.

³ Schlitt, J., Santelli, J., Juszczak, L., Brindis, C., Nystrom, R., Klein, J., Kaplan, D., Seibou, M.D. (2000) Creating access to care for children and youth: School-based health center census 1998-1999. National Assembly on School-Based Health Care: Washington, DC.

⁴ Graham-Lear, J., Eichner, N., Koppelman, J. The growth of school-based health centers and the role of state policies. *Arch Pediatric Adolescent Medicine*. 1999 Nov; 153 (11): 1177-80.

⁵ 1998-1999 SBHC Census. NASBHC.

Figure 1
School-Based Health Center Distribution
By School Type



Source: Graham-Lear, J., et. al. The growth of school-based health centers and the role of state policies. November 1999.

The role and mission of SBHCs continues to evolve; presently, there is nationwide variation in SBHC structure. There is no standard definition of SBHCs or a federal lead agency responsible for their standardization and operation.

Although the definition of SBHCs varies across the states, the National Association of Community Health Centers, Inc. (NACHC), an organization which represents SBHCs and community health centers nationwide, provides a general description of SBHCs. NACHC defines SBHCs as entities that are: 1) authorized under state or local law to deliver medical and health services to children in schools or educational settings; and 2) organized, sponsored, or supported by school districts, school cooperatives or other educational institution or entity. An SBHC can be organized as an independent, non-profit program or agency, a satellite of a larger clinical provider, or an operational component of a local school system.⁶

There are three basic service delivery types for school-based health centers: 1) a *medical* type where SBHCs are identified as providers of primary care and preventive services; 2) a *public health* type in which the SBHC is responsible for identifying and responding to the major health problems within the school community; and 3) an *add-on program* type where the SBHC may replicate other services available in the community.⁷ There are also different organizational perceptions of SBHCs: providers may view the SBHC as a function of primary care; sponsoring organizations such as hospitals

⁶ Rosenbaum, S. Adolescent and school health initiative school-based health centers: Assessing the future in a managed care era. Prepared for the National Association of Community Health Centers, Inc.: Washington, DC. October 1998.

⁷ Asay, M., Behrens, D., Guernsey, B., Koppelman, J., Graham-Lear, J., Malone, C., Noyes, L., Nystrom, R., Reilly-Chammat, R., Rosenberg, S., Schaedel, G., Simpson, S., Sterne, S. Nine state strategies to support school-based health centers: A Making the Grade monograph. Occasional papers on policies affecting school-based health centers. October 1998.

and community health centers may view the SBHC as a corporate service or as a way to expand their primary care mission; and public health officials may view SBHCs as natural partners for achieving public health functions.⁸ Defining the SBHC delivery type helps determine certain financing mechanisms and policies the SBHC needs to consider.

Regardless of definition, SBHCs may assist students with functioning appropriately in their social and educational environment by meeting their physical, social and behavioral needs in a comprehensive primary care center within a school-based health program.⁹ The Joint Committee on Health Education Terminology states that “a comprehensive school health program includes an organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff.”¹⁰ Comprehensive program features include:

- the ability to offer children unfettered access to services;
- stable, easily administrable funding arrangements;
- fluid financing (financing must be sufficiently fluid to permit use of funds for the variety of medical and health related activities all of which fall within the mission of SBHCs);
- the ability to extend to children and youth immediate access to care in accordance with basic principles of consent; and
- the need for confidentiality.¹¹

Although wide variation exists among SBHCs, SBHCs are designed to address barriers to care such as transportation, inconvenient appointment times, burdensome out-of-pocket costs and other personal barriers to seeking care.¹² SBHCs can reach a large number of high risk populations because they are primarily located in low-income and underserved communities. In addition, they can also provide outreach and enrollment for Medicaid and the State Children’s Health Insurance Program (SCHIP).

Populations Served by SBHCs

Insurance Status

SBHCs embrace an open access policy, thus distinguishing themselves as providers of care for all students. Within schools, the average SBHC enrollment is 64 percent of the school population with a utilization rate of 84 percent.¹³ SBHCs provide care regardless of the recipients’ ability to pay.¹⁴ The

⁸ National Assembly on School-Based Health Care. (NASBHC) Determining a policy agenda to sustain school-based health centers: NASBHC assesses the health care safety net environment. National meeting, June 2000.

⁹ Making the Grade National Program Office and Rosenberg & Associates. Issues in financing school-based health centers: A guide for state officials. September 1995.

¹⁰ Gottlieb, N.H., Keogh, E.F., Jonas, J.R., Grunbaum, J., Walters, S.R., Fee, R.M., Saunders, R.P., Baldyga, W. Partnerships for comprehensive school health: Collaboration among colleges/universities, state-level organizations and local school districts. *Journal of School Health*. 1999; 69:307-313.

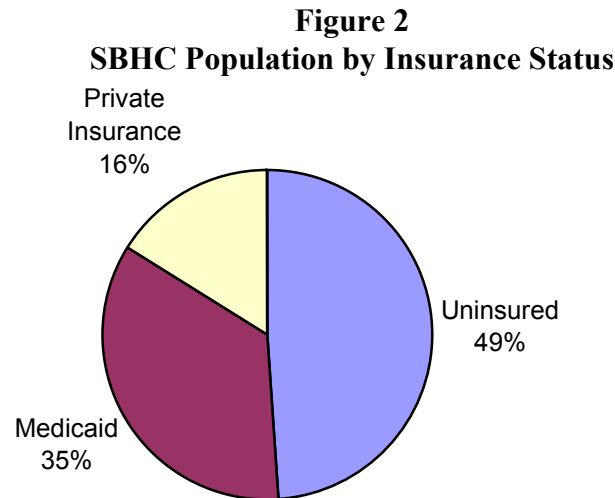
¹¹ Rosenbaum, S. op cit.

¹² Adams, E.K., Johnson, V. An elementary school-based health clinic: Can it reduce Medicaid cost? *Pediatrics*. 2000 Apr; 105:780-8.

¹³ 1998-1999 SBHC Census. NASBHC.

¹⁴ National Assembly on School-Based Health Care. Issue Brief. Critical issues in school-based health care financing. September 1999.

insurance status of a large portion of SBHC users is either uninsured, underinsured or unknown. SBHCs serve a large number of Medicaid enrollees, as well as eligible children who are not enrolled.¹⁵ Figure 2 below illustrates the insurance status of the SBHC population; almost 50 percent of the population is uninsured, 35 percent are insured by Medicaid and 16 percent have private insurance.



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

The SBHC Medicaid population is increasingly being enrolled in managed care. While managed care penetration of the Medicaid population nationwide is 55 percent, 41 percent of Medicaid enrolled SBHC registrants are enrolled in managed care plans.¹⁶

Population Needs and Utilization

The SBHC population has many unique needs including the need for care to be given in a confidential, convenient, age appropriate, and culturally competent manner. Because of their locations, most SBHCs are in schools with a multicultural and multi-ethnic student body. In many cases, students are from immigrant and undocumented resident alien families with limited English proficiency (LEP). In general, LEP individuals often receive substandard health care and lack regular immunizations (which may lead to a number of health problems and common diseases.)¹⁷ In general, past studies have indicated that access to and use of care is related to family income and race or ethnicity. Adolescents from low-income families are more at-risk for being uninsured and therefore more likely to forego care. Hispanics and African Americans are less likely to access care even when financial barriers are

¹⁵ As SBHCs increase access to the underserved, they uncover many children who are Medicaid eligible but whose family will not apply. Armbruster, P., Andrews, E., Couenhoven, J., Blau, G. Collision or collaboration? School-based health services meet managed care. *Clinical Psychological Review*. 1999. March; 19 (2) :221-37.

¹⁶ National Assembly on School-Based Health Care. Issue Brief. Medicaid reimbursement in school-based health centers: State association and provider perspectives. June 2000.

¹⁷ Perino, J.P., Brandis, C. Payment for services rendered: Expanding the revenue base of school-based clinics. April 1994.

eliminated.¹⁸ SBHCs bridge this gap by locating in areas where high-risk populations reside and by providing culturally competent care regardless of insurance status.

SBHCs offer numerous opportunities to increase access to care for adolescents. Most patterns of care of adolescents show that they do not seek routine medical care and often wait until problems become severe before soliciting treatment.¹⁹ SBHCs present a point of access for students who may not feel comfortable accessing any other source of care for certain services, especially mental health. The literature indicates that mental health/substance abuse counseling accounts for a large proportion of SBHC visits. Thirteen percent of 6 to 11 year olds and 19 percent of 12 to 17 year olds have emotional or behavioral problems.²⁰ At least 20 percent of adolescents have one serious health problem and many suffer from diagnosable mental health disorders.²¹ Prior studies have also described other teenage morbidities including youth drug and alcohol abuse and sexually transmitted diseases (STDs).²² In a comparison of adolescents with and without access to SBHCs, adolescents with access were more than 10 times more likely to make a visit to a mental health or substance abuse counselor.²³ Students use SBHCs most often for primary health care and mental health care; 70 percent of visits are for physical medical care, 20 percent mental health and 10 percent for reproductive care.²⁴

A 1999 study assessing the health insurance status of adolescents found that insured adolescents were more likely to have a usual source of care than uninsured adolescents;²⁵ compared to insured adolescents, uninsured adolescents are 5 times more likely to lack a usual source of care therefore, the SBHC often becomes their medical home.²⁶ Although insured adolescents usually have a regular source of care, it appears that they still utilize SBHCs for services. When comparing the SBHC utilization rates between privately and publicly insured adolescents, privately insured adolescents seek care more frequently. A 1995 study revealed that students with private insurance or HMO coverage had the highest (67 and 66 percent respectively) SBHC utilization rate and students without health insurance or with Medicaid had the lowest (57 and 59 percent respectively).²⁷

Scope of Services Provided by SBHCs

¹⁸ Shenkman, E., Wegener, D., Winner, L., Curtis, K., Freedman, S. The school enrollment-based health insurance program: An analysis of health care use patterns. Prepared for the Healthy Kids Corporation Board of Directors Meeting. June 22, 1995. Port St. Lucie, Florida.

