

Critical Issues in School-Based Health Care Financing

A report of the National Assembly on School-Based Health Care, September 1999

School-based health care providers, administrators, and state policy makers from across the country were convened in a series of regional meetings in 1998 and 1999. Eighteen states and more than 125 individuals representing state health policy and financing agencies, health plans, and school-based health centers participated.¹ The primary objective of the meetings was reconnaissance: what does this audience believe to be the critical issues regarding the long-term sustainability of school-based health centers? This paper summarizes the discussions that were shaped to 1) identify the various mechanisms for financing school-based health care; 2) explore challenges in utilizing those resources as long-term funding sources; and 3) outline future opportunities for creating a sustainable national network of school-based health centers.

Financing Mechanisms: Grants

State Grant Funding

Many of the state health departments represented at the critical issues meetings provide state-directed funding to school-based health centers, whether as a competitive grant program or an earmark to a community-based health organization. The state grants, typically allocations of the state/federal maternal and child health block grant, general revenue, tobacco tax, or any combination of the above, represent essential, core funding for many of the programs. Nearly two in three centers (281 of 443) from the nine states profiled in the table below receive financial support from the state health department. Of those centers with state grants, 83 percent rely on those funds to cover one-half or more of their operating budget.

Without this financial support from the states, a majority of the programs would not survive. For example, in Connecticut, as local sites faced difficulty in replacing seed dollars from two foundation-supported initiatives, the state stepped in to shore up budget deficits. In Illinois, the state's grants were initially deployed as start up funds; however, as communities were unable to supplant state funds with local dollars, the school-based health care community persuaded the state to change its policy in favor of longer-term support.

The forecast for maintaining the states' grants appears positive. Most believe that their own state grants will be sustained for the foreseeable future. Legislative and gubernatorial political support appears strong, even from more conservatively governed states such as Louisiana and Connecticut. There is pressure, however, by some states to step down funding in light of Medicaid managed care and state child health insurance initiatives. In Texas, for example, the state health commissioner abolished new start-up dollars through the state's school-based health care grant program because of perceived redundancies. A greater number of insured patients should yield more patient care revenue to the centers, argue some state policy makers. And with significant public dollars being directed to escalating Medicaid costs and expanded health coverage for low-income children and youth, states are eager to match federal funds with whatever public health resources they can muster. Continuation of grant support might be a greater challenge in the years ahead.

With rare exception, program expansions are not expected or planned, a byproduct some hypothesize of states' fiscal belt-tightening. Some participants reasoned that the most recent expansions of public health insurance for children have tapped out state investments in children's health services. Data from

Role of State Grant Programs in Supporting SBHCs, 1997-98

	State-Directed Funds	# of SBHCs Receiving State Funds	> 50% SBHC Budget
CT	\$ 4,950,000	45 of 51	45
DE	\$ 3,600,000	23 of 23	23
IL	\$ 1,700,000	16 of 18	5
LA	\$ 3,600,000	30 of 30	30
MA	\$ 1,950,000	31 of 36	7
ME	\$ 183,000	5 of 14	4
MI	\$ 2,892,000	20 of 41	10
NY	\$ 9,860,000	99 of 158	99
TX	\$ 1,465,000	12 of 77	12
Total	\$30,200,000	281 of 443	235

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¹ The National Assembly and the Kellogg Foundation convened five regional meetings: Denver, Colorado (April 1998), Baltimore, Maryland (June 1998), Lansing, Michigan (October 1998), Boston, Massachusetts (November 1998), and New York, New York (March 1999).

the 1998 Making the Grade National Program Office survey reveal a slight drop in collective school-based health care investments across states. Funding dropped overall from \$40.3 million in 1996 to \$38.8 million in 1998, a four percent decrease (see table, page 3). The average state share across all centers dropped 23 percent, from \$44,000 to \$34,000. Contributing to this decline was a 30 percent decrease in state allocations of the Title V MCH block grant to school-based health centers. The slight increase in general revenues — a factor due largely to increases from New York and Louisiana — will do little to ease the loss. Some advocates have a legislative agenda for increasing state funding; as of this reporting, one state, Texas, has been successful.

State Directed Funds for SBHCS, 1992-98 (in millions)				
	1992	1994	1996	1998
MCHB	8.2	12.0	13.1	9.4
State Rev	9.2	22.1	27.3	28.2
Total	\$17.4	\$34.1	\$40.3	\$37.6

Source: Making the Grade National Program Office, The George Washington University

Local Funding

As national foundations' grant-making shifts from direct service to larger, more long-term systemic change initiatives, and state grant program dollars remain stagnant, local funding will be essential to the continued growth of school-based health care. In states where a financial supporting role has been limited or nonexistent, school-based health care has been a product of local leadership, vision, and financing. Whether through a patchwork of education and community health sources or a line item in the county budget, community leaders from such states as California, Indiana, Maine, Maryland, New Jersey, Ohio, Oregon, and Texas have leveraged public and private funds to create and sustain school-based health care.

