

# Partners in Access: School-Based Health Centers and Medicaid

## Policies & Practices

National Assembly on School-Based Health Care  
October 2001

## Partners in Access: School-Based Health Centers and Medicaid

As interest in children's and adolescent's health and mental health care access has grown, school-based health centers have become more commonplace in American schools. In seeking a diverse array of public and private funding sources to implement, sustain, and expand these innovative programs, communities have increasingly come to regard Medicaid as an essential component of the school-based health center's financing strategy. It was logical to assume that Medicaid reimbursement would provide critically needed resources for programs that deliver services to a population likely to be covered by public insurance. But as providers, policy makers, and advocates would soon learn, the "quick fix" that was to be third-party revenue collection proved far more complicated.

Significant stumbling blocks were identified at the outset. Medicaid policies that prohibited centers from providing free care, required on-site physician supervisors, and denied services not considered to be "medically necessary" were seemingly unsolvable barriers. But the barriers were not singularly policy-driven. Lack of experience and limited administrative capacity on the part of school-based health centers contributed to frustration and marginal returns. The requirements of health services billing -- information systems, coding technology, collections personnel -- were often out of reach for the small health care programs.

The pursuit of third-party reimbursement, especially Medicaid and Medicaid managed care, has in recent years dominated the public discourse on school-based health centers. The Robert Wood Johnson Foundation's six-year national program (1994-2000), *Making the Grade*, devoted great attention to assisting states in the development of financial policies, including public insurance reimbursement. The National Assembly has in its first six years convened numerous information sessions with key stakeholders to assess Medicaid reimbursement policy, and collected finance data from the field to measure its impact on school-based health center revenue.

Despite the increased attention to Medicaid reimbursement by many states across the regions, a popular sentiment among the participants was that billing is not regarded as advantageous or profitable. Put more colorfully by one provider, "the juice isn't worth the squeeze." Providers enumerated several reasons for their position:

- Medicaid's free care policy requiring health centers to bill non-Medicaid clients is described as burdensome because full-time billing and collections staff are needed to collect fees, insurance co-pays and deductibles, as well as track insurance status of users.

**NOTE:** *Medicaid legal expert Andy Schneider suggests that Medicaid's free care policy has no statutory basis. See Appendix, page 8.*

- Billing of health plans and commercial insurers that results in an “explanation of benefits” being forwarded to the client’s home is considered a breach of confidentiality. As a result, providers are reluctant to bill for potentially confidential services.
- Uninsurance is still a significant problem in some communities, especially where immigrant populations are not eligible, or families simply do not want to be on public assistance.
- School-based health care providers have difficulty getting accurate and updated insurance information from students.
- State Medicaid/CHIP service and provider eligibility may preclude revenue recovery for certain school-based providers (nurse practitioners, clinical social workers) or services (preventive mental health and counseling including individual, family and group, risk assessment, health education, self-management of chronic issues, etc.).
- Medicaid reimbursement is often not re-invested back in school health services, reducing incentives to programs to invest in billing capacity.

## **Policies and Practices**

Most recently, in the spring of 2001, the National Assembly conducted a series of regional roundtables with providers and state and federal Medicaid staff in Atlanta, Chicago, and Dallas (see agenda and participants rosters in appendix, pages 57-63). Participants explored regulatory issues that were perceived as barriers to reimbursement, and sought the advice and assistance of state and

regional staff to clarify policies and amplify those practices that have resulted in Medicaid revenue recovery. NASBHC’s goal was to foster relationships among school-based health care advocates and state and regional health care financing officials.

Reports by providers and policy makers illuminated a number of successful, promising, or “too early to tell” policies and practices. At the conclusion of each session, the group identified what it viewed as “best practice” from the region. Other state practices or policies, although not described at the regional meetings, are also identified here.

### ***States as Problem-Solvers***

Common among a number of state reports was the necessity of state leadership from public health and Medicaid agencies to address reimbursement barriers and forge solutions. Several of the participating state teams (Illinois, Louisiana, North Carolina, and New Mexico) were emphatic about the importance of collaboration among state public health department, Medicaid agency, and school-based health centers in developing proactive, interagency problem-solving and technical assistance to address policy barriers and build the health centers’ capacity. In Illinois, for example, state-funded public aid agents are deployed to school-based health centers to help staff develop enrollment and billing expertise.

### ***Define School-Based Health Centers as Medicaid Provider Type***

States may define school-based health centers as Medicaid providers. The Illinois Department of Public Aid, in 1999, adopted school-based health centers as one of seven non-institutional Medicaid service provider types, which also includes hospital-based organized clinics, rural health clinics, federally qualified health centers, and maternal and child health clinics. To be enrolled as a “SBHC” provider type in the Illinois Medicaid, centers must meet standards established in the State Department of Human Services (DHS) administrative code. The application process includes a certification letter from DHS, a public aid enrollment application, medical provider agreement and CLIA certificate.

New York defines school-based health center reimbursement rates through the health care institutions that serve as sponsoring agencies (New York’s Article 28 facilities). School-based health centers are added to the operating certificate of the health care organization, which can bill for school-based health center services at the facility’s all-inclusive Medicaid reimbursement rate.

#### **Policy Documentation in Appendix**

- Illinois Register – SBHCs Defined as Medicaid Provider Type (p. 16)
- New York Medicaid reimbursement policy and billing information (p. 18)

### ***Set Standards***

Several states have established credentialing or licensure processes to ensure that school-based health centers seeking public grant funds and Medicaid reimbursement will adhere to quality

standards consistent with health care industry practice. Examples include Illinois, Michigan, New York, and North Carolina, which have promulgated state-defined standards for clinical and administrative policies and procedures, scope of service, staffing, data management, etc. The state “stamp of approval” entitles school-based health centers to Medicaid billing advantages, depending on specific state policies.

#### **Policy Documentation**

- Illinois Certification Requirements (p. 20)
- Michigan Certification Requirements (p. 25)
- North Carolina Credentialing Requirements (p. 28)

### ***Prior Authorization Exemption***

Under typical Medicaid primary care case management (PCCM) models, authorization to provide services to Medicaid enrollees is required from the child’s case manager. The North Carolina Medicaid agency has exempted school-based health centers that meet credentialing or certification criteria from seeking PCCM prior authorization in order to provide services to an enrollee. The school-based health centers bill the state Medicaid agency directly at a standard fee-for-service Medicaid rate.

#### **Policy Documentation in Appendix**

- *North Carolina Medicaid Policy on Prior Authorization and SBHCs (p. 31)*

## ***Health Plan Required to Reimburse SBHC***

Some states have elected to mandate reimbursement by Medicaid health plans to school-based health centers. Michigan and Maryland Medicaid agencies require state managed care plans serving Medicaid enrollees to pay for services delivered in school-based health centers.

### **Policy Documentation in Appendix**

- Maryland Code on Conditions for Reimbursement (p. 33)
- Michigan Medicaid and SBHCs Policy (p. 35)

## ***SBHCs Exempted from Managed Care***

New York has explicitly exempted its school-based health centers from its Medicaid managed care program. Instead of billing the child's health plan, all school-based health centers that hold a license with the state health department bill the state Medicaid agency directly. Although the policy was adopted as a temporary solution to managed care relationships, the carve out has been extended over the past several years.

### **Policy Documentation in Appendix**

- New York State Health Department correspondence (1999, 2000, 2001) on managed care carve out (p. 37)

## ***Mandate Contracts***

In Connecticut, the state's four Medicaid managed care organizations are required to have contracts with all school-based health centers in their service area. Contract specifications are left to the SBHC and health plan to negotiate.

Similarly, New Mexico Human Services and Health Departments have partnered on a pilot effort in the Albuquerque area to require contracts between school-based health centers and Medicaid managed care organizations.

### **Policy Documentation in Appendix**

- Connecticut's Medicaid managed care and SBHC contract policy (p. 40)
- New Mexico SBHCs and Managed Care Plans Pilot Project (p. 41)
- New Mexico Managed Care and SBHC contract template (p. 42)

## ***Mental Health Reimbursement***

Reimbursement codes for mental health-related services delivered in school-based health centers were created in North Carolina and New Mexico, the result of advocates who urged the state health care payers to adopt more prevention-friendly reimbursement. The goal of each state's policy is to provide remuneration for services that are not directly tied to treatment of emotionally disabled children. Adjunct, or enhanced, services care that complement therapeutic services include assessment and diagnosis, individual and group preventive short-term visits that don't result in diagnosis, professional collaboration meetings, family communication, classroom observation, etc.

### **Policy Documentation in Appendix**

- New Mexico Behavioral Health Initiative (p. 49)
- MOA with mental health designating LA SBHCs as providers (p. 52)
- North Carolina Policy (p. 55)

## Designating SBHCs as Presumptive Eligibility Providers

Connecticut's school-based health centers were designated as presumptive eligibility "qualified entities" in the state's Medicaid and S-CHIP programs (HUSKY) to expand enrollment at the point of service, as well as generate revenue for reimbursable services provided by SBHCs to presumptively eligible children on the actual date that service was provided. Five SBHCs were identified as pilot sites in the first month of implementation, with the remaining SBHCs rolled into the program shortly thereafter.

### Policy Documentation in Appendix

- *Connecticut's Presumptive Eligibility policy* (p. 56)

What each of these states has in common is an historical commitment to school-based health care with the view that they represent an important part of the health care safety net. The pursuit of Medicaid-friendly policies for school-based health centers is regarded by many public health agencies as critical to the development of long-term sustainable funding.

The effect of the policies described in this report – many only recently implemented – is not fully known. National Assembly data, recently collected from a national finance survey of school-based health center revenue and expenditures, may provide additional information about the contributions of Medicaid, CHIP and other public and private third party payers to health center operating expenses. No matter the fiscal impact, patient care revenue pursuit has most decidedly changed the way school-based health centers do business.

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*Partners in Access is made possible by a generous grant from the W.K. Kellogg Foundation.*

## Acknowledgements

Special thanks to the state public health and Medicaid agency representatives who kindly supplied the National Assembly with documentation of Medicaid policies related to school-based health centers: Connecticut, David Parrella; Illinois, Judy Redick; Louisiana, Maureen Daly; Maryland, Donna Behrens; Michigan, Kathy Stiffler; New Mexico, Mary Kay Pera; New York, Annette Johnson, Barbara Frankel; North Carolina, Carolyn Sexton.

# Appendix

## **Technical Policy Support**

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- C. New York School-Based Health Centers and Medicaid (p. 18)

## **SBHC Standards for Medicaid Reimbursement**

- D. State Of Illinois Handbook for School Based Linked Health Centers, Illinois Medical Assistance Program (p. 20)
- E. Michigan Department of Community Health Certification of School Based or Linked Health Centers (p. 25)
- F. North Carolina SBHC Credentialing Standards (p. 28)

## **Prior Authorization Policies**

- G. North Carolina Medicaid Policy on Prior Authorization for SBHCs (p. 31)

## **Health Plans Required to Reimburse SBHCs**

- H. Maryland Medicaid Managed Care Program: School-Based Health Centers, Maryland Register, Volume 23, Issue 25, Friday, December 9, 1996 (p. 33)
- I. Michigan Department of Community Health Medical Services Administration Bulletin (p. 35)

## **Exempting SBHCs from managed care**

- J. New York State Health Department correspondence (1999, 2000, 2001) on managed care carve out (p. 37)

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## **Mental Health Reimbursement**

- N. New Mexico Behavioral Health Initiative (p. 49)
- O. Interdepartmental Agreement for School-Based Mental and Addictive Disorder Services within the Louisiana Office Of Public Health (p. 52)
- P. North Carolina Early Intervention Behavioral Health Care (p. 55)

## **Presumptive Eligibility**

- Q. Connecticut's Presumptive Eligibility and SBHCs Policy (p. 56)

## **Agenda and Participants Roster**

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FROM: Andy Schneider

RE: HCFA's "Free Care" and "Third Party Liability" Policies

DATE: June 12, 2001

As requested, here is a brief analysis of HCFA's "free care" and "third party liability" (TPL) policies as they apply to SBHC billing for primary care services furnished to Medicaid-eligible children and adolescents. This memo reviews each of these policies, their legal bases, and their rationales, and it identifies some open issues on which clarification from HCFA would be helpful. The memo concludes with recommendations to NASBHC for improving the ability of SBHCs to bill state Medicaid programs for primary care services to Medicaid beneficiaries.

### *HCFA's "Free Care" Policy*

HCFA's "free care" policy is that federal Medicaid matching funds are not available for payments to a provider unless the provider has "the authority to charge" all patients for services rendered and uses this authority. As stated in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), at p. 42, "If only Medicaid [beneficiaries] or their third parties are charged for the service, the care is free and Medicaid will not reimburse for the service." [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm).