¹⁹ Department of Health and Human Services. [DHHS 05-92-00680] School-based health centers and managed care. December 1993.

²⁰ Making the Grade National Program Office and Rosenberg & Associates. Issues in financing school-based health centers: A guide for state officials. September 1995.

²¹ Ibid.

²² DHHS 05-92-00680.

²³ Ninety-eight percent of all mental health visits made by adolescents in the study were made at the SBHC. Kaplan, D.W., Calonge, B., Guernsey, B. P., Hanrahan, M.B. Managed care and school-based health centers. Use of health services. *Arch Pediatrics Adolescent Medicine*. 1998; 152:25-33.

²⁴ Brindis, C., Kapphahn, C., McCarter, V., Wolfe, A.L. The impact of health insurance status on adolescents' utilization of school-based clinic services: Implications for health care reform. *Journal of Adolescent Health*. 1995; 16:18-25.

²⁵ Newacheck, P.W., Brindis, C.D., Cart, C.U., Marchi, K., Irwin, C.E. Adolescent health insurance coverage: Recent changes and access to care. *Pediatrics*. 1999; 104: 195-202.

²⁶ Ibid.

²⁷ Brindis, C., et al. op cit.

There is a great deal of variability in SBHCs' scope of services, which vary according to the SBHC model definition. In general, SBHCs provide a mix of comprehensive medical and mental health services, health education and preventive services. However, few states have had success in including dental services in their SBHC programs. Most SBHCs do not provide all services on site; many are referred out. Examples of SBHC services include:

- Preventive and primary care;
- Health education;
- Diagnosis and treatment of injury or illness;
- Referrals;
- Follow up care and longitudinal management of chronic illness;
- On- site lab capability;
- Radiology services;
- Mental health services; and
- Behavioral and social support.²⁸

The location of the SBHC plays a role in the types of services that it provides. Urban centers report a broader scope of services and more on-site primary care and mental health staff hours than rural and suburban SBHCs. Services among urban and rural centers also differ in the areas of prescriptions, psychosocial assessments, the dispensing of medications and STD diagnosis and treatment.²⁹ Urban centers generally provide a greater amount of these services. This wide variation demonstrates that just as there is no standard definition of an SBHC, there is also no nationally defined scope of services for them. Example 1 lists selected state SBHC services:

²⁸ Making the Grade National Program Office and Rosenberg & Associates. op cit.

²⁹ 1998-1999 SBHC Census. NASBHC.

Example 1 **Sample SBHC Service Variation³⁰**

Oregon: Under Oregon SB 760, Medicaid prepaid health plans are required to pay public health providers (SBHCs included) for immunizations, diagnosis and treatment of STDs, and testing and treatment for tuberculosis.

Maryland: SBHCs provide diagnosis, treatment and limited follow-up (one visit) of acute or urgent somatic illness, related prescribing of medications and family planning services.

Florida: SBHCs provide triage, health education, counseling, mental health assessment and counseling, injury prevention, pregnancy counseling, baby and mother services-these benefits all fall within the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit for Medicaid eligible students.

California: SBHCs provide free and confidential primary care, acute care, mental health, and health education.

Findings from an SBHC survey allow us to draw generalizations of SBHC services. Eighty-nine percent of SBHCs provide the basic tools of primary and preventive care; the most common elements are comprehensive health assessments, anticipatory guidance, vision and hearing screening, immunizations, treatment of acute illness, laboratory, and prescription services.³¹ Many SBHCs offer mental health services to address the mental health needs of adolescents. Eighty percent of SBHCs offer crisis intervention; a slightly smaller percentage offer case management and comprehensive individual evaluation (70 and 71 percent respectively). Two thirds of all SBHCs offer preventive mental health programs (62 percent) and more than half offer comprehensive individual treatment (57 percent).³²

Provider Issues

Provider Types

The type of staff and the amount of time that staff practice at the SBHC varies by site. Full-time staff at most SBHCs generally include a nurse practitioner (NP), school nurse, mental health counselor, a health educator, a medical office assistant, and a health aide. Part-time staff generally include supervisory physicians, additional NPs, substance abuse counselors, case managers, social

³⁰ DHHS 05-92-00681.

³¹ 1998-1999 SBHC Census. NASBHC.

³² DHHS SAMHSA CMHS. Policy Report. School-based mental health services under Medicaid managed care. April 2000.

workers, and nutritionists.³³ A 1998-1999 census of SBHCs revealed that 92 percent of SBHCs employ a combination of physicians, physician assistants or NPs. Mental health professionals were employed by 57 percent of SBHCs surveyed. Ninety percent included support staff (registered nurse or PN), 19 percent had health educators, 19 percent had social services workers, and 14 percent employed a nutritionist.³⁴ A majority of states require that at least a mid-level practitioner (e.g., nurse practitioner or physician assistant) with physician oversight lead the SBHC core staff. Some states also require SBHCs to employ mental health professionals as part of the core staff.³⁵

SBHC staff come from an unlimited number of sources including the SBHC’s sponsoring organization (e.g., in some cases the SBHC may serve as a training site for medical students), a member of the school staff (usually the school nurse), or a member of a collaborating organization such as the Public Health Department. Depending on their scope of services, SBHCs can either function as primary care physicians (PCPs) or as extensions of a child’s medical home. Although clinically capable, many SBHCs are not staffed to provide the 24 hour, 365 day a year medical availability required to be a primary care provider. However, sponsored SBHCs or SBHCs in collaboration with other providers and/or organizations may acquire the provider availability necessary to function as a child’s medical home.

SBHC Formal and Informal Arrangements

SBHCs operate under an array of informal and formal arrangements. SBHCs may stand alone or engage in different forms of collaboration involving, for example, sponsorship, affiliation or partnership. Sponsorship is the most common form of affiliation; it indicates that another organization has assumed responsibility for the operation and fiscal health of the SBHC. SBHCs can be sponsored by a number of different organizations; however, most are sponsored by a hospital, a medical center or public health department. See Table 1 for a breakdown of SBHC sponsorships.

Table 1
SBHC Sponsorship of all SBHCs Nationwide

Sponsoring Organization	Percentage of SBHCs
Hospital/Medical Center	29%
Health Department	22%
Community Health Center	18%
Non-Profit Organization	11%
School Systems	9%

³³ DHHS 05-92-00681.

³⁴ 1998-1999 SBHC Census. NASBHC.

³⁵ Schlitt, J., Rickett, K.D., Montgomery, L.L., Graham-Lear, J. State initiatives to support school-based health centers: A national survey. Making the Grade: Washington, D.C. November 1994.

Medical/Nursing School	6%
All other (miscellaneous group of sponsoring institutions)	5%
Total	100%

Source: Making the Grade State and Local Partnerships to Establish School-Based Health Centers. School-based health centers: Critical caring on the front line (meeting packet). Meeting sponsored by Making the Grade and National Assembly on School-Based Health Care: Washington, DC.

SBHC Funding Strategies

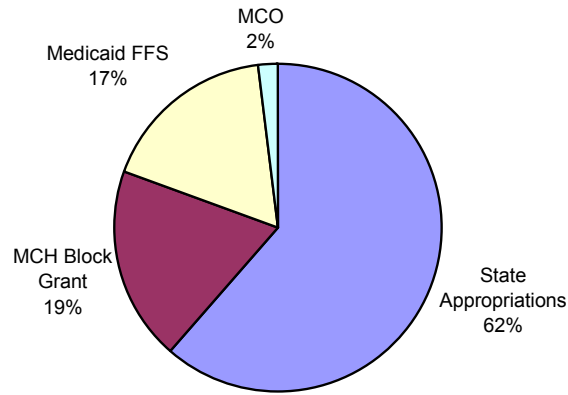
The nation’s safety-net providers face an uncertain future as they struggle to adjust to changes in the health care environment that focus on efficiency rather than access. SBHCs’ “open access for all” policy makes them especially vulnerable to these changes. SBHCs’ method of care encompasses several components: public health concerns, primary and acute medical care, mental health, and health education. SBHCs’ multi-faceted approach to care distinguishes them from other providers in the health care delivery system and may make it difficult for them to determine their proper reimbursement stream (e.g., public funding from the Departments of Education or Public Health versus private funding or third party reimbursement).

SBHCs have traditionally been supported through a combination of funding streams. Sixty-two percent of SBHC funding comes from state appropriations and another 19 percent from state allocations of Title V Maternal and Child Health (MCH) Services Block Grant funds. Medicaid FFS accounts for 17 percent of total revenues and payments from billings to MCOs for both Medicaid and commercial insurance enrollees account for less than two percent of SBHC funding.³⁶ Figure 3 illustrates how SBHCs are currently funded.

Figure 3

³⁶ Morone, JA, Kilbreth, E.H., Langwell, K.M. Back to school: A health care strategy for youth. *Health Affairs*. 2001; 20:122-35.

SBHC Funding Strategies



Source: Morone, JA., Langwell, K.M. Back to school: A health care strategy for youth. *Health Affairs*. 2001; 20:130.

State SBHC Funding Strategies

A primary source of SBHC funding is state revenue, which tend to include grants to states³⁷ and budget allocations. Eighty-three percent of SBHC surveyed in 1999 by the NASBHC said that they rely on state grant funds to cover half or more of their operating budget.³⁸ There are a range of other funding options that states have used, including the use of tobacco settlement money. Example 2 describes various state SBHC funding strategies.

