School-Based Health Centers and Managed Care

John Schlitt

National Assembly on School-Based Health Care

Historical Context for SBHCS: 20-30 years ago

- **School-aged children had limited access to insurance and health care services; indications of untreated illness.**
- **Fee-for-service was dominant payment mode, but it didn't matter anyway because we didn't concern ourselves with insurance status.**
- **Small # of communities and foundations seeking creative alternative access points for school-age kids.**

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All in all…

A most pleasant era when 1115, 1915b, PMPM, PCCM, CQI, and medically necessary weren't yet part of our lexicon.

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SBHCs Expand

- **By 2000, an estimated 1380 SBHCs are reported operating in 45 states**
- **Geographically dispersed across urban, rural, and suburban communities**
- **Movement into middle and elementary school settings**
- **$62 million directed by state government**

Center for Health and Health Care in Schools, 2001

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Simultaneously, another access strategy emerges

- **Commitment to improving access for low-income children of all ages (0-18 yrs)**
- **Twin goals of providing medical home and achieving cost-savings through utilization control**
- **By late 90s, more than half of Medicaid beneficiaries are in managed care**
- **S-CHIP increases potential for greater number of insured school-aged youth**

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Policy Intersection?

- **What role should SBHCs play as primary care providers in a managed care environment?**
- **From the MCO perspective, is there value added in an access program with a comprehensive, preventive focus?**
- **How will information be exchanged between SBHCs and PCP to ensure continuity of care?**
- **How will SBHCs be reimbursed for care?**
- **Will intersection occur naturally or otherwise?**

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Seminal Events

- **St. Paul's Health Start and HealthPartners provide early model of collaboration**
- **1993 OIG Report documents earliest known SBHC/MCO relationships; strikes an optimistic tone for future**
- **1994 RWJ's Making the Grade national program takes aim at state policy to support SBHCs; managed care quickly dominates the agenda.**
- **1115/1915b waivers on fast track**

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Seminal Events

School Health Policy Initiative

1995 work groups

- Described three relationships (specialty provider, primary care gatekeeper, co-manager of PC)
- Established seven principles as guidelines for structuring relationships

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Seminal Events

- **New York convenes work groups; provides SBHC exemption for MC**
- **Connecticut issues managed care RFP requiring contracts between SBHCs and MCOs**
- **Maryland allows adolescents to self-refer to SBHCs**
- **Illinois/North Carolina create SBHC certification process to guarantee reimbursement under MC**

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NASBHC Assesses Impact

Regional Provider and Payer Roundtables

- Education about each of the partners is critical
- Ill-equipped programs bear administrative burden of contracting/billing
- Data/communication technology challenge SBHCs as co-providers
- Scope of service more narrowly prescribed by plans

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Positive Impact

- Forcing field to define standards
- Creating attention to accountability, performance measures
- Certification, licensure and credentialing are byproducts
- Introspection/compelling clarity about our role in health care system.

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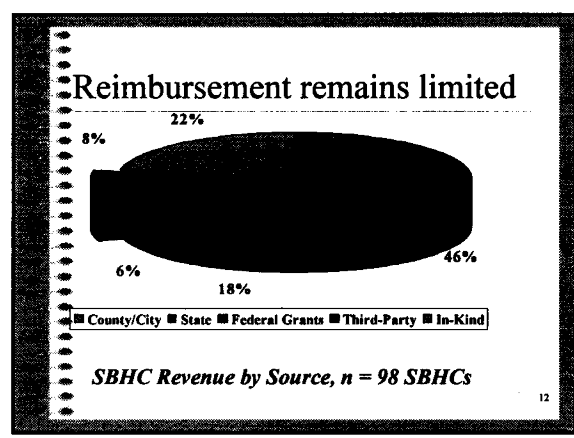
Reimbursement remains limited



SBHC Revenue by Source, n = 98 SBHCs

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Opportunities

- EPSDT goals (OBRA 97)
- Quality assurance goals related to access, utilization, satisfaction
- Growing advocacy/awareness re: health and mental health needs of youth

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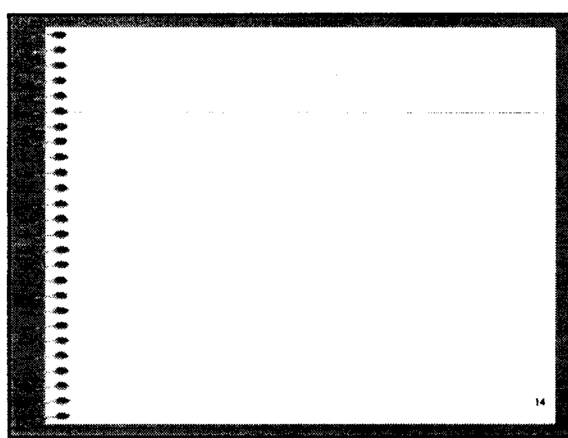

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MEDICAID REIMBURSEMENT FOR SCHOOL-BASED HEALTH CENTERS

Wendy Leader Johnston
Florida Medicaid
Tallahassee, Florida

Medicaid Basics

Each state develops its own unique program within limitations of the mandatory/optional services outlined in Title XIX of the Social Security Act.