In the case of schools, HCFA has stated that the "free care" policy would not prevent payment for Medicaid-covered services to an SBHC if the SBHC:

- (1) establishes a sliding-scale fee schedule for its services,
- (2) determines whether every student served has any third-party coverage other than Medicaid, and
- (3) bills the student (the student's insurer, if any) for the cost of the services.

HCFA recognizes two exceptions to this "free care" policy:

- (1) Medicaid-covered services "provided under an IEP or IFSP;" and
- (2) Medicaid-covered services "provided by Title V".



In the case of each exception, the school is still required to “pursue any liable third party insurers for reimbursement.” (TPL is discussed at pp. 3-4 of this memo).

**Legal Basis for HCFA’s “Free Care” Policy.** In its August 1997 *Guide* setting forth its “free care” rule, HCFA cites no statutory or regulatory basis for the policy (Attachment I). In fact, neither the federal Medicaid statute nor HCFA’s own regulations state such a policy, much less a policy specific to SBHCs delivering primary care services. Similarly, there is no statutory or regulatory basis for the two exceptions that HCFA has carved out; HCFA has imputed the exceptions from statutory language identifying Medicaid as the first dollar payor for purposes of IDEA and Title V.

In short, it appears that HCFA has relied upon its inherent authority to administer the Medicaid program in order to craft its “free care” rule. It has chosen to use this authority in a manner that makes it difficult for SBHCs to bill Medicaid for covered primary care services delivered to Medicaid beneficiaries. In my view, HCFA could use its inherent authority to carve out another exception to the “free care” rule that allows states, at their option, to permit SBHCs to bill Medicaid for primary care services provided to Medicaid-eligible students without billing all students for all services.

**Rationale for HCFA’s “Free Care” Policy.** The rationale for HCFA’s “free care” rule is that federal Medicaid funds should not be used to pay for services that are furnished without charge. As a general matter, this is eminently reasonable. However, in the case of SBHCs, which provide primary care services to all students seeking care regardless of ability to pay and which generally do not bill the students, their parents, or any insurers or managed care plans for services rendered, this “free care” rule is problematic.

As HCFA itself acknowledges in its August 1997 *Guide* at p. 43, the effect of its “free care” rule is to establish a barrier for SBHCs in accessing Medicaid payments: “This policy on free care somewhat limits the ability of schools to bill Medicaid for covered services provided to Medicaid eligibles unless the school charges all students for the services provided or meets either [the IDEA or Title V exceptions].” HCFA pointedly notes that “many schools provide a wide range of health services which would *not* fall under either exception” (emphasis added).

**Open Issues in HCFA’s “Free Care” Policy.** The August 1997 *Guide*, combined with the absence of any statutory or regulatory guidance on the “free care” policy, leaves several important issues unresolved. In particular, there is considerable uncertainty in the field as to the scope of the Title V exception. In the absence of an SBHC-specific exception to HCFA’s “free care” policy, a broad Title V exception could be of great value to SBHCs seeking to participate in Medicaid as well as those state Medicaid agencies interested in using SBHCs to increase access to care for eligible children. HCFA clarification of the following questions – at either the Central or the Regional Office level – could frame such a broad Title V exception.

The August 1997 *Guide* states that Medicaid-covered services “provided by Title V” are exempt from the “free care” rule (p. 43). Which of the following meets this “provided by Title V” test?

- 1.) The SBHC is sponsored by the state or local Title V agency.
- 2.) The SBHC is sponsored by a school or by a nonprofit entity, but the majority (50 percent or more) of its operating budget comes from the state Title V program in the form of a grant or contract.
- 3.) The SBHC is sponsored by a school or nonprofit entity, its revenues come from a variety of sources, including a grant or contract it receives from the state Title V agency for the provision of a specified set of services (e.g., immunizations). May the SBHC bill Medicaid for the Title V-specific services (e.g., immunizations) without billing all patients for all services? May the SBHC bill Medicaid for other Medicaid-covered services that it provides to children who are eligible for Medicaid and Title V without billing all patients for all services?
- 4.) The SBHC is sponsored by a school or nonprofit entity, and it receives no Title V funding. However, under the state's Title V program, some of the children it treats are eligible for Title V services. May the SBHC bill Medicaid for the Medicaid-covered services it furnishes to Title V-eligible children who are also eligible for Medicaid without billing all patients for all services?
- 5.) The SBHC is sponsored by a school or nonprofit entity, and it receives no Title V funding. However, under the state's Title V program, the SBHC is designated as a "safety net" provider with a policy of treating all children regardless of source of payment. May the SBHC bill Medicaid for the Medicaid-covered services it furnishes to Medicaid-eligible children without billing all patients for all services?

#### *HCFA's "Third Party Liability" (TPL) Policy*

Unlike the State Children's Health Insurance Program (CHIP), Medicaid does not deny eligibility to children who have private health insurance coverage. Children and adolescents qualify for Medicaid based on their age and their family income (and in some states, resources). If Medicaid-eligible children also happen to have coverage as dependents under one or both parents' private health insurance policies, this coverage is viewed not as a disqualifying event but as a liable "third party" that should pay for covered services before Medicaid pays. Accordingly, the federal Medicaid statute requires state Medicaid agencies to take "all reasonable measures" to determine the legal liability of third parties (including health insurers and managed care plans) to pay for care and services covered under the state Medicaid program.

HCFA's August 1997 Guide interprets this TPL policy in the context of "schools" (not just SBHCs). The general rule is that schools, like other Medicaid providers, must bill a beneficiary's health insurer first, before billing Medicaid. This practice is known as "cost avoidance," a reference to the purpose of helping Medicaid avoid paying the costs of covered services for which other insurers are responsible. However, in the case of "preventive pediatric care services," a different policy applies: "pay and chase." This means that, in the case of these services, the school provider "may bill the state Medicaid agency, which will pay the claim, and the state will seek reimbursement from a liable third party." (Attachment II).

This “preventive pediatric care services” exception to the general TPL “cost avoidance” rule is of particular importance to SBHCs furnishing primary care to children and adolescents. The August 1997 *Guide* at p. 46 notes that HCFA’s *State Medicaid Manual* “includes a list of diagnosis codes that, at a minimum, states are required to pay and chase,” including preventive medicine visits and screening and preventive treatment for infectious and communicable diseases. (Attachment III). Of particular importance to SBHCs is the August 1997 *Guide*’s statement that “States are given discretion to define the list [of preventive pediatric service diagnoses] more broadly. For instance, states should pay and chase for additional diagnoses whenever using the cost avoidance method would discourage provider participation.” Clearly, the use of the cost avoidance method has discouraged many SBHCs from participating in Medicaid, so states could easily justify the designation of additional “pay and chase” diagnoses for SBHCs.

**Legal Basis for HCFA’s “TPL” Policy.** In contrast to HCFA’s “free care” policy, there is actually a statutory basis for “TPL” policy. The problem is that HCFA’s interpretation of the statute in the context of SBHC services is highly restrictive and makes life unnecessarily difficult for SBHCs.

Section 1902(a)(25) of the Social Security Act requires state Medicaid agencies to “take all *reasonable* measures to ascertain the legal liability of third parties (including health insurers...) to pay for care and services available under [the state Medicaid program]...” (emphasis added). The statute goes on to specify that in the case of “preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the [state Medicaid program],” the State “shall” make payment for the services “without regard to the liability of a third party for payment for such services” and “seek reimbursement from such third party ... where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery.”

**Rationale for HCFA’s “TPL” Policy.** In HCFA’s view, “Medicaid is generally the payer of last resort. Congress intended that Medicaid, as a public assistance program, pay for health care only after a beneficiary’s other health care resources have been exhausted.” (August 1997 *Guide* at p. 43). As a general matter, this is unassailable. But it is not an absolute policy. Otherwise, Congress by statute would have required that state Medicaid agencies make “every possible effort” to determine third party liability rather than take “all reasonable measures.” Similarly, Congress would have mandated cost avoidance in all cases, rather than carving out an exception for “preventive pediatric care (including EPSDT services).”

A close reading of the August 1997 *Guide*, and especially the text set forth in Appendix II, suggests that HCFA was not focusing on SBHCs delivering primary care when it developed the *Guide*. Instead, HCFA’s concern appears to have been services such as speech therapy or physical therapy furnished by schools to children under IEPs and IFSPs. The policy considerations with respect to these services differ substantially from those relating to access to primary care services for children not under IEPs or IFSPs.

## *Recommendations*

In its August, 1997 *Guide*, HCFA expressly acknowledged that “these requirements and policies regarding third party liability and free care are problematic for school-based providers. Schools typically do not have the staff, experience, or equipment to run an efficient billing operation. HCFA has considered alternatives to these requirements but as yet, no changes have been made.” (p. 49).

It is now well over 3 years since this *Guide* was written, and, judging from the Regional meetings NASBHC facilitated in March, HCFA has still not developed alternatives to address the issues facing SBHCs that deliver primary care services to Medicaid-eligible children. There is now a new Administration that has expressed its interest in making HCFA more responsive. I would therefore recommend that NASBHC pursue the following policy clarifications with HCFA:

- Work with states Medicaid and Title V agencies to seek HCFA clarification, ideally in the form of a State Medicaid Director (SMD) letter, of the questions listed at page 3 regarding the Title V exception to HCFA’s “free care” policy.
- Depending upon HCFA’s willingness to clarify the Title V exception to address SBHC concerns, seek a statutory exemption from HCFA’s “free care” policy for SBHCs providing primary care services.
- With respect to TPL “cost avoidance” requirements, work with interested states and HCFA Regional Offices to tailor the statutory “preventive pediatric care” exception to the billing codes used by SBHCs
- If the statutory “preventive pediatric care” exception proves not to be sufficiently broad to accommodate all SBHC billing codes, seek a statutory change to broaden the exception to include primary care services provided by SBHCs.

I recognize that these recommendations will not address the problems faced by SBHCs in states that are not supportive of SBHCs or that do not want to facilitate participation by SBHCs in Medicaid. I do not believe it is realistic to expect either Congress or HCFA to require or even encourage states to be supportive of SBHCs. However, I do believe that there is sufficient flexibility in the current Medicaid statute to allow HCFA to enable states, at their option, to minimize the “free care” and “TPL” policy barriers to SBHC participation in Medicaid.

## ATTACHMENT I

HCFA articulates its “free care” policy in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm), as follows:

Free Care. An important requirement related to billing for Medicaid covered school-based services is the issue of “free care.” From the outset of the Medicaid program, a principle basic to public assistance has applied to Title XIX, in that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free care, or services provided without charge, are [sic] services for which there is no beneficiary liability and for which there is no Medicaid liability. In applying the free care principle to determine whether medical services are provided free of charge and, thus, there is no payment liability to Medicaid, a determination must be made whether both Medicaid and non-Medicaid beneficiaries are charged for the service. Providers of Medicaid services must have the authority to charge for their services and utilize this authority, before Medicaid will make payment. If only Medicaid recipients or their third parties are charged for the service, the care is free and Medicaid will not reimburse for the service.

Schools may employ certain methods to ensure the care is not considered free, allowing Medicaid to be billed. The services would not be considered free if the following conditions are met. The provider:

- (1) Establishes a free schedule for the services provided (it could be sliding scale to accommodate individuals with low income);
- (2) Ascertains whether every individual served by the provider has any third-part benefits, and
- (3) Bills the beneficiary and/or any third parties for reimbursable services.”

Exceptions to Free Care. For purposes of the provision of school-based health services, there are two exceptions to the free care rule, described below.

- (1) IDEA. ...Medicaid-covered services provided under an IEP or IFSP are exempt from the free care rule. This means that school providers may bill Medicaid for Medicaid-covered services provided to children under IDEA even though they may be provided to non-Medicaid eligible children for free...although the services would be exempt from the free care rule, the school would still have to pursue any liable third party insurers for reimbursement.
- (2) Title V. ....Medicaid-covered services provided by Title V are exempt from both the free care rule and the policy of Medicaid as the payer of last resort in that Medicaid will pay before Title V for Medicaid-covered services. Again, although the services would be exempt from the free care rule, the school would still have to pursue any liable third party insurers for reimbursement before billing Medicaid.

