NASBHC National Assembly on School-Based Health Care

Bringing Health Care To Schools For Student Success

School-Based Health Center Third-Party Billing: Policies and Systems

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To bill… or not to bill?

It is a seemingly simple question for school-based health centers, yet its answer remains terribly complex. For many years, the issue of billing and collecting patient revenue has both challenged and frustrated school-based health care providers. The desire to bring in a reliable and constant source of revenue is tempered by the energy and resources needed to create an effective infrastructure for such an operation. Health care practice management skills and expertise are not routinely part of the training and experience for clinicians and clinical administrators that populate SBHCs. The small clinical school-based programs often do not have the administrative support to be either efficient or effective at revenue collection.

"What can national and state partners do to assist SBHCs in strengthening their capacity to bill and collect?"

The supposition that school-based health centers could be made financially stable through recovery of patient care revenue has been posited by policy makers who believe, reasonably, that the growing number of publicly insured school-aged children should provide a sufficient pool of insured SBHC users. But issues like patient volume, persistent uninsurance (yes, still), limited administrative capacity, potential breaches of confidentiality, the volume and importance of non-billable services performed in SBHCs, managed care, and philosophical mission confound the idyllic notion that SBHC budgets can be made more secure through third party billing.

"Technology is a critical partner in the pursuit of practice management excellence."

A two-day meeting of SBHC administrators and public and private funders was convened by the National Assembly in January 2002 (see page 6 for roster). Participants explored with NASBHC leaders and staff the current state of third-party patient revenue recovery and were asked to determine a two-pronged national technical assistance agenda:

- What can national and state partners do to assist SBHCs in strengthening their capacity to bill and collect?
- What Medicaid and commercial insurer policies prevent or limit reimbursement to SBHCs?

The work group's recommendations follow.

Work Group Recommendations

Capacity Development and Technical Assistance

“NASBHC should approve and promote a minimum SBHC data set…”

Practice Management Resources
The work group supports the development of a national SBHC practice management initiative to include a print/electronic manual with coding guidelines and sample encounter forms that can be adapted to meet local needs. Hands-on training through national, regional and/or local venues should be organized to accompany the manual. Train-the-trainer efforts directed at state SBHC associations would be helpful for creating practice management infrastructure within a geographic area.

Potential collaborators in this endeavor were identified as: national and regional foundations with interest in survivability of SBHCs; state public health departments, HRSA’s Center for Health Services Financing and Managed Care, the National Association of Community Health Centers, and state SBHC associations.

Support Federal SBHC Network Legislation
Federal financial support for state-level technical assistance to school-based health centers would provide much needed resources to fund the above-described activities and to advocate for policy-level changes that limit reimbursement. NASBHC and its federal and state partners should make the passage of this legislation a high priority.

Funder-Directed Advocacy for Increased Support
If a higher level of skill, expertise and systems support is needed in the SBHC in order to collect third-party revenue efficiently, a concomitant increase in financial support will be necessary, at least in the initial stages. NASBHC should state its support for adequate levels of funding on order to develop the infrastructure required for higher level functioning in the SBHC.

MIS Information Broker and Analyst
Technology is a critical partner in the pursuit of practice management excellence. Yet many programs have limited technological proficiency and resources. The field could benefit from analytical tools that would allow them to review and evaluate systems that could better serve their practice management needs, including compatibility of software language and sharing data elements between data collection and practice management or billing/accounting software systems. Three major actions should be undertaken by NASBHC towards improving data systems integration and practice management for SBHCs.

Minimum SBHC Data Set. NASBHC should approve and promote a minimum SBHC data set that includes the following data points: procedure and diagnosis codes for most common encounters that occur in SBHCs, behavioral and biomedical risk factors in the CQI tool, services for primary care and behavioral health providers, date and length of services, demographics (race, grade, sex, age), insurance, free lunch eligibility or income proxy, disposition codes for tracking, languages spoken, confidentiality (services and billing), consent (registered/non-registered students), group screening and health education sessions/activities, and unique identifier.

SBHC Software Guidelines. NASBHC should develop and disseminate a set of SBHC software guidelines for use by SBHCs when selecting, upgrading, or changing practice management software systems. The guidelines would examine requirements of any system (interface/ compatibility), license cost, annual support cost, web-based or computer based application, cost of updates, technical support availability, HIPAA compliance, maintenance and operations, process for updating CPT and ICD 9 codes, and a listing of the data and practice management software programs that meet these requirements.