Example 2

³⁷ Examples of grant funding include the federal grant program known as “Healthy Schools, Healthy Communities” and the Robert Wood Johnson School-Based Adolescent Health Care Program grant.

³⁸ National Assembly on School-Based Health Care. Issue Brief. Critical issues in school-based health care financing. September 1999.

State SBHC Funding Strategies

California, Massachusetts, and Missouri: Tobacco excise taxes generate revenue to fund SBHCs

Colorado: Encourages health plans to use publicly funded health insurance dollars from both Medicaid and SCHIP to support SBHCs.

Connecticut: The state requires that Medicaid MCOs contract with SBHCs. Prior to that, the state's financing strategy was based primarily on grants that funded a majority of SBHCs in the state.

Florida: Sales taxes on physical fitness membership fees yield millions of dollars annually for Florida's supplemental school health program.

Louisiana: Funding for SBHCs is solidly based on line item support in the state budget. Medicaid revenue is only about 3% despite the fact that about a third of the centers' population are Medicaid eligible.

Maryland: Managed care plans participating in HealthChoice (MD's Medicaid MCO) are required to reimburse centers for up to 4 acute care visits per semester with one follow-up per acute visit. SBHCs must negotiate contracts with each participating plan to receive payment for any services.

North Carolina: Financing strategies are based on 1) building financial linkages between SBHCs and managed care arrangements and third party payers; 2) partnering with private foundations; and 3) increasing state funding.

Rhode Island: RiteCare (RI's Medicaid MCO) contract defines SBHCs as essential community providers and required plans to contract with centers in their service areas. Four of the five managed care plans in the state have signed contracts with SBHCs. Some RiteCare dollars are now accruing to the centers.

Vermont: Basic state funding strategy focuses on using state administered EPSDT dollars as well as money used to pay for "related health services" for special education students. Schools are paid for providing comprehensive, preventive health services to students.

Source: Schlitt, J., Rickett, K.D., Montgomery, L.L., Lear, J.G. State initiatives to support school-based health centers: A national survey. Making the Grade: Washington, D.C. November 1994. And Asay, M., Behrens, D., Guernsey, B., Koppelman, J., Graham-Lear, J., Malone, C., Noyes, L., Nystrom, R., Reilly-Chammat, R., Rosenberg, S., Schaedel, G., Simpson, S., Sterne, S. Nine state strategies to support school-based health centers: A making the grade monograph. Occasional papers on policies affecting school-based health centers. October 1998.

Although an important revenue source, state funding is unequally distributed across states and cannot be viewed as a long-term funding option. In addition to unequal distribution, the literature indicate that state funding for SBHCs is actually decreasing. A 1998 Making the Grade survey revealed a slight drop in collective SBHC investments across states which is partially attributed to states' desires to direct state funds toward escalating Medicaid costs and their SCHIP programs.³⁹

Third Party Reimbursement

Some of the reasons why third party reimbursement has not been a priority or significant revenue source among SBHCs are addressed below.

- Many SBHC patients are uninsured.
- Many SBHC services provided to both the insured and uninsured are non-reimbursable.

³⁹ Ibid.

- Each MCO has its own criteria for services delivered and which services are reimbursable. For example, some MCOs will not reimburse nurse practitioners for primary care services, nor will they reimburse for mental health services, unless they are delivered by a clinical social worker.
- Pursuing third party payments are viewed by some as not being cost effective for SBHCs. A 2001 survey of 26 states revealed that no SBHC receives more than 10 percent of its revenue from third party billings to MCOs; most centers average less than two percent in Medicaid reimbursement.⁴⁰
- SBHCs who contract with MCOs must comply with licensing and credentialing requirements, which vary by state and frequently by MCO.

Although complicated, decreasing amounts of private and public funding force SBHCs to increasingly consider third party billing. Fee-for-service Medicaid reimbursement has historically been the most common SBHC third party payor; however, managed care penetration has modified the payment structure from FFS to capitation resulting in decreased revenue because capitation payments are generally on a discounted FFS basis. For example, researchers predict that the most probable result of New York state SBHCs participation in managed care arrangements will be a decrease in Medicaid reimbursement of approximately 35 percent across all SBHCs.⁴¹ SBHCs in Massachusetts noted an 80 percent decrease in billing to Medicaid since the onset of Medicaid managed care.⁴² However, not all third party billing results have been negative. As of 1995, Health Start, an organization that operates SBHCs in St. Paul, Minnesota, receives reimbursements of nearly \$100,000 per year, nearly the annual operation cost of one SBHC, from third party payors.⁴³

Patient Revenue

Patient revenue is a small source of SBHC funding. National data from 1991 documented that patient revenue accounted for only 5 percent of total SBHC support. In addition, a 1993 survey of 23 Robert Wood Johnson Foundation-supported SBHCs revealed that 15 percent of SBHC costs were covered by patient revenues.⁴⁴ Since many SBHCs are located in low-income communities, it is unlikely that patient revenue will be a significant factor in the financial viability of SBHCs.

PART II: SBHCs AND MEDICAID MANAGED CARE

As previously discussed, establishing a long-term financing mechanism is essential to SBHC viability. Since a majority of the SBHC patient population is either Medicaid enrolled or eligible,

⁴⁰ Morone, JA, Kilbreth, E.H., Langwell, KM. op cit.

⁴¹ This decrease in revenue assumes that the amount of reimbursement under a capitated arrangement will be significantly less than that under a fee-for-service arrangement. For example, in New York the 35% decrease in revenue is assuming an average Medicaid fee-for-service reimbursement of \$85 per visit compared to an estimated MCO reimbursement of \$57 per visit. Honig, Michael. School-based health centers and managed care: Contracting issues and options. July 2000.

⁴² Hacker, K. op cit.

⁴³ Zimmerman, D., Reif, C. School-based health centers and managed care health plans: Partners in primary care. *Journal of Public Health Management and Practice*. Winter 1995.

⁴⁴ Making the Grade. (1995, June 26). Medicaid, managed care and the school-based health centers: Proceedings of a meeting with policy makers and providers. The Robert Wood Johnson Foundation administered by the George Washington University: Washington, DC.

including SBHCs in Medicaid managed care arrangements is a logical financing option. However, SBHC's inclusion in such an arrangement is a complex process. This section explores the various types of Medicaid managed care reimbursement arrangements that SBHCs may employ as well as the challenges associated with the process.

SBHCs and Medicaid

Although states originally discouraged SBHCs who were already receiving public funds from seeking Medicaid reimbursement, SBHCs are now encouraged to participate in both Medicaid and SCHIP programs as participating providers.⁴⁵ A 1994 study reported that a total of 29 states were participating in Medicaid with reimbursement mechanisms in place to cover services provided at the SBHC to Medicaid enrollees.⁴⁶ On average, Medicaid revenue has represented under 10 percent of operating cost for most SBHCs. Although the amount of Medicaid revenue varies across states, overall it has been small compared to the number of Medicaid beneficiaries served at SBHCs. One national survey reported that although 35 percent of the primarily low-income students who were utilizing SBHC services had Medicaid coverage, less than one percent of SBHC's funding came from Medicaid revenues.⁴⁷ In another study, New York SBHCs reported that 40 percent of their users were insured by Medicaid, yet only 25 percent of SBHC funding came from Medicaid.⁴⁸

Managed care enrollment for all Medicaid enrollees is mandatory in some states. In these states, Medicaid enters into contracts with MCOs for a capitation payment to manage the care of Medicaid enrollees. In these cases, the possibility of duplicative payment by SBHCs has been a potential concern of some state Medicaid agencies. Duplicative payment refers to receiving payment twice for the same patient (i.e., once from the state/local grant funds and second through Medicaid). In other words, Medicaid already pays Medicaid MCOs a capitated rate for beneficiaries at the same time that Medicaid pays SBHCs for Medicaid reimbursable services to Medicaid beneficiaries enrolled in managed care. Likewise, MCOs may duplicate payments by paying the PCP a capitated payment for an enrollee in addition to paying SBHCs a FFS payment for Medicaid reimbursable services provided to the same enrollee. Although the child may receive the same services from the SBHC and PCP (who in most cases is already paid a capitated payment), allowing children to receive services at the SBHC can be advantageous to MCOs. MCOs cited as the principal advantages of including SBHCs in their network improved immunization levels and fewer emergency room visits because of the ability of the SBHC to provide urgent care.⁴⁹

Conversely, some state and SBHC administrators believe that SBHCs subsidize managed care providers when serving MCO enrollees. SBHCs reason that they often treat managed care enrollees even though the SBHC is not in the managed care network and receives no reimbursement for such services. In effect, this results in a duplicative payment for the enrollees' care since the state has

⁴⁵ Graham-Lear, J., Eichner, N., Koppleman, J. The growth of school-based health centers and the role of state policies: Results of a national survey. *Arch Pediatr Adolesc Med*, Vol. 153, Nov. 1999.

⁴⁶ Schlitt, J., Rickett, K.D., Montgomery, L.L., Graham-Lear, J., op cit.

⁴⁷ McKinney, DH., Peak, GL. School-based and school-linked health centers: Update 1994. Washington, DC, Advocates for Youth, 1995.

⁴⁸ Brellocks, C., Zimmerman, D., Zink, T., English, A. School-based primary care in a managed care environment: options and issues. *Adolescent Medicine: State of the Art Reviews*. 1996; 7: 197-206.

