

Opportunities to Use Medicaid In Support of School-  
Based Health Centers

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# Opportunities to Use Medicaid In Support of School-Based Health Centers

## I. Purpose of this Document

This document is intended to assist State and local health officials who would like to ensure that School-Based Health Centers (SBHCs) are appropriately reimbursed for comprehensive primary care and other covered health care services that they provide to Medicaid beneficiaries.<sup>1</sup>

*Use this document to find answers to these questions:*

- What services can Medicaid pay for in SBHCs?
- When will Medicaid not pay SBHCs for medical services?
- How does managed care affect the availability of Medicaid reimbursement for SBHCs?
- Why is the kind of managed care used by a State Medicaid program important for SBHCs?
- How does Medicaid reimbursement to SBHCs change when Medicaid uses capitated managed care? When Medicaid uses a Primary Care Case Management system?
- What options does Medicaid have to pay SBHCs when patients are enrolled with capitated managed care organizations?
- How can SBHCs help enroll students in Medicaid so they qualify for Medicaid coverage the same day?
- How does Medicaid reimbursement to SBHCs relate to Medicaid coverage to schools for special education students?
- Can the State Children’s Health Insurance Program pay for services in SBHCs?
- What other information is available regarding Medicaid support of school-based health services?

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<sup>1</sup> This paper focuses on school-based health centers (SBHCs). It occasionally references “school-based health services” provided by schools and school districts rather than SBHCs. These services are provided under the Individuals with Disabilities Education Act (IDEA) and include services in the student’s Individualized Education Plan (IEP), plus Medicaid administrative outreach services provided by school staff. School-based health services provided by schools are not the focus of this paper.

## Outline of this Document

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## II. Brief Overview of Medicaid

Medicaid is a Federal-State program for medical and long-term care services for low-income Americans. Established in 1965 as Title XIX under the Social Security Act, Medicaid was designed to provide health coverage for persons with lower incomes and to help States pay for the costs of their health programs. Medicaid is financed with Federal matching funds, along with State funds and (in some States) local funds.

Over 40 million persons were enrolled in Medicaid during all or part of the year in 1999 (the most recent data available). In general terms, about one-half of all Medicaid enrollees are children or adolescents up to the age of 18. About one-fourth are adults who care for these children and adolescents or are women who are pregnant, and about one-fourth are persons who are disabled or age 65 and older. Persons who qualify for Medicaid must be in households with incomes below certain income levels. These income levels are set by each State. States also set a limit on the value of assets (although some States exempt families with children from an asset test).

At the Federal level, the Center for Medicare and Medicaid Services (CMS, formerly known as the Health Care Financing Administration [HCFA]) pays the Federal share of these costs by providing matching funds to the States. The amount of matching funds provided is based on a State's qualifying expenditures and the State-specific Federal matching rate, which is known as the "Federal Medical Assistance Percentage" or FMAP. The FMAP percentage is recalculated each year for each State based on a formula that considers the level of personal income in that State compared to the national average. The FMAP for medical and dental services for each State is always at least 50% and currently is as high as 77%. The Federal share of Medicaid administrative costs is the same for all States at 50% for most administrative functions, with certain administrative functions qualifying for higher matching rates. Federal Medicaid payments to States for services and for administrative costs are not capped. Eligible individuals are entitled to the services that are covered in their State.

States design and administer Medicaid within Federally defined boundaries. Each State decides who is eligible for coverage, what medical services are covered, which medical providers can participate, and the amount providers are paid when they provide a service. States also decide whether to contract with managed care organizations (MCOs), such as health maintenance organizations (HMOs) or to use other forms of managed care such as a Primary Care Case Management (PCCM) system.

The way each Medicaid Program works is the product of these State policy decisions. As a result, no two State Medicaid Programs are the same.<sup>2</sup> However, State Medicaid programs are alike in that all provide comprehensive medical and dental coverage for

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<sup>2</sup> Each State Medicaid program is described in detail and can be compared with other programs at: [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org)

children and adolescents who are enrolled in Medicaid. This is because of requirements in Federal Medicaid law relating to the *Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) Services* benefit. EPSDT requires Medicaid coverage for children and adolescents through age 20 for screening exams and for the treatment and follow-up for problems identified through an EPSDT screening exam including hearing, vision and dental care.