- Broad discretion to operate within federal guidelines
- Placement of school-based services

For more information, refer to HCFA publication "Medicaid and School Health" August 1997.

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Medicaid State Plan

- State's contract with HCFA to ensure federal dollars
- Allows state to develop both unique program coverages and reimbursement methodologies

Policies:

- Freedom of choice
- Amount, duration and scope
- Statewideness
- Confidentiality
- Provider qualifications

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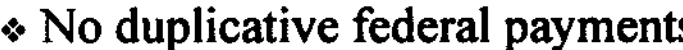
Reimbursement Issues



- No duplicative federal payments
- School-based centers affiliated with
  - FQHCs / Community Health Centers
  - Hospitals
- Title V – Health Departments

HMOs = Capitated

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Certified Match

- ✓ School districts and Health Departments (Title V agencies) contribute local and state dollars that permit Medicaid to receive federal dollars for services performed at schools.
- ✓ Without having to transfer dollars to Medicaid, the school district and the Health Departments certify that they have the state match and are eligible to receive the federal dollars as payment for services.
- ✓ Federal match rates vary from 76% to 50%.

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Free Care Issue

Medicaid cannot be billed for services that are provide free of charge to the general population.

Two Exceptions:

- Medicaid eligible children receiving health related services provided under Part B or C of I.D.E.A. (I.E.P. specific)
- Title V Agencies (Health Departments) can serve al Medicaid eligible children regardless of I.E.P. statu

I.D.E.A. – Individuals with Disabilities Education Act
I.E.P. – Individualized Education Plan

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Determining Who is Medicaid Eligible

School districts have the ability to do an online data match with the Medicaid Eligibility System. Health Departments can work with their local school districts to develop mechanisms to share this eligibility data.

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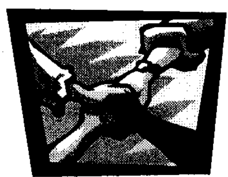
Partners

- ☑ Title V – Health Departments
- ☑ Department of Education / School Districts
- ☑ Medicaid
- ☑ Legislature
- ☑ HMOs
- ☑ HCFA



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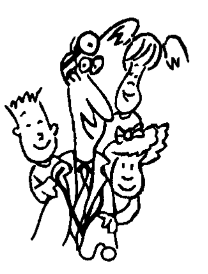
Managed Care Options

- ➢ Carve out
- ➢ Work with HMO
- ➢ Part of HMO panel
- ➢ Gatekeeper



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Billing Issues

- EOB (Explanation of Benefits)
- Recoupment
- Documentation
- Procedure code
- Insurance forms

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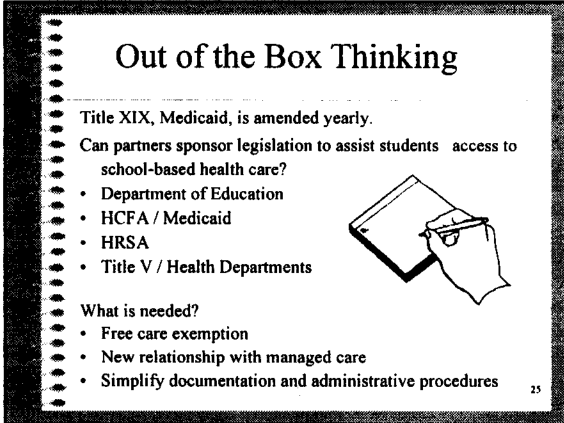
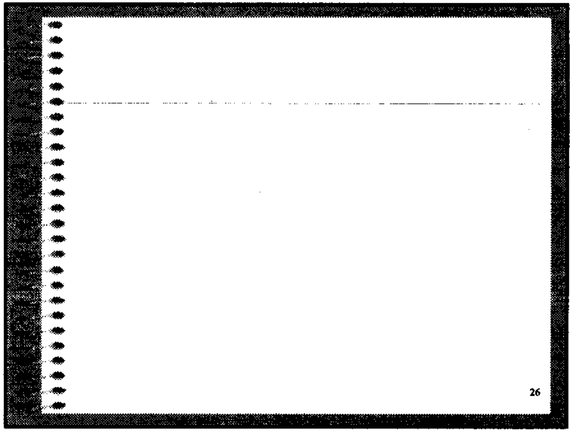
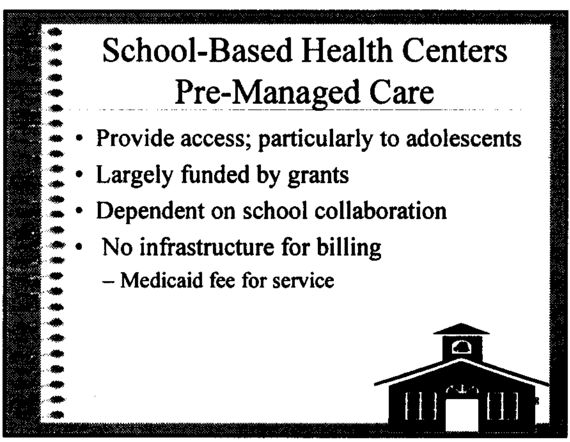