⁴⁹ Honig, M. School-based health centers and managed care: Contracting issues and options. July 2000.

already paid the MCO a capitated payment for the enrollees, in addition to the SBHC paying for the service out of its own funds (if it is not included in the MCO network).⁵⁰

MCO Contracting

Some states require formal SBHC-MCO relationships by virtue of legislation requiring Medicaid MCOs to contract with Essential Community Providers (ECPs, of which SBHCs are included), or by explicitly requiring MCOs to contract with SBHCs. However, states leave discretion to the MCOs to define and structure the SBHC-MCO relationship.⁵¹ Developing linkages between MCOs and SBHCs is dependent on factors such as state and local politics, Centers for Medicare and Medicaid Services (CMS) waivers, pressures of the health care market, vision of the MCO, and the needs of the population.⁵²

As previously discussed, a large percentage of the SBHC population is Medicaid eligible or enrolled. Forty-nine states now rely on some type of managed care arrangement to serve Medicaid beneficiaries. As of 2000, fifty-five percent of all Medicaid beneficiaries nationwide were enrolled in managed care,⁵³ making coordination between MCOs and SBHCs an important endeavor. Examples of coordination between MCOs and SBHCs include:

- State law requiring Medicaid managed care providers to coordinate with SBHCs;
- Entering into a contract between an MCO and a SBHC;
- Developing formal protocols for referral and treatment between managed care providers and SBHCs;
- Including managed care providers in coalitions which fund and develop SBHCs;
- Managed care providers authorize SBHCs to provide care and bill Medicaid directly for services;
- Managed care organizations give expedited patient care for SBHC referrals.⁵⁴

SBHCs that link with MCOs must abide by staffing, credentialing and preauthorization requirements imposed by the plan in addition to regulations imposed by the state.⁵⁵ The SBHC's role in the managed care provider network is also determined by the plan since the plan dictates how the SBHC is to link with other network providers. In short, the MCO plan type⁵⁶ will determine which

⁵⁰ Department of Health and Human Services, Office of Inspector General. School Based Health Centers and Managed Care: Examples of Coordination. December 1993. (Publication OEI 05-92-00681). See also, Department of Health and Human Services, Office of Inspector General. School Based Health Centers and Managed Care. December 1993. (Publication OEI 05-92-00680).

⁵¹ Rosenbaum, S. op cit.

⁵² Hacker, K. op cit.

⁵³ Centers for Medicare and Medicaid Services. 2000 Medicaid managed care enrollment report: Summary statistics as of June 30, 2000. www.cms.gov.

⁵⁴ DHHS, OIG, op cit. footnote 50.

⁵⁵ For example, the amount of time that physician staff practice at the center will predict whether or not a SBHC may operate as a gatekeeper for managed care enrollees since not all states permit nurse practitioners (NPs) to fulfill this position. Thirty- nine states and the District of Columbia allow NPs to function as PCPs; however, 5 states do not. State law also stipulates how many hours a physician must be on-site for the SBHC to serve as a child's medical home. Graham-Lear, J., Eichner, N., Koppelman, J., op cit.

⁵⁶ The four most common types of managed care organization are the staff model (HMO), capitated group network, independent association, and preferred provider organizations. Brellochs, C., et. al. op cit.

services the SBHC can provide without prior authorization, and how the SBHCs will be linked to the plan's PCPs, specialists, pharmacies, and lab services.⁵⁷

There are three major types of roles SBHCs play in managed care arrangements:

1) *Specialty Provider*: SBHCs have the same status as medical subspecialty providers and ancillary services within the plan. Authorization must be obtained for each service unless it is a waived service. Prior authorization can be waived for specific primary care services. As specialty providers, the SBHC is only authorized to provide specific services (not a full range of primary care services); therefore, they should coordinate with the child's PCP and other community providers in order to ensure continuity of care. Carved out services include family planning and physicals.

2) *Primary Care Gatekeeper*: The SBHC can provide primary health care services without prior authorization, use the health plan's formulary, reference lab, and specialist panel, and follow the "plan's procedures in accessing other needed services." SBHCs provide primary care services without prior authorization and act as gatekeeper to other services not provided on-site.⁵⁸

3) *Co-Manager of Primary Care*: The SBHC can provide care without prior authorization; however, it must routinely communicate all but confidential information to the plan's designated primary care clinic and obtain other services through it. The SBHC will seek prior authorization for services not provided on site.⁵⁹

Managed Care Implementation Issues

SBHC-MCO linkages can be impeded by several factors. Finances, legal issues, communication, and confidentiality are the most common barriers to linkages, as well as provider stability and concerns about SBHC quality assurance measures. In our interviews, we found that MCOs are reluctant to include SBHCs in their networks for several reasons. Some MCOs believe that they will lose control over the type and quality of care that their enrollees receive. Others are concerned about the sharing of information between the MCO and SBHC (e.g., privacy issues, medical records, etc.).⁶⁰

Although states may seek to include SBHCs in Medicaid managed care arrangements, some studies have reflected differences between SBHCs and MCOs which may create barriers to establishing relationships. The studies found that the primary interest of MCOs is to control costs and serve only those who are in their service plan, while the primary interest of SBHCs is to increase access and

⁵⁷ Ibid.

⁵⁸ Most SBHCs do not function in this capacity; however some many function in this relationship (PCP) as a satellite of primary care clinics. In a recent survey, thirty-four states and the District of Columbia reported that they allow SBHCs to participate in managed care plans as primary care providers; ten states do not permit these arrangements. Graham-Lear, J., et. al., op cit.

⁵⁹ Brellochs, C., Zimmerman, D., Zink, T., Juszczak, L., English, A., in collaboration with participants of the national work group meetings. A partnership for quality and access: School-based health centers and health plans. A special report on the 1995 national work group meetings. School Health Policy Initiative. 1996.

⁶⁰ United States General Accounting Office. School based health centers can expand access for children. December 1994. Washington, DC: GAO/HEHS-95-35.

address the needs of students.⁶¹ The open access policy of SBHCs creates contracting concerns for some commercial insurers who believe that SBHCs will use insurance payments to subsidize treatment provided to the uninsured or underinsured.⁶² In addition, the public health nature of SBHCs causes them to operate very differently from managed care. A possible arrangement may be expecting SBHCs to function in a manner compatible with managed care (even if not as a formal managed care network provider) in exchange for MCO support in the form of an assessment against all MCOs functioning in the SBHC service area.⁶³

One barrier to MCO-SBHC linkages has been in the area of quality assurance. While controlling costs, MCOs must ensure that enrollees are receiving appropriate, effective care that adheres to quality standards imposed by the state. SBHCs that bill Medicaid must meet Medicaid's quality standards, and SBHCs that contract with MCOs must develop continuous quality improvement (CQI) activities in accordance with MCO requirements. In response, some SBHCs have heightened their credibility by adhering to widely accepted quality standards such as the Health Plan Employer Data and Information Set⁶⁴ (HEDIS) (8 percent) or Joint Commission on Accreditation of Health Care Organizations⁶⁵ (JACHO) (35 percent).⁶⁶

Information Exchange

The literature repeatedly underscored the importance of SBHCs' ability to produce data. Producing data on utilization and cost gives the SBHC the ability to self-evaluate and is useful when seeking inclusion in managed care arrangements. The four main purposes of data collection are:

1. Patient information for medical management;
2. Composite data for funding agency request;
3. Aggregate data to enhance provision and management of services; and
4. Research to answer questions that are best addressed in the SBHC setting.⁶⁷

⁶¹ Armbruster, P., Andrews, E., Couenhoven, J., Blau, G. Collision or collaboration? School-based health services meet managed care. *Clinical Psychological Review*. 1999. March; 19 (2) :221-37.

⁶² Less than 20 percent of SBHC users are covered by private insurance compared to the nearly 40 percent that are uninsured. Brindis, C. et. al. op cit.

⁶³ Rosenbaum, S. op cit.

⁶⁴ HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care, and claims processing. HEDIS is sponsored, supported and maintained by National Committee Quality Assurance.

⁶⁵ The Joint Commission on Accreditation of Healthcare Organizations (JACHO) is a voluntary, nongovernmental organization based in Oakbrook Terrace, Illinois. that establishes standards for the operation of hospitals and nursing homes. JACHO is an arm of five professional groups that also represent the interests of doctors, dentists and hospitals. Compliance with JACHO is recognized by the issuance of certificates of accreditation. In essence JACHO gives their "stamp of approval" to nursing homes and hospitals which pay them to inspect their facility. Being JACHO certified has become a selling point for hospitals.

⁶⁶ 1998-1999 SBHC Census. NASBHC.

⁶⁷ Guernsey, BP., Pastore, D.R. Comprehensive school-based health centers: Implementing the model. *Adolescent Medicine: State of the Art Reviews*, June 1996; 7 (2):181-196.

Along with the ability to produce data, the ability to exchange data with MCOs is essential for in-network SBHCs. Specific outcome measures to document quality and costs are needed from SBHCs contracting with Medicaid managed care organizations because these MCOs are required to report these data to the Medicaid agency. SBHC data also allow MCOs to conduct internal quality assurance. However, the most commonly reported barrier to information sharing is the lack of a system or history of relationships that fosters information sharing between SBHCs and MCOs.⁶⁸

Some states have addressed the information exchange issue through Medicaid administrative rules. For example, Maine has proposed rules that state “a protocol for reciprocal client information exchange between MCO and SBHC must be established.” SBHCs must provide the data necessary for the MCOs to conduct quality assurance requirements as specified in the MCOs’ contract with the state.⁶⁹ In short, any type of collaborative effort necessitates a sufficient amount of data exchange, and SBHCs should have a well-designed system for managing data if they intend to be successful in managed care environments.