### **III. Medicaid and School-Based Health Centers (SBHCs)**

Medicaid is the largest source of financing of health care for school-age children and adolescents. In 1997, Medicaid provided health coverage for about one-fourth of all children and adolescents up to age 18 in the U.S.<sup>3</sup> Medicaid is an uncapped entitlement program, so there is no limit on the number of eligible children and adolescents that can be enrolled, and all covered services can be reimbursed by Medicaid.

For School-Based Health Centers (SBHCs), Medicaid can be a significant source of financial support for health services they provide.<sup>4</sup> This is because a large number of school-age children and adolescents they serve may have Medicaid as their health coverage. Health services provided to them in a SBHC setting can qualify for Medicaid reimbursement.

Medicaid provides comprehensive health coverage at no cost to children and adolescents who are enrolled in the program. Medicaid programs vary greatly from State to State. However, all Medicaid programs cover services through EPSDT that are important for school-age children and adolescents, including primary care and preventive services, such as well-child health screenings and immunizations, hearing, vision and dental screenings. Medicaid also covers treatment services, including behavioral health services.

School-Based Health Centers (SBHCs) specialize in providing primary and preventive health care services and almost two-thirds of SBHCs also employ mental health professionals. SBHCs can receive payment for these services from Medicaid when they provide them to school-age children and adolescents who have Medicaid coverage. However, Medicaid is only able to make payment to enrolled providers. Some SBHCs meet this requirement on their own and others do so through a sponsoring organization. Many SBHCs are sponsored by mainstream medical institutions such as hospitals, community health centers, health departments or another health care entity that is enrolled with Medicaid. A sponsoring organization typically takes primary responsibility for financial management and billing.

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<sup>3</sup> Data reported in: "MCH Update: Income Eligibility for Pregnant Women and Children," National Governors Association, January 20, 2000.

<sup>4</sup> SBHC services may also be covered by the State Children's Health Insurance Program (SCHIP), as is discussed later in Section VI of this document.

A note about school-based health services provided by schools and school districts: The focus of this paper is on SBHCs and how Medicaid can help support SBHCs and the services they provide. SBHCs are distinct from school-based health services provided by schools and school districts. In some States, schools and school districts can enroll as providers under Medicaid. Generally the State Medicaid office and the State Department of Education have an agreement on the scope of school-based health services that will be reimbursed by Medicaid. This agreement would describe the documentation required and the procedures to be followed for the school districts to participate in Medicaid claiming. In some cases, State legislation governs the process.

Schools typically provide occupational therapy, speech therapy and physical therapy for students who receive special education assistance through the Individuals with Disabilities Education Act (IDEA). In some States, schools (unlike SBHCs) can also qualify for Medicaid reimbursement for certain Medicaid outreach activities carried out by school staff. There is wide variability among States in their policies for Medicaid reimbursement for schools, and policies in some States have been subject to recent Federal oversight.<sup>5</sup> Note that services provided by SBHCs have not been the subject of this oversight.

#### How the Information in this Document Can Help SBHCs

This document is intended to provide information in simplified terms that can help identify the possibilities for using Medicaid to support health care provided by SBHCs. It is intended to inform the process of strategic planning, policy making and negotiation of agreements that can lead to appropriate Medicaid reimbursement for SBHCs.

For many SBHCs, Medicaid has the potential to be a significant source of revenue. Medicaid revenue can help ensure the continued availability of SBHC services. Since Medicaid rules are complex, billing for and receiving Medicaid revenue sometimes proves to be a challenge. Nevertheless, in recent years an increasing number of SBHCs have found it worthwhile to pursue this important source of financial support.

The next section provides basic information about school-based health centers as Medicaid providers. This information will help explain where Medicaid can help SBHCs and where it cannot.

Additional information about Medicaid is provided in Attachment A to this document.

In 2000, Medicaid helped finance 73% of all State health-related expenditures. Medicaid is the largest single expenditure item in many State budgets.

--National Association of State Budget Officers, *The Fiscal Survey of the States*, June 2001.