School-Based Health Centers Face Managed Care

Karen Hacker, MD MPH
Division Director
Division of Child and Adolescent Health
Boston Public Health Commission



Medicaid and Managed Care

- Waivers-1115, 1915b
- Where are/were school-based health centers?
  - Waived or carved out services
  - Essential services/ public health services
  - Community health centers
  - Out-of-network services requiring approval

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Impact of Managed Care on SBHCs

- Erosion of medicaid dollars
- Pressure from government funders to conform to managed care
- Fast Forward plan for accessing dollars
- Transforming mission

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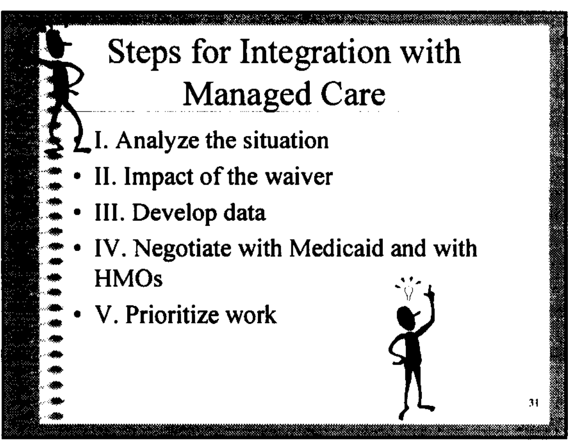

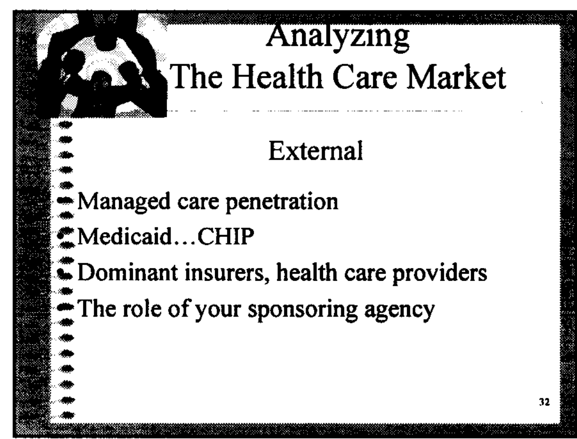

Internal

- School population insurance mix
  - public
  - private
- Dominant primary care provider
- Percent uninsured

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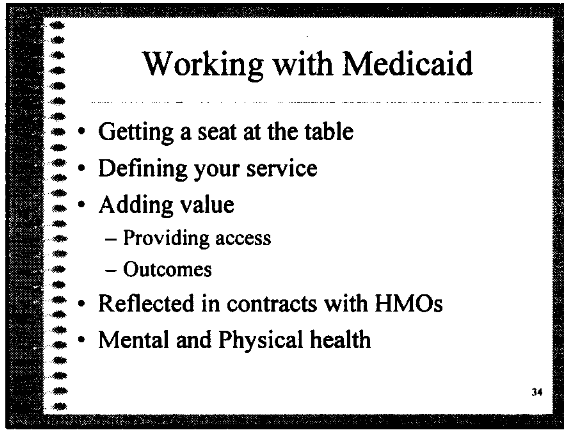

Building Relationships with HMOs/Insurers

- Negotiate relationships
  - data about shared population; visits, ICD9 codes, emergency use, referrals
- What is your value added?
- Where is the pressure to collaborate?
- What can and will be paid for?
- How will it get paid

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Issues for SBHCs

- administrative capacity
- data
- small shared population
- no outcomes; ie impact on HEDIS measures

