NASBHC National Assembly on School-Based Health Care

Unlocking the Benefits of Public Health Insurance for Children

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Ever been frustrated by frequent flyer programs that lure you in with the promise of great rewards –like no-cost travel to exotic ports of call - only to discover that you can't redeem your air miles *when you want to use them*, or for *where you want to go?* It's not unlike public health insurance for children and adolescents. On paper, low-income children and youth are entitled to a comprehensive set of health care benefits. But try to redeem those benefits – either as a consumer accessing care or a provider seeking reimbursement - and the bureaucratic barriers that result would make the airlines blush: lengthy waiting times for preventive visits, denials for services not covered or considered "not medically necessary," limited choices for adolescent-oriented providers and sites, prior authorization policies that restrict reimbursement for visits out-of-plan, or transportation barriers to reaching the pre-assigned "medical home."

On this occasion of the tenth anniversary of the State Child Health Insurance Program (SCHIP) and its impending reauthorization by Congress, it's time to take stock of publicly financed health insurance coverage for children and adolescents. Are Medicaid and SCHIP fulfilling their promise of assuring America's youth access to high quality health care that meets nationally accepted standards for primary and preventive care? Or are the benefits - like too many frequent flyer programs - technically available, yet in practice, simply out of reach?

It is fairly well established that states' Medicaid and SCHIP programs have a dismal track record for meeting basic utilization goals for school age children, including Congressionally mandated measures (for Medicaid) established under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Consider a recent study of Medicaid benefits that found a majority of states didn't require screening on conditions that pose significant public health problems, including alcohol, tobacco and substance use, school problems, depression, obesity, and risky sexual practice. Many of these conditions take seed in adolescence; all of them have potential long-term consequences. Another study of states' EPSDT compliance, this one by the U.S. General Accounting Office (GAO), found that states have an unreliable and incomplete assessment of health care utilization – especially for children and teens enrolled in capitated managed care plans. Other performance evaluation reports of Medicaid managed care organizations found well child visit rates for adolescents (that is, the percent of adolescents 12-21 who had a comprehensive well care visit) ranging 30-40 percent. Only *three* or *four* teens out of ten are receiving a standard of care regarded as good practice – a far cry from the 80 percent target rate established by Congress. Worse still, teens self-report that when they do get care, their primary care providers aren't screening or counseling on behavioral and emotional health issues.

The chasm between what we know to be good practice and what we accept as the current reality in child and adolescent health is huge. The good news is there are voices in the wilderness seeking progressive change (and challenging entrenched institutions) for how we organize and finance child and adolescent health care. Nothing short of a complete transformation is called for fixing a broken system, they assert. Their vision: a high performing system of care that is patient- (and family-) centered with emphasis on health promotion, risk reduction, and care coordination. At its core is an interdisciplinary team of allied health professionals from medicine, nursing, behavioral health, and social work. Because of the important influence of family and environment in young people's lives, primary care settings are expanded to include schools, homes and community-based settings, which afford unprecedented opportunities for continuous developmental surveillance to detect and prevent problems. A key factor of success is a health care environment that is perceived as engaging, safe, comfortable, respectful, culturally appropriate, and teen friendly.

These thought leaders most certainly must have had school health centers in mind. After all, the hallmark of this health care innovation is inter-disciplinary, patient-centered, environmentally and behaviorally conscious preventive and early intervention care. And this thirty-year experience has taught us a thing or two about attracting young people, adolescents especially, into preventive, primary care services.

- Young people don't show up for preventive visits (a fact well known by managed care organizations and substantiated by woeful performance measures), but the school health center visits for stomach ache, nausea, and sports physicals are windows of opportunity for deeper engagement. "*I noticed you haven't had a risk assessment or physical exam in some time – can I get you back here for follow up?*" And if they don't show up, you simply walk down the hall to retrieve them.
- Young people are open to health promoting messages and skills-building for behavioral

change – but it takes time to establish trust, which means many visits may be required - time-intensive visits that currently are uncovered by third-party payers.

- Young people have no qualms about accessing mental health care when services are incorporated into primary care, as it often is in school health centers. Teens use mental health services in school health centers far more than traditional community-based settings because there's little stigma attached to the school clinic.
- Geography does matter. Health services must be "where students can trip over them," as an early school health center pioneer described the importance of access. Any system that requires complicated transportation to unfamiliar providers in unfriendly settings will fail.

Nothing short of transformation is necessary to bring public health care financing closer to the highest standards of quality preventive, primary care for Medicaid and SCHIP school-age enrollees. The traditional capitation and fee-for-service reimbursement methods, based on a history of underutilized medical encounters by physicians in traditional single discipline settings, fail miserably in achieving a vision for a more effective, comprehensive, coordinated and responsive system of primary care. School based health centers and similar interdisciplinary adolescent- and child-friendly access models have too often been left out of traditional finance systems – not surprising given that they are often organized as a response against mainstream health care systems. They deserve not to be marginalized but rather to lead the way in creating disruptive innovations in a field hungry for better outcomes.

Let's not allow this occasion of national significance in children's health care policy slip by without making necessary changes for ensuring meaningful access to comprehensive, health care benefits that deliver on the promise of prevention and early intervention for some of our most vulnerable citizens. Let's not waste another ten years experimenting with failed mechanisms. We know what works for young people; school health centers teach us that we know how to respond to their health and mental health needs.

For additional reading about transformational ideas for child and adolescent well care:

Fox, H, Limb, S and McManus, M, Preliminary thoughts on restructuring Medicaid to promote adolescent health," Incenter Strategies for the Advancement of Adolescent Health, Issue Brief No. 1, January 2007.

D. Bergman, P. Plesk and M. Saunders, A high-performing system for well-child care: A vision for the future, The Commonwealth Fund, October 2006.

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The National Assembly on School-Based Health Care (NASBHC) is an advocacy organization that is the voice for those who work in, are served by, and support an important model of health care that delivers services where children and adolescents learn and grow: their schools.