<sup>5</sup> State Medicaid Director Letter #01-013, January 19, 2001. Also see: "Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit," (April 5, 2000) General Accounting Office / T-HEHS/OSI-00-87. See: [www.gao.gov](http://www.gao.gov).

## IV. School-Based Health Centers as Medicaid Providers

School-based health centers (SBHCs) have become an important part of the U.S. health care delivery system. They provide access to many needed health care services that children in school might otherwise not receive. SBHCs can be especially effective in providing needed preventive and primary care services, as well as treatment for medical and behavioral health problems.

Until a few years ago, the number of SBHCs was quite limited. Over the last decade, the number of SBHCs increased nationally from about 200 in 1990 to 1,380 in 2000. SBHCs are in urban, rural and suburban areas of 45 States and the District of Columbia. About 38% of SBHCs are now in elementary schools, 17% in middle schools and 34% in high schools.<sup>6</sup> From the time they were established in the 1970s, the primary goal of SBHCs has been to make health care more accessible for children and adolescents. Medicaid can support this goal by paying for eligible medical services and interventions for children and adolescents enrolled in Medicaid.

SBHCs are supported financially from a variety of sources. Historically, State general funds are the largest component of SBHC funding, now comprising about 28% of the total. County and city funds are 19% and Federal funds are 9%. Schools and sponsor agencies provide in-kind support representing 18%. Private sources add 13% of revenue. Patient revenue totaled 13%, and most of which is Medicaid.<sup>7</sup> Medicaid has the potential to be a more significant source of funding for SBHCs in the future.

In part, the historical reliance on grant funding reflects the nature of the SBHC mission and the characteristics of SBHC patients. SBHCs serve students with and without health insurance. Billing an insurer is not an option when there is no health coverage. As a practical matter, SBHCs (like any other provider) find it difficult to obtain needed information about insurance coverage and keep it up to date, since changes occur constantly and the students themselves often do not know if they are covered by Medicaid or other insurance. Many SBHCs focus on adolescents who as a group are less likely than younger children to have Medicaid. When students do have private health

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<sup>6</sup> “School-Based Health Centers: Results from a 50-State Survey,” The Center for Health and Health Care in Schools, The George Washington University. March 2001. See also: “School-Based Health Centers Continue Strong Expansion across the U.S., National Survey Finds,” Center for Health and Health Care in Schools, Press Release, March 1, 2001, at: <http://www.healthinschools.org/press/PR00002.asp>.

<sup>7</sup> Preliminary data from 2001 Survey of SBHC Revenues and Expenditures, National Assembly on School-Based Health Care. Additional information on support provided by State government is provided in: James Morone, Elizabeth Kilbreath and Kathryn Langwell, “Back to School: A Health Care Strategy for Yourth,” *Health Affairs*, Vol. 20, Number 1, January/February 2001. 122-136. See “Exhibit 2: Aggregate National Funding Sources for School-Based Health Centers, 1999,” page 130.

insurance, large deductibles or coinsurance often apply, and coverage might not include the primary care services provided by SBHCs.<sup>8</sup> As a result, in the past most SBHCs and their sponsoring organizations discounted the benefit of billing Medicaid or other insurers.<sup>9</sup>

In recent years, however, many SBHCs have begun to participate with Medicaid and other third party payers. As SBHCs have gained experience in fulfilling their mission, they have found that Medicaid funding can provide significant revenue to support the costs of services provided to Medicaid enrollees.

One reason SBHCs are now considering Medicaid is that throughout the 1990s, an increasing proportion of school-age children and adolescents became enrolled in Medicaid. As a result, an increasing proportion of SBHC patients had Medicaid coverage, and it became more beneficial for SBHCs to develop the capacity to bill Medicaid and other third party payers. Medicaid programs in 43 States (of the 45 States with SBHCs) now allow SBHCs to bill for patient care. Significantly, SBHCs in 22 States have negotiated contract agreements to serve in the provider networks of managed care organizations (MCOs).<sup>10</sup>

#### **A. General Medicaid Payment Requirements**

Many SBHCs have found the key to success in billing Medicaid is knowing the requirements that must be met for Medicaid to pay for services, and also knowing when Medicaid is not able to pay. When the necessary conditions are met, SBHCs can be successful in securing payment for the Medicaid-covered services they provide. The purpose of this section is to describe what Medicaid can pay for in a SBHC setting, and what a SBHC must do to be paid.