Even among the state grantees there is recognition for the value of local investment. Community partnerships and financial support as prerequisite for state funds have served to make many of the state-funded programs stronger. Participants believe that communities must express value, not just symbolically, but through commitment of financial resources. Only with local political support can education, health and social services funding be re-deployed toward integrated multi-disciplinary school-based efforts.

There are distinct differences in programs within states without standards or quality guidelines. Without a uniform definition, the term school-based health center has come to mean many things, resulting in great variability in facilities, operations, sponsorship, scope of services, and staffing across sites. Services may or may not include case finding and referral, sick child

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care, comprehensive primary care, and reproductive health. The levels and types of staffing, as well as time on school site, are also quite varied. According to providers, this has been confusing to payers who are being asked to cover an ill-defined range or package of services.

Federal Grants

With the exception of the federal grant program, Healthy Schools, Healthy Communities, which supports approximately 40 centers nationwide, communities do not have direct access to federal grant support for school-based health care services. Although the program has established a national standard that reflects a comprehensive, multidisciplinary model, Healthy Schools, Healthy Communities is limited in its ability to support expanded program growth, or to sustain existing centers over the long term.

Participants did identify a litany of federal sources, the majority of which flow through the state and local education and public health/mental health agencies to support services for categorically high risk and underserved school age students. These include:

- Titles I and XI, Improving America's Schools Act
- Safe and Drug Free Schools and Communities
- Section 504 and related special education funds that support health-related services for children with individual education plans
- Substance abuse and mental health services block grant
- Violence prevention initiatives

While these have not played a significant role in school-based health care financing, a small number of communities are making in-roads. Participants believe national advocacy efforts are needed to expand the programs' eligibility and services criteria to foster creative partnerships between local education and community health organizations.

Financing Mechanisms: Patient Care Revenues

Public and Commercial Insurance

The history of billing and collecting patient care revenues in school-based health care is relatively brief. Many of the early school-based health centers did not bill for services provided

to Medicaid and commercial enrollees. Financed by private foundations and public health grants, the centers did not find it necessary to collect revenues. As efficiency and accountability are sought within the health care system, policy makers question the practice of school-based health centers subsidizing Medicaid and other insurers by giving services away for free to insured school age children. As a matter of sound fiscal policy, most school-based health care providers report that more aggressive efforts are being undertaken to recover reimbursement for services rendered to Medicaid enrollees.

As those with more experience have attested, putting into operation a billing and accounting system is complicated and the rewards have been disappointing at best:

- Collecting insurance information from the students and their parents is both challenging and burdensome: many students don't know their insurance status, and insurance providers change routinely.
- The insurance status of a large portion of the program's population is either uninsured, underinsured, or unknown.
- Some states explicitly prohibit billing for nurse practitioner services.
- Many insurers require a co-payment for some or all services.
- Explanation of benefits (EOB) are sent to the family, potentially compromising patient-provider confidentiality.

Even when successful, participants admit — and studies support — that revenue collection will not provide for more than five to fifteen percent of the operating budget. Such returns have naturally prompted concerns about the cost-benefit of establishing capacity to generate bills.

Self Pay

Some programs report collecting payments for services from the student and/or family, either in the form of a one-time registration fee, or at the time of the visit. This practice, although not widespread, was thought to be important in establishing buy in from the patient and family. "It may add up to very little, but it contributes to the families' investment in the program," suggested one participant.

Medicaid Managed Care

As Medicaid managed care unfurls in varying degrees across the country, state health departments and school-based health care providers have had varying degrees of success in building relationships with managed care organizations. The identification of school-based health centers as essential community providers, or required partners, within some states' Medicaid managed care contracts (CT, RI) has resulted in some minor head-way and a "wait and see" attitude among providers. School-based health care carve outs and self-referral policies in other states (IL, NY, MD) have sustained access to Medicaid

revenues while more long-term solutions to managed care partnerships are sought. Many state health departments have adopted a policy of encouragement and détente. The state plays the facilitator, explicitly expressing the value of school-based health centers to health care networks, while leaving the specifics to the local partners.