## ATTACHMENT II

HCFA articulates its “third party liability” (TPL) policy as it affects schools in *Medicaid and School Health: A Technical Assistance Guide* (August 1997), [www.hcfa.gov/medicaid/scbintro.htm](http://www.hcfa.gov/medicaid/scbintro.htm), at p. 48:

“...schools must abide by the payment of claims provisions at 42 CFR 433.139 where liable third parties are involved. This means that, as a Medicaid provider, schools may be required to bill the beneficiary’s health insurance first before billing Medicaid to determine the extent of the insurer’s payment liability. If, under Medicaid, the services meet one of the regulatory exceptions or the state has obtained a waiver of the cost avoidance requirements, the state may pay in full and seek recovery of reimbursement from the liable insurer. This removes the administrative burden of seeking TPL for services from the school provider and places it on the state Medicaid agency. For preventive pediatric care services, the school provider may bill the state Medicaid agency, which will pay the claim, and the state will seek reimbursement from a liable third party. However, unless the state interprets the typical treatment services under the scope of an IEP or IFSP such as the speech or physical therapy, to fall under the preventive pediatric services exception to the cost avoidance method of payment of claims, the school provider will have to pursue any liable third parties before billing Medicaid.”

### ATTACHMENT III

Excerpt from HCFA's *State Medicaid Manual*, Part 03, Section 3904.4, relating to the scope of "pay and chase" for preventive pediatric care,  
[www.hcfa.gov/pubforms/45\\_smm/sm\\_03\\_3\\_3900\\_to\\_3910.15.htm#\\_toc490897594](http://www.hcfa.gov/pubforms/45_smm/sm_03_3_3900_to_3910.15.htm#_toc490897594)

"B. Prenatal and Preventive Pediatric Care – You must pay and chase in situations where the claim is for prenatal care for pregnant women or preventive pediatric services (including EPSDT services) that are covered under the State plan. The intent of this requirement is to alleviate the administrative burden associated with TPL efforts so as not to discourage participation in the Medicaid program by physicians and other providers of these types of services, since beneficiaries in need of such services already have difficulty finding providers in many communities....

The following exhibits are provided as guidelines for determining certain claims for which you must use the pay and chase method....The second exhibit includes diagnosis codes related to preventive pediatric care. These diagnosis codes were selected since it would be impractical to identify every procedure code which could relate to prenatal and preventive pediatric care. In order to identify prenatal claims which must be paid and chased, use the appropriate procedure codes related to these diagnoses. These guidelines define the terms prenatal and preventive pediatric care narrowly. You have the option of defining these terms more broadly. For example, the definition of prenatal care may be expanded to include preexisting conditions which are likely to affect the pregnancy."

Exhibit 2: "Preventive pediatric care is defined as screening and diagnostic services to identify congenital physical or mental disorders, routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from ever occurring in children under age 21. This includes immunizations, screening tests for congenital disorders, well child visits, preventive medicine visits, preventive dental care, and screening and preventive treatment for infectious and communicable diseases."

The following ICD-9-CM Diagnosis Codes are listed: VO1, VO2, VO3-VO6, VO7, V20, V70.0, V72.0-.3, V73-V75, V77.0-.7, V78.1-.3, V79.2-.3, V79.8, V82.3-.4



## **Illinois Department of Public Aid**

### **Payment for Non-Institutional Services**

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#### Section 140.461

g) School-based/Linked Health Clinics (centers) must be certified by the Department of Human Services (DHS) that they are meeting the minimum standards established by DHS (77 III. Adm. Code 2200). Examples of certification requirements include:

- 1) School based health centers must be located in schools or on school grounds, serving at least the students attending that school.
- 2) School linked health centers are located off school grounds, but a formal relationship must exist to serve students attending a particular school or multiple schools within the district.
- 3) All medical services performed by mid-level practitioners (i.e., medical services providers who are not physicians), such as nurse practitioners, must be under the direction of a physician.
- 4) The center must have a medical director. The medical director of the center must be a qualified physician, licensed in Illinois to practice medicine in all its branches. Each center's medical director must develop standing orders and protocols for services provided at the center. The medical director shall ensure compliance with the policies and procedures pertaining to medical procedures and health care services. The medical director shall supervise the medical protocols involving direct care of students. The center must have consultant or back-up physicians with hospital admitting privileges. The consultant provider of the clinic for obstetrical care, as appropriate, must have delivery privileges. All medical services must be delivered in accordance with the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American Academy of Family Practice Guidelines and the standards established by outside regulatory agencies.
- 5) All laboratory services must be in compliance with the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (42 USC 263a). DHS will provide ongoing monitoring to assure that appropriate standards are followed.
- 6) The center shall be staffed by Illinois licensed, registered, and/or certified health professionals who are trained and experienced in community and school health, and who have knowledge of health promotion and illness prevention strategies for children and adolescents. The center must ensure that staff are assigned responsibilities consistent with their education and experience, supervised, evaluated annually and trained in the policies and procedures of the center.
- 7) The center must establish procedures for the availability of primary care providers and for 24-hour back-up services when the center is not open.
- 8) Services may be provided to eligible students who have obtained written parental consent, or who are 18 years of age, and/or who are otherwise able to give their own consent.

- 9) The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and/or parental consent to share information regarding a student's health care.
- 10) The center must operate in accordance with a systematic process for referring students to community-based health care providers when the center is not able to provide the services required by the student. The center may provide medical care to a Managed Care Entity (MCE) enrolled student. The center shall refer that MCE enrolled student to the MCE primary care provider for continuing and definitive care.
  - a) The center shall refer a student who requires specialty medical and/or surgical services to his or her primary care provider of MCE to obtain a referral for a specialist.
  - b) The center shall document in the student's record that the referral was made, and document follow-up on the outcome of the referral when relevant to the health care provided by the center.
- 11) The center must develop a collaborative relationship with other health care providers, insurers, managed care organizations, the school health program, students and parents or guardians with the goal of assuring continuity of care, pertinent medical record sharing and reducing duplication and fragmentation of services.
- 12) Data Requirements  
The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

#### Section 140.462 Covered Services in Clinics

##### f) School Based/Linked Health Clinics (Centers)

Covered services are the following services, when delivered in a school based/linked health center setting as described in Section 140.461(g):

- 1) Basic medical services: well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures and age appropriate anticipatory guidance; immunizations; EPSDT services; diagnosis and treatment of acute illness and injury; basic laboratory tests; prescriptions and dispensing of commonly used medications for identified health conditions, in accordance with Medical Practice and Pharmacy Practice Acts; and acute management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.
- 2) Reproductive health services: gynecological exams; diagnosis and treatment of sexually transmitted diseases; family planning; prescribing and dispensing of birth control or referral for birth control services; pregnancy testing; treatment or referral for prenatal and postpartum care; and cancer screening.

## **NEW YORK SCHOOL-BASED HEALTH CENTERS AND MEDICAID**

### **BACKGROUND**

- In August 1992, the New York State Department of Health issued a directive outlining a new policy for the Article 28 sponsors of school-based health centers (SBHCs). This policy allowed an Article 28 to add a SBHC site to their operating certificate as a satellite clinic and to bill for SBHC services at the facility's all inclusive Medicaid reimbursement rate.
- The SBHC Medicaid reimbursement policy was altered by changing from a special two-category rate (comprehensive visit and a routine visit) to the Article 28 facility rate. Billing for Medicaid was to be done in conformance with pertinent Federal and State statutes, rules, regulations and policies applicable to the scope of services listed on the operating certificate for that satellite clinic site.

### **SBHC SERVICES BILLABLE TO MEDICAID**

- SBHC Article 28 providers should bill for all eligible Medicaid and third party visits.
- Medicaid can be billed for SBHC visits by eligible students at the rates established by the New York State Department of Health for the sponsoring Article 28 facility.
- Eligible students are those enrolled in the SBHC and in Medicaid. For a few specialized schools that serve both students and their children, these children can also receive services.
- A special carve-out allows for fee-for-service billing for eligible services provided to students enrolled in Medicaid managed care plans. This carve-out expires March 31, 2002.

### **BILLABLE SBHC SERVICES**

- Article 28 sponsors can bill Medicaid for all SBHC services that are in conformance with pertinent Federal and State statutes, rules, regulations and policies applicable to the scope of services listed on their operating certificate for that satellite clinic site.
- Generally, medically necessary services are billed on a once-a-day threshold visit basis. Examples of the services that can be billed include, but are not limited to:
  - Comprehensive physical examinations.
  - Initial visit for a condition not previously diagnosed or followed.
  - Follow-up visit for a previously diagnosed and treated condition.
  - Follow-up visit for an abnormal screening or a laboratory test.
  - Visit during which one or more immunizations are administered
  - Acute injury or trauma visit

## **SBHC SERVICES NOT BILLABLE TO MEDICAID**

- **Services provided by a social worker are not billable.**  
While a social worker may provide services within the scope of his/her practice, including the provision of mental health services, a claim for a visit cannot be submitted.
- **Mass screenings are not billable.**  
This includes, but is not limited to:
  - Hearing
  - Vision
  - Dental
  - Scoliosis
  - Pediculosis
- **Minor problems and complaints, including first aid are not billable.** This includes attention to minor problems and complaints of students which could be cared for at home without professional medical assistance including, but not limited to:
- **Other Article 28 non-billable services** are also non-billable for SBHCs. These include, but are not limited to:
  - Medical social services
  - Pharmacy
  - Nutrition
  - Respiratory and recreational therapy
- **Services provided to a student as part of their Individualized Educational Plan (IEP)** are not billable by the Article 28.

STATE OF ILLINOIS HANDBOOK FOR  
SCHOOL BASED LINKED HEALTH CENTERS  
*Illinois Medical Assistance Program*

SECTION 11  
SCHOOL BASED/ LINKED HEALTH CENTER SUPPLEMENT

For consideration to be given by the Illinois Department of Public Aid (IDPA) to reimburse a School Based/Linked Health Center (SBLHC), such services must be provided by a center enrolled for participation in the Illinois Medical Assistance Program (IMAP) and certified by the Illinois Department of Human Services (IDHS). This supplement is intended to be used in conjunction with Chapter I 00-General Policy, Chapter A-200 Handbook for Physicians, and the Healthy Kids Provider Manual. The Handbook for Physicians includes guidelines and specific billing issues applicable to providers of primary care services.

S-200      CERTIFICATION

School Based/Linked Health Centers must be certified by IDHS that they meet the standards established by IDHS in 77 111. Adm. Code, Part 2200. For the centers to be certified these standards include but are not limited to:

- SBLHCs must be located in schools or on school grounds, serving at least the students attending that school or SBLHCs not located at the school must have a formal relationship to serve students attending a particular school or multiple schools within the district.
- The medical director of the center must be a qualified physician. Each center must develop protocols for the health care professionals.
- All laboratory services must be in compliance with Clinical Laboratory Improvement Amendments (CLIA).
- The center shall be staffed by Illinois licensed, registered, and or certified health professionals who are trained and experienced in community and school health. The center must establish procedures for the availability of the primary care providers and for 24 hour per day, 12 months per year access to routine, urgent, and emergency care, telephone appointments and advice.
- The center must have in place telephone answering methods that notify students and parents/guardians where and how to access 24 hour back-up services when the center is not open.
- The center must provide services to eligible students who have obtained written parental consent, or who are 18 years of age, or who are otherwise able to give their own consent.
- The center must coordinate care and the exchange of information necessary for the provision of health care of the student, between the center and a student's primary care practitioner, medical specialist or managed care entity. Written policies must address obtaining student and or parent/guardian consent to share information regarding a student's health care.

**NOTE:** If the recipient is enrolled with an MCE, it is the center's responsibility to assure that all necessary follow-up, drugs and treatment are coordinated with the MCE.

- The center must have a referral mechanism in place for medically necessary services they are unable to provide. The center shall document in the student's record that the referral was made and document follow-up on the outcome of the referral when relevant to the health care provided by the center.
- The center shall maintain a health record system that provides for consistency, confidentiality, storage and security of records for documenting significant student health information and the delivery of health care services.

S-201 PARTICIPATION

For consideration to be given by IDPA to reimburse for school based/linked medical services:

- the center must be enrolled and approved for participation in the Illinois Medical Assistance Program.
- services must be provided in full compliance with the general provisions in Chapter 100, the Physicians Provider Handbook, the Healthy Kids Provider Manual and the policy and procedures set forth herein.

S-202 PROTOCOL

The protocol is the instrument which defines the relationship between the doctor and health care professionals at the center and identifies the medical services to be provided within the scope of each practitioner's expertise. This document must be available for review by IDPA's Bureau of Medical Quality Assurance upon request. This document is to be reviewed and updated annually. This review must be documented in writing and maintained on file at the center. For the purposes of this document health care professionals are defined as Resident Physician, Advanced Practice Nurse, Physician Assistant and Registered Nurse.

The Protocol on file must meet the following guidelines:

- The written document reasonably describes the kind of services to be provided and, as appropriate, criteria for referral and consultation.
- The document must specify which authorized procedures do not require a physician's presence as the procedures are being performed.
- The document must specify arrangements for communication with physician for services that are outside of the established protocol.