SBHCs can claim Medicaid payment for “medical services.” In Medicaid parlance, medical services include the entire range from primary and preventive care to acute, chronic and long-term care.

In general, the rules that Medicaid applies to reimbursement for medical services provided by SBHCs are the same rules that Medicaid applies to doctors, dentists, therapists or other medical professionals providing the same services in any setting in

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<sup>8</sup> “Issues in Financing School-Based Health Centers: A Guide for State Officials,” Prepared by *Making the Grade* Program Office, The George Washington University, September 1995.

<sup>9</sup> Morone, Kilbreath and Langwell, *Health Affairs*. January/February 2001.

<sup>10</sup> According to Julia Graham Lear: “These developments mark the transition of school-based health centers from the margins to the mainstream of the American health care system.” See: press release for the release of the 50-State survey of school-based health centers for 2000, Center for Health and Health Care in Schools, March 1, 2001: [Http://www.healthinschoolsw.org/press/PR00002.asp](http://www.healthinschoolsw.org/press/PR00002.asp).



which medical care can be lawfully practiced in a State (based on the professional and organizational licensure and practice laws defined by each State.)

To claim Medicaid reimbursement for medical services, the following requirements must be met:

- 1) the service must be covered by the State's Medicaid program;
- 2) the provider of the service must be enrolled in the State's Medicaid program; and
- 3) the individual receiving the service must be enrolled in the State's Medicaid program.

Each of these requirements is discussed below.

### **1) The Service Must be Covered by Medicaid**

In general, Medicaid coverage is comprehensive. All Medicaid programs are required to pay for comprehensive coverage for children and adolescents from birth through age 20, under the EPSDT component of Medicaid. The EPSDT requirement for comprehensive coverage includes the types of services provided in SBHCs and school settings. The comprehensive coverage includes any needed primary care, preventive care, medical, mental health, dental, hearing and vision services. Medicaid also can reimburse for services not usually covered by regular health insurance, such as medical and administrative case management<sup>11</sup> and transportation. The EPSDT requirements are described in more detail below.

#### Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

EPSDT is a specific benefit under Medicaid that provides well-child and comprehensive pediatric care for children and adolescents up to age 20. Under EPSDT, Medicaid must ensure the availability and accessibility of required health care services, and also help beneficiaries and their parents use these services effectively. Medicaid is expected to manage a comprehensive child health program of prevention and treatment, to seek out eligibles and inform them of the benefits of prevention and the services that are available, and to provide assistance that may be needed to ensure that health problems are diagnosed and treated early, before they become more complex and more costly to treat.<sup>12</sup>

*Screening exams:* EPSDT requires coverage of comprehensive physical and mental health, growth and developmental history and assessments, including an unclothed physical exam, appropriate immunizations (according to the schedule set by the Advisory Committee on Immunization Practices for pediatric vaccines), lab and other diagnostic

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<sup>11</sup> See recent HFCA policy direction on Medicaid coverage for case management in State Medicaid Director Letter #01-013. Available at: <http://www.hcfa.gov/medicaid/smd119cl.htm>.

<sup>12</sup> See the Federal description of EPSDT at: [www.hcfa.gov/medicaid/epsdthm.htm](http://www.hcfa.gov/medicaid/epsdthm.htm).

tests, health education and anticipatory guidance. Screening exams are covered on a clinically sound periodicity schedule specific for each age group or as needed at any age.

*Treatment services:* EPSDT requires coverage of any medically necessary service reimbursable under Medicaid for the treatment of a condition identified under a periodic health exam or an “as needed” health exam, even if the service is not otherwise a covered benefit in that State. A provider at the SBHC may identify a service as medically necessary.

*Hearing, vision and dental services:* Under EPSDT, States specifically must cover hearing, vision and dental diagnosis and treatment services for children and adolescents, even if Medicaid does not cover those services for adults. Services are covered according to a periodicity schedule developed by the State or at other intervals when they are medically necessary. Coverage includes services for defects in vision, including eyeglasses; relief of dental pain and infections, restoration of teeth and maintenance of dental health; and diagnosis and treatment for defects in hearing, including hearing aids.

