"Reimbursement in School-Based Health Centers: A Dialogue with National and State Partners"

Proceedings

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Rockville, Maryland

EXECUTIVE SUMMARY

On April 23, 2001, a working conference was held to discuss the participation of school-based health centers (SBHCs) in Medicaid and the State Children's Health Insurance Program (SCHIP). The Health Resources and Services Administration (HRSA) and its Bureau of Primary Health Care/Center for School-Based Health Services, Maternal and Child Health Bureau, and Center for Health Services Financing and Managed Care, along with the Health Care Financing Administration (HCFA) co-sponsored the meeting, held at the Parklawn Building in Rockville, Maryland. The co-sponsors of the meeting have common interests in assuring that school-based health centers realize their potential for improving children's and adolescents' access to quality comprehensive primary care services. The National Assembly on School-Based Health Care (NASBHC) shares this common interest and participated in the planning for the meeting and follow up.

The meeting included approximately 85 representatives from State Medicaid agencies, school-based health centers, managed care organizations, relevant national association partners, and Federal agency staff from HRSA and HCFA. Each participant in the meeting had a vested interest in the health of children and adolescents and ensuring that these youth were receiving accessible, quality comprehensive primary health care in school settings.

SBHCs provide a broad array of primary care services in more than 1,300 sites across the country and currently serve over one million students. The ability of school-based health care organizations to reach underserved children and adolescents in a convenient and accessible environment is well documented. It is also clear that SBHCs already provide care for low-income children and adolescents, many of whom are either enrolled in, or eligible for, Medicaid or SCHIP. Although some SBHCs currently participate in their State Medicaid programs, others would like to do so but face challenges in joining Medicaid managed care networks and other arrangements.

The focus of the conference was on reimbursement of the direct primary and preventive services provided by school-based health centers, particularly through participation in managed care networks. This conference did not address issues related to the Medicaid claiming of administrative costs related to school health services or the reimbursement of services provided to children with Individualized Education Programs (IEP) or Individualized Family Services Plans (IFSP) under the Individuals with Disabilities Education Act.

The following pages document the discussion that took place during the meeting. In the morning, there were a series of presentations, including an overview of the issues of

reimbursement for School Based Health Centers under Medicaid managed care arrangements as well as two sets of State-specific presentations involving participants from Colorado and Connecticut. The materials from those presentations are included with this meeting summary. The afternoon sessions began with a plenary discussion listing of key barriers identified by the morning speakers and the meeting participants (see page 15).

This was followed by small group breakouts that focused on recommendations for overcoming barriers to SBHC participation in Medicaid managed care. The meeting concluded with a discussion of the recommendations from the breakout groups and suggestions for developing technical support.

By bringing together individuals directly involved in providing services with those organizations responsible for funding services to children and adolescents, sponsors of this meeting hoped to gather a great deal of relevant suggestions for the participation of school-based health centers in the Medicaid and State Children's Health Insurance Programs.

MEETING REPORT

INTRODUCTION

The Health Resources and Services Administration (HRSA)[1] and Health Care Financing Administration (HCFA) co-sponsored this one-day meeting to discuss school-based health care issues and reimbursement for primary and preventive services under Medicaid and SCHIP. In addition to HRSA and HCFA representatives, meeting participants included representatives from State Medicaid Agencies, School-Based Health Centers (SBHCs), managed care organizations (MCOs) and national associations such as the National Assembly on School-Based Health Care (NASBHC).

Attached to this report are: the meeting agenda (Attachment A), participants list (Attachment B), detailed illustrations of barriers discussed (Attachment C), and PowerPoint presentations from the meeting (Attachment D).

OPENING REMARKS

In her opening remarks, Rhoda Abrams, HRSA's Director for the Center for Health Services Financing and Managed Care, acknowledged that while this forum had been a "long time in the making," it was being initiated within an already-existing collaborative relationship between its Federal and private partners (e.g., HRSA, HCFA, the NASBHC). She added that having all the key parties at the table and communicating to one another would be critical to the continued success of this effort. Toward this end, HRSA planned to continue today's discussion through future regional meetings and other forums.

Dr. Elizabeth James Duke, HRSA's Acting Administrator, echoed the importance of collaboration and noted that with HRSA's direct funding to over 75 SBHCS (through its Bureau of Primary Health Care) and its relationships with many Title V programs, SBHCs have evolved to be "of natural importance to the agency's mission." She pointed out that, as State Medicaid programs and managed care play an increasing role in the care for children, it would become the collective task of HRSA and its partners to ensure that SBHCs are able to participate in this new environment. Dr. Duke also emphasized the importance of encouraging frank and open discussion on past successes, areas for improvement, and new innovations.

Penny Thompson, HCFA's Acting Director for the Center for Medicaid and State Operations, noted that with the new Administration's focus on uninsured and vulnerable

[1] HRSA sponsoring groups included the Center for Health Services Financing and Managed Care; the Bureau of Primary Health Care; and the Maternal and Child Health Bureau.

populations (particularly children), there would undoubtingly be an increase in both questions and potential opportunities regarding SBHC reimbursement. She added that the HHS Department Secretary has emphasized working across Agency lines within the Department and that the HCFA/HRSA collaboration would be a valuable case study on successful collaborations.

PRESENTATION: Role of School-Based Health Centers in Serving Children and Adolescents and the Challenges in Obtaining Reimbursement for those Services

This panel group discussion provided an overview of some of the issues regarding participation between SBHCs and MCOs across three perspectives: (1) The State Medicaid Perspective; (2) the SBHC Perspective; and (3) the Medicaid MCO Perspective. As an introduction to the presentation, NASBHC Executive Director, John Schlitt, provided a historical overview of SBHCs and the importance of the SBHC/MCO relationship.