**All services billed to IDPA that are provided by a Resident Physician or a Registered Nurse must have the physician's counter signature in the medical record. For complete policy regarding physician oversight/participation in these services, see the Handbook for Physicians.**

S-203 COVERED SERVICES

Services listed below are reimbursable covered services when provided in a SBLHC setting as described in 111. Code Section 140.461 (g):

- Basic Medical Services
- EPSDT Services as defined in the Healthy Kids Manual
- Immunizations

- Basic Laboratory Tests
- Screening and Treatment of Sexually Transmitted Diseases
- Family Planning Services
- Acute Management and on-going monitoring of chronic conditions, such as asthma, diabetes and seizure disorders.
- Maternity Care (Prenatal and Postpartum)

**Listed in Appendix 1 of this supplement are the only procedure codes that a SBLHC can submit for reimbursement.**

S-203.1 Laboratory Tests

- Only those laboratory tests and examinations which are essential for diagnosis, evaluation and treatment are covered. Batteries of "rule out " tests are not covered.
- The center may charge only for those tests performed at the center using the center's staff, equipment and supplies.
- When the recipient presents for laboratory tests only, an office visit charge may not be made.
- Centers providing laboratory services must be in compliance with the Clinical Laboratory Improvements Amendment (CLIA) Act.

**NOTE:** The center may not charge for laboratory tests performed by any outside laboratory. Charges are not to be made when a specimen is obtained by center staff and sent out of the office. (For complete laboratory policy see the Handbook for Physicians)

S-203.2 Injections and Devices

The center may bill for injectables and devices only when they have been purchased by the center. CPT procedure code 99211 is to be used for the actual "administration" of an injectable medication when the purpose of the visit is only to receive the injection. The eligible services are listed in Appendix 1.

S-203.3 Maternity Care

To provide prenatal and postpartum care at the center, the center must arrange for or have an agreement with a physician who has delivery privileges. ( For complete maternity care policy see the Handbook for Physicians).

S-204 SERVICES REIMBURSABLE BY IDPA TO OTHER PROVIDER TYPES

Certain services by the SBLHC are not reimbursable by IDPA to the SBLHC. The services include but are not limited to:

- Mental Health or Alcohol and Substance Abuse (DASA) Services - When the clinic determines these services are required contact IDHS.



- Dental Services -IDPA contracts with Doral Dental Services of Illinois to manage the state Medicaid Dental program. If the center provides dental services contact Doral Dental at 1-888 286-2447.
- Any medical services not listed in Appendix I must be referred to the Managed Care Entity (MCE) or a primary care provider as stated on page 2 of this document or other appropriate source of medical care.

S-205 INVOICE PREPARATION AND SUBMITTAL

S-205.1 Electronic Claims Processing

Any services which do not require attachments or documentation may be billed electronically. The specifications for electronic billing are found in the ILLINOIS BILLING MATRIX which may be obtained from Blue Cross Blue Shield at (312) 653-7954. ( For additional information refer to the Handbook for Physicians) Questions regarding electronic claims submittal should be directed to the Bureau of Comprehensive Health Services at (217) 782-5565.

S-205.2 Paper Claims Submittal

- Section I, Chapter 100, Topics 122.14, 14 1. 1 and 141.2 provide general policy and procedure for the preparation and mailing of paper invoices.
- Form DPA 2360 (Health Insurance Claim Form) is to be used to submit charges for all services provided by the School-Based/ Linked Health Center. A copy of the form and detailed instructions for completion are included in the Handbook for Physicians.
- Routine invoices are to be submitted in Form DPA 1444 ( Provider Invoice Envelopes) a pre-addressed mailing envelope provided by IDPA for this purpose. Use of this pre-addressed envelope should insure that billing invoices will arrive in their original condition and that they will be properly routed for processing.
- In some instances, a second type of pre-addressed envelope, Form DPA 1414 (Special Approval Envelope) is to be used for mailing claims. This envelope is to be used when submitting a non-routine invoice. A non-routine invoice is:

S-205 INVOICE PREPARATION AND SUBMITTAL (continued)

- An invoice to which Form 1411 (Certificate for Interim Medical Care -Emergency Service) is attached.
- An invoice to which a document is attached.

S-205.3 Charges For Service

Charges are to be made to IDPA only after services have been provided and only for services provided at the center. Charges made, unless otherwise specifically indicated with respect to individual procedures or services, are to be the usual and customary charges made to non-public aid patients.

S-205.4 Procedure Codes

Listed in appendix I of this document are the only procedure codes that may be submitted for reimbursement by the SBLHC.

S-205.5 Diagnosis Codes  
All claims require a primary diagnosis code as listed in the International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-"M

S-206 REIMBURSEMENT  
Section I, Chapter 100, Topics 142 and 143 provides general policy and procedures for payment.  
Payment made by IDPA for allowable services is based on usual and customary charges within the limitations established by IDPA.  
Payment made is the lesser of the provider's charge or the maximum established by IDPA for the services provided.

S-207 RECORD REQUIREMENTS  
Refer to Section I, Chapter 100, Topic I I I (11) for information pertaining to the required retention period for medical records. Additionally, clinics are to comply with applicable State regulations that govern maintenance of medical records.

IDPA regards the maintenance of adequate medical records as essential for the delivery of quality medical care. Medical records are key documents for the audit of payments. In the absence of proper and complete records, no payment will be made and/or payments previously made for which services are not documented will be recouped.

The patient record must include:

- Patient name and address
- Public Aid Recipient Number
- History and physical examination findings
- Diagnostic and therapeutic orders
- Doctors and Nurses notes with appropriate signature
- Laboratory results
- Needs assessment and referrals
- Consent form if appropriate

The record is to include the essential details of the client's health condition and of each service provided. All entries must be dated and legible. Records which are unauditible because of illegibility may result in sanctions if an audit is conducted.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH (MDCH)  
CERTIFICATION OF SCHOOL BASED OR LINKED HEALTH CENTERS**

Medicaid policy has established, that effective 12-1-97, MDCH certified School Based or Linked Health Centers (SBLHC) are authorized to bill and be reimbursed by Medicaid contracted health plans for Medicaid reimbursable services rendered to health plan enrollees regardless of authorization from the health plan. This certification does not expand the scope of Medicaid covered/reimbursable services, nor the scope of service provision per provider type allowable under Medicaid policy or Michigan Law.

Please complete the information below and return the document, signed by the person authorized to sign SBLHC legal transactions and binding agreements, to:

Michigan Department of Community Health  
Adolescent Health Unit Attn: Raquel Montalvo  
3423 N. Logan/MLK Jr. Blvd., P.O. Box 30195  
Lansing, MI 48909

School Based or Linked Health Center Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Person Authorized to Sign for SBLHC Legal Transactions** \_\_\_\_\_

The following items are the minimum certification requirements. Please check one response per statement.

<u>Minimum Certification Requirements</u>	<u>Yes</u>	<u>No</u>
<b><u>Services</u></b>		
1. The SBLHC provides, as a minimum, the following services: immunization screening, primary care for common and acute illness, and referral to a health plan of enrollment (when the child is enrolled in a health plan) for other needed clinical services not available at the SBLHC.	_____	_____
1.1 The SBLHC provides the following specifically for the 10-21 age population: HIV and STD education, and either provision of or a referral for HIV and STD voluntary counseling and testing; and follow preventive services guidelines such as Guidelines for Adolescent Preventive Services (GAPS) or Bright Futures.	_____	_____
2. The SBLHC clinical services meet the recognized, current standards of practice for care and treatment of adolescents and children.	_____	_____

<b><u>Minimum Certification Requirements</u></b>		<b><u>Yes</u></b>	<b><u>No</u></b>
3.	Current School Code and Michigan Compiled Laws 388.1766 prohibits prescribing, dispensing, or otherwise distributing of family planning drugs and/or devices for SBLHCs operating on school property. Is the SBLHC on school property?	_____	_____
3.1	If yes, the SBLHC adheres to the above prohibition	_____	_____

**Administrative**

4.	The SBLHC has completed, updated or gained access to a health survey or assessment that was done within the last two to three years to determine the health needs of the target population.	_____	_____
5.	The SBLI-IC is located in a school building or an easily accessible alternate location to the target population.	_____	_____
6.	The SBLHC is open during hours accessible to the target population, and provisions are in place for the same services to be delivered during times when school is not in session. "Not in session" refers to times of year when schools are closed for extended periods, such as holidays, spring breaks, and summer vacation.	_____	_____
6.1	The SBLHC hours of operation are posted in areas frequented by the target population.	_____	_____
7.	The SBLHC has a licensed physician as a medical director who supervises the medical services provided.	_____	_____
7.1	There are written standing orders and clinical procedures approved by the medical director and the contracting agency available for use by clinical staff.	_____	_____
8.	The SBLHC is staffed by (please circle one):		
	a) a nurse practitioner who is either certified or eligible for certification in Michigan and accredited by an appropriate national certification association or board or;		
	b) a physician who is licensed to practice in Michigan or;		
	c) a physician assistant who is licensed to practice in Michigan;		
	c.1) if the SBLHC is staffed by a physician assistant, he or she is working under the supervision of a physician during all hours of clinic operation.		

<b><u>Minimum Certification Requirements</u></b>		<b><u>Yes</u></b>	<b><u>No</u></b>
9.	The SBLHC has a quality assurance plan that, at a minimum, includes clinical audits to determine conformity with standards and current acceptable clinical practices that are conducted on an ongoing basis, and that includes a plan to implement corrective actions when deficiencies are noted.	_____	_____
10.	The SBLHC has, at a minimum, a policy and procedure regarding the following areas:		
	a) parental consent;	_____	_____
	b) requests for medical records and release of information which include the role of the non-custodial parent and parents with joint custody;	_____	_____
	c) confidential services	_____	_____
11.	The SBLHC has adequate space and equipment for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and electronic client records.	_____	_____
11.1	The SBLHC physical facility is barrier free, clean and safe.	_____	_____
12.	The SBLHC staff follow all Occupational Safety and Health Act guidelines regarding transmission of blood borne pathogens, such as HIV and Hepatitis B, to health care and Public Safety Workers, as referenced in PL 100-607, the Health Omnibus Programs Extension Act of 1988.	_____	_____
13.	The SBLHC conforms to the regulations determined by the Department of Health and Human Services for laboratory standards, referencing Clinical Laboratory Improvement Amendments of 1988 (CLIA).	_____	_____

**Billing and Fee Collection**

14.	The SBLHC has established a billing process, which does not breach the confidentiality of the client.	_____	_____
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I affirm that to the best of my knowledge the above stated information to be factual and true. In addition, should these factors change regarding the operations of this SBLHC, I will notify the Michigan Department of Community Health within sixty (60) days of said change.

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Agency authorized signature	Date
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## **North Carolina School-Based Health Centers Credentialing Standards and Evidence of Performance**

- 1.0 The SBHC has established organized relationships with the school, students, parents/ guardians, collaborating agencies, primary care providers and the community.**
  - 1.1 Memorandum(s) of Understanding (MOUs) and/or Letters of Agreement are currently in place between the SBHC's sponsoring organization and all collaborating agencies.
  - 1.2 24-hour access to services is assured through back-up health services (medical and mental health) when the SBHC is closed.
  - 1.3 SBHC informs Carolina ACCESS enrollees and their parent(s)/guardian(s) that the SBHC or their PCPs should be accessed for non-emergency care rather than the emergency room.
  - 1.4 A written plan is in place for collaboration between SBHC and Carolina ACCESS PCPs for including outline of services provided and process for reciprocal sharing of information between providers.
  - 1.5 Records of Carolina ACCESS enrollees are shared with students' PCPs according to confidentiality laws
  - 1.6 SBHC has a community advisory committee/council/board
  - 1.7 SBHC obtains one informed written consent covering all services from parent(s) / guardian(s) of enrolled students unless student is 18 or older or an emancipated minor.
  - 1.8 SBHC has a written policy concerning treatment of students who are not enrolled in the SBHC
  - 1.9 SBHC assesses student and parent satisfaction with the services at least annually.
  
- 2.0 SBHC provides services that are accessible to all enrolled students.**
  - 2.1 Enrolled students have access to needed SBHC services during hours of operation.
  - 2.2 SBHC notifies students and their parents/guardians how to access 24-hour back-up services (medical and mental health).
  - 2.3 SBHC facilitates referrals to specialists in accordance with student's third party insurance coverage. Carolina ACCESS requires prior authorization from PCPs for referrals to specialist(s) excluding those for mental health and nutrition services.
  - 2.4 SBHC tracks all referrals to help assure that students receive appropriate services.
  - 2.5 SBHC does not deny services to students based on insurance coverage or ability to pay.