*Immunizations:* As discussed above, immunizations are a specific part of EPSDT. All childhood vaccinations are covered under EPSDT and Medicaid. Providers obtain the vaccines under the Vaccines for Children (VFC) program.

*Lead screening:* Under EPSDT, specific testing for lead is a covered service, as are certain remedial services necessary to remedy a problem with lead in a child’s home.<sup>13</sup> Current CMS policy specifies that blood test screening for lead should occur for all Medicaid-eligible children at 12 and 24 months of age.

*Transportation and scheduling assistance:* Medicaid covers transportation and scheduling assistance related to EPSDT screening, diagnosis or treatment. Medicaid is unique in its ability to pay non-emergency transportation to and from the site where medical or dental services are provided. Transportation may be reimbursed as a medical service or as an administrative activity, at the option of the State Medicaid program. As a medical service, Medicaid can pay a qualified and enrolled transportation vendor. Medicaid payment does not go to the beneficiary. When a State opts to cover transportation as an administrative activity, Medicaid can use any of several methods to pay for transportation, including paying a vendor or a program, providing vouchers or tokens, or reimbursing for actual out-of-pocket costs to the beneficiary.<sup>14</sup>

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<sup>13</sup> CMS (formerly HCFA) guidance to State Medicaid Directors on August 22, 1999 indicated “any follow-up services, including diagnostic or treatment services determined to be medically necessary that are within the scope of the Federal Medicaid statute, should also be provided. This would include both case management services and the one-time investigation to determine the source of lead for children diagnosed with elevated blood levels.”

<sup>14</sup> See 42C.F.R. §440.170(a)(1) (transportation defined) and 42 C.F.R. §440.170(a)(3) (travel expenses defined).

## **2) The Provider Must Be Enrolled and Meet Medicaid Provider Requirements**

To be reimbursed under Medicaid, a medical provider must be enrolled with Medicaid and have a Medicaid provider number. Medicaid defines the qualifications for each type of provider.

A SBHC may participate in Medicaid as an individually enrolled provider, or through a sponsoring organization that is enrolled as a Medicaid provider. A “sponsoring agency” may be a health care organization such as a hospital or FQHC, or a school or school district. The sponsoring organization can provide the oversight and structure within which the SBHC operates, including the necessary financial and legal infrastructure such as licensure and enrollment with Medicaid. The enrolled provider is the entity that is paid and who is responsible and accountable for satisfying all Medicaid requirements relating to services which are reimbursed.

How a SBHC is enrolled will determine how Medicaid reimburses the SBHC. Medicaid will have a specific reimbursement methodology for each provider type. The SBHC may find that Medicaid reimbursement is more favorable through a sponsoring organization such as an FQHC or hospital compared to reimbursement to a physician’s office or clinic. The reimbursement methodology is an important consideration in how the SBHC enrolls with Medicaid. This issue is discussed further in a following section on reimbursement options.

The receipt of grant funds from Federal, State or local governments or foundations is not a factor in whether a SBHC can participate in Medicaid as an enrolled provider. Grantees of such funds are able to provide services and bill Medicaid for services provided to Medicaid enrollees.<sup>15</sup> Note that Federal grants cannot be used as State matching funds to obtain Medicaid reimbursement.

## **3) The Individual Must Be Enrolled**

Medicaid can only pay for services provided to persons who are actually enrolled in the Medicaid program at the time a service is delivered. It is not enough that individuals are actually eligible. They must have gone through the eligibility determination process administered by the local agency designated by the State and be listed as covered by Medicaid at the time a service is delivered.

Medicaid eligibility is retroactive for up to 90 days prior to the date the individual filed the application for Medicaid.<sup>16</sup> With retroactive eligibility, a provider can be paid for services delivered during this 90-day period.

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<sup>15</sup> For an example in one State, see: Jane Koppelman and Julia Graham Lear, “The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?” *Journal of School Health*, 68(10): 441-446 (1998).

<sup>16</sup> See 42 CFR §435.914 (a).