In his presentation, Mr. Schlitt noted that, while school-based health centers have been in existence for at least 20 years, it wasn't until the1990's, with the initiation of SCHIP and the expansion of Medicaid MCOs, that SBHCs began to focus on obtaining reimbursement for health services. Mr. Schlitt added that, during this period, a number of State organizations and SBHCs initiated collaborative and innovative approaches to address concerns such as waivers/exemptions, certification, and the negotiation process with MCOs. While reimbursement for services still remains limited nationally at less than 8%, there have been a number of positive impacts from these efforts, including the development of standards, establishment of the seven principles for structuring relationships, and a growing advocacy/awareness regarding health and mental health needs of youth.

Attachment III details Mr. Schlitt's presentation, as well as the presentations from the three perspectives. A summary of each perspective is provided below.

The State Medicaid Perspective

From her perspective as the Program Administrator for Florida's Medicaid Program Development, Wendy Leader Johnston identified the following strategies that SBHCs can use to deal with the challenges of obtaining Medicaid reimbursement:

- **Gain a better understanding (knowledge basis) of the Medicaid System** – States are afforded considerable discretion and, thus, States vary in how their Medicaid program is administered. For example, Florida places a heavy focus on the elderly population; another State may have a predominant interest in rural populations, etc. In addition, States vary regarding covered services; payment

rates; eligibility verification and claims processing; and their relationships with other agencies.

- **Locate a niche within the system** – SBHCs have had to become familiar with the terminology and systems issues in order to identify how they may best "fit in" (e.g., as part of EPSDT, clinical services, rehabilitation, etc.).

- **Be able to address State Plan Requirements** – Consent issues, confidentiality concerns (as a Medicaid recipient), and provider qualifications are usually issues that SBHCs have had to deal with in order to participate in Medicaid programs.

- **Avoid the issue of duplicative Federal funds** – Federal grant funds and Federal Medicaid dollars cannot be disbursed for the same services. As a result, SBHCs may need to consider allocating grant funding towards payment of administrative staff in order to bill Medicaid for clinical services.

- **Be prepared to discuss the "Free Care Issue"** – A provider cannot bill services if the provider does not also pursue payment from other sources. However, affiliating with a Title V Agency (which are exempt from this provision) may be an alternative for addressing this issue because services provided by such agencies are considered exceptions to the Free Care rule under Medicaid Law.

- **Identify a system for determining student eligibility** – Many students are unsure if they are eligible for Medicaid (and if so, under which plan). While some State agencies may provide the SBHC with access to their online enrollment information, it should be noted that these records get outdated rather quickly.

- **Address MCOs' concerns** – Issues, such as lack of after-hours coverage (e.g., weekends, summers, evenings); and the need to meet licensure requirements (e.g., facility or profession) are often concerns that MCO's mention as contributing to their reluctance to consider a SBHC as a Primary Care Provider (PCP).

- **Discuss confidentiality considerations** – To ensure patient confidentiality, SBHCs need to inform MCOs of the importance of suppressing Explanations of Benefits (EOBs), which are routinely sent to a student's home.

- **Recognize the high turnover in Medicaid MCOs** – Before investing considerable time and effort marketing to an MCO, a SBHC should consider the possibility that the MCO may not be participating in a few years. A number of MCOs have withdrawn from Medicaid in recent years.

- **Train or hire staff for billing activities –** Whether done by the sponsoring facility or the SBHC, proper billing and follow-up are necessary for reimbursement once an arrangement with the MCO has been made.

Despite these challenges, Ms. Johnston acknowledged that there were also a number of opportunities that SBHCs should consider tapping into. Some of her suggestions were to:

- **Work with Title V Agencies (e.g., Health Departments)** – These agencies are required to work with SBHCs and can serve as a valuable partner/sponsoring organization in negotiations.

- **Consider carve outs** – Often this alternative is a more effective option to MCO capitations. Under a carve out, certain services or populations are excluded from managed care arrangements.

- **Maximize revenues through certified matching** – SBHCs can encourage Title V Agencies to contribute funds which can then be matched with Federal dollars, further increasing the budget. However, Federal Title V grants cannot be used as the State match to obtain Federal Medicaid dollars.

- **Participate in legislative process** – Legislatures can become strong allies, particularly if the SBHC proposal does not entail an increase in expenditures. As an example, Ms. Johnston noted that State plans are amended on a yearly basis and SBHCS can encourage their partners to sponsor legislation that might support SBHCs or help to define their niche within the system.

The SBHC Perspective

In her role as Director of Child and Adolescent Health for the Boston Public Health Commission and as past-president of the NASBHC, Dr. Karen Hacker highlighted some of the overarching barriers that SBHCs face in negotiating and working with MCOs. These include:

- **A limited capacity to bill** – The mission of most SBHCs are to provide access to all, and the billing requirements of MCOs can be a new responsibility for many SBHCs.

- **Exclusion of the SBHCs in Medicaid Waivers** – While New York and Connecticut are examples of two exceptions, in most States, SBHCs are not involved in discussions until after Medicaid waivers are submitted.

- **An erosion of funds** – SBHCs who had been able to work with fee-for-service reimbursement are seeing current funds erode just as new expenditures of resources are leading them to negotiate with MCOs.

- **Potential tensions in a SBHC's relationship with its sponsoring agency and/or school** – A sponsoring agency (particularly a hospital) may be concerned about competing interests with an MCO that its SBHC is negotiating with. In addition, schools may feel a SBHC's pursuit of reimbursement for services conflicts with the free access goal of SBHCs.

- **Small number of enrollees served** – The small number of enrollees served at a SBHC may not be of sufficient number to interest an MCO, which typically works with organizations representing much larger volumes.