- 2.6 SBHC informs enrolled students and their parents/guardians of their rights and responsibilities regarding:
  - a. Confidentiality
  - b. Privacy
  - c. Safety and security
  - d. Informed consent
  - e. Release of information
  - f. Financial responsibility
  - g. Carolina ACCESS (if applicable)
- 2.7 SBHC does not deny services on the grounds of race, color, age, religion, gender, marital status, national origin or handicapped status.

**3.0 The SBHC shall provide comprehensive services to all enrolled students**

- 3.1 Diagnosis and management of acute illnesses and injuries are provided in accordance with protocols and scope of practice.
- 3.2 Management of chronic illness is provided in collaboration with the student's primary care provider (PCP).
- 3.3 Comprehensive health assessments are provided (NC Adolescent Health Check exams every three years and Interim Health Check Exams annually if indicated).
- 3.4 Health promotion and education are provided
- 3.5 Immunizations are provided
- 3.6 Mental Health Services are provided
- 3.8 Nutrition Services are provided
- 3.9 Age-appropriate reproductive health care services are provided. They minimally include, but are not limited to
  - a. Education on abstinence,
  - b. Screening for sexual development as outlined in the Health Check screening guidelines,
  - c. Laboratory tests as clinically indicated, and
  - d. Diagnosis and treatment as clinically indicated.
- 3.10 Laboratory testing and specimen collection is provided.
- 3.11 Medications are prescribed, administered, dispensed, and stored in accordance with NC statute, agency protocols, and scope of practice.
- 3.12 Dental Services are provided

**4.0 The SBHC operates under a personnel management system.**

- 4.1 SBHC has a written job description defining the qualifications, responsibilities and supervision (including administrative and clinical if appropriate) for each staff member working in the SBHC.
- 4.2 All SBHC medical, nutrition, mental health, alcohol and drug treatment, and dental professionals are qualified and have required licensure and/or certification.
- 4.3 SBHC implements a personnel management system for all staff working in the SBHC including employees, shared positions, and/or volunteers



- 5.0 SBHC sets standards for the maintenance, access, content and review of student medical records and information.**
- 5.1 A single confidential medical record is maintained on site for each student receiving services at the SBHC.
  - 5.2 SBHC medical record contains sections for recording consent and release of information; patient history; visits/procedures; problem list; screening and diagnostic tests; medications; referrals, and follow-up.
  - 5.3 SBHC follows the NCOA standard for medical records, systematically reviews the records for compliance, and institutes corrective action if indicated.
- 6.0 The SBHC provides a safe, accessible, effective and efficient environment of care consistent with its mission, services, and laws/regulations.**
- 6.1 SBHC maintains a current policy and procedure manual which addresses all aspects of the facility and its operations
  - 6.2 SBHC has a billing system in place that includes billing all third parties sources.
  - 6.3 The SBHC is in compliance with OSHA rules regarding occupational exposure to blood borne pathogens
  - 6.4 SBHC is in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA ) regulations for the type of laboratory tests being performed on site
  - 6.5 SBHC complies with NC Department of Health and Human Services Communicable Disease Reporting Rules for the control and reporting of communicable diseases
  - 6.6 The SBHC is in compliance with all building and safety codes
  - 6.7 SBHC has adequate space to accommodate staff, patients, laboratory, and clinical activities
- 7.0 The SBHC has implemented a quality assurance plan, which assures accessibility and effectiveness of services.**
- 7.1 The SBHC reviews, updates, and revises its goals and objectives annually.
  - 7.2 SBHC reviews, updates, and revises its policies and procedures at least annually.
  - 7.3 SBHC reviews processes and outcomes of care at least annually.

## **Memorandum of Understanding Between The North Carolina Division of Medical Assistance and The North Carolina Division of Women's and Children's Health**

The goal of Carolina Access is to improve access to coordinated, quality health care for persons enrolled in Medicaid. Older children and adolescents from low-income families are among the groups whose access to health care is most limited. The Department of Health and Human Services recognizes that school-based health centers (SBHCs) have been effective in increasing access to care for older children and adolescents. This Interagency Agreement between the Division of Medical Assistance (DMA) and the Division of Women's and Children's Health (DWCH) outlines the relationship between the parties that is needed to meet the mutual goal of improving access and promoting preventive health care for school-aged children.

### **I. Administrators for the Agreement**

The Assistant Director in DMA and the Chief of the Children and Youth Section in DWCH shall serve as agency liaisons for the purposes of implementing this Agreement. Each agency will designate other staff members to represent it when their expertise is required concerning programmatic or reimbursement issues.

### **II. Joint Responsibilities of DMA and DWCH**

1. Cooperate in the development and implementation of activities outlined in this Agreement.
2. Consult with appropriate professional organizations and societies to promote policies and standards that support accessible, coordinated health care for older children and adolescents through SBHCs.
3. Cooperate with outreach and marketing strategies that promote SBHCs delivering services to children and adolescents. This includes providing information through the Medicaid Bulletin to raise awareness and knowledge concerning program use.
4. Collaborate on the development and implementation of a credentialing process for SBHCs, and enrollment of SBHCs with DMA as providers of Medicaid services as permitted under Federal Medicaid laws.
5. Share data to support efforts of both agencies in meeting program objectives.

### **III. Responsibilities of DWCH**

1. Serve as an intermediary between the Carolina Access Program and SBHCs with regard to credentialing, execution of written agreements, and assignment of Medicaid provider numbers.
2. Establish, implement, and maintain a credentialing process for SBHCs based on best-practice guidelines for the provision of high quality care for children and adolescents. Assure that school-based health centers enrolled as Carolina Access providers are properly credentialed.
3. Execute and maintain written agreements with SBHCs which include, at a minimum, the requirements described in IV. of this Agreement.
4. Give SBHCs reasonable notice of any impending change in their credentialed status.
5. Notify SBHCs of any substantive change in the terms of this Agreement.

**IV. Provider Participation Requirements**

DWCH and the credentialed SBHCs with which it has written agreements agree to:

1. Comply with the terms of the agreement and all regulations and policies of the Medicaid Program, the requirements in the Medicaid Provider Participation Agreement, and the additional requirements outlined in this agreement.
2. Meet and follow the “Essential Characteristics for School-Based Health Centers Which Are Providing Services to Carolina Access Enrollees“ which are attached and incorporated as part of this agreement.
3. Identify the patient’s Primary Care Provider (PCP) at the first visit, and send summaries/copies of pertinent findings to the PCP within one week of preventive, mental health, and/or social services and within twenty-four hours for acute care services. SBHCs will obtain PCP prior authorization for referral(s) that they make to any other source(s) of care.
4. Accept that the credentialing authority for SBHCs rests with DWCH.

**V. Responsibilities of DMA**

1. Enroll as providers in the Medicaid Program and assign provider number to SBHCs which are fully credentialed by DWCH.
2. Provide technical assistance, policy and program guidance to SBHCs regarding Carolina ACCESS.
3. Reimburse for services that are provided and correctly billed by SBHCs who have been assigned a Carolina ACCESS provider number.
4. Exempt credentialed SBHCs that are enrolled as Medicaid providers from the Carolina ACCESS primary care provider (PCP) authorization requirement.

**VI. Effective Period**

The terms of this agreement shall begin on February 1, 1999 and remain in force until modifications identified by either party are deemed necessary and changes mutually acceptable are negotiated.

**VI. Termination**

Either party may terminate this Agreement on sixty days advance notice by certified mail to the other party.

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Signature of Authorized Official  
 Division of Medical Assistance  
 Department of Health and Human Services

Date

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Signature of Authorized Official  
 Division of Women’s and Children’s Health  
 Department of Health and Human Services

Date

Revised February 16, 1999

*Conditions for reimbursement for self-referred services.*

- A. A school-based health center, designated by the Department as meeting the criteria specified in Regulation .01 of this chapter, is eligible for reimbursement by the student's MCO for the following self-referred services:
  - 1) Diagnosis, treatment and uncomplicated follow up (limited to one follow up visit to the SBHC, of acute or urgent somatic illness, and related prescribing of medications; and
  - 2) Family planning services specified in COMAR 10.09.6520A(2), (6) and (7).
  
- B. An MCO is not required to reimburse a school-based health center for providing:
  - 1) Basic school health services as defined in COMAR
  - 2) Follow up treatment for acute or urgent illnesses that exceeds one visit
  
- C. The school-based health center providing self-referred services shall:
  - 1) After providing acute or urgent follow-up care for somatic illness, refer the student back to the student's PCP for any additional indicated follow-up care:
  - 2) Refer the student to the student's PCP whenever the student needs to have a treatment plan developed, or when any change in the student's treatment plan is needed:
  - 3) Transmit to the student's MCO, within 2 business days, reports regarding self-referred services provided, for inclusion in the student's medical record but, if the student needs follow-up care by the PCP within 1 week, the school-based health center shall telephone or fax the information to the student's PCP;
  - 4) If the student receives more than four acute or urgent visits per semester:
    - a) Notify the student's MCO to determine if the student's PCP wants to see the student for a thorough physical evaluation, and
    - b) Assist the MCO in scheduling follow-up visits: and
  - 5) To the extent possible, bill third-party insurers rather than the MCO for covered services.
  
- D. Required Timeliness of Reports to MCO.
  - 1) To receive reimbursement for self-referred school-based health center services, the school-based health center shall transmit to the MCO, within 60 days of performing the services, encounter data and billing information using the HCFA 1500 format.
  - 2) If the school-based health center is delinquent in transmitting to the MCO encounter data as required by D(1) of this regulation, the MCO may withhold payment until it receives the information.

- E. An MCO shall provide school-based health centers in its service area with the current information needed to facilitate communication between the SBHC and the MCO regarding care provided to the MCO's enrollees, and to effect reimbursement by the MCO, including:
- 1) Information concerning the MCO's policies and procedures regarding provision of pharmacy and laboratory services; and
  - 2) Contact information, including a listing of:
    - a) The name and number of an MCO representative who serves as the MCO's contact person for the school-based health center,
    - b) The address for submitting encounter information,
    - c) If appropriate, the name and number of the MCO's contact person for contracting services, and
    - d) The name and address of the MCO's contact perso for payments.
- F. An MCO Shall pay undisputed claims of the SBHC for services provided to its enrollees within 30 days of the MCO's receipt of the invoice.

**Michigan Department of Community Health  
Medical Services Administration Bulletin**

**Distribution:** Practitioner 97-10  
Health Maintenance Organizations 97-10

**Issued:** October 31, 1997

**Subject:** Reimbursement for Services Provided by School Based or Linked  
Health Centers (Adolescent Health Centers)

**Effective:** December 1, 1997

**Programs Affected:** Medicaid

The following policy is effective for dates of service on and after December 1, 1997. Health Maintenance Organizations (HMOs), Clinic Plans (CPs), and Qualified Health Plans (QHPs) are responsible for reimbursing School Based or Linked Health Centers (SBLHC), certified by the Michigan Department of Community Health, Bureau of Child and Family Services for Medicaid clients enrolled with HMOs, CPs or QHPs who choose to obtain health care services from the SBLHC. The SBLHC should not be confused with Medicaid's School Based Program for students enrolled in special education. This policy is effective without prior Plan authorization and regardless of whether a contract exists between the HMO/CP/QHP and the SBLHC.

HMOs, CPs, and QHPs are encouraged to work with SBLHCs to develop contractual relationships. Contracts should include policies and procedures relative to maintaining the confidentiality of information. However, when enrolled clients choose to obtain health care services without Plan authorization from a SBLHC that does not have a contractual relationship with the HMO/CP/QHP, the HMO, CP, or QHP is still responsible for payment to SBLHC, at Medicaid fee for service rates in effect on the date of service.

The SBLHC must advise the HMOs/CPs QHPs as to what service was provided in order to facilitate continuity of care for the client.

A list of the approved SBLHCs may be obtained by telephoning the Bureau of Child and Family Services at (517) 335-8911.

**Manual Maintenance**

Please retain this bulletin for future reference.

**Michigan Department of Community Health  
Medical Services Administration**

**Distribution:** Practitioner 99-03

**Issued:** December 1, 1999

**Subject:** School Based/School Linked Health Centers (SBSLHCs)  
Reimbursement under Contracts with Qualified Health Plans  
(QHP) or Special Health Plans (SHPs)

**Effective Date:** January 1, 2000

**Program Affected:** Medicaid

Centers may continue to provide services to Qualified Health Plan enrollees under policy published in the MSA 97-14 bulletin. Under this existing policy, Medicaid beneficiaries may choose to obtain services from a School Based/School Linked Health Center (SBSLHC) without prior authorization from the Qualified Health Plan (QHP). If the SBSLHC does not have a contract with the QHP, then the QHP is still responsible for payment to the SBSLHC at Medicaid fee-for-service rates in effect on the date of service. Please note that the Children's Special Health Care Services Special Health Plans (SHP) are not required to reimburse centers for Medicaid services provided to SHP enrollees.