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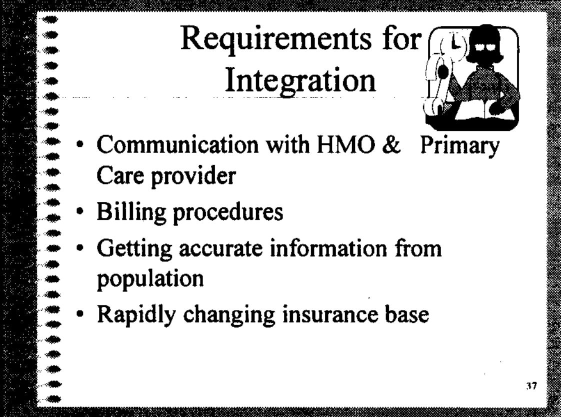

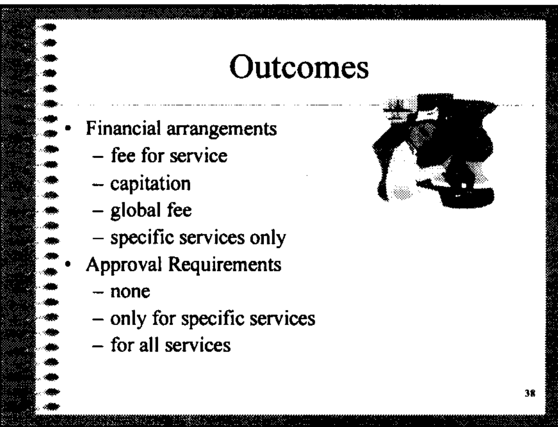

Impact on care/access

- High need for administrative support
  - bill insurer
  - receive reimbursement
  - train staff
- Unequal treatment depending on insurance

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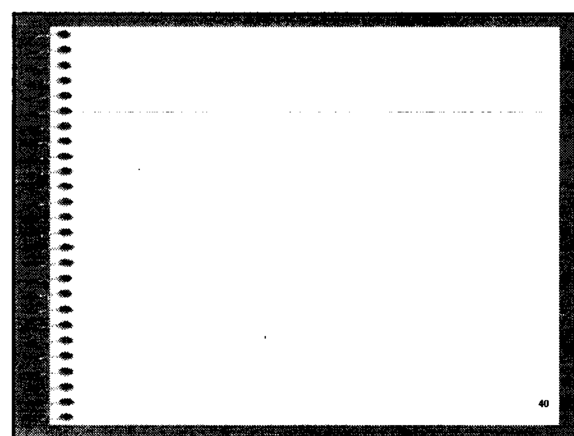

Including School Based Health Centers in Managed Care Networks

Sue Luce
BlueCross/BlueShield of the Rochester Area

Background

- BCBSRA Medicaid managed care since 1988 - Mature managed care market - IPA model
- 36,000 Medicaid managed care enrollment
- 17,000 Child Health Plus enrollment
- NYS has 1115 waiver with mandatory enrollment
- Currently SBHCs carved out of managed care
- NYS wants SBHCs in managed care networks

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Major Questions

- Who/What are SBHCs?
- Do SBHCs add value to the managed care network?
- Can SBHCs meet MCO contracting requirements?
- Is there a value in SBHCs contracting with MCOs?

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Who/What are SBHCs

- MCOs frequently in the dark as to who SBHCs are and what they do
- Important for SBHCs to educate and develop relationship with MCO

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Do SBHCs add value to MCO network?

- Improve adolescent access to care, particularly family planning
- Find hard to reach children
- General increase of access to care
- Increase health prevention and promotion
- Coordinate chronic care

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Can SBHCs meet MCO Contracting Requirements?

- Credentialing - use of NPs/PAs
  - PCP or co-manager
  - NP as PCP
  - Medicaid managed care requirements
    - Hours of operation
    - On Call, Afterhours

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Contracting with the MCO

- Reimbursement
  - Fee for service
    - Perception by SBHCs of low reimbursement from MCO
    - Payment for covered services agreed to by MCO
  - Capitation
    - Perception of double payment by MCO
    - Will be based on services to be provided, not Medicaid clinic or "average rate"
  - Other methods

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Contracting with the MCO

- Administrative
  - Eligibility determination
    - obtain and maintain accurate Medicaid and CHP eligibility
  - Billing, encounter reporting
  - Infrastructure and staff to handle pre-certs, coordination of services, data transfer, etc.

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Contracting with the MCO

- Scope of Services
  - comprehensive primary care
  - mental health
- Provider Community
  - MCO physicians acceptance of SBHCs
  - Communication from PCP to SBHCs

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Value for SBHCs in contracting with MCOs

- Become part of an organized delivery system
- Access to sophisticated computer systems and methods of communication
- Access to MCO Case management programs

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Challenges

- Do SBHCs have the administrative and operational infrastructure to participate in an MCO network?
- Is it prudent to add administrative layers and additional costs to SBHCs to participate with MCOs?