Information sharing between providers is essential as well, particularly information exchange between the SBHC and the child’s PCP. Information exchange ensures continuity of care for the patient and provider accountability. Better patient care is the result of a seamless system of information transfer between providers (e.g., PCPs, SBHCs, and SBHC parent institution or sponsor).⁷⁰

Confidentiality and Information Exchange

Research has shown that a major issue in access to care for adolescents is confidentiality. There is a great deal of literature concerning how adolescents are unlikely to seek SBHC services without an assurance of confidentiality.⁷¹ Thus, the issue of confidentiality is especially pertinent to SBHCs; SBHCs serve as the provider of choice for adolescents when seeking mental health and substance abuse services. The need for confidentiality in these services, as well as reproductive matters, is of large concern to SBHCs and adolescents.⁷²

Some services are confidential by federal and state law, including contraceptive care, mental health services and substance abuse treatment. The most common services requested by law that do not require parental consent are emergency treatment, STD treatment, substance abuse counseling, family planning, mental health, and prenatal care.⁷³

SBHCs in managed care arrangements must establish confidentiality protocols that are compliant with state and federal regulations and work to build relationships with community providers

⁶⁸ DHHS, OIG, op cit. footnote 50.

⁶⁹ Finnegan, F.T., Proposed rule: Maine medical assistance manual, chapter VII, section 2, Medicaid managed care initiative. April 8, 1998.

⁷⁰ Hacker, K.A., Weintraub, T.A., Fried, L.E., Ashba, J. Role of school-based health centers in referral completion. *Journal of Adolescent Health*. 1997 Nov; 21(5):328-34.

⁷¹ Guernsey, B.P., Pastore, DR. op cit.

⁷² This preference was indicated by a study that compared utilization rates of adolescents in managed care who had access to SBHCs with the utilization rates of adolescents in managed care without access to SBHCs. Kaplan, D.W., Calonge, N., Guernsey, B. Managed care and school-based health centers: Use of health services. *Archives of Pediatrics and Adolescent Medicine*. 1998 Jan; Vol. 152.

⁷³ 1998-1999 SBHC Census. NASBHC.

and MCOs that foster the confidential exchange of data.⁷⁴ Formal mechanisms are needed to ensure student confidentiality while simultaneously ensuring that all relevant information is shared between different systems of care (e.g., between PCP and SBHC).⁷⁵ SBHCs have used various approaches to do this. For example, Minnesota SBHCs have adopted a series of policies to address confidentiality. SBHCs act as co-managers of primary care, so that confidential visits are not reported to the primary care clinic. If further treatment is needed outside of the SBHC after the confidential visit, information is exchanged with the student's permission to the primary care clinic.⁷⁶

Ninety-four percent of SBHCs have addressed the confidentiality issue between parent and child by requiring parental consent for children to be enrolled in the SBHC. Some individual SBHCs have taken the consent requirement one step further by requiring parental consent for each visit (12 percent) and although 64 percent of SBHCs allow parents to restrict student's access to certain services, most parents do not choose to do so.⁷⁷ Example 3 shows three state's approaches to the confidentiality issue.

Example 3 **Sample State Approach to Confidentiality Issues**

California: Parents must sign a blanket waiver consenting to services when enrolling children in a SBHC. SBHCs share information informally by telephone or fax with the Department of Public Health. All other entities require specific patient release of information.

Oregon: Children 15 years and older have control over their medical care. MCO contract allows for reimbursement for confidential services.

Source: Department of Health and Human Services. Office of the Inspector General. School-based health center and managed care. DHHS 05-92-00681 and DHS 05-92-00680. December 1993.

Any negotiated contract between an SBHC and an MCO should specify how the two organizations will preserve the confidentiality of services and how they will collaborate to ensure that confidentiality is maintained.⁷⁸ SBHCs often do not bill for a service if they do not completely trust the health plan to maintain confidentiality. The common health plan and Medicaid practice of sending either a denial of benefits or an explanation of benefits (EOB) letter to the enrollees' home jeopardizes confidentiality. This issue must be addressed prior to an enrollee's receiving service at the SBHC.

⁷⁴ Finnegan, F.T. op cit.

⁷⁵ Brindis, C., Wunsch, B. Finding common ground: Developing linkages between school-linked/school-based health programs and managed care plans. April 1996.

⁷⁶ Brellocks, C., et al. op cit.

⁷⁷ By law, certain services do not require parental consent. 1998-1999 SBHC Census. NASBHC.

⁷⁸ Center for Health and Health Care In Schools. School-based health centers-managed care: NCQA accreditation: A guide for SBHCs. 2001, www.healthinschools.org.

Although MCOs may make special considerations so that an SBHC is not required to send an explanation of benefits or denial of service letters to the child's home, most MCOs refuse to reimburse for services unless information on the service is obtained.⁷⁹ This may be a barrier to utilization because students may fear that medical records will be less confidential if SBHCs bill for services or notify MCOs.⁸⁰ Despite confidentiality being an issue, MCOs must be able to track utilization via data exchange as they are ultimately liable for their enrollees' care.⁸¹

PART III: MEDICAID MANAGED CARE REIMBURSEMENT MODELS⁸²

Our research focused on three models that states have used to include SBHCs in Medicaid managed care arrangements: **Carve-Out (Approach A)**; **Self-Referral (Approach B)**; and **Contract Requirement (Approach C)**. This section defines each model and discusses issues related to its implementation. This section also includes case studies⁸³ which provide a detailed description of a state's experience in incorporating SBHCs into Medicaid managed care arrangements.

Our case studies include four states: Connecticut, Illinois, Maryland and New York. The Illinois and New York case studies are described under carve-outs in Approach A, Maryland is described under self-referrals in Approach B, and Connecticut is described under contract requirements in Approach C. The case studies describe the background and structure of the SBHC model, the process by which the state developed and implemented the model, and the lessons learned in the development and implementation of the model.

Approach A: Carve-Out

This model enables SBHCs licensed by the state to be reimbursed for Medicaid reimbursable services regardless of a patient's managed care status. The SBHC does not participate in the provider network of the Medicaid or SCHIP MCO(s) in which the children served by the SBHC are enrolled. This arrangement allows the agency to receive reimbursement for the provided service to the managed care enrollee. Carved-out services are reimbursed at a FFS rate. Although mental health and family planning are common carve-out services under Medicaid managed care, states may choose any number or type of service to carve out.

Although states may use carve-outs as a permanent strategy to secure funding for SBHCs, carve-outs may also be used as a temporary arrangement that sustains access to Medicaid revenues while more long-term solutions to managed care partnerships are sought.⁸⁴ Illinois and New York⁸⁵

⁷⁹ Armbruster, P. et. al. op cit.

⁸⁰ DHHS, OIG, op cit. footnote 50.

⁸¹ DHHS, OIG, op cit. footnote 50.

⁸² For sample contract language on these reimbursement models, see *Optional Purchasing Specifications: Delivery of School-based Health Center (SBHC) Services Through Medicaid or SCHIP Managed Care*, (January 2002), www.gwhealthpolicy.org.

⁸³ These case studies involved an in-depth review of each state's SBHC Medicaid managed care arrangement. Specifically, we examined the process by which the state incorporated SBHCs into Medicaid managed care. The information included in the case studies were derived from telephone interviews conducted with state informants most knowledgeable about the state's SBHC and MMC environment.

⁸⁴ NASBHC. op cit.

use carve-out arrangements under their states' Medicaid managed care plans, allowing SBHCs to bill the state Medicaid agency directly for services provided to Medicaid enrollees regardless of the students' assigned medical home.⁸⁶

Illinois: Carve-Out Case Study

Background

Illinois describes the structure of its SBHC arrangement as a carve-out or exclusion. Illinois actually has two approaches: a carve-out for some SBHCs and direct contracting for others; there are two SBHC models operating in the state: Type 56 and Federally Qualified Health Centers (FQHCs)/FQHC look-alikes. Fifty SBHCs currently operate in the state: ten SBHCs are Type 56 providers and 40 are FQHC/FQHC look-alikes. The state's carve-out arrangement applies to Type 56 SBHCs only. The model type determines the SBHC's role in the Medicaid managed care approach and determines how the SBHC is reimbursed. Although the models vary, all of the state's SBHCs are Medicaid providers, and must be certified by the Illinois Department of Human Services and meet the Department's Medicaid provider standards.

“Type 56.” Type 56 SBHCs are independent provider types under Medicaid. Type 56 SBHCs have a limited number of reimbursable services they are permitted to provide. These SBHCs are not required to contract with Medicaid MCOs; however, they are required to coordinate with them, which they do by providing unduplicated services and referring children back to their PCPs. This coordination alleviates the concern that the insurer will pay the SBHC for services that are also being provided by the PCP, and it helps maintain the PCP's role as the child's gatekeeper. Type 56 SBHCs bill the state directly for the services they provide, and are paid the lesser of the usual and customary state maximum.

FQHCs/FQHC look-alikes. Forty SBHCs in Illinois are FQHCs/FQHC look-alikes, and are hospital and/or community health center sponsored. These centers are their own provider type under Medicaid and are not part of the state's Medicaid independent provider Type 56 SBHCs. They must subcontract with MCOs to be included in the state's Medicaid managed care arrangement. FQHC look-alike SBHCs receive reimbursement directly from the MCOs. There is no requirement that MCOs contract with FQHC-sponsored SBHCs; any contracting is done on a voluntary basis. FQHC-sponsored SBHCs are reimbursed through their sponsoring organization who negotiates and contracts with the MCO (i.e., reimbursement is made to the FQHC sponsoring organization). No coordination with PCPs is required since the SBHC is designated as the child's PCP. Although the vast majority of the state's SBHCs are under this category, our discussion focuses on Type 56 SBHCs because they are independent providers in Medicaid managed care arrangements.

Structure

⁸⁵ New York is a temporary carve out situation. The state originally intended to implement a contract requirement model once the state went into Medicaid managed care. However, the state's SBHCs are still operating under the carve-out because the state has had difficulty in implementing a contract requirement model. (Information derived from informant interview).

⁸⁶ NASBHC. Issue Brief. Medicaid reimbursement in school-based health centers: State association and provider perspectives. June 2000.