Once the SBSLHC and the QHP negotiates and signs a contract, the SBSLHC is reimbursed according to the provisions of the contractual agreement. Contracts between the SBSLHC and the QHP or SHP should include policies and procedures relative to maintaining the confidentiality of information.

Do not confuse SBSLHCs with Medicaid's School Based Program for students enrolled in special education or who receive outreach services through school districts enrolled in the School Based Services Program. SBSLHCs provide access to preventive and primary care services for low-income children that live in communities that tend to be served by fewer providers.

A list of the approved SBSLHCs is attached.

**Manual Maintenance**

Retain this bulletin for future reference.

# STATE OF NEW YORK DEPARTMENT OF HEALTH

Coming Tower, The Governor Nelson A. Rockefeller Empire State Plaza  
Albany, New York 12237

**Antonia C. Novello, M.D., M.R.H., Dr.P.H.**  
*Commissioner*

**Dennis P. Whalen**  
*Executive Deputy Commissioner*

March 28, 2001

Dear Colleague:

This letter is to inform you that the contracting requirement for school-based health centers (SBHCs) and Medicaid managed care organizations (MCOs) has been extended from March 31, 2001 until March 31, 2002. School-based health centers will be able to continue Medicaid fee-for-service billing for services provided to students enrolled in Medicaid managed care plans until March 31, 2002.

During the coming year, the Department of Health will refine SBHC operating principles and plan for the delivery of health care that minimizes duplication of services and develops linkages between SBHCs, academic medical centers, managed care plans, community-based health centers and other providers. The Department of Health will implement several initiatives designed to expand and enhance the services provided by SBHCs. The **Department** is collaborating with the State Education Department and the Office of **Mental Health** to develop models to expand much needed mental health services. The Department will provide grants both to medical schools to use SBHCs as training sites for students and residents and to SBHCs to add dental health prevention and treatment services.

The New York State Department of Health is committed to maintaining SBHCs as important access points and providers of health care for New York's most needy and vulnerable children and youth. We will continue to work with you to assure the highest quality and most effective health care delivery possible.

Very truly yours,

Dennis P. Whalen  
Executive Deputy Commissioner



# STATE OF NEW YORK DEPARTMENT OF HEALTH

Coming Tower, The Governor Nelson A. Rockefeller Empire State Plaza  
Albany, New York 12237

Dennis P. Whalen  
*Executive Deputy Commissioner*

January 4, 1999

Dear Colleague:

This letter is to provide you with updated information on the status of the Department of Health's policy regarding participation of school based health centers (SBHC) in the Medicaid Managed Care Program. Our goal remains to achieve the maximum clinical integration of SBHCs with both Medicaid managed care and Child Health Plus, because we believe SBHC services are so important to children enrolled in these programs. The New York Medicaid managed care waiver, approved by the Health Care Financing Administration and currently being implemented in the State, requires that SBHCs and managed care plans contract with each other.

The Department has received correspondence from, and met with many SBHC and managed care plan representatives. In recognition of concerns regarding the complexity of contracting between managed care plans and SBHCs, the Department will continue fee-for-service Medicaid reimbursement for SBHCs through March 31, 2000 subject to managed care plans and SBHCs achieving each appropriate implementation milestone listed in the attachment to this letter, within the time frames specified.

An amendment to the Medicaid managed care contract setting forth the milestones contained in this letter will be distributed shortly to assure health plans' commitment to achieving those milestones in the time frames -indicated. Plans with signed contract amendments will receive new 1999-2000 rates which prospectively exclude SBHC expenditures from the capitated benefit package. Failure to comply with the milestones as detailed in the contract amendment will constitute breach of contract. The Department is currently in the process of establishing new premium rates for managed care plans serving Medicaid recipients in New York. The rates will be effective April 1, 1999 through March 31, 2000.

The Department will work with the Coalition for School-Based Primary Care and the newly formed Health Services Integration Work Group to assist managed care plans and SBHCs to meet these milestones. The work group is comprised of representatives of school based health centers, managed care plans and state and local agencies that serve the needs of school children, and will, over the coming months, assist the

Department in developing protocols for coordination between SBHCs and primary care providers in the community. If SBHCs fail to achieve the appropriate milestones attached to this letter within the time frames specified, Medicaid reimbursement will no longer be available for children enrolled in Medicaid managed care pursuant to the 1115 waiver terms and conditions. These milestones include the information sharing and clinical referral activities discussed in past work group meetings and represent the steps needed to enter effective contractual relationships.

If you have any questions regarding the contents of this letter, please contact Claire Malone of the Office of Managed Care at (518) 486-4934 or Annette Johnson, Director of the School Health Program at (518) 486-4966. We look forward to continuing to work with you to promote the health of school age children in New York.

Sincerely,

Kenneth C. Spitalny, M.D.  
Director  
Center for Community Health

Ellen Anderson  
Director  
Office of Managed Care

Attachment

cc: Local DSS Commissioners  
Local PH Directors  
Area Offices

## **Connecticut Medicaid Managed Care Request for Proposals Connecticut Department of Social Services Medical Care Administration**

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### *Section Seven*

1.10 Health plans will be required to contract with Department of Public Health (DPH) licensed school-based health centers (SBHCs) for the range of services they provide in accordance with National Committee for Quality Assurance (NCQA) standards in the service area.

1.10.1 As an appendix to this proposal, marked as Section VII – Appendix 1.10.1, provide a specimen copy of all such contracts or executed letters of intent.

1.10.2 As an appendix to this proposal, marked as Section VII – Appendix 1.10.2, provide a copy of the signature page(s) for the SBHC contracts.

**NOTE WELL: In the evaluation of the adequacy of a plan's contracts with SBHCs, the Department will only consider those contracts for whom the plan has provided a copy of the signature pages(s) or an executed letters of intent.**

## **Improving Coordination Between School-Based Health Centers and the Medicaid Managed Care Delivery System (SALUD!)**

*Funded by the Center for Health Care Strategies, Inc.*

*under the Robert Wood Johnson Foundation's Medicaid Managed Care Program*

- 1997 New Mexico's Medicaid managed care program, Salud! was implemented on July 1, 1997, as a single statewide managed care program. Contracts were awarded to three managed care organizations (MCOs), Cimarron Health Plan, Lovelace Community Health Plan, and Presbyterian Salud, to provide the full array of services that are part of the Medicaid managed care benefit package.
- 1997-98 New Mexico MCOs were encouraged to work with SBHCs; however, the priorities associated with building the new health care system took precedent over establishing contracts with the SBHCs. SBHCs struggled to find their place in the new managed care system.
- 1999 The New Mexico Human Services Department Medical Assistance Division (HSD/MAD) and Department of Health (DOH) held a "school summit" to explore how schools could participate in Salud!.
- 1999 A pilot project workgroup, comprised of representatives from HSD, where Medicaid is administered; DOH; Children, Youth, and Families Department; State Department of Education; the three Salud! MCOs; providers; advocacy groups; and consumer representatives, was convened to discuss how to proceed.
- 2000 State receives grant to support a three-year pilot project
- 2000-01 Grant activities in first year:
- Pilot sites were chosen, from rural and urban areas;
  - a contract template was developed, provisions of which are included in all individual contracts between the SBHCs and MCOs
  - Scope of services was established, including the list of services that will be provided in all centers. These services will be covered without prior approval, at least initially. The SBHCs will be a resource to the students' PCPs but not function as PCPs.
  - Protocols were developed to facilitate communication and coordination of care among the SBHCs, PCPs, BHPs and the MCOs, and for management of asthma. Protocols for sharing of information and protecting confidentiality and for management of depression are in development. Protocols for management of obesity and Type II diabetes are planned for development later in Phase II.
- 2001 Evaluation of the project has begun; an assessment was undertaken to identify existing data sources, and consideration was given to desirable data not yet collected. Encounter data will be collected by the MCOs, demographic and other service data will be collected by the Department of Health, and there are plans to conduct focus group discussions and surveys to help evaluate the project's impact and outcome.

AGREEMENT TO PROVIDE SCHOOL BASED HEALTH CENTER SERVICES  
BETWEEN \_\_\_\_\_ SCHOOL-BASED HEALTH CENTER CONTRACTOR

and

\_\_\_\_\_MANAGED CARE ORGANIZATION (MCO)

March 6, 2001

**AGREEMENT TO PROVIDE SCHOOL-BASED HEALTH CENTER SERVICES**

**AT SCHOOL**

THIS AGREEMENT is made and entered into on the \_\_\_\_\_ day of \_\_\_\_\_ between \_\_\_\_\_ (MCO) and the \_\_\_\_\_ (Contractor).

**WITNESSETH**

WHEREAS, as part of its community service, \_\_\_\_\_ (Contractor) operates a School-Based Health Center Program ('SBHC') providing primary medical care, behavioral health care and health promotion services to students at \_\_\_\_\_ (School).

WHEREAS, \_\_\_\_\_ (Contractor) desires to participate in the Salud! program, consistent with the New Mexico State School-Based Health Center Standards.

WHEREAS, \_\_\_\_\_ (School) is willing to provide the physical site and necessary custodial and maintenance services to support the SBHC program, with \_\_\_\_\_ (Contractor).

NOW, THEREFORE, in consideration of the mutual covenants and obligations contained in this Agreement \_\_\_\_\_ and \_\_\_\_\_ agree as follows:

**ARTICLE I**  
**OBLIGATIONS**

- 1.1 **Program Services.** \_\_\_\_\_ (Contractor), either itself or through its subcontractors shall provide medical and behavioral health services limited to Exhibit \_\_\_\_ to Enrollees (as defined in this Agreement) at \_\_\_\_\_ (SBHC(s)) in accordance with the terms of this Agreement and the Salud! program. The services provided as part of the Salud! program shall include, but not be limited to, primary care services, behavioral health services, health promotion and risk reduction services. \_\_\_\_\_ (Contractor) shall use its reasonable best efforts to assure that the SBHC is operated and administered in substantial compliance with all applicable Federal, State and local laws.
- 1.2 **Enrollee.** An Enrollee shall be any person who is currently a Salud! member and enrolled in School or family dependent thereof. Each enrollee must have a properly executed Consent Form/Application ("Parental Consent and Member Consent") on record at the SBHC(s).
- 1.3 **Family Dependent.** Shall mean a dependent child of an enrolled member who is entitled to Salud! benefits.
- 1.4 **Hours of Operation.** The SBHC shall provide services during normal hours of operation (insert definition of normal hours of operation for each SBHC).
- 1.5 **Emergency Care.** \_\_\_\_\_ (SBHC) providing services pursuant to this Agreement shall respond to emergency care situations by stabilizing the situation until an emergency medical technician is on-site. Emergency care provided in this Agreement shall be limited to the extent of services available on-site. Critical emergencies determined by the

on-site nurse or clinician are to be referred by the school to Emergency Medical Services (911).

- 1.6 **Quality Initiatives.** \_\_\_\_\_(Contractor) agrees to cooperate with all of \_\_\_\_\_(MCO) Quality Assurance requirements and activities. The Contractor and the MCO shall work together to develop and maintain continuous quality improvement activities in the SBHC(s).
- 1.7 **Staff.** \_\_\_\_\_(Contractor) shall provide competent, qualified medical and behavioral health providers to administer, coordinate, and provide health and health-related services pursuant to the SBHC program. During the Term of this Agreement, \_\_\_\_\_(Contractor) shall utilize providers, who are appropriately licensed to practice in the State of New Mexico and are members of the MCO staff or otherwise credentialed by the MCO.
- 1.8 **Credentialing of SBHC Staff.** \_\_\_\_\_(Contractor) will require its Licensed Individual Health Care Providers to adhere to the following requirements in connection with their professional credentials: 1) Licensed Individual Health Care Providers shall be duly licensed to practice in the State of New Mexico, within the scope of their license, and maintain themselves in good professional standing at all times; 2) \_\_\_\_\_(Contractor) agrees that either it will carry or it will require its SBHC Licensed Individual Health Care Providers to carry comprehensive general liability insurance in reasonable and customary amounts and either (i) to qualify as a health care provider entitled to the protection of applicable Federal or State malpractice law(s) or (ii) to carry professional liability insurance in reasonable and customary amounts. Certificates of coverage and proof of qualifications shall be available for inspection by the MCO; 3) \_\_\_\_\_(Contractor) agrees that to the extent required by the Social Security Act and regulations there under, all persons or organizations with whom it arranges to provide services hereunder shall be certified to provide basic and supplemental health services under Title XVIII, Title XIX and Title XXI of the Social Security Act, known as the Medicare and Medicaid program respectively; and 4) otherwise satisfy the current credentialing standards of the \_\_\_\_\_(MCO).
- 1.9 **Program Expenses.** \_\_\_\_\_(Contractor) shall be solely responsible for all costs associated with the operation of the SBHC program, including, but not limited to, costs of personnel, telephone, when not provided by the school, supplies and materials utilized in the SBHC program.
- 1.10 **Confidentiality and Informed Consent.** \_\_\_\_\_(Contractor) shall assure that all services rendered to Enrollees shall be confidential in nature and any records generated as a result of any services being rendered to Enrollees shall be confidential and not disclosed without prior written authorization, except as otherwise required by State and Federal law. Confidential services shall be provided in compliance with all requirements related to confidentiality and informed consent for minors, including those at NMSA 1978, Sections 24-1-9, Sexually Transmitted Diseases; 24-1-13, Pregnancy; 24-8-5, Contraception; 24-10-2, Emergency Care of Minor; and 32A-6-14, Mental Health Counseling of Minor. Notwithstanding this provision, \_\_\_\_\_(Contractor) shall provide

the MCO such data and statistical information as required under Section 2.2 and 2.4 of this Agreement.