- **Limited resources for marketing** – SBHCs tend to have minimal administrative staff and, as a result, marketing activities with MCOs (which can be rather time-intensive) are often done by clinical staff who must sacrifice time for direct clinical services to do so.

- **Separation of mental health services** – Because of behavioral health carve outs, SBHCs may find that separate negotiations are needed for obtaining reimbursement for mental health services.

Some suggestions provided by Dr. Hacker to enable SBHCs to more effectively integrate into managed care systems include:

- **Become well-versed in reimbursement systems** – i.e., be "reimbursable savvy."

- **Get to the table early –** It may take a long time to establish a relationship with an MCO partner.

- **Prepare data** – While it may be difficult to obtain reliable information from young clients, knowing who you serve, your "value added", and other outcomes can become a strong negotiating point with a particular MCO. Outcomes data are also a standard part of the MCO contract.

- **Prioritize** – Before even beginning negotiations, a SBHC will need to consider if the penetration of Medicaid managed care among its patients is worth the investment of marketing and negotiation. SBHCs should also take into consideration the number of MCOs participating in Medicaid. A SBHC's resources may only accommodate negotiations with a few MCOs, and the SBHC should also assess the likelihood that the MCO will still be participating in Medicaid in the future.

The Medicaid MCO Perspective

With over 16 years of experience at BlueCross/BlueShield of Rochester, Sue Luce provided an overview of concerns and issues that her program and other Medicaid MCOs encounter in negotiating and working with SBHCs. Specific obstacles include:

- **The need to educate MCOs about SBHCs** – Ms. Luce acknowledged that there are still a good number of MCOs that are unaware of the role SBHCs can play. In the negotiation process, it is the SBHC's responsibility to educate MCOs about the added value of SBHCs and to let them know that these centers are able to meet the standardized requirements set by the MCO. Some of the added benefits to MCOs cited by Ms. Luce included improved access for adolescent care and the ability to provide preventive services and support in the treatment of chronic illnesses. Standard requirements that the MCO will be concerned about are access (hours of operation) and credentialing (many HMOs do not recognize nurse practitioners as eligible PCPs). The concept of co-management is new to MCOs and a challenge in the areas of coordination, communication and reimbursement.

- **Complications in the reimbursement structure** – Many SBHCs need to be clear about which services they provide and how much the MCO will pay them for each. In addition, perceptions about the fee structure (SBHCs may perceive fee-for-service payments as being too low, and MCOs may find capitation to be a "double payment") may create tension during the negotiations.

- **Lack of administrative infrastructure** – Many SBHCs will find that they need to build up their administrative infrastructure to accommodate billing needs and eligibility determination requirements. A cost-benefit review should be made to determine whether the additional revenues from the MCO warrant hiring additional administrative staff.

Question and Answer Session

Following these presentations, David Greenberg, Senior Health Insurance Specialist with HCFA's Center for Medicaid and State Operations, facilitated a brief question-and-answer session. Some of the key thematic questions are detailed below.

- Can SBHCs be designated as presumptive eligibility sites?

  This is defined by each State, so it varies. Connecticut is one good example, and this will be discussed in their presentation today.

- What is the difference for SBHCs in working with the Medicaid side of MCOs versus the commercial side?

  There has been very little discussion and negotiations on the commercial side at Blue Cross/Blue Shield of Rochester. Since many insurance providers know very little about SBHCs, these centers have a big challenge in educating these groups even before beginning negotiations.

- Are there any legal or confidentiality concerns in sharing eligibility data with a SBHC?

  Once a contract is signed, this data can usually be shared with the SBHC to facilitate billing. It should be noted that SBHCs should include a provision in their contracts that allows them access to their own enrollment forms, as some sponsoring agencies may be reluctant to return this information back to the SBHC.

PRESENTATION: School-Based Health Centers and Medicaid Managed Care: Two States' Experiences

Laverne Green, the Director for HRSA's Center for School-Based Health Care, facilitated this panel presentation. Representatives from Colorado and Connecticut presented their State experiences with having SBHCs participate in their State's Medicaid Managed Care programs. In the course of their discussion, presenters focused on the following seven key principles: (1) Common Mission; (2) Scope of and Authorization for Services; (3) Linkages with the Health Plan's Primary Care Provider; (4) Linkages with the Health Plan's Specialists; (5) Confidentiality; (6) Quality Improvement ; and (7) Reimbursement.

Colorado

Background

According to Bruce Guernsey, Director of the SBHC Initiative within Colorado's Maternal and Child Health Section (MCH), Colorado's small population size is an advantage, as it is not hard to figure out "who the players are." Colorado's system is based on localized planning, and State dollars are not a readily accessible source of funding for the 36 current SBHC sites (representing 15 sponsoring organizations).

Billing capacity is quite low, with less than half of all sponsoring agencies having billing capabilities (and even the most aggressive facility in billing has yet to recoup more than 25% of its operating costs). While the MCH provides seed money for replication of SBHCs, centers are required to obtain significant local funding (which makes it easier to "wean" once grant dollars are used up). The Colorado MCH Program also provides a consultant to help with contracting and billing issues and has tried to encourage MCOs to work with the SBHCs. Mr. Guernsey added that in Colorado, State policymakers are quite familiar with and supportive of the SBHC program.

Gary Snider, Director of Managed Care in Colorado's Office of Medical Assistance, added that there are currently five MCOs in the Medicaid program (three not-for-profit; two for-profit) and that while plans don't mandate working with SBHCs, relationships are strongly encouraged. In 1997, legislation was approved which designated SBHCs as an essential community provider.

A Case Example from the SBHC Perspective

Linda Therrien, Director of Community Health Programs at Children's Hospital in Denver, noted that the hospital's sponsorship of SBHCs was based on the premise that emergency services utilization would decrease and SBHC operating costs and revenues would break even. While there has been a decrease in emergency room usage, funding

self-sufficiency hasn't yet materialized. However, the hospital remains committed to the centers.