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Challenges

- SBHCs have to deal with multiple MCOs
- MCOs have to deal with multiple SBHCs
- Mobile population
- If technical and infrastructure issues can be resolved, the challenge could become and opportunity

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PROGRESS REPORT:
AN 11 YEAR EFFORT TO LINK COLORADO'S SBHCs AND MCOs

School-Based Health Centers & Managed Care: A Dialogue
- April 23, 2001 -
Health Resources & Services Administration
Department of Health & Human Services

1

Colorado Backdrop and MCH Perspective

Bruce P Guernsey
Director, SBHC Initiative
Maternal & Child Health Section
CO Dept of Public Health & Environment

2

State's Political and Business Climate Favors:

- Local planning and control
- Market-based, private sector solutions
- Competitive managed care market

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Current Status of SBHCs

- 36 sites in 14 school districts
- Access for 56,000 (7.8% of State's public school students)
- 18,000 users and 55,000 visits
- 15 sponsoring organizations:
  - 7 sponsors (23 sites) capable of billing
  - aggressive billing achieves 20% to 25% of operating costs

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History of Maternal and Child Health Involvement in SBHCs

Since 1982

A Range of $44,280
To $300,000 / Year

2 to 20 Programs / Year

5

SBHCs Contribute to MCH Performance Measures:

- Reduce teen births, improving birth outcomes
- Prevent injuries
- Reduce homicide, suicide, and child abuse
- Prevent substance abuse
- Serve special needs children
- Improve access to oral & behavioral health care
- Improve immunization rates
- Increase family participation

6

MCH Role in Replication of SBHCs

- Secure MCH Block funding
- Award Making The Grade funding
- Fund local planning & new start-up
- Impose few requirements
- Encourage diverse sponsorship
- Require strong local match
- Sponsor state budget initiatives

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MCH Efforts to Promote MCO/SBHC Contracting

- Convene stakeholders
- Develop SBHC standards
- Offer consultation and TA
- Explore/support statute and rule changes
- Get SBHC sponsors to the table on CHIP
- Encourage formation of a provider association

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SBHC Provider Member Organization

- Contributes to contracting effort:
  - Certification Standards
  - Provider credentialling process
  - CQI measures
  - Consultation
- Promotes SBHCs through:
  - Educating policy makers
  - Legislation and rules
  - Publications

9

The State Perspective: Medicaid Managed Care

Gary Snider

Director, Division of Managed Care

CO Dept of Health Care Policy and Financing

10

Colorado Medicaid and CHIP

- Standalone programs
- Medicaid EPSDT enrollment: 154,000
- CHIP enrollment: 29,000 (41% of estimated eligibles)

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Relevant Statutes, Rules, and Contracting Practices

- Senate Bill 97-005
- Senate Bill 00-020
- Definition of "Essential Community Providers"
- Departmental philosophy and practice
- Two different approaches attempted in contract language

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Requirements for Provider Participation in Medicaid

- Must have:
  - Credentialed providers
  - 24 hour access
  - Serve as a PCP
- To receive reimbursement for most of Medicaid population, must have contracts with MCOs

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Compatibility – SBHCs and Medicaid Managed Care

1. Mission and goals
2. Scope of and authorization for services
3. Linkages with Medicaid PCP
4. Linkages with specialty care and pharmacy
5. Confidentiality
6. Quality improvement
7. Reimbursement

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Experiences with Managed Care: The SBHC Perspective

Linda Therrien
Director of Community Health
The Children's Hospital

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Why do Hospitals Sponsor School-Based Health Centers?

- Consistent with mission and vision of The Children's Hospital; generates a positive image of the hospital in the community
- Schools provide access to children
- On-site health plan enrollment will assure that children have a payer source
- Potential to decrease utilization of costly inappropriate care (emergency room visits)
- Expectation that health center income will cover direct expenses

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School-Based Health Center Partnerships

- **Operates two school-based health centers:**
  - **Adams School District 50 at Gregory Hill Preschool**
  - **Sheridan Health Services at Sheridan Middle School**
- **Collaborative partnerships**
  - **University of Colorado School of Nursing**
  - **Community Physician practices**
  - **Adams Community Mental Health Center; Arapahoe House**
  - **St. Anthony's Hospital**
  - **Tri-County Health Department**
  - **Westminster Rotary Club**

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School-Based Health Center Staffing