The Illinois Department of Human Services Administrative Code dictates how state-recognized SBHCs are to operate. All SBHCs must meet certain criteria in order to be reimbursed for their services. They must: be an enrolled Medicaid provider; provide the state with a monthly list of their affiliations with MCOs;⁸⁷ and meet certification requirements established by the Illinois Department of Human Services.

Process

A working group comprised of local and state agencies, MCOs, school-based agencies, and the maternal and child health coalition worked together to develop language to include SBHCs in the state's Medicaid managed care arrangement. Initially, managed care organizations did not think that SBHCs were comprehensive enough or had high enough standards of care required for inclusion in their networks. MCOs resisted SBHC inclusion because they did not want to be held liable for any mistakes made by SBHCs. The standards of care developed and implemented by the working group made Type 56 SBHCs a separate, distinct, and identifiable service that collaborated with PCPs rather than an organization that contracted with an MCO. MCOs accepted this arrangement and agreed to the inclusion of Type 56 SBHCs.

The inclusion of SBHCs was made more palatable to constituents when the state mandated parental consent for children treated at SBHCs.⁸⁸ The criterion for SBHC inclusion involved regulatory requirements on privacy protections, quality assurance requirements, and parental consent and involvement.

PCPs supported SBHC inclusion in MMC after the state clearly defined SBHCs' reimbursable services. Originally, most PCPs were reluctant to give their support because they feared service duplication and migration of patients to the SBHC. While all SBHCs provide some primary care services (since the state recognizes them as safety-net providers), Type 56 SBHCs do not participate as PCPs. Illinois law states that Type 56 SBHCs are to be expedient in treating children and coordinate efforts to get them back to their primary care provider; on-going collaboration is expected. This language in effect minimizes the duplication of services between the PCP and the SBHC.

Lessons Learned

The process of SBHC inclusion has resulted in collaborative efforts throughout the state. Illinois has been very successful in building collaborations; these collaborations have enabled the state to include SBHCs in a comprehensive healthcare delivery system. Stakeholders' efforts to recognize and include SBHCs in Medicaid managed care resulted in the formation of The Coalition for School-based Health Centers, a state advocacy group for SBHCs. MCOs want to work with SBHCs, since SBHCs will help them meet the state mandated EPSDT rate.

PCPs and MCOs originally resisted the inclusion of Type 56 SBHCs but relented once they were able to identify the SBHCs' reimbursable services and understood that they would not be duplicating services. The most important ingredient in developing this approach is a strong coalition of SBHCs working very closely from the beginning with all stakeholders in order to figure out what

⁸⁷ In accordance with their model type, SBHCs either subcontract or coordinate with MCOs.

⁸⁸ Legally, there are some statutes that do not require parental consent for treatment (e.g., substance abuse, mental health and family planning services). In those cases, legal statutes are considered before the state's policies.

works for them. Having very strong standards of care, ongoing monitoring and linkage requirements are also essential. In addition, there needs to be someone continually facilitating the on-going collaboration between PCPs and MCOs. All of these factors affect the general acceptance of SBHCs' inclusion in Medicaid managed care arrangements by all the parties involved.

New York: Carve-Out Case Study

Background

New York has 162 SBHCs that serve about 120,000 children, approximately half of whom are Medicaid enrolled. New York currently has a carve-out arrangement for school-based health services statewide. Under the carve-out, SBHCs bill Medicaid directly for services delivered to children enrolled in managed care plans. At the time of our interview, the state was planning to implement a contract requirement that would require Medicaid MCOs to contract with SBHCs. This case study describes the current carve-out arrangement and discusses the state's efforts to transition to the contract requirement.

Structure

New York's carve-out arrangement allows SBHCs to provide services to Medicaid enrollees and bill Medicaid FFS. Carve-out services include but are not limited to comprehensive and follow-up exams. Although SBHCs have been issued two separate Medicaid rate reimbursement codes for those services, they are required to treat all children registered regardless of their payment source. SBHCs obviously encourage families to obtain insurance coverage; however, no child is denied care.

Process

New York applied for a Medicaid 1115 waiver in 1995, which provided an opportunity to include SBHCs in managed care arrangements. The motivation behind the inclusion was to ensure that SBHCs would be an access point for children needing health services. Those who collaborated in the effort included representatives from SBHCs, managed care plans, trade organizations carrying the plans, practitioners, SBHCs' sponsoring institutions⁸⁹ (e.g., hospitals, CHCs), billing and financial representatives, the state mental health agency, as well as others from the state health department. Informants reported that there was some resistance to involving SBHCs in the managed care arrangement, primarily due to widespread misperceptions and lack of knowledge of the role SBHCs play in health care delivery.

New York's 1115 waiver included SBHCs in the managed care program and required contracting between SBHCs and managed care plans. It took several years to work out the details of the plan, as the early planning stages were difficult. The state had to work with both the SBHCs and the managed care plans to move toward their objective of including SBHCs in Medicaid managed care.

⁸⁹ An SBHC cannot be independent; it must be sponsored by a hospital or community health center.

Structural Constraints

A number of work groups in New York have been convened over the past five years to study contracting. As a result of many meetings between SBHCs, managed care plans, state agencies and other interested parties, a model contract was developed with the help of a consultant. However, contract arrangements between SBHCs and MCOs were never made because of complications involving the numerous plans and the mobility of school age children. During contract planning the state realized that requiring MCOs to contract with SBHCs would be an enormous task because of SBHCs' need to contract with multiple plans. New York City's SBHCs alone contemplated contracting with 30 plans. More than half of New York's SBHCs (about 100) were operating in New York City. Contracting between 30 managed care plans and 100 SBHCs meant multiple contracts for the state. In addition to the multiple plans, there was also the issue of families choosing to send their kids to schools in other boroughs. For example, a child living in the Bronx could chose to attend a school in Manhattan. However, the plan operating in the Bronx where the family lives may not include Manhattan in its service area. Thus the question was how the school would get reimbursed for services given to that child.

Lessons Learned

There were many complications in New York in the development of contractual relationships between Medicaid MCOs and SBHCs. For example, how students utilize services in SBHCs made it difficult to implement managed care arrangements. In addition to utilization issues, MCOs are concerned about SBHC staff qualifications. In most cases, the SBHCs were staffed by NPs; however, plans wanted physicians supervising the NPs. Other SBHCs had physician's assistants staffing the center and most plans do not allow physician assistants to be PCPs.

Credentialing, logistics, 24 hour, 7 day a week service, and questions concerning what happens when the school is closed were all issues to be considered. These issues have resulted in an extension of the state carve-out model for SBHCs. The NY School-based Health Center Coalition educated the state legislature and the governor's office to continue the carve-out because they felt it was in the SBHCs' best interest.

Another major problem has been rate negotiation between SBHCs and MCOs. The MCOs were willing to contract with the SBHCs as PCP and pay them a capitation rate, but SBHCs were not receiving referrals from MCOs and parents were not choosing SBHCs as their child's PCP. Although SBHCs offer another source of primary care for families, parents do not consider the SBHC as a PCP option.

The role of SBHCs in managed care was originally unclear in NY. Informants reported that MCOs and SBHCs could not reach a consensus. One possible SBHC role was that of the auxiliary provider who would work in collaboration with the child's PCP. Guidelines and protocols were established for coordination of services, but nothing was satisfactory to all parties. Consequently, the state continued with the carve-out model that had already been established and continued to work with the MCOs and SBHCs to find ways to help them coordinate services. Meetings between MCOs and SBHCs helped establish a mutual respect and understanding for each other's roles.

Although there has been considerable progress in bringing MCOs and SBHCs together to understand each other, informants report that many outstanding and unresolved issues still remain (e.g., SBHC staff credentials, logistics, 24 hour, 7 days a week service, and collaboration with PCPs). Despite the problems and falling back to the carve-out approach, the state still intends to implement the contract requirement in the future.

Approach B: Self-Referral

This model allows adolescents to self-refer to the SBHC for a prescribed set of acute care and follow-up visits. The chief objective of this policy is to keep the primary care functions (and its reimbursement) within the medical home and allow the SBHC to serve as an acute care provider. The SBHC does not participate in the provider network of the Medicaid or SCHIP MCO(s) in which children served by the SBHC are enrolled. In addition, the SBHC does not receive direct payment from the state, but rather the state mandates that the MCO make payment to an out-of-network SBHC for the services it provides to children enrolled in the MCO. SBHCs are reimbursed by the health plans on a FFS basis.⁹⁰

Maryland: Self Referral Case Study

Background

Maryland's SBHC system is unique among the states in the way it was developed and in its current structure. Although Maryland's SBHCs have existed since 1985, SBHC activities were not overseen by the state until 1996. Maryland's SBHC originally developed on a local level without state guidance or oversight, and continue to grow on a local level. However, the state is in the process of standardizing SBHC activities. The process has been slow because the state is working with local jurisdictions used to operating and controlling their own SBHCs.

There are a total of 64 SBHCs throughout the state. Each operates differently depending on the influence of the various jurisdictions, sponsorship, structure, and funding. Baltimore City SBHCs have the most stable funding; they have existed the longest and receive the majority of the state's Title V MCH block grant dollars used to fund SBHCs. Twenty-eight SBHCs are located in Baltimore City alone. The city Public Health Department operates 21 of them, two are associated with a FQHC, three are in schools for parenting or pregnant teens and are operated by the University of Maryland's School of Nursing, two are operated by Maryland General Hospital.

Structure

Medicaid managed care organizations must reimburse the SBHCs for four self-referred acute care visits and four follow-up visits per semester, per student. No prior authorization requirement is needed for these four visits. The language of this state rule is often interpreted incorrectly by MCOs because some schools do not have semesters, but in general, a Medicaid eligible child can receive eight acute visits and eight follow-ups during a school year.

⁹⁰ HRSA. op cit.