- 1.11 Communication Protocol.** \_\_\_\_\_(Contractor) shall refer Enrollees to off site medical facilities in accordance with the policies and procedures contained in the Communication Protocols and Care Coordination and Case Management Protocols.
- 1.12 Space.** \_\_\_\_\_(School) shall provide adequate space, which is in compliance with the Americans with Disabilities Act, for the operation of the SBHC.
- 1.13 Support Services.** \_\_\_\_\_(School) shall provide building support services, including, but not limited to, janitorial services and routine maintenance for the SBHC during days of operation, all without charge to the MCO.
- 1.14 Utilities.** \_\_\_\_\_(School) shall provide heating, water and electricity to the SBHC at no charge to the MCO.
- 1.15 Access to SBHC program.** \_\_\_\_\_(SBHC) shall allow the Enrollees to have reasonable access to the SBHC for routine and acute medical and behavioral health care visits.

## **ARTICLE II** **BILLING, DATA COLLECTION AND SUBMISSION OF DATA**

- 2.1 Billing for Clinical Services.** \_\_\_\_\_(Contractor) shall have the right to bill \_\_\_\_\_(MCO) and to collect payment for services, as reflected in Exhibit A, provided through the SBHC. Notwithstanding the above, Enrollees shall not be denied the opportunity to enroll in the SBHC or be denied health services based on the enrollee's ability to pay for health services rendered.
- 2.2 Timely Submission of Claims/Encounter Data.** \_\_\_\_\_(Contractor) understands that \_\_\_\_\_(MCO) has certain contractual reporting obligations which require timely submission of claims and/or encounter data. Therefore, \_\_\_\_\_(Contractor) shall submit claims or encounter data to \_\_\_\_\_(MCO), or its designee, within 60 days of the date of services. Claims shall be submitted in a HCFA 1500 format, using ICD-9 Codes and any Medicaid-assigned codes, as reflected in Exhibit A. Encounter data should be in the same format and include the same data as a standard claim, and should be submitted within 90 days of the date of services.
- 2.3 Payment of Claims.** When \_\_\_\_\_(Contractor) is compensated hereunder on a claims made basis, \_\_\_\_\_(MCO) shall pay such claims as follows, unless requirements more favorable to \_\_\_\_\_(Contractor) are imposed by federal law:
  - 1.** A claim submitted electronically shall be paid within 30 days from the date of \_\_\_\_\_(MCO)'s receipt of a Clean Claim.
  - 2.** A claim submitted manually shall be paid within 45 days from the date of \_\_\_\_\_(MCO)'s receipt of a Clean Claim.



3. \_\_\_\_ (MCO) shall pay interest on its liability at the rate of one and one-half percent a month on any Clean Claim not paid within the time periods specified above.
4. If \_\_\_\_ (MCO) is unable to determine liability for or does not pay a claim within the time periods specified above, \_\_\_\_ (MCO) shall make a good-faith effort to notify \_\_\_\_ (Contractor) by fax, electronic or other written communication, within 30 days of receipt of the claim if submitted electronically or 45 days of receipt of the claim if submitted manually, of all specific reasons why it is not liable for the claim or that specific information is required to determine liability for the claim.

For purposes of this section, a “Clean Claim” means a manually or electronically submitted claim that:

- (a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of \_\_\_\_ (MCO)’s system; and
- (b) is not materially deficient or improper, including lacking substantiating documentation currently required by \_\_\_\_ (MCO); or
- (c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by \_\_\_\_ (MCO) within the applicable period of time specified in the Section.

**2.4 Reporting Requirements.** \_\_\_\_ (Contractor) shall use its reasonable best efforts to provide to the MCO the following information on a quarterly basis:

**2.4.1** Number of students served and the types of services;

**2.4.2** Number of students referred to other health services and the type of services;

**2.4.3** Any other information deemed appropriate, which does not violate the confidentiality of the Enrollee.

### **ARTICLE III** **MEDICAL RECORDS AND CONFIDENTIALITY**

**3.1 Medical Records.** \_\_\_\_ (Contractor) shall require its Licensed Individual Health Care Providers to maintain adequate medical records for MCO enrollees and comply with the standards and procedures for maintaining medical records, as found in Exhibit \_\_\_\_\_. The medical records, subject to all applicable privacy and confidentiality requirements, shall be kept in a locked, fireproof file. The medical records shall be made available to any Licensed Individual Health Care Provider treating the Enrollee and shall be made available to any committee of the SBHC or MCO, upon request, to determine that content and quality are acceptable, as well as for peer review or grievance review.

- 3.2 SBHC Records.** \_\_\_\_ (MCO) shall have access at reasonable times upon demand and after reasonable notice to the books, records, and papers of SBHC and SBHC Licensed Individual Health Care Providers relating to the health care services provided to Enrollees, and to payments received by Contractor or SBHC Licensed Individual Health Care Providers from Enrollees or from others on their behalf.
- 3.3 Copy of Patient Records.** SBHC Licensed Individual Health Care Providers shall copy, upon request from Enrollees, all the Enrollee's records and charts to a successor professional corporation, medical group, or Licensed Individual Health Care Provider(s) designated by the Enrollees.

#### **ARTICLE IV** **MUTUAL AGREEMENTS**

- 4.1 Cooperation.** \_\_\_\_\_ (MCO) and \_\_\_\_\_ (Contractor) agree to maintain effective liaison and close cooperation with each other to the end of providing maximum benefits to each Enrollee at the most reasonable cost consistent with applicable standards of medical care.
- 4.2 Education and Outreach.** \_\_\_\_\_ (MCO) and \_\_\_\_\_ (Contractor) will collaborate on any educational and outreach activities associated with this Agreement.
- 4.3 Marketing Materials.** \_\_\_\_\_ (Contractor) and the MCO shall work together on any marketing materials associated with this Agreement where the MCO's name will be used. Such marketing materials, which must be written in English and Spanish, must be reviewed and approved by the State of New Mexico Human Services Department Medical Assistance Division, according to MAD Managed Care Policy Section 606.
- 4.4 Data.** \_\_\_\_\_ (MCO) and \_\_\_\_\_ (Contractor) agree to freely and fully exchange data and cooperate in the continuing effort to refine the policies, systems, and procedures, which address the availability, continuity, and quality to care to \_\_\_\_\_ (MCO) Enrollees.
- 4.5 Organizational Operations.** \_\_\_\_\_ (MCO) and \_\_\_\_\_ (Contractor) respectively acknowledge that each has full and complete authority and responsibility with respect to administering its organizational operations.
- 4.6 Grievances initiated by an Enrollee and Individual Licensed Health Care Provider.** \_\_\_\_\_ (MCO) and \_\_\_\_\_ (Contractor) agree to cooperate in good faith in any grievance procedure initiated by an Enrollee or Licensed Individual Health Care Provider and follow the MCO and Salud! Grievance Procedures.
- 4.7 Provider Manual.** \_\_\_\_\_ (MCO) will establish and maintain a Provider Manual to describe accurately the administrative and operational policies of the MCO.
- 4.8 Grievances between the MCO and Contractor.** Controversies or claims between \_\_\_\_\_ (MCO) and \_\_\_\_\_ (Contractor) (other than matters related to medical malpractice or substantiated breach with this Agreement) arising out of or relating to the interpretation or application of this Agreement must be resolved by direct negotiations

between the MCO and Contractor within six months of the date of the originating party identified the matter in dispute in writing to the other party. Should said negotiations result in failure to reach agreement within the stated six month period, parties to this Agreement shall submit said controversies or claims to Arbitration for settlement in accordance with the rules of the National Health Lawyers Association Alternative Dispute Resolution Program, and judgment upon the award rendered by the arbitration may be entered in any court having jurisdiction.

- 4.9 Administrative, Financial and Accounting Records.** \_\_\_\_\_(MCO) and \_\_\_\_\_(Contractor) shall maintain such administrative records and such financial and accounting records as shall be necessary, appropriate, and convenient for the proper administration of this Agreement, and for compliance with any applicable state or federal rules and regulations governing managed care organizations. Such records shall be retained for at least six years, notwithstanding any termination of this Agreement, whether by rescission or otherwise.

**ARTICLE V**  
**GENERAL PROVISIONS**

(MCO to add language here.)

**ARTICLE VI**  
**TERM AND TERMINATION**

- 6.1.1 Term.** This Agreement shall commence as of \_\_\_\_\_, 2001, and shall expire on June \_\_\_\_\_, 2003. This agreement will automatically terminate in the event the MCO no longer participates in Medicaid Managed Care.
- 6.1.2 Right of Renewal.** This Agreement shall automatically renew for successive one (1) year terms unless either Party provides the other Party with a written notice of non-renewal at least thirty (30) days prior to the commencement of a renewal term.
- 6.1.3 Termination.** Notwithstanding any other provision to the contrary, this Agreement may be terminated, with or without cause, by giving thirty (30) days' advance written notice of termination to the other party.

# **ALBUQUERQUE PUBLIC SCHOOLS / BEHAVIORAL HEALTH ORGANIZATIONS SCHOOL MENTAL HEALTH PILOT PROJECT**

## **The Vision and Initial Planning**

Planning for the collaborative pilot project in school mental health between the Albuquerque Public Schools (APS) and the Behavioral Health Organizations (BHOs), Medicaid Managed Care began in the spring of 1998. The Office of School Health was approached by one of the BHOs that was interested in restructuring their network of community service provision in the Albuquerque area. After discussing the possibility of linking their Medicaid Managed Care services directly to school sites, contacts were initiated with APS Student Support Services to discuss the feasibility of such a plan. A series of meetings between APS; the three BHOs; and representatives from the Department of Health (DOH), Office of School Health; the Children, Youth, and Families Department; and the Human Services Department were then initiated. The vision was to improve student access to mental health services and to support their success in school.

After several internal meetings, APS decided that it would be best to implement this pilot in the Albuquerque High School Cluster. In the first year of the pilot, five schools would be included. Following successful implementation in the first five schools, the pilot would increase to include more schools.

A preliminary needs assessment of all the schools in the Albuquerque High School Cluster was done jointly between APS and DOH to determine:

1. The mental health needs and priorities within each school;
2. The existing services related to children's mental health within each school; and
3. The number of existing school and community mental health providers at each school.

A strong need for more family and group therapy interventions was identified in all the schools, with many of them also requesting expanded individual therapy services.

Representatives of APS, the BHOs, and the various state agencies involved then formed four subcommittees to facilitate the implementation of this pilot. The four areas of focus included eligibility, screening and assessment, service provision, and evaluation.

## **Medicaid Eligibility and Enrollment**

One of the reasons the pilot schools were selected is that they represented schools with high numbers of Medicaid eligible students. The primary task of the "eligibility" subcommittee was to develop a plan to facilitate the enrollment of Medicaid eligible students within the five pilot schools. APS used Medicaid in the Schools funds to hire a full-time nurse to oversee the enrollment of Medicaid eligible students throughout the district. The nurse leads a team of three paraprofessionals who enroll students for Presumptive Eligibility and Medicaid on Site Application Assistance (PE/MOSAA).

### **School-Based Screening and Referral to Behavioral Health Service Providers**

The “screening and assessment” subcommittee created a flowchart to show the interface of the existing school referral and service processes with the new referral process for expanded mental health services within the pilot project. Critical to the system was the establishment of a “one point” intake process for referrals. The members of the “service provision1” subcommittee assembled an “Array of Behavioral Health Services” that are available to the pilot schools. This group, comprised primarily of representatives from the BHOs and their network providers, jointly developed informal agreements for assigning therapists to the schools and for a coordinated system for intake referrals.