- **Pediatric Nurse Practitioners**
- **Registered Nurse**
- **Patient Services Coordinator/Financial Counselor**
- **Mental Health Counselor**
- **Substance Abuse Prevention Counselor**
- **Physician Consultation**

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Comprehensive Services

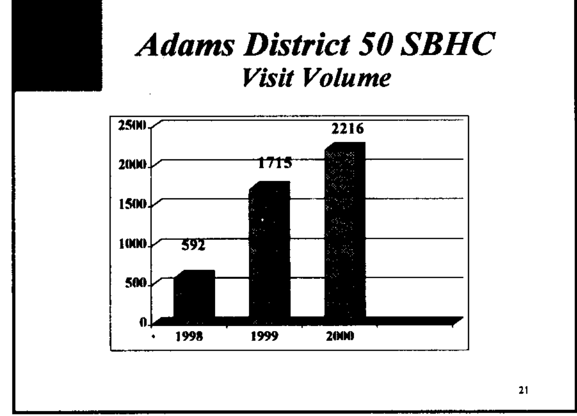
- **Immunizations and physical exams**
- **Diagnosis & treatment of minor illnesses and injuries**
- **Chronic illness management (Asthma & ADHD)**
- **Mental health counseling & support groups**
- **Dental screening & education**
- **Medications dispensed; Lab tests**
- **Health promotion programs**
- **Financial counseling and health plan enrollment**
- **24 hour on-call availability**

SBHC Enrollment and Users

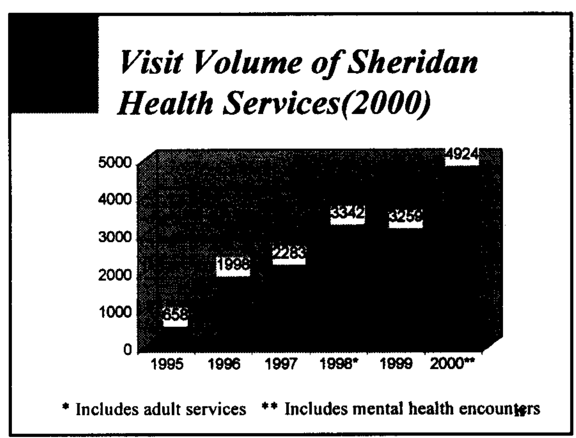
- Sheridan:
  - 3023 enrolled
  - 1839 users
- Adams:
  - 2216 enrolled
  - 1108 users

Adams District 50 SBHC

Visit Volume



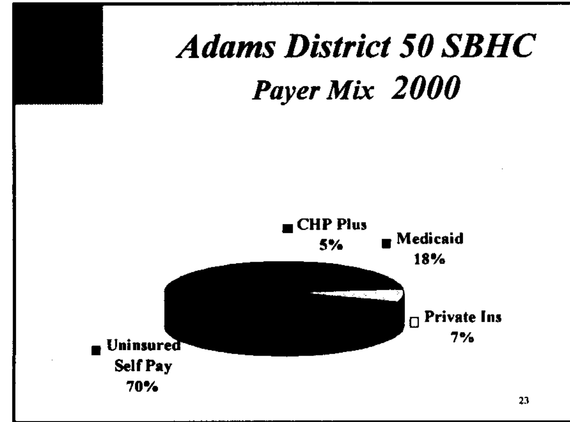
Visit Volume of Sheridan Health Services(2000)



* Includes adult services ** Includes mental health encounters

Adams District 50 SBHC

Payer Mix 2000



SBHC Business Plan

- Diversify revenue sources: grants, donations, foundation support
- Charge for services
- On site health plan enrollment
- Develop a sliding Fee Scale
- Establish a billing system
- Contracts with managed care companies

Adams District 50 SBHC
2000 Final Financials

- **Revenue** **$261,965**
  - **Grants -** $80,200
  - **Foundations/Donations -** $158,518
  - **Self pay** $16,000
  - **Insurance** $ 7,247
- **Expenses** **$336,706**
  - **Direct - $270,300**
  - **In-kind - $66,406**
- **Margin** **($74,741)**

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Barriers and Approaches in Managed Care Contracting

- Selling the value of the model
- Determining the scope of services and authorization process
- PCP Relationship
- Linkages for down stream care
- Confidentiality and billing
- Communication and sharing of medical record information
- Agreement on quality performance benchmarks for entire population

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SBHC Outcomes

- **Health insurance for the uninsured, undocumented**
- **Improved rate of children receiving well child exams and increased immunization rates year 2**
- **Positive family satisfaction with services**
- **JCAHO accreditation 1999**
- **Positive BPHC Primary Care Effectiveness Review 2000**
- **Decreased emergency room use**