Some States have adopted “presumptive eligibility.” Under presumptive eligibility, Medicaid allows temporary enrollment of individuals whose family income appears to make them eligible, until a formal determination of eligibility is made. Using preliminary information, providers designated by Medicaid are able to enroll a qualifying child or adolescent immediately so Medicaid can pay for services provided that day. This process then initiates the formal eligibility determination process by the local agency. In the meantime, the individual is considered enrolled and providers can be paid for services they provide.

As enrolled Medicaid providers, SBHCs are “qualified entities” for purposes of Medicaid presumptive eligibility.<sup>17</sup>

## **B. Medicaid Reimbursement for SBHCs**

In general, Medicaid reimbursement for a SBHC depends on how the SBHC is enrolled with the State Medicaid program. A SBHC enrolled as a clinic will be reimbursed as a clinic and Medicaid payment will usually be the same as Medicaid payment to other ambulatory providers providing similar services. A SBHC associated with a hospital as a sponsoring organization can qualify for reimbursement as a hospital outpatient clinic. A SBHC associated with an FQHC can qualify for the cost-related reimbursement of the FQHC. SBHCs that contract with MCOs may be able to negotiate a reimbursement rate similar to other community providers that contract with that MCO (as discussed further in a following section), but there is no requirement that the negotiated rate fully cover the costs of providing services.

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<sup>17</sup> Federal legislation adopted in December 2000 (P.L. 106-554, the Consolidated Appropriations Act of 2001, Sections 708 for Medicaid and 803 for SCHIP) clarified that State Medicaid agencies may allow elementary or secondary schools to make presumptive eligibility determinations.

SBHCs and FQHCs: Specific reimbursement rules apply to FQHCs under Federal Medicaid law. To increase the accessibility of primary and preventive health services for low-income persons, Congress adopted requirements that Medicaid payment to FQHCs be related to reasonable costs incurred for the services provided to Medicaid beneficiaries. Recent amendments to the Federal Medicaid statute require a prospective payment reimbursement methodology.<sup>18</sup> Under the prospective payment system Medicaid reimbursement may or may not fully cover the costs incurred by SBHCs and their FQHC sponsoring organizations, depending on the specific approach adopted in the State.<sup>19</sup>

FQHCs that serve as a sponsoring organization for a SBHC can include the SBHC services under the FQHC Medicaid reimbursement provisions. Note that when the SBHC is an FQHC, Medicaid beneficiaries are entitled to SBHC services covered by Medicaid.<sup>20</sup>

Free care and billing other insurers: Medicaid agencies are concerned about certain other issues that will affect SBHCs. Among these are the issues of “free care” and billing other insurers. Medicaid agencies may raise these issues because of the tradition of open and free access to services in school settings, and may expect the SBHC to set up a sliding fee schedule and to bill other health insurers. SBHCs are afforded special exemption from these rules when they receive funding from the Federal Title V Maternal and Child Health Services Block Grant for part or all of the cost of providing child health services.<sup>21</sup> Medicaid regulations also require cooperative interagency arrangements between Title V grantees and the State Medicaid agency.<sup>22</sup>

## **V. SBHCs and Medicaid Managed Care**

Almost every State Medicaid program now uses some form of managed care. Medicaid’s use of managed care has important implications for SBHCs and how they are paid for services they provide to Medicaid beneficiaries.

Medicaid programs are often committed to managed care because of its potential to improve access and quality and to control costs. However, for SBHCs, managed care can

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<sup>18</sup> See CMS guidance to Medicaid programs in State Medicaid Director Letter #01-014, dated January 19, 2001. Available at: [www.hcfa.gov/medicaid/cmsosmd.htm](http://www.hcfa.gov/medicaid/cmsosmd.htm).

<sup>19</sup> “Health Centers and Rural Clinics: Payments Likely to Be Constrained Under Medicaid’s New System,” June 19, 2001, U.S. General Accounting Office (GAO-01-577). See: [www.gao.gov](http://www.gao.gov).

<sup>20</sup> See CMS letters to State Medicaid directors relating to FQHC reimbursement dated January 19, 2001 and January 27, 2000 at: [www.hcfa.gov/medicaid/cmsosmd.htm](http://www.hcfa.gov/medicaid/cmsosmd.htm).

<sup>21</sup> The State’s Primary Care Association will be a source of information about the practice in each State.