If anything, Medicaid managed care has provoked important debate about the role of school-based health care in a changing health care market. Responding to that debate, some school-based health centers are positioning themselves as full-fledged providers (or co-providers at least) of primary care, wanting to bear the risks and rewards inherent in that model. To the other end of the spectrum are those seeking to carve out a public health role, emphasizing broader preventive and early intervention services rendered to an entire population rather than a patient load, and serving as gatekeeper to the provider community. To the middle lie those programs seeking to strengthen aspects of health care that are rarely present in our current system: immediate access to acute care, risk reduction, substance abuse counseling and prevention, behavioral, and mental health services. And there are those who will be whatever the child needs at that particular moment: a medical home, a confidential session, a sports physical, or a simple acute visit.

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A few school-based programs sponsored by health care organizations that also serve as health plans have been identified on primary care provider panels. The strategy has met with unexpected surprises. After two years of experience, one program was able to enroll only 26 school-based health care patients with the center as primary care provider. Distance between the school and the family's home was often raised as an issue. Additionally, families with children in different schools preferred a provider whom the entire family could see. It is not a winning strategy, suggest some administrators, because the volume of potential enrollees in a school setting simply isn't sufficient to sustain any reasonable risk for primary health care needs.

The pursuit of Medicaid managed care relationships and the implementation thereof has provided important lessons. Education about what school-based health care is and is not takes time; moreover center staff must invest in understanding the health plans' perspectives. Not all plans eagerly embrace the states' requirements or encouragement to partner with school-based health centers. Contracts that have resulted are

often restrictive and don't reflect preventive and mental/behavioral health services. Pre-authorization requirements are placing administrative burdens on the center staff. The plans' credentialing requirements are perceived as burdensome and redundant. And fees, when collected, have been significantly less than what the program generated from Medicaid prior to managed care.

Despite the drawbacks, many participants report the process is necessary, especially for the development of stronger clinical connections between plans and school-based health centers. And while the exchange of information may feel one-sided initially, it is an important beginning.

Present Challenges to Sustainability

Administrative Burden

The administrative costs to operate school-based health care programs are growing. Increasing demand for accountability by funders and health care sponsors has necessitated multiple (and perhaps redundant) quality audits, improved data collection, and technology to exchange clinical information. Managed care partnerships require complicated negotiations about roles, scopes of services, information exchange, and financing. The burden for all of this lies predominantly with the school-based health centers. Many advocate that the parent institutions must take more responsibility for accepting these administrative functions, thereby lessening the burden to the centers and center staff. This will not be easy, warn some providers, because the relative scale of the program, the uniqueness of the site and the population create tension with the larger institutions. School-based health centers simply aren't on their radar screen.

Because several states had not required billing and collection of their school-based health center grantees, the more recent emphasis on revenue collection has challenged the centers' administrative capacity. Several of the programs reported that their institutions were not eager to provide billing services because of the low volume and poor return. In some instances, billing clerks' salaries were not being met by the revenue returns. Moreover, those programs that did collect had difficulty verifying that their sponsoring institutions were returning revenues to the program.

Continuity of Care

The role of the school-based health center as co-manager of primary care raises enormous issues about continuity of care and information exchange. The need to establish procedures and technology for maintaining continuity of care between the various co-providers was voiced repeatedly from participants. Accordingly, some raised concerns about the state of the art in MIS systems for school-based health centers and

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its implications for billing and information exchange. The most popular software in use, School HealthCare On-Line, has limitations as a billing program, and because it is not capable of printing a bill or transmitting data electronically, requires double entry for billing purposes. Caution was urged by one provider that information needs—those data that quantify what SBHCs do—be separated from billing needs.

Outcomes Data

Many decried the critical shortage of data that has meaning to policy makers and purse holders and show the value of important medical and non-medical functions of school-based health care. How do school-based health centers demonstrate that they are keeping kids out of emergency rooms and other inappropriate health care settings? That compared to traditional pediatric and adolescent health care practices, school-based health centers do a better job of achieving primary care goals? How can school-based health care data incorporate national medical and public health quality assurance yardsticks and goals such as HEDIS and Healthy People 2010? How can these yardsticks be augmented to include preventive services, such as AMA's Guidelines for Adolescent Preventive Services (GAPS)? Advocates suggested that data from the New York school-based health center Medicaid carve out will be very valuable. How will the extensive billing of more than 100 school-based health centers inform a national audience about normative access and utilization for school-age Medicaid enrollees?

Future Opportunities

Standards/Licensure Guidelines

The lack of uniformity across school-based health care programs was perceived by payers and plans to be problematic. Varied services, staffing and hours of operation left payers confused about what it was they were being asked to reimburse. The development of standards and licensure requirements by some states was considered helpful toward productive health care plan/insurer relationships. Many participants reported that health plans had very limited understanding of school-based health centers. Those states and local programs that could point to the standards or license were able to offer a guarantee of quality.