The hospital sponsors two centers (a preschool and middle school). Both sites provide comprehensive year-round services, along with a lab and pharmacy. Dental services are anticipated to be added in the near future.

The SBHCs provide enrollment services on-site, and it is estimated that between 70% to 90% of clients have either private or public insurance. Specific barriers the SBHC has encountered include:

- **Trying to market the value of the model** – Both the hospital and participating MCO view the SBHC predominantly as an enrollment site. While enrollment did increase, it was predominantly due to SCHIP. The MCO also expected costs to be comparable to a PCP even though the context of the service delivery was quite different. While positive relationships were developed, Ms. Therrien acknowledged that the income generated from MCO participation has been limited.

- **Recouping money through outsourced billing services** – Three different billing vendors were used. In each instance, the vendor was unfamiliar with the unique issues of the SBHC, and billing for the centers tended to receive low priority. Currently billing is done directly by the hospital, but even this alternative has not significantly increased the recoupment rate.

- **Identifying student eligibility** – Ms. Therrien estimates that there is a 40% mobility rate in her client population (across MCOs and/or in overall program participation). In addition, many families were getting confused during the enrollment process and became dismayed to learn that they may not have signed with the right MCO (i.e., one participating with the SBHC).

As a final note, Ms. Therrien noted that in measuring outcomes, SBHCs should focus on users of service rather than enrollees. Her centers made this mistake and were embarrassed to discover that their HEDIS measures were significantly below standard (at 30%). The change in focus from enrollees to users has since improved these numbers to a range of 80 to 90%.

<u>A Case Example from the MCO Perspective</u>

Maureen Hanrahan, Director of Government Programs with Kaiser Permanente (KP), noted that KP participated in a pilot program with ten SBHCs to: (1) design a better insurance product for low-income children; and (2) forge new partnerships around the seven SCHIP principles.

The product that was developed was very similar to CHIP (e.g., no copay), and allowed participants free choice in selecting their SBHC. Some successes of the program include a high rate in the number of kids served (over 1,700 in two-and-a-half years); increased communication and dialogue between partners; and a better understanding of the strengths and weaknesses of MCOs and SBHCs.

Some of the lessons learned during the process are:

- Collaboration takes time.
- Volume is important – There needs to be a critical mass to create an incentive to collaborate, as well as to produce quality outcome data.
- Population mobility is a challenge – Clinical HEDIS data depends on continuous enrollment (6 months to a year).
- Persistence is critical to success.

Connecticut

Background

According to David Parrella, Director of Medical Care Administration for Connecticut's Department of Social Services, a State mandate in 1995 by the Governor was a critical factor in the success of MCO/SBHC negotiations. Specifically, this mandate required MCOs to contract with all SBHCs in their service area. Today, Connecticut has four participating MCOs and nearly 100% enrollment of eligible participants.

In initial discussions between MCOs and SBHCs, Mr. Parella noted that there was a bit of a "culture clash" between the entities - with MCOs being unfamiliar with the SBHC client setting and SBHCs not quite understanding the billing and contract process. As a result, enforcement of the mandate was enhanced in 1996 with all MCOs and SBHCs participating in an all-day marathon contract negotiation and signing.

Future plans include recruitment of dental hygienists (an acute problem in Connecticut) and establishing SBHCs as alpha sites for presumptive eligibility.

A Case Example from the SBHC Perspective

Kate Gredinger, Supervisor of the school-based health center sponsored by Bridgeport's Health Department, acknowledged that her SBHC had experienced resistance to the mandate. Some examples of issues/concerns from the SBHC perspective include:

- **Administrative costs** – Clinical staff were increasingly needing to assume more administrative functions rather than direct clinical services.

- **Communication with the PCP** – While some providers were responsive, others weren't. It has taken some time to build these relationships.

- **Reimbursement for medications** – The Bridgeport SBHC dispenses almost $100,000 in medicines annually. Most of these costs have yet to be recouped. The SBHC is working with their MCOs to determine whether or not MCOs would be able to reimburse the SBHCs for medication costs.

- **Credentialing** – Credentialing can be problematic if it is tied to the provider rather than the facility, especially with staff turnover.

- **Presumptive Eligibility** – because the presumptive eligibility process has proved to be very successful for the Bridgeport SBHC program, they are expanding it to all their SBHC sites.

Bridgeport's SBHC has found that, while the process was time consuming, being qualified as a presumptive eligibility site has been helpful and the Bridgeport Health Department has even provided a dedicated outreach worker for enrollment efforts.

The Managed Care Organization Perspective

Catherine Jackson from Health Net (formerly PHS Health Plans) spoke about her organization's history of contracting with School Based Health Centers. One of the first plans in Connecticut to implement contracts with SBHCs – she gave examples of the culture clash, described a solution to the credentialing problem, and suggested improvements underway that will enhance the partnership between SBHCs and MCOs.

- Using the Internet, Health Net is developing electronic systems to verify membership and expedite billing.

- Health Net's solution to credentialing and provider turnover is to credential the supervising professional rather than individual providers.

Ms. Jackson believes that the areas with the best potential for partnership between SBHCs and MCOs are: 1) enhancing dental access and treatment; 2) outreach and education about their health plans to school children; 3) follow-up contacts with students the MCOs can't reach to improve EPSDT visit rates (especially among adolescents); and 4) coordinating case management for children with asthma or other chronic diseases.

Question and Answer Session

Following these presentations, Ms. Green facilitated a brief question-and-answer session. Some of the key thematic questions are detailed below.

- Is Kaiser Permanente initiating similar programs outside of Colorado?