### **Behavioral Health Service Providers and School-Based Services**

Both Value Options and their contracted network provider, the Consortium, as well as Value Behavioral Health and the University of New Mexico Health Sciences Center have remained actively involved as providers in this project. In February 1999, MCC increased their involvement in the planning and implementation of the pilot project. At this point, social workers, either from UNM Programs for Children and Adolescents or from the Consortium, have been assigned to work at the identified schools. In some schools, “case managers” have also been assigned to link students and families needing services with the appropriate provider agency.

At this point, individual, family, and group therapy services; case management services; and behavior management services are provided on the school site. In addition, child psychiatrists from the University of New Mexico, who are working in the School Based Health Centers at several of the pilot schools, provide psychiatric evaluations and treatment.

### **Evaluation**

The task of the “evaluation” subcommittee was to determine the tools, processes and timelines that would be used to evaluate the success of the pilot. A formal evaluation process, tied to access and educational outcomes, is in the process of being developed for this project. The tentative outcome measures, used to assess the results of the pilot project initiatives, include:

- number of students referred
- length of time between referral and access to care
- penetration rate (i.e., the number of students who access services) of school age population at the pilot schools compared to non-pilot schools
- student attendance rates
- student grades
- suspension rates
- number of students enrolled in Medicaid

### **Training**

School teams consisting of administrators, counselors, social workers, special education teachers BHO representatives, and community providers received initial training about the pilot project. In addition to providing an overview of Managed Care in New Mexico, the training also covered the process the pilot schools should use to access expanded mental health services. The participants indicated their desire to meet on an ongoing basis to discuss issues that would inevitably surface as a result of implementing the project.

**NEW MEXICO MEDICAL ASSISTANCE DIVISION  
INFORMATION SYSTEMS BUREAU**

TO: MCOs and BHOs

FROM: Robert Stevens, Chief MIS Bureau  
Carolyn Ingram, Chief Contract Bureau

DATE: July 31, 2000

BY: Lillian Prada, Manager V

SUBJECT: **Code for Behavioral Health Enhanced Services in a School Setting**

On July 6, 2000, you were sent instructions to use the code 0305T to report encounters for behavioral health enhanced services in a school setting. This instruction came pursuant to a discussion regarding the use of a state assigned code versus a CPT code that is not defined to fit the needs for enhanced services in school settings.

Since then, we have become aware of considerations that, we believe, warrant reconsideration of our previous instructions. We have reassigned a new number for behavioral health enhanced services in a school setting. That code is: 0312T. Behavioral health enhanced services in a school setting are defined as:

Those services provided to children and adolescents with psychiatric and/or behavioral disorders by therapists located on-site at elementary, middle and high schools. Behavioral health enhanced services in a school setting are a collection of adjunct services designed to complement therapeutic interventions, such as: Assessment, Individual, and Group and Family Therapy. These services are designed to increase the likelihood that the child or adolescent will function at a higher level academically, socially and behaviorally in and out of the school setting.

The nature of these services may include: professional collaboration and information sharing, including teachers, support team members, IEP committees, SBHC, school counselor or other school personnel, parent, liaison, meetings with other community mental health professionals, attorney, police, and/or the client's Juvenile Parole Officer (JPO). Additionally, these services may include observation of student/students in the classroom, playground or other school setting for the purpose of evaluation, reassessment, or providing treatment recommendations, client support services and linkages with community resources.

The code 0312T is effective as of July 1, 2000 and will be incorporated into the Salud! systems manual. If you have any questions, please call Marc Perry, HPM at: (505) 827-3178.

INTERDEPARTMENTAL AGREEMENT  
For  
SCHOOL-BASED  
MENTAL AND ADDICTIVE DISORDER SERVICES  
Within the  
LOUISIANA OFFICE OF PUBLIC HEALTH  
ADOLESCENT SCHOOL HEALTH INITIATIVE

PURPOSE

To meet the multiple needs of Louisiana school children, this Department of Health and Hospitals (DHH) collaborative agreement is a commitment to integrating common school-based psychosocial objectives; progressively coordinating school-based mental and addictive disorder services with community-based services; and expanding existing school-based services into a seamless state wide network of comprehensive child health care. This interdepartmental agreement shall remain in effect until June 30, 2004; or until revised, whichever occurs first.

SCHOOL-BASED ROLES OF THE THREE COLLABORATING OFFICES

The Office of Public Health -Adolescent School Health Initiative (OPH-ASHI) will focus on establishing School-Based Health Center (SBHC) standards, policies and guidelines; establishing SBHC contracts; monitoring contract compliance; facilitating SBHC continuous quality improvement; and facilitating SBHC collaboration with other agencies or potential funding sources.

The Office for Addictive Disorders (OAD) will focus on providing school-based primary prevention services pertaining to addictive disorders associated with alcohol, tobacco, other drugs and/or gambling.

The Office of Mental Health (OMH) will focus on providing school-based primary prevention services pertaining to mental health disorders (excluding addictive disorders associated with alcohol, tobacco, other drugs and/or gambling); e.g. explosive personality and depressive disorders.

INTERAGENCY CONTRIBUTIONS TO SCHOOL-BASED SERVICES

OPH-ASHI contributions to this interdepartmental agreement shall include:

- A. Providing preventive and primary health care to school children who are without financial means, without primary care providers, and without access to an alternative source of primary health care.

- B. Modifying the SBHC standards, policies and guidelines to appropriately accommodate the unique OAD and OMH school-based mental or addictive disorder service requirements.
- C. Assuring that each SBHC contractor provides a minimum of 20 hours per week of direct primary health care for mental and/or addictive disorders which includes the psychosocial assessment, treatment plan, and progress/follow-up notes. These services will be provided by a mental health professional licensed in Louisiana as either a Psychologist, Professional Counselor (LPC) or Clinical Social Worker (LCSW); or by a non-licensed, but academically qualified mental health professional (i.e., a graduate from an accredited institution) who is progressing towards a written plan for obtaining a license.
- D. Assuring that each SBHC contractor initiates local collaboration to eliminate duplication of service, and expand seamless child health care/referrals. At a minimum this will include entering into signed Memorandums of Agreement with the DHH Regional Offices for Addictive Disorders, Office of Mental Health, and also the local Parish Health Unit.
- E. Offering incentives to SBHC contractors to encourage voluntary participation in initiatives which will eventually transfer clinical supervision of SBHC mental and addictive disorder services to the Administrative Regions.
- F. Authoring an Inter-Agency Transfer (IAT) to OAD and/or OMH to cover the monthly Civil Service pay level and (% 17) fringe benefits necessary for the Administrative Regions to hire or contract GS-17 Social Worker Specialist-BCSWs to deliver a minimum of 20 hours per week of direct primary mental health care, plus 20 hours per week of direct primary addictive disorder care in SBHCs.
- G. Modifying the standard SBHC data collection system to appropriately accommodate the unique OAD and OMH school-based mental or addictive disorder data collection requirements.
- H. Assuring that each SBHC contractor participates in the uniform data collection system established by OPH-ASHI.

OAD contributions to this interdepartmental agreement shall include:

- A. A minimum of four hours per month of Regional OAD staff participation in case management consultation with SBHC practitioners to identify children who need referral for addictive disorder assessment or treatment.
- B. A minimum of four hours per month of Regional OAD staff preventive education presentations in schools which house SBHCs.



- C. Inclusion of SBHC practitioners on OAD mailing lists for announcements of OAD sponsored programs which provide continuing education units for addictive disorder credentialing.
- D. An average of one day per month of designated OAD staff participation in OPH-ASHI Continuous Quality Improvement (CQI) reviews of SBHCs for compliance with school-based addictive disorder service standards.

OMH contributions to this interdepartmental agreement shall include:

- A. A minimum of four hours per month of Regional OMH staff participation in case management consultation with SBHC practitioners to identify children who need referral for mental disorder assessment or treatment.
- B. A minimum of four hours per month of Regional OMH staff preventive education presentations in schools which house SBHCs.
- C. Inclusion of SBHC practitioners on OMH mailing lists for announcements of OMH sponsored programs which providing education units for mental health credentialing.
- D. An average of one day per month of designated OMH staff participation in OPH-ASHI Continuous Quality Improvement (CQI) reviews of SBHCs for compliance with school-based mental disorder service standards.

## Medicaid Provider Bulletin

### North Carolina Division of Medical Assistance

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**Attention: North Carolina Mental Health/Substance Abuse Providers**

**Subject: New Health Benefit**

*Effective July 1, 2000 a new preventive/early intervention mental health benefit will be available to approximately 400,000 state employees and teachers and 60,000 children enrolled in North Carolina Health Choice. Medicaid will adopt this policy for recipients under the age of 21. This plan will allow children to get mental health checkups similar to annual physicals.*

**Billing guidelines:**

Medicaid will pay for six unmanaged visits without a diagnosis of Mental Illness.

Diagnosis coding: Claims may be diagnosis coded in either of two ways: (1) only the first two visits can be coded with ICD-9-CM code 799.9 (a non-specific code) and the following four visits can be coded with "V" diagnosis codes; or (2) the first visit can be coded with diagnosis 799.9 and the rest of the visits can be coded with "V" diagnosis codes. In either case, a specific diagnosis code should be used as soon as a diagnosis is established. After the sixth visit, a definitive diagnosis must be submitted in order for claims to be processed.

**Prior approval:**

Prior approval is not required for area mental health centers, however physicians and Ph.D. or Masters-level psychologists employed by physicians and who are not employed by area mental health centers must follow prior approval guidelines. Beyond the six unmanaged visits Medicaid will cover without a diagnosis of mental illness, Medicaid will cover up to 20 additional visits without prior approval. Prior approval must be requested for children under age 21 after the twenty-sixth visit. This permits a total of twenty-six unmanaged visits in a calendar year for the under 21 years of age population. This preventive mental health benefit will make it possible for children to receive services at the earliest signs of trouble.

**Contact Carolyn Wiser, RN at 919-857-4025**

## **CONNECTICUT STATUTE**

### **Section 17b-297**

#### **Outreach program for HUSKY Plan, Part A and Part B.**

- (a) The commissioner, in consultation with the Children’s Health Council, the Medicaid Managed Care Council and Infoline of Connecticut, shall develop mechanisms for outreach for the HUSKY Plan, Part A and Part B, including, but not limited to; development of mail-in applications and appropriate outreach materials through the Department of Revenue Services, the Labor Department, the Department of Social Services, the Department of Public Health, the Department of Children and Families and the Office of Protection and Advocacy for Persons with Disabilities.
- (b) The commissioner shall include in such outreach efforts information on the Medicaid program for the purpose of maximizing enrollment of eligible children and the use of federal funds.
- (c) The commissioner shall, within available appropriations, contract with qualified entities authorized to grant presumptive eligibility, severe need schools and community-based organizations for purposes of public education, outreach and recruitment of eligible children, including the distribution of applications and information regarding enrollment in the HUSKY Plan, Part A and Part B. In awarding such contracts, the commissioner shall consider the marketing, outreach and recruitment efforts of organizations. For the purposes of this subsection, (1) “community-based organizations” shall include, but not be limited to, day care centers, schools, school-based health clinics, community-based diagnostic and treatment centers and hospitals, and (2) “severe need school” means a school in which forty per cent or more of the lunches served are served to students who are eligible for free or reduced price lunches.
- (d) All outreach materials shall be approved by the commissioner pursuant to Subtitle J of Public Law 105-33.

**National Assembly on School-Based Health Care  
HHS Regional/SBHC Meetings  
10:00AM – 3:00PM**

*Medicaid Reimbursement in School-Based Health Centers*

10:00AM Welcome and Introductions

John Schlitt, National Assembly on School-Based Health Care  
Andy Schneider, Medicaid Policy L.L.C., *Facilitator*

10:15AM Overview of SBHCs in Region (by state)

*Fee-for-Service*

- For what services are the SBHCs currently billing Medicaid, and at what rates?
- For what services are the SBHCs not billing Medicaid, and why?
- Have there been any utilization management issues (e.g., prior authorization requirements, retrospective claims denials, etc.)
- Are there any Medicaid fee-for service billing or payment policies that are unclear and need clarification?
- Are there any Medicaid billing or payment policies that are problematic and should be reconsidered?

*Managed care/contracting with MCOs*

- What types of subcontracting or other arrangements have SBHCs established with Medicaid MCOs?
- Are these arrangements working for SBHCs? If not, what are the issues?
- What “carve out” or other policies have state Medicaid programs adopted with respect to SBHCs that do not subcontract with Medicaid MCOs?
- Are these “carve out” policies working for SBHCs? If not, what are the issues?

12:30PM Lunch (continued discussion)

2:00PM Continued Challenges/Opportunities for Technical Assistance

- Best practices across region
- Common challenges across region
- Policy clarifications needed
- Potential policy solutions
- Technical Assistance agenda

3:00 Wrap up/Adjourn

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