Education as Partner

There was general agreement that the function of being school-based should increase the opportunity for more successful education collaborations—with infusion of education-related dollars. Schools should not and cannot be passive participants in this endeavor; co-ownership must be fostered. Some school-based health care programs have been developed and sustained under the auspices of the school district. Advocates maintained that greater attention must be paid to the role of education, its myriad funding streams that can effectively finance comprehensive school health services programs, and commitment to sharing accountability for education goals. State and federal education aid programs are substantial and stable; these sources must be considered in the quest for long-term funding.

Perhaps the greatest barrier to such a collaboration is the autonomy of the school districts and the pressure for accountability to education achievement outcomes, none of which support human service delivery in the school. Few programs, if any, in the participating regions have had success in tapping into federal and state school aid for pupil support services. Reportedly, local decision makers prefer to keep those dollars in classroom remediation and teacher support efforts. While important contributions have been made to facility development, maintenance, and staff support from school personnel, the perceived threat of cost-shifting to the schools is a constant concern of education officials.

State Child Health Insurance Programs

Participants agree that the federal/state child health insurance initiatives' goal to decrease the number of uninsured children is unassailable. Many worry, however, about the inherent assumption that insurance coverage connotes meaningful, accessible services. The critical eye being cast by policy makers toward special access programs questions the need for these initiatives if health insurance is available to most children and teens. School-based health care providers will need to be vigilant about continued access issues, unabated uninsurance and under insurance, and inadequacy of meaningful systems to serve all children and youth. Insurance outreach and enrollment is a worthy activity, but a narrow view of school-based health centers.

Marketing Added Value

Increasingly, as health care purchasers and insurers — whether state government, employers, or health plans — seek greater emphasis on early, preventive health care, and greater accountability to consumer satisfaction and utilization, school-

based health centers are found to be valued as access points. Advocates spoke of plans' interest in school-based health centers' ability to help achieve goals for EPSDT compliance and substance abuse service visits. Kaiser Colorado found school-based health centers to be ideal primary care entry points for their low-income insurance product, School Connections. Such exposure to the centers will no doubt prompt a more expansive look at school-based health centers as primary care providers.

A New Paradigm for Adolescent Health Financing

The link between Medicaid, Medicaid managed care, and school-based health care is proving to have limitations on how school-based health care can be organized and financed. The population-based approach, a foundation of many school-based health centers, is not compatible with the illness/episodic insurance model. Visit codes and rates, based on private pediatric practice, do not reflect the time-intensive anticipatory guidance, and health education that is idiosyncratic of the school-based health center visit. Moreover, the industry construct of medical home is inadequate for many adolescents who often do not know it exists, where it is, or how he/she relates to it.

Participants share a desire to re-frame the current paradigm for financing adolescent health care delivery. With decreasing enrollment and discounted fees, Medicaid cannot be relied upon to significantly support school-based health centers over

the long term, exclaim participants. A divorce from Medicaid might compel creative thinking about organizing resources for the school age population, especially adolescents, and not just those who are Medicaid-enrolled and uninsured. Key principles of an alternative financing strategy advanced by participants include open access for children and youth, particularly those traditionally underserved, to a broad range of comprehensive and preventive health services delivered by the health care

provider of their choosing. Health Care for the Homeless, a federal insurance/service program, operates under a similar policy design. Similarly, a group practice model, employing schools as grouping mechanism, would enable communities to organize and finance comprehensive, integrated services including public, primary, behavioral, dental, and school health services for the entire school population. By accepting fiscal responsibility AND accountability for services, demonstrating health and learning links to absenteeism and drop out, and providing greater efficiency in delivering health-related services mandated by federal education law, school-based health centers can offer a compelling reason for expanding the school/community health partnership.

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School-based health care represents an intersection of public health, medical care, mental health, and education. Its survival depends on a policy and financing structure that adequately rewards this intersection and the unique clinical opportunities, including group and population-focused services, that are not part of standard health care reimbursement. Advocates urge that, as school-based health care services are marketed to multiple stakeholders, the field must set clearer definitions of scope of practice, illuminate distinctions from mainstream practice, and demonstrate the value of those distinctions. Without political awareness about the comprehensive nature of school-based health care practice and its impact, school-based health centers risk being held captive to a tenuous funding strategy—a strategy that bears great burden to the administrator who must serve as fund raiser, grant writer, and billing & collections agent.

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National Assembly on School-Based Health Care
666 11th Street, NW, Suite 735
Washington, DC 20001
888/286-8727 toll-free
www.nasbhc.org