  KP is a federation, so each local market is separate. Different KP markets try to share information, but there is no formal mandate for them to do so.

- With regard to presumptive eligibility, how do you obtain information from undocumented parents?

  In Connecticut, applications only require the social security number for the child, not the parent. The biggest challenge has been the language barrier. Connecticut has had a large influx of Eastern Europeans (e.g., Bosnians), and there are a number of languages that need to be accommodated.

- How do you deal with the transience issue?

  Connecticut has an outreach alliance that is working to address this issue. Now that most Medicaid recipients don't receive welfare checks, the incentive to keep their address information current has disappeared.

- Are there any guidance documents for SBHCs to use in negotiations with MCOs? It is quite a task for small organizations.

  This has been contemplated in Colorado, but no action has yet materialized.

CHALLENGES AND BARRIERS FOR SCHOOL BASED HEALTH CENTERS PARTICIPATING IN MEDICAID MANAGED CARE

During lunch there was a discussion involving all the meeting participants regarding the barriers identified by the morning session speakers as well as other issues brought up during the meeting. Trina Anglin, M.D. of the HRSA Maternal and Child Health Bureau facilitated the discussion. The following pages describe the range of challenges/barriers identified by the meeting participants. In addition, meeting participants divided up and

met in smaller groups to continue in-depth discussions on a subset of the identified challenges/barriers (see Attachment C).

The discussion of barriers identified five major themes**:**

Population Issues

Young children and adolescents seen in school-based health centers present unique challenges for providers. For example, gathering accurate insurance eligibility information can be difficult, especially if insurance status changes. In addition, minor consent laws can make delivery and payment of confidential services difficult in many States.

Working with MCOs, Outside Providers, and Medicaid Agencies

It is difficult for many school-based health centers to fit into discreet categories that make contracting easier - the variety of school-based health center arrangements (comprehensive versus non-comprehensive) and managed care models (capitated primary care providers paid by health plans, primary care case managers paid directly by Medicaid, etc) makes a uniform approach to contracting unrealistic. The perception of differences between managed care and school-based health care can present a barrier to creating strong working relationships. Emphasis needs to be placed on the potential value school-based health centers can bring to the goals of a managed care organization.

Critical Mass

Most SBHCs run relatively small organizations. Learning, understanding, and following billing procedures for prior authorization or referral protocols can be a challenge - especially when students are enrolled in a variety of health plans among different insurers. For the SBHC's sponsoring organization, the administrative and collections burden may reduce their interest in billing a Medicaid managed care organization. Similarly for the managed care plan, a low volume of enrollees seen in a SBHC provides little incentive for the plans to invest the resources to ensure that a school-based health center can effectively participate in the plan.

Dialogue and Education

SBHCs and managed care organizations need to know and understand more about the role each can play. SBHCs need to improve their communication regarding the role and mission of school-based health centers and develop data that can be used to highlight the value of SBHC models of care.

Administrative Capacity

While some school-based health centers possess the management information system capacity or technical expertise to provide the information sought by plans and insurers, many others do not. This diversity of abilities to collect necessary billing data and a lack of aggregate clinic level data leads to managed care organization concerns about the quality of *care* delivered in school-based health centers. SBHCs should do whatever they can to assure that billing and information on the quality of care provided is available and utilized.

PLENARY GROUP DISCUSSION OF BARRIERS

The following is the list of challenges/barriers identified by the meeting participants during this session[2]:

Population Issues

- Lack of ability to identify insurance coverage.
- Lack of ability to determine if a child is eligible for insurance coverage.
- The need to assure confidentiality in billing for services.

Working with MCOs, Outside Providers, and Medicaid Agencies

- *Lack of perceived benefit for the MCO to contract with SBHCs*[3].
- *Lack of marketing sophistication within SBHCs to sell to MCOs.*
- *A Lack of the necessary expertise to negotiate with MCOs.*
- *The difficulty in accessing payment for mental health services.*
- The need to meet the credentialing requirements of the MCO.
- *The difficulties in negotiating the role of the SBHC under a PCCM Model.*
- The need to address the issue of a "Medical Home".

Critical Mass

- *The importance of addressing leverage and positioning issues for the SBHC.*

[2] During a post-meeting conference call, a working committee categorized the barriers across five key areas and modified some wording to improve clarity.

[3] Barriers in italics are those that were selected for further discussion during the breakout sessions (see following pages).

Dialogue and Education

- *The limited appreciation of some States on the SBHC role in the service delivery system.*
- Lack of recognition in perceiving SBHCs as part of the safety net.

Administrative Capacity

- *Limited capacity for billing.*
- *The difficulty of costing out services.*
- The need to meet the data requirements of MCOs.
- *The need to improve relationships with Parent Organizations regarding billing and administrative needs.*

The meeting participants then selected several of these barriers for further discussion. Details of a subset of the barriers discussed by the breakout groups is provided in Attachment C. Summaries from each of the breakout groups are provided below.

SUMMARY FINDINGS FROM BREAKOUT GROUPS[4]

Following is feedback from the breakout groups regarding their assigned barrier discussions:

Lack of Perceived Benefit for the MCO to Contract with SBHCs – While the approach taken in Connecticut to mandate has its benefits, most other States have followed a collaborative approach that encourages partnerships. Results have been mixed. The breakout group agreed that SBHCs need to take the lead role in terms of "bringing people to the table". They also need to develop a market-driven approach with business models and data. Finally, SBHCs should try to become involved in State Medicaid waiver submissions, so their issues and needs are recognized on the front-end.