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The Managed Care Perspective: Working Towards "Win-Win" Solutions

Maureen Hanrahan
Director, Government Programs
Kaiser Permanente/Colorado Region

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KP School Connections Vision

- Design an insurance product for low income children that builds upon SBHC/HMO collaboration
- Forge a managed care partnership that addressed the 7 principles (prior to the 7 principles)

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KP School Connections

- Funding
- Benefits
- Premiums
- Family Choice of Provider Site
- Contracting Elements

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"Pluses" of KP School Connections

- Quality Care to Over 1,700 low income children over 2 1/2 years
- Beginnings of a SBHC/MCO collaboration and payment model
- Understanding and respect for the strengths and limitations of each partner
- Core group of determined champions

Lessons Learned

- Collaboration takes time and patience
- Volume is Important:
  - To the SBHC for Cash Flow
  - To the MCO for Efficiency
- Transiency of population is constant challenge

Lessons Learned - Continued

- Population-based/outcomes-based approaches hold promise for collaboration
- Alternatives to capitation and administrative demands of regulatory environment are tough
- A model is needed that could apply to multiple MCO partners; or is flexible to meet individual MCO needs and interests

Why Is KP Interested in SBHC's?

- Not for profit 501-C3, social mission
- SBHC's can reach tough populations (low income, adolescents, monolingual) that HMO's may not
- Innovative pediatric leadership
- Targeted outcome improvements
- Opportunity to collaborate/learn

On the Ground: The "Fit" – SBHCs and Managed Care

1. Mission
2. Scope of and Authorization for Services
3. Linkages with PCP
4. Linkages with Specialty Care and Pharmacy
5. Confidentiality
6. Quality Improvement
7. Reimbursement

Next Steps

- Persistence!
- Provide data
- Physician leadership on clinical communication
- Complement rather than compete with the medical home
- Attraction of the model to all MCO kids and parents (including commercial):
  - Simple yet meaningful value-added services
- Sustainable fiscal relationship

School Base Health Centers in Connecticut
A State Agency Perspective

David Parrella, Director
Medical Care Administration
Department of Social Services

1

Background

- State had placed a great deal of emphasis on the development of SBHCs during the early 1990s under former Governor Weicker
- Sites were funded by the State Department of Public Health and private foundation grants
- Medicaid was in the process of developing regulations for direct fee for service reimbursement

2

1995

- In October Connecticut Medicaid implements statewide mandatory enrollment in managed care for families and children
- Initially 11 Managed Care Organizations (now down to four)
- 230,000 enrollees statewide, 160,000 children
- Virtually all school aged Medicaid eligible children enrolled by April, 1996

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1995 - *Continued*

- General concern about the viability of safety net providers
- Concern particularly acute for SBHCs because there was no fee for service baseline for billing prior to the advent of managed care
- DSS requires all MCOs to contract with all SBCHS within their service area

4

Culture Clash – The MCOs

- MCOs not used to dealing with school-based providers
- Concerns about SBHCs as PCPs without coverage 24 hours/day, 12 months/year
- No precedent for credentialling facilities as opposed to individual staff
- Most SBHCs were not Medicaid providers prior to managed care

5

Culture Clash – The SBHCs

- Not used to billing insurance as opposed to grant reimbursement
- Difficult internal and external contract process

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Problem

- Contract process proceeds very slowly
- Lack of SBHC participation impacts progress on EPSDT/dental access
- Public scrutiny by oversight bodies, Medicaid Managed Care Advisory Council

7

Resolution

- 1996 DSS and DPH meet and agree that managed care participation is required both for the plans and for the SBHCs as a pre-condition to continue to receive funding from the state
- May, 1996 DSS and DPH invite all the MCOs and the SBHCs to participate in an all day contract marathon at DSS
- As of now all 60 SBHCs funded by the Department of Public Health have contracts with the remaining 4 Managed Care Organizations

8

Lessons Learned

- Coordination between Medicaid and the Public Health Agency is essential
- Mandates work
- Cultural sensitivity on both sides needs to be fostered

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Future Plans

- School Based Health Centers are expanding the array of credentialed services within the MCO networks (i.e. dental hygienists)
- School Based Health Centers are an alpha site for Medicaid presumptive eligibility
- Improved communication on Medicaid eligibility (AEVS, batch download, etc.)

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Connecticut School-Based Health Centers

in partnership with Medicaid Managed Care

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Common Mission

- DSS GOAL: to demonstrate improved pediatric health under managed care by increasing access to medical & dental care for low income kids.
- PHS GOAL: to ensure that pediatric members obtain urgent medical care and health education, identify problems early, avoid ER use for primary care, and gain access to preventive dental care.
- SBHCs' GOAL: to enhance services and ensure future by expanding funding base and increasing payer sources.