<sup>22</sup> HCFA, *Medicaid and School Health: A Technical Assistance Guide*, August 1997.

complicate the process for seeking reimbursement for services provided to Medicaid enrollees.

In many States, most families on Medicaid are now required to enroll in managed care. Depending on the State, enrollment may be in either a managed care organization (MCO<sup>23</sup>), or in a State-administered Primary Care Case Management (PCCM) program.<sup>24</sup> Under either managed care arrangement, the enrollee is required to choose a primary care provider and that provider is expected to serve as a medical home for the enrollee, ensuring access to primary care and arranging or authorizing other needed care, such as that provided by specialists. The two managed care approaches differ in their reimbursement arrangements, and those differences are important to SBHCs.

### Medicaid, SBHCs and MCOs

Unless special provisions are made for SBHCs when Medicaid contracts with MCOs (these options are discussed below), Medicaid's capitation payment to the MCO typically would include reimbursement for all primary care, preventive and specialty services, including payment for services typically provided by SBHCs. When a covered service is provided, payment for the service is made by the MCO (not by Medicaid). To be eligible for reimbursement by the MCO, a provider must be enrolled in the MCO's network. To be enrolled, a provider must meet the MCO's qualification criteria, agree to the MCO's rules for service authorization and payment and be accepted into MCO provider network. Thus, the ability of the SBHC to be paid for services it provides to Medicaid enrollees who are in the MCO will depend on becoming a part of the MCO provider network and following the MCO rules -- unless the State makes other arrangements such as "carving out" SBHC services from the State contract with the MCO, as discussed below.

Unless Medicaid decides to make special managed care provisions for SBHCs, an MCO is not obligated to include a SBHC in its network, and therefore is not obligated to pay the SBHC for any service it may provide. Even when the SBHC provides services that are necessary and otherwise covered, the MCO can deny reimbursement when the SBHC is not in the MCO provider network, the services were not authorized by the MCO or if the medical records are incomplete.<sup>25</sup>

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<sup>23</sup> The term "MCO" refers to all capitated managed care organizations. In some States, these managed care organizations may only include HMOs. In other States, MCOs may include pre-paid, Medicaid-only managed care plans that are not licensed as HMOs.

<sup>24</sup> A Primary Care Case Management program, or PCCM, is a form of managed care that is administered by the State Medicaid program. Under a PCCM, beneficiaries enroll with a primary care provider (PCP), who provides or authorizes most medical services. The PCP usually is paid a capitated case management fee, commonly \$3 per member per month, plus services are paid on a fee-for-service basis.

<sup>25</sup> Mark Greiner, Gail Nickerson and Steven Rosenberg, *State Policy Context for School-Based Health Centers, with Special Focus on Development of Mental Health and Dental Health Services*. (Rosenberg & Associates Policy Memorandum, Summer 2001). Available at: <http://www.healthinschools.org/sh/policypaper.asp>.

Even without a special provision in the Medicaid contract with the MCO, an SBHC can negotiate a contract with the MCO that reflects the unique contribution that the SBHC can make by providing health care in a school setting. Some SBHCs have become primary care providers in the MCO provider network. In this role enrolled children can select the SBHC to be their primary care provider and medical home. This usually requires that the SBHC is able to meet certain terms in the contract, such as 24-hour, 365-day operation, credentialing and the ability to provide a comprehensive array of primary care services.<sup>26</sup> To meet these requirements, SBHCs have formal links with their sponsoring organization or other community providers or pediatric groups who can serve as back up to the school-based provider for specific days or hours.

Medicaid has the flexibility (but is not required) to make special provisions for SBHCs and MCOs. State Medicaid Programs can elect certain policies to ensure that SBHCs are paid for services they provide to Medicaid MCO enrollees.<sup>27</sup> Four options are listed below:

#### **MCOs and SBHCs: Four Medicaid Policy Options**

1. *Carve Out: Medicaid can pay for services directly by excluding them from services in the MCO contract.*
2. *Mandated inclusion: The Medicaid contract with MCOs can specify that SBHCs must be included in the MCO provider network:*
3. *Mandated payment: Medicaid can require that MCOs pay SBHCs for specified “out-of-network” services they provide to MCO enrollees.*
4. *Incentives: Medicaid can encourage contracting by providing incentives to MCOs.*

1. *Carve out: Medicaid can pay SBHCs directly for services “carved out” of the MCO contract.*

<sup>26</sup> For a description of how States have dealt with these issues see: Michael H. Honig, “School-Based Health Centers and Managed care: contracting Issues and Options,” Center for Health Care Strategies, July 2000; and Koppleman and Lear, “The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?” *Journal of School Health*, 68(10): 441-446 (1998).