Lack of Marketing Sophistication within the SBHC to Sell to, and Negotiate with, MCOs – With regard to this barrier, the breakout group focused on standardizing services for contracting reasons and addressing credentialing concerns. The group agreed that a mechanism needs to be in place for providing a minimum set of standard services. While the States are in the best position to play a leadership role, other entities, including the SBHC, MCOs, and professional associations should be included in these discussions. The group also noted that since SBHCs are essentially "guests in someone else's house," these discussions need to reflect a sensitivity to the environment in which SBHCs function (i.e., the schools themselves). Finally, it was suggested that State agencies might consider developing a contract template (with purchasing specifications) and/or

[4] These summaries represent a recording of the actual summary presentations provided by the breakout group leaders to the meeting participants.

consider conducting contract negotiations through the Medicaid Agency rather than individual MCOs.

The Difficulty in Accessing Payment for Mental Health Services – Determining what mental health services are reimbursable and by whom is quite a challenge for SBHCs. Representatives from New York indicated that they have developed a "road map" detailing a variety of service options and the responsible payee. Another obstacle relates to the requirement that accreditation be held by a licensed professional rather than the organization.

The Difficulties in Negotiating the Role of the SBHC Under a PCCM Model – Determining and negotiating the appropriate role for a SBHC once a primary care provider has been assigned within a PCCM model can be a challenge - how can the SBHC work most effectively within that arrangement? Another challenge concerns what SBHCs need to know about participating as a PCCM provider under State Medicaid programs.

The Importance of Addressing Leverage and Positioning Issues for the SBHC – Also identified as the "David and Goliath" dilemma by the group, it was acknowledged that the inequity between the partners made negotiations difficult. For example, data collection and administrative efforts may not be cost-effective for a small SBHC, and the volume of patient users is minimal compared to the MCO's overall client populations. One recommendation was to explore opportunities for developing combined efforts across a group of SBHCs (though not all SBHCs are the same). It was also suggested that SBHCs need to improve their marketing in terms of identifying the added value that their services bring. Finally, it was recommended that financing studies may shed some light on the value of MCO reimbursement as well as the impact SBHCs have on health and education needs.

The Limited Appreciation of Some States on the SBHC Role in the Service Delivery System – Breakout participants agreed that the best way to educate policymakers on SBHCs is to document and market the centers' successes. For example, a stronger focus on HEDIS measures would be an asset. Support from the educational and medical communities regarding the SBHC as an access point should be emphasized.

The Limited Capacity for Billing – The breakout group for this barrier noted that limited capabilities at SBHCs are not just in billing, but also management and quality assurance. One recommendation was for the Federal government to provide technical assistance and create incentives for States and sponsoring facilities to provide support for improvement in the billing infrastructure.

The Difficulty of Costing Out Services – SBHCs need to incorporate payment models in presenting services to MCO buyers and consider whether services should be bundled together. The group also noted that in supporting rate-setting requirements, outcome data was just as important as claims information in negotiating with the MCOs.

The Need to Improve Relationships with Parent Organizations Regarding Billing and Administrative Needs – While SBHCs have traditionally relied on their sponsoring organization for funding, SBHCs should be responsible for identifying new sources of revenue (e.g., MCOs), as the activities of the SBHC may not be significant enough in terms of volume to garner much attention from the parent organization.

CLOSING COMMENTS

In his closing remarks, Dr. Alexander Ross, of HRSA's Center for Health Services Financing and Managed Care, noted that HRSA does have a range of technical assistance components and that today's feedback will be shared with these organizations so focused assistance may be provided to the field. In addition, there are a number of current initiatives that these recommendations can enhance. Finally, Dr. Ross emphasized the importance of a continued dialogue and noted that additional discussions are planned in conjunction with upcoming regional meetings in order to expand upon, and ultimately, implement the group's recommendations.

ATTACHMENTS

A. Meeting Agenda

B. Participants List

C. Detailed Illustrations of Barriers Discussed At The Meeting

D. PowerPoint Presentations From The Meeting

AGENDA

9:00 a.m.-9:15 a.m. Welcome and Introductions
Facilitator: Rhoda Abrams, M.B.A.
Director, HRSA Center for Health Services
Financing and Managed Care

Elizabeth James Duke, Ph.D.,
Acting Administrator, HRSA

Penny Thompson
Acting Director
Center for Medicaid and State Operations, HCFA

9:15 a.m.-10:30 a.m. Opening Presentation: Role of School-Based Health Centers in Serving Children and Adolescents and the Challenges in Obtaining Reimbursement for those Services

Facilitator: David Greenberg
Senior Health Insurance Specialist
Center for Medicaid and State Operations, HCFA

Presentor: John Schlitt, Executive Director
National Assembly on School Based Health Care

Responder Panel

State Medicaid Perspective
Wendy Johnston
Program Development/Child Health Unit
Florida Agency for Health Care Administration
Tallahassee, Florida

School Based Health Center Perspective
Karen Hacker, M.D., M.P.H.
Director, Child and Adolescent Health
Boston Public Health Commission

Medicaid Managed Care Organization Perspective
Sue Luce, Director, State Government Programs
Blue Cross and Blue Shield of the Rochester Area
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10:45 am.-12:00 p.m School-Based Health Centers and Medicaid Managed Care: Two States' Experiences

Facilitator: Laverne Green
Director, Center for School Based Health
Bureau of Primary Health Care, HRSA

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12:15 p.m.-1:30 p.m. **Lunch: Facilitated Group Discussion Regarding Barriers Identified by the Morning Speakers**

Facilitator: Trina Anglin, M.D.
Maternal and Child Health Bureau, HRSA

1:45p.m.-3:00 p.m. **Small Group Breakout Focusing on Recommendations for Overcoming Barriers to SBHC Participation in Medicaid Managed Care: Strategic Directions for Development of Technical Support**

3:15 p.m.-4:30 p.m. Discussion of Recommendations From Small Group Discussions and Next Steps

Facilitator: Alexander Ross, Sc.D.
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ATTACHMENT C

Barrier Worksheets[5]

[5] For the breakout sessions, each workgroup was given a set of worksheets as a framework for discussions. Each group was unique in their approach and application of the worksheet. The attached worksheets have the framework categories but the content was left basically intact to capture the "flavor" of the discussions. A more synthesized summary of these discussions can be found on pages 16 -18 of the Meeting Report.