In contrast to other states like New York and Connecticut, Maryland does not have standards or credentialing for its SBHCs. Maryland has found it difficult to create standards because the SBHCs are locally run, independent and vary greatly in operation. Informants reported that a base of state dollars would be needed as leverage to require SBHCs to meet standards of care, obtain credentialing, and meet quality assurance standards. The state is moving toward creating a standard definition for SBHCs, standards of care, and quality assurance programs, and will also conduct active site reviews. SBHCs will be in a better position to contract with MCOs once this is done. SBHCs can be valuable additions to MCO networks, especially in light of the recent problems encountered by Maryland's MCOs. Maryland holds MCOs to very strict quality assurance standards and data requirements. The MCOs were sanctioned last year for not meeting standards set by the state. This creates opportunities for SBHCs to demonstrate how SBHCs can help MCOs meet those standards of care.

Support for SBHC services varies across providers and MCOs. Many PCPs are extremely pleased with the structure of SBHCs. They view SBHCs as an extension of primary care services provided through the schools. Some practitioners even co-sponsor NPs in SBHCs who work part-time in the practitioner's office and part-time in the SBHC. Informants reported that not all PCPs support SBHCs as providers of care because some providers believe that all care should be received in the PCP's office. Informants also reported that some pediatricians threatened to refuse treatment if a child continually seeks care from the SBHC, and that some MCOs have written letters to families urging them not to enroll their child in an SBHC. Some practitioners are selective in their support depending on services provided by the SBHC. For example, although some practitioners do not want SBHCs to provide primary health care, they do support SBHCs' provision of mental health care services. This is because they recognize the value of receiving mental health care in a timely manner from conveniently located SBHCs.

Preventive dental health has been a success in SBHCs with the exception of fillings, crowns, and other invasive dental work that requires analgesic, anesthetic medication (e.g., tooth extraction). For example, dental healthcare services provided in elementary schools include sealants, fluoride treatments, and cleanings.

Process

Informants reported that some MCOs are concerned about Maryland's self-referral arrangement for SBHCs. MCOs believe that the schools are receiving duplicative payments because the MCO is paying PCPs to provide care in addition to SBHCs who bill the MCO for seeing the same children. Furthermore, MCOs have no control over SBHCs because they are out-of-network providers. MCOs may reason that the self-referral process negates gatekeeping and puts the MCO at a disadvantage. For these reasons, MCOs have implemented a mechanism to track SBHC utilization and billing. However, in spite of this initial resistance from MCOs, the political climate for SBHCs is currently very positive.

Lessons Learned

One of the major issues Maryland SBHCs have had difficulty with Medicaid managed care has been around reimbursement. Developing the SBHC payment arrangement was a very contentious process, and it has impacted the relationship between MCOs and SBHCs. Issues regarding timely payments, claims denials and the amount of paperwork required for reimbursement are concerns for SBHCs. Reimbursement rates are pre-set; SBHCs have two days to submit claims and MCOs must

reimburse within 60 days (which is currently not happening). Informants reported that the amount of reimbursement received from the MCOs covers one to two percent of the operating costs of SBHCs statewide. In general, although SBHCs have a defined scope of reimbursable services, these SBHCs do not want their services to be driven by the reimbursement stream. Another SBHC reimbursement concern involves the MCO coding system. Informants reported that the ICD and the CPT codes on SBHC claims must match what the MCO has on its self-referred list. Otherwise, the SBHC will not be reimbursed.

Communication and understanding the “language” of each organization is essential to MCO-SBHC linkages. State officials have found that many differences exist between MCOs and SBHCs. Informants reported that MCOs are viewed as businesses that provide care through cost controls, while SBHCs are viewed as public health organizations to increase access to care.

There is no consensus on the role of SBHCs in Maryland; however, state officials believe that SBHCs should not serve as PCPs. State officials also believe that one of the goals of SBHCs should be to connect children and families to the health care delivery system. The SBHC serves as a point of education; they teach families and children the importance of seeking preventive health services and how to find it in the community.

Approach C: Contract Requirement

Under this approach, Medicaid managed care organizations are required to contract with SBHCs so that the SBHC can be reimbursed for services delivered to the MCOs’ enrollees. MCOs must subcontract with any willing SBHC that serves children enrolled in the MCO. Because the SBHC is not party to the contract between the MCO and the state, the contract cannot compel the SBHC to participate in an MCO’s provider network.

Many barriers to contracting have already been discussed in previous sections of this report; however, it is important to underscore the difficulties that SBHCs have encountered during the contracting process. Simply mandating that MCOs contract with SBHCs does not guarantee that a contract will be negotiated or that negotiated contracts will be in good faith.⁹¹

SBHCs acquire many new tasks when contracting with MCOs. Obtaining pre-authorization for services, billing and tracking payments, and maintaining and transmitting data to the health plan as well as the child’s PCP (if the SBHC is not designated as such) all while still ensuring patient confidentiality are tasks unfamiliar to SBHCs. The contracting process itself is new to SBHCs, who may require a great deal of technical assistance in this area. It appears the easiest route to SBHC inclusion is sponsorship by a larger organization that will assume responsibility for these tasks, thus relieving the SBHC of the responsibility and keeping its resources directed toward care provision.

Although a state may mandate contracting between SBHCs and MCOs, details of that contract are determined individually. When negotiating contracts, it is helpful for SBHCs to have data to demonstrate their utility to MCOs. For example, MCOs in Massachusetts requested SBHC data on visits, diagnosis, and explanations why students chose SBHCs over their own Health Maintenance Organization (HMO) providers before even considering contracting with SBHCs.⁹² Unfortunately,

⁹¹ Informants reported that many negotiated contracts have narrowly defined scope of services, which may mitigate the benefits of SBHC inclusion in the managed care network.

⁹² Hacker, K. op cit.

most SBHCs do not have data systems that are sophisticated enough to supply this data or to integrate with an MCO's data system after contracts are negotiated.

SBHCs located in areas that have more than one MCO face another set of problems. SBHCs must remain aware of the difference in each negotiated contract because each MCO has its own criteria for inclusion (e.g., licensing, credentialing, procedures, expectations, scope of services).⁹³ Listed below are recommended guidelines on SBHC contracting developed by the Center for Health Care in Schools:

- Stipulate the relationship between the MCO and SBHC;
- Provide the framework for the clinical and administrative relationship among MCO, PCP, and SBHC;
- Clearly identify services (e.g., PCP or specific reimbursable services);
- Describe procedure and schedule for submission of clinical data from SBHC to MCO and PCP;
- Specify that the sponsor permits the MCO and state Department of Health access to medical records; and
- MCOs may reimburse sponsors for SBHC services through a negotiated fee for service rate schedule, a capitation arrangement or another mutually agreed upon arrangement. The terms of any of those arrangements should be equivalent to what the MCO offers to other providers delivering similar services.⁹⁴

The scope of an SBHC's reimbursable services is a critical element of the contract. Many SBHC services are non-reimbursable, especially those related to mental health. Frequently mental health compromises between 25 and 50 percent of the services utilized by SBHC enrollees and is generally uncovered by Medicaid managed care.⁹⁵ Example 4 below shows sample state contracting requirements.

⁹³ MCOs cited improved immunization levels and fewer emergency room visits because of the ability of the SBHC to provide urgent care as the principal advantages of including SBHCs in their network. Honig, M. op cit.

⁹⁴ Making the Grade. School-based health centers-managed care: Guidelines for contracting with managed care. Available on-line www.hfni.gsehd.gwu.edu/%7Eemtg/sbhcs/papers/Nycontract.htm.

⁹⁵ 1998-1999 SBHC Census. NASBHC.

Example 4- Sample State Contract Requirements

Connecticut, Delaware, Massachusetts, New York: While avoiding any explicit guarantees to SBHCs, these states have used the state contracting process to require managed care plans serving Medicaid beneficiaries to contract with SBHCs located in their service area.

Minnesota: MinnesotaCare, Minnesota's Medicaid managed care program, requires all MCOs to develop action plans for addressing the health care needs of adolescent enrollees. In addition Medicaid providers under the prepaid plan must offer contracts to community clinics and public health departments. Health Start (operates SBHCs in St. Paul) successfully negotiated comprehensive fee for service contracts with all plans serving Medicaid beneficiaries in its service area and is also contracting with two plans for commercial enrollees. This income only represents 20 percent of the combined operating budget for 7 centers.

West Virginia: The state established a financial incentive of up to two percent in additional capitation payments for plans to contract with public health providers, including SBHCs.

Source: Schlitt, J., Graham-Lear, J., Ceballos, C., Chuckovich, D., Hacker, K., Hazzard, K., Johnston, K., Rosenthal, B., Zimmerman, D. School-based health centers- Financing school-based health centers and managed care: Seven school-based health center programs forge new relationships. Washington DC: Making the Grade. 1996.

Incentives for MCO/SBHC Linkages

SBHCs can be assets to managed care plans. SBHCs provide the MCO with a network capable of furnishing prompt services or coordinating care in non-traditional locations.⁹⁶ SBHCs seem to have a synergistic effect for adolescents enrolled in managed care in providing comprehensive health supervision, primary and mental health care and in reducing after-hours (emergency or urgent) visits.⁹⁷

SBHCs can help MCOs meet the quality and access standards required of Medicaid MCOs (e.g., EPSDT requirements) and they can even educate enrollees on the proper use of medical care. Moreover, SBHCs ensure prompt access to medical care and thereby prevent costly intervention due to delayed treatment. The ultimate outcome of SBHCs' improved access is expected to be increased utilization that will lead to changes in adolescents' health status and health related behaviors.⁹⁸

As we previously stated, the location and convenience of SBHCs may increase utilization and thus raise the MCOs' expenditures. SBHCs must be able to justify increased utilization through supportive data (e.g., decreased ER visits, increased EPDST rates). SBHCs that use a data management system are in a better position to present data on their enrollees and answer MCOs' questions on utilization patterns, diagnosis and patient demographics.⁹⁹

⁹⁶ Rosenbaum, S. op cit.