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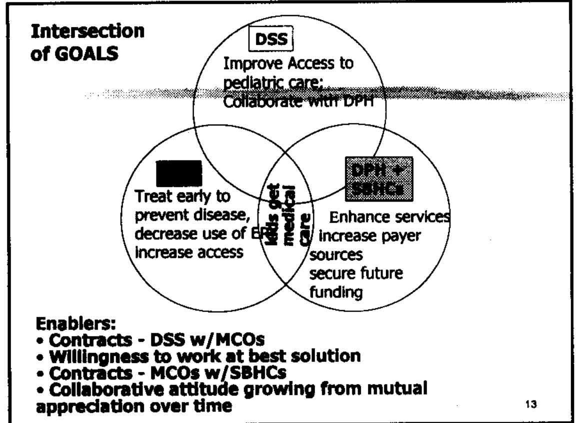

Enablers:
- **Contracts - DSS w/MCOs**
- **Willingness to work at best solution**
- **Contracts - MCOs w/SBHCs**
- **Collaborative attitude growing from mutual appreciation over time**

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Principle 2: Scope of Authorization for Services Cultural differences - PHS/MCO

Differences to surmount, e.g.:

- ➡ Unfamiliarity - "What's a school-based Health Center?"
- ➡ What do they do?
- ➡ Who works there?
- ➡ How can we manage it?
- ➡ How much should we pay?
- ➡ Why should we contract with a school?
- ➡ How do we assure the kind of quality care as provided in a physician's office?
- ➡ How do we credential providers in a school?
- ➡ How should we list them in the Providers Directory?

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Principle 2: Scope of Authorization for Services Cultural differences - SBHC

- ☺ Different kinds of entities as contractors
- ☺ Different relationships for each SBHC director to negotiate
- ☹ Dizzying array of plans with different processes, contract requirements, policies, procedures, personalities - for each director to juggle, compile - usually alone!
- ☺ Credentialing - another struggle with paper and staff time!
- ☹ Staff resistance to billing for services that were formerly free
- ☹ SBHCs must develop billing mechanisms - without software experience, training, personnel, expertise, support, or volume to make it worthwhile

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Principle 3: Linkages with PCPs

- Continuity of Care is paramount for both MCOs and SBHCs
- Who's the Plan? Who's the PCP?
- Keeping communication open, School-PCP
- Permission to perform physicals
- Referral forms
- Notes to PCP

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Principle 4: Linkages with Specialists

- Same issues as Principle 3, plus...
- Dental health
- Behavioral health
- Conversations in progress regarding medication distribution and administration

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Principle 5: Confidentiality

- Kids will seek care at SBHCs if they are sure the services are confidential
- Contracts with MCOs assure confidentiality
- No bills are generated, so there are no Explanations of Benefits (for Medicaid)
- Sensitive services administered to adolescents without parental consent
- Medical records are confidential.

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Principle 6: Quality Improvement

- Credentialing - instead of re-shaing SBHCs to fit MCO standards, apply credentialing criteria only to supervising professional
- Problem identification - meet regularly to communicate about what's working and what's not
- Dental services for kids are most accessible at schools! Worth the effort!

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Principle 7: Reimbursement

- Presumptive Eligibility - Schools are ideal sites as qualified entities
- Electronic Billing - align reporting specs with encounter data for medical services
- Schools have hardware and internet
- Plans have software
- The future is now.

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Calming the Qualms

Patience - take satisfaction in small gains
Persistence - don't shelve the project
Flexibility - try different approaches
Experience - build on what works with one plan or one center

Key: gradual implementation

- start with one or two to learn what works
- start next negotiation with lessons from past obstacles
- define and then refine definitions until they work
- keep an open mind to find what works for each issue

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...ticalities

No magic instant solution!

- Plans should make contracts the same, tailor internally for differences
- SBHCs need assistant coordinators who focus on completing contracts
- Plans need to learn and understand the political complexity of SBHCs
- SBHC need to understand the political complexity of Plans
- Plans should make concessions, i.e. credential supervising physician
- SBHCs should make concessions, credential as necessary.

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What we've learned so far . . .

Don't need PCP to co-ordinate everything
Inform PCPs as partners
Centers don't know what plan to bill (kids don't bring ID cards to school)
DSS offers lists of Medicaid enrolled kids
PE+Lock-in & fewer plans will facilitate more collaboration

Need to standardize lists of codes MCOs pay
Develop policy for coding new procedures
SBHCs get plan on child's registration form; call AVES to verify
Schools not open 24/7; don't assign them as PCPs
Better to get care early before problems are big!

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