Lack of Perceived Benefit for the MCO to Contract with SBHCs

What is the underlying problem?

SBHCs need to identify and present the benefits to MCOs. Some examples of such benefits include that the SBHC:

- *Can increase MCO enrollment.*
- *Is a cost-effective alternative for direct service delivery.*
- *Can support and institute prevention and screening initiatives (i.e. asthma care, behavioral health, decrease ER visits).*
- *Provides an opportunity to market products to students and their families who may want to change MCOs.*
- *Enhances competition.*

Some of the problems SBHCs may encounter in working with the MCO include:

- *The limitations of capitated payment that MCOs receive from a State to provide services to beneficiaries.*
- *Challenges to assure continuity of care/coordination of care with the primary care provider in the MCOs network.*
- *The decision to move from an FFS model to a capitated model.*

Who could take a lead role in overcoming the challenge/barrier?

School-based health centers
MCOs (though that is currently unusual)

Who else needs to be involved in overcoming the challenge/problem?

All parties (SBHC, MCO, State Medicaid Agency, etc.)

Are new resources needed to solve the problem or is more effective use of current resources appropriate?

SBHC need to develop different business models. A market-driven approach would help the SBHCs appeal to MCOs.

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

- *Become involved before the State submits a 1915(b) or 1115 waiver.*
- *Get involved in the State negotiations of Medicaid managed care contracts.*

The group also noted that it would be helpful if the State requires MCOs to contract with SBHCs (e.g., Connecticut).

Lack of Marketing Sophistication within the SBHC to Sell to MCOs and Negotiate with MCOs.

What is the underlying issue?

Whether to use the primary care practice (PCP) model or not.

Credentialing

Acceptance of billing by nurse practitioners (NP) as the provider of care (nurse practitioners and physician assistants provide the bulk of the care in SBHCs).

Adequate SBHC staffing to meet the administrative burden.

A structure for accountability between the MCO and SBHC.

A mechanism available to the MCO that is supportive of the mission of SBHCs.

The three models described include:

- *Primary Care Provider (PCP) -- This applies to the many SBHCs that are part-time,(i.e. operate less than 30 hours/week)*
- *Comprehensive Medical and Mental Health Model --Most of these SBHCs are full- time operations.*
- *Full Service School Model -- This includes services other than medical and mental health, (e.g. counseling, educational services)*

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

Develop some mechanism for meeting minimum MCO contracting requirements by all of the SBHCs (a universal statement that gets buy-in from everyone).

Specifically, this statement should:

- *Be set high in terms of quality.*
- *Take into account professional requirements, the sponsoring organization's requirements, payer requirements - along with sensitivity to the educational environment of the SBHC and the need for quality standards regarding data collection.*
- *Provide some recognition to the SBHC if these standards are met.*

Other recommendations include:

- *Standardize elements of a contract (create templates).*
- *Develop and share data about SBHCs that is understood by all of the concerned parties.*
- *Include requirements to collect HEDIS type data, but also must go beyond (e.g. decrease in ER use).*
- *Identify ways to communicate results that are valued by the partners. For example focus on the value-added concept and include data directed toward the value to the schools themselves.*

The Difficulty in Accessing Payment for Mental Health Services

What is the underlying problem?

Hard to get paid for providing those services - as an example, a group counseling of teens to prevent depression cannot be billed as there is no DSM4 code for it.

Hard to define what specific services.

Credentialing issues.

Carve outs and subcontracting make negotiations complicated.

Prevention is outside the universe of reimbursable services.

Who could take a lead role in overcoming the challenge/barrier?

State Mental Health Directors

Who else needs to be involved in overcoming the challenge/problem?

Schools have an incentive, so they may be a good contact (though roles/responsibilities issues between clinical providers and guidance counselors may be an issue).

State policymakers need to be informed of the important role SBHCs play in this situation.

Are new resources needed to solve the problem or is more effective use of current resources appropriate?

Front end money to get the information out about the role SBHCs can play.

Marketing materials for the SBHCs---SBHCs seem to do well in providing behavioral services for youth.

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

New York has a model that provides a "road map" of what services are covered and by whom.

Use HEDIS or CQI Tool data to educate public and mental health professionals regarding the role SBHCs play.

The Difficulties in Negotiating the Role of the SBHC Under a PCCM Model

What is the underlying problem?

There is no sharing of lessons learned in utilizing a PCCM model in SBHCs.

There are differences between elementary health and adolescent health.

Should an adolescent have his/her own primary care case manager and the latitude to choose that provider.

There can be difficulties in identifying who the appropriate PCCM is. Also, the SBHC needs to be careful that it doesn't stand in competition for the Primary Care Provider's patient base.

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

Consider case management fees (which are allowed in the PCCM model).

Find a way to fund school services but not on an "every service" basis. SBHCs would have a different kind of contract with Medicaid, which would allow a relationship with both the PCP and the SBHC.

Consider lessons learned from other models, such as Urgent Care Centers. Many of the issues are the same and they may have resolved some of the patient care/billing reimbursement services concerns.

The Importance of Addressing Leverage and Positioning Issues for the SBHC

What is the underlying problem?

Need data (must be measurable) to show value added.

Field needs to go from "this feels right" to "this is the difference can we make."

Need to invest in health services research, especially about how SBHCs are financed (financing data has always been poor).