Feasibility of Data/Practice Management Integration. NASBHC should conduct a case study toward understanding the feasibility of data/practice management integration in SBHCs. Five SBHC sites that are representative of centers in the field would be selected to receive consultation regarding internal and software systems integration, training in practice management related skill sets, and technical assistance support during the integration period. The five sites that participated in BPHC’s study would receive first priority as case study sites. The case study would examine an array of pre and post practice management related data; identify the barriers, opportunities, and strategies used in each site; and document the lessons learned. A practice management guide/tool kit and a national training strategy should be developed and disseminated to the field based on the lessons learned from the case study.

NASBHC is encouraged to work with the Bureau of Primary Health Care and NACHC, which have pioneered the development of Integrated Management Information Systems for the community health field.

Work Group Recommendations

Reimbursement Policy Issues

Standardization

Reimbursement policy appears to be confounded by the lack of universal definition for what constitutes school-based health center services (and a perception that each center is unique). Several participants observed that the desire to embrace uniqueness across SBHCs is a hindrance to establishing common understanding about SBHCs among health care payers. The field would do well to communicate those services that are common to SBHC – a strategy that would befit a national costing model (see below).

Develop "cost-basis for SBHC" study

There is little-to-no knowledge of a cost basis for determining reimbursement for services delivered in SBHCs. The field needs a methodology for establishing its costs – a process that gives value to the collateral (non-clinical) and non-billable activities associated with patient care in the SBHC. Rural and community health centers have tools used nationally that might have applicability for SBHCs. NASBHC should assess the availability and utility of these tools and explore the feasibility of their application in a national representative sample of school-based health centers.

Explore federal/state policies that support reimbursement of the full cost of providing services

There is precedent for Medicaid to reimburse at full cost those services delivered by unique provider types. Information gathered from the above recommended cost study should be used to advocate for federally and state-supported reimbursement methodologies that allow full recovery of costs. SBHCs sponsored by federally qualified health centers are entitled to cost-based reimbursement; what types of reimbursement could be recommended for non-FQHC SBHCs that deliver the same services to the same high risk population?

Federally Qualified SBHCs

The designation of SBHCs as federally qualified health center "look-alikes" bears reimbursement advantages. Yet most SBHCs view the federal requirements for "look-alikes" to be inappropriate for a youth-focused access program. NASBHC should explore the possibility of a federal waiver from certain "look alike" requirements that would bring a broader number of SBHCs under the federal definition, and accordingly, afford cost-based (or prospective payment) reimbursement to SBHCs.

Promote best reimbursement practices among state decision makers

Several states have established Medicaid reimbursement policies specific to SBHC (carve outs and SBHC provider eligibility). These policies should be routinely documented and disseminated to SBHC advocates and state health care financing policy makers to stimulate creative thinking. NASBHC's report, *Partners in Access: School-Based Health Centers and Medicaid*, should be used by state SBHC advocates to strategize with Medicaid agencies about adoption of SBHC-friendly policies.

Explanation of Benefits and Confidentiality

Efforts to collect revenue for minor sensitive services such as reproductive health and mental health services are not made by many SBHCs because of fear that an Explanation of Benefits (EOB) will be sent by the insurer to the subscriber. An EOB sent to the home is a breach of the adolescent's privacy, and even a breach of law in some states. Although Medicaid policy does not require EOBs, commercial insurer's that participate in Medicaid managed care programs often send them. Furthermore, because Medicaid's free care policy requires that it will not pay for services that are delivered free of charge to non-Medicaid populations, SBHCs that do not bill private insurers for sensitive services cannot bill Medicaid either.

And finally… a word of caution

It is fine to develop tools for school-based health centers to document productivity, evaluate clinical services, and enhance billing and collection. In our efforts to re-tool the field, however, do we risk sacrificing the values that compelled us into this business in the first place? Are we setting ourselves up for failure with expectations that can't be met? We are HMO refugees, participants exclaimed. Disruptive innovators. We will resist that which makes us look more like them. Our natural inclination is "services first," and not just those that will earn us more reimbursement. The shift to a business orientation will no doubt be difficult and not easily digested for some, but necessary for many.

"Do we risk sacrificing the values that compelled us into this business in the first place?"

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