⁹⁷ Ibid.

⁹⁸ Brindis, C., et al. op cit.

⁹⁹ Hacker, K. op cit.

SBHCs are encouraged to follow three guidelines to building a successful partnership with an MCO: 1) understand the MCO perspective; 2) market the centers' strengths; and 3) collect, analyze and use data.¹⁰⁰ The prospects of successful relationships also appear to be higher when they are strongly influenced by a state agency that requires or encourages the contracting process, and by an effective state SBHC association that can educate members and health plans. Ultimately, participation in the MCO network rests on the SBHCs' ability to meet MCO industry quality standards, and on their ability to clearly define themselves as valid and valuable candidates for provider networks.¹⁰¹

Connecticut: Contract Requirement Approach

Background

Connecticut uses a contract requirement for including SBHCs in their Medicaid managed care arrangement. The state received a Robert Wood Johnson (RWJ) Making the Grade grant while applying for a Medicaid 1915(b) waiver to allow them to include SBHCs in their Medicaid managed care arrangements. The RWJ grant was the impetus for developing a method to secure long-term financing for SBHCs. The state's policy efforts (e.g., 1915(b) waiver, legislation) culminated in the state's contract requirement. During the 1998-1999 school year there were 18,000 students seen and 73,000 visits provided by SBHCs in the state.

The Connecticut Department of Public Health began funding SBHCs in the mid-1980s with either Title V MCH Block Grant funds or appropriated funds from the state legislature. At that time, there were only four SBHCs in the state. Currently, there are 57 fully operational SBHCs and three that are in the developing stages all of which are funded by the Department of Public Health. Six additional SBHCs are funded by other funding streams such as city funds, community health centers, and private foundations.

The state implemented mandatory Medicaid managed care in 1995. The state named SBHCs as the only safety net provider and mandated that managed care plans contract with them. In effect, the plans and SBHCs went from having absolutely no relationship into a mandated arrangement by the state in 1995-1996. Connecticut's contract requirement was a big change for the state since SBHCs were previously prohibited from billing Medicaid because of potential "double-dipping" in state Medicaid dollars. Connecticut initially thought that state grant funds would sufficiently sustain SBHC sites; however, cost of living increases and other factors made it clear that grant funds were not enough. It also became clear that "double-dipping" was not a real threat since a number of SBHCs services are not billable to Medicaid. The Connecticut Department of Public Health worked with the state Department of Social Services for several years to develop changes in regulations to permit SBHC to bill Medicaid for services.

¹⁰⁰ Schlitt, J., Graham-Lear, J., Ceballos, C., Chuckovich, D., Hacker, K., Hazzard, K., Johnson, K., Rosenthal, B., Zimmerman, D. School-based health centers- financing school-based health centers and managed care: Seven school-based health center programs forge new relationships. Washington DC: Making the Grade. 1996

¹⁰¹ Making the Grade and The National Assembly on School-Based Health Care. The New Child Health Insurance expansions: How will school-based health centers fit in? A report from a workshop sponsored by Making the Grade and NASBHC. June 1998.

Structure

Connecticut has developed a comprehensive model for SBHCs based on primary/preventive physical and behavioral health care, as well as health education. Each center's staff includes an advanced practice medical provider (APRN) or physician assistant, and a master's level-prepared mental health clinician licensed by the state. Sites that are not funded by the state, as some SBHCs are sponsored by private organizations, do not have to follow this model. The state has also developed standards for all SBHCs, making relationships with MCOs easier to establish. The state conducts yearly site visits and requires SBHCs to document their quality assurance measures.

Process

Prior to 1997, MCO contracts with the state often limited the number of reimbursable SBHC services as well as required preauthorization for many services delivered by SBHCs. To fix this problem, the Connecticut Department of Social Services, during MCO contract renegotiations in 1997, included contract language requiring MCOs to "pay for all reimbursable services as appropriate."¹⁰²

When Connecticut first mandated contracting with MCOs, there were 13 MCOs in the state. Because several of the MCOs carved-out services such as dental and mental health to other MCOs, health services organizations had to contract with multiple MCOs to cover primary and ancillary services. In some cases, SBHCs had to sign 20 contracts to be able to provide comprehensive services. Contracting with multiple MCOs complicates credentialing requirements; SBHCs contracting with multiple MCOs are required to adhere to the different provider credentialing procedures of each. These problems have lessened in degree since the state now only has three Medicaid managed care plans.

SBHCs are expected to develop relationships with PCPs and refer children to them for care. Communication between PCPs and SBHCs promotes continuity of care and reduces the possibility of duplicating services. To ensure that interaction is taking place the state requires SBHCs to document how they coordinate with community providers. Informants believe that children receiving services from both providers may experience a greater range of services because SBHCs provide many enabling services, such as assistance with enrollment in SCHIP and Medicaid, that may not be available from the PCP.

Contracts between MCOs and SBHCs are confidential, however the Connecticut Department of Public Health and the Department of Social Services have helped to facilitate discussion between the two entities. Both departments have also surveyed MCOs and SBHCs to uncover barriers to developing contracts in addition to providing hands-on technical training to SBHCs in the contracting process.

Lessons Learned

The state offered contracts to any MCO that submitted a complete application; it was not a competitive process. However, it took time for MCOs to become comfortable with the SBHC contract requirement. For SBHCs, billing, confidentiality, and care coordination are the biggest concerns when including SBHCs into managed care arrangements. Billing third party payors has been difficult for

¹⁰² Information quoted from informant interviews.

SBHCs who often do not have the time and resources to devote to completing paperwork and tracking payments. Billing also presents a problem for SBHCs who are reluctant to share information with health plans for fear of compromising patient confidentiality. Confidentiality is a sensitive issue for adolescents when receiving family planning and mental health services. In general, adolescents report that confidentiality in these two areas is of utmost importance to them. Even sending denial of service letters can be problematic when trying to keep the request for the service confidential. In addition, care coordination becomes an issue when the child's needs go beyond what can be provided in the SBHC and there are not enough network providers to refer children.

Other Models

Although we have discussed three particular Medicaid managed care SBHC models in detail; there are many other methods states may use to secure funding for SBHCs. Other state strategies are briefly described below:

Market Approach: The state defines the SBHC as an essential service. Thus, the state can specify that an MCO is authorized to serve an area with more than a certain percent of Medicaid enrollment, and it must include SBHC services as part of their Medicaid contracts.¹⁰³

Pool Fund Approach: The state assumes direct responsibility over SBHC programs, determines the SBHC budget, and creates a "fund to pay for a specific number of centers by pooling money from a variety of sources." The project is administered by an appropriate state agency.¹⁰⁴

Private HMO/SBHC Partnership: This arrangement is not regulated or encouraged by any state agency but is an independent arrangement between a commercial managed care organization and one or more SBHCs. Colorado's Kaiser School Connections Program is an example of this type of arrangement. Although the state strongly encourages managed care organizations to contract with essential community providers (school-based health centers are included as ECPs), there is no state law mandating it.

CONCLUSION

The number of SBHCs in the United States continues to grow rapidly. The literature repeatedly demonstrates the value of SBHCs as significant points of access for both the uninsured and insured school-age population. One particular population where access is increased is with adolescents, and their use of mental health services.

SBHCs have engaged in various formal and informal arrangements with different organizations that have assisted them with reimbursement mechanisms. However, the inclusion of SBHCs into the mainstream health care delivery system has been impeded by several factors, including the lack of a

¹⁰³ Making the Grade National Program Office and Rosenberg & Associates. Issues in financing school-based health centers: A guide for state officials. September 1995.

¹⁰⁴ Ibid.

standard definition, scope of services and staffing. This variation makes it difficult for SBHCs to develop relationships that will provide for long-term financing, particularly MCO contracts.

States realize the importance of SBHCs and have employed various short-term funding strategies. SBHC inclusion in Medicaid managed care provides a long-term financing mechanism for SBHCs that have been traditionally funded through grants and state appropriations. States have used various methods to include SBHCs in Medicaid managed care arrangements, such as legislation or encouragement of MCO-SBHC linkages or strongly encouraging MCO-SBHC linkages. However, implementation of laws and inducements have been difficult primarily because of the philosophical differences between managed care and SBHCs. The primary interests of both MCOs and SBHCs differ in that SBHCs seek to increase access and address the needs of students while MCOs seek to contain costs and serve only those who are in their service plan.¹⁰⁵

The key to SBHC inclusion into mainstream funding mechanisms, primarily third party reimbursement and thus their viability appears to be the SBHC's ability to demonstrate how they benefit and enhance provider networks. Producing data that demonstrates the SBHC's ability to increase immunization and EPSDT rates while decreasing ER visits is only one example of ways that SBHCs can demonstrate utility. Producing data will require resources that have not been readily available to SBHCs, which may require SBHCs to augment current practices and allocate available resources differently (e.g., obtaining preauthorization, billing third party payors, tracking utilization and payments, increasing efforts to enroll Medicaid eligibles, finding out which students are insured and billing their insurance) if they intend to operate in the mainstream environment.

While the literature reveals numerous funding strategies states have used to fund SBHCs, the most logical source of continuous SBHC funding is the Medicaid program, since a large proportion of the SBHC population is either Medicaid enrolled or eligible. The penetration of managed care in Medicaid necessitates that SBHCs not only learn how to operate under Medicaid but also in a managed care environment. SBHCs are already an important component of the nation's safety net, and their incorporation into mainstream delivery and funding systems would be a valuable addition to the national health care delivery system.

¹⁰⁵ Armbruster, P. et al. op cit.

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