Would be valuable in developing a few measures to show return on investment (e.g., health care costs, health behaviors, educational outcomes, etc.).

Need to seek opportunities for schools and health care/managed care organizations to work together via SBHCs to solve problems (instead of working cross-purposes).

MCOs need to identify and communicate needs, (e.g. what will you do for my quality numbers).

Approaches/Recommendations to Overcome Barriers

Underwrite national studies to show value-added by SBHCs and address financing approaches/issues.

Need to involve multiple sites – collaboration of SBHCs within a geographic area.

The Limited Appreciation of Some States on the SBHC Role In The Service Delivery System

What is the underlying problem?

Policymakers are not aware or convinced of the benefits and successes of the SBHC.

Many States are concerned about the controversial issues (e.g., family planning) which interferes with other messages.

Some may have an understanding of the SBHC role, but are faced with monetary constraints (and SBHC are susceptible to being on the "chopping blocks" for funding).

Who could take a lead role in overcoming the challenge/barrier?

SBHCs/Federal partners/Associations (NASBHC)

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

Use data (HEDIS/CQI) tool to validate effectiveness.

Develop partnerships (not just clinical ones) to get the message out.

Market and educate State Policymakers—show the successes.

The Limited Capacity for Billing

What is the underlying problem?

Large administrative investment…most SBHCs don't have the infrastructure and the money received doesn't always offset the additional expense of billing.

Sponsoring agencies and outsource vendors define it as a low priority.

Need a billing model that works (mentioned that New York already has a fee-for-service model though it may not translate easily for the MCO model).

Volume of MCOs—A SBHC may need to work with as many as 10 MCOs and each organizations billing requirements may be different.

Some sponsoring agencies think that grant money is a sufficient source of income that doesn't need to be supplemented.

Who could take a lead role in overcoming the challenge/barrier?

SBHCs should be accountable and invest in the administrative infrastructure – sponsoring facilities should also be involved.

Who else needs to be involved in overcoming the challenge/problem?

Pressure from State legislation/HCFA might also be helpful.

Are new resources needed to solve the problem or is more effective use of current resources appropriate?

HRSA/HCFA might provide technical assistance and grants for billing model development and infrastructure. For example, in North Carolina, there is TA for rural SBHCs.

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

Make sure your program is supported in-house (i.e., market to your sponsoring agency).

Consider having organized billing across SBHCs.

Provide a mentoring program for SBHCs to help one another.

Mandate through contracts/grants that SBHCs must bill (NY is a case example).

Make it worthwhile for sponsoring agencies to assist (e.g., incentives)—this means having good data to motivate the sponsoring organization.

Debunk the "grant myth."

Perhaps consider an in-kind approach to reimbursement.

Get designation as a presumptive eligibility site—this makes a SBHC more attractive to MCOs.

The Difficulty of Costing Out Services

What is the underlying problem?

Adjusting Medicaid payments to cover the costs of providing care to the SBHC population. For example, the average cost per visit in a State may not match what the billable services yielded for Medicaid eligible children.

Providing access to people who didn't have access when rates were set.

Dental/Oral Health – most dentists won't participate in Medicaid because fees are too low. If payments were to rise and States raise their share, this could attract more dentists. With current payment rules, States don't have flexibility. But, this may be changing.

Who could take a lead role in overcoming the challenge/barrier?

Left blank.

Who else needs to be involved in overcoming the challenge/problem?

Left blank.

Are new resources needed to solve the problem or is more effective use of current resources appropriate?

Is there a research arm to HCFA/HRSA that can look at this issue? For example, information on "pull-out payments" for dental services, may be one aspect that can be examined for covering the costs of dental care.

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

Medicaid match issue - are there States using State and local dollars as a way of getting a Federal matching payment?

To the extent that dental care is a covered service, why not request a Federal match.? If States want to do that, no reason why Medicaid can't match. Perhaps with a carve out service, like school based health care, it may be easier.

The Need to Improve Relationships with the Parent Organizations Regarding Billing and Administrative Needs

What is the underlying problem?

SBHCs are dependent on how the parent organization reinvests in the SBHC.

Physicians in the community don't know about SBHCs. And for those that do, it puts them in a competitive mode! Pediatricians don't like to lose their patient base.

Unclear whether SBHCs are primary care providers or conduits to the primary care Provider.

Who could take a lead role in overcoming the challenge/barrier?

HRSA and HCFA.

Department of Education - may need to bring this issue to the State or county level .

Who else needs to be involved in overcoming the challenge/problem?

Left blank.

Are new resources needed to solve the problem or is more effective use of current resources appropriate?

HCFA has been trying through best practice guides to highlight what States are doing. Since this may be outdated, updated information could be insightful towards highlighting.

Finally and based on the discussion, what are some approaches/recommendations for overcoming this barrier/challenge?

In Denver, they use a feeder approach (12 SBHCs feed into the FQHC). This may serve as a model (although there may be some difficulty with areas where there are multiple sponsors--e.g., NY)

Need to look beyond a "micro exchange" of who's getting part of the money. Rather the macro question of "what is the best way to finance health care for all kids" should be the driving consideration.

Use the NASBHC to communicate to the broader public health community about SBHCs.

Hold State meetings to develop a State plan - include providers and business community.

ATTACHMENT D

Opening Presentation: Role of School-Based Health Centers in Serving Child and Adolescents and the Challenges in Obtaining Reimbursement for those Services

Presentor: John Schlitt, Executive Director
National Assembly on School Based Health Care

Responder Panel

State Medicaid Perspective
Wendy Johnston
Program Development/Child Health Unit
Florida Agency for Health Care Administration

School Based Health Center Perspective
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Sue Luce
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School-Based Health Centers and Medicaid Managed Care: Two States' Experiences

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