<sup>27</sup> Approaches used in Connecticut and Rhode Island are discussed in: “Critical Issues in School-Based Health Care Financing,” National Assembly on School-Based Health Care, September 1999.

The Medicaid contract with MCOs can be written to exclude from the responsibility of MCOs specific services furnished by SBHCs. With a carve out; Medicaid adjusts the capitation payment it pays to MCOs so the payment does not include the actuarial value of services provided by SBHCs. State Medicaid Agency is then able to pay SBHCs directly on a fee-for-service basis for these services.

2. *Mandated inclusion: Medicaid can require that MCOs include SBHCs in the MCO provider network:*

Medicaid can require in its contract with MCOs that SBHCs must be included in the MCO provider networks. Medicaid has the latitude to specify how SBHCs are to be included, how and for what services they are to be paid. For example, Medicaid can specify that an SBHC may not need to obtain authorization from the MCO for specific services that the MCO will reimburse.

3. *Mandated payment: Medicaid can require MCOs to pay SBHCs for “out-of-network” services provided to MCO enrollees.*

Medicaid can specify in its contract with MCOs that selected services provided by SBHCs must be paid by the MCO even when the SBHC and its sponsoring organization are not otherwise a part of the MCO provider network. The contract can specify that payment is the same as the MCO pays other providers for the same services, or can specify another specific reimbursement methodology.

4. *Incentives: Medicaid can encourage contracting by offering incentives to MCOs.*

Incentives to MCOs to encourage the coordination with SBHCs include enhanced capitation rates, enhanced scoring in competitive bidding and increased Medicaid enrollment. For example, Medicaid often has an automatic enrollment method for persons who do not choose a specific plan during the open enrollment period. MCOs that include SBHCs might receive greater numbers of enrollees. MCOs that do not include SBHCs might be excluded from this automatic enrollment process.

The Medicaid program can use these options to facilitate reimbursement for SBHCs. Note that fee-for-service reimbursement from Medicaid or reimbursement from MCOs may not be possible for SBHCs in a State that mandates enrollment in capitated MCOs and does not pursue a specific policy to ensure reimbursement to SBHCs.

#### Medicaid Primary Care Case Management (PCCM) Programs and SBHCs

In some States, Medicaid enrollees have the option of enrolling in a PCCM system of managed care.<sup>28</sup> Under a Medicaid PCCM an individual enrolls with a PCP who has

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<sup>28</sup> HCFA reported PCCM programs in 28 States in 1998, including five States in which the PCCM program was the only form of Medicaid managed care. See: Joanne Rawlings-Sekunda, Deborah Curtis and Neva Kaye, *Emerging Practices in Medicaid*



responsibility for coordinating care and arranging for specialists or other providers. Medicaid reimburses the provider of each service directly on a fee-for-service basis.

Under a Medicaid PCCM, a SBHC may be allowed to be a PCP. To be a PCP requires that the SBHC serve as the medical home for those who chose to enroll. Again, Medicaid has flexibility to adapt provider participation requirements to reflect its policy objectives. For example, the Medicaid agency might allow a SBHC to serve as a PCP even though it is not open for service 24 hours a day, year-around, if alternative arrangements are made to meet the access requirement. Or, the Medicaid agency might allow payment to the SBHC without authorization from the PCP.

When the SBHC is not the PCP, Medicaid may require that the SBHC communicate with the PCP when services are provided. In this way the PCP and the SBHC can ensure that services are coordinated and consistent with other services the enrollee may be receiving.

#### Mental Health Services, Managed Care and SBHCs

In many SBHCs, mental health is the most frequently provided service. Mental health counseling is frequently identified as the leading reason for visits by students. As a result, SBHCs have worked to develop school-based mental health services while also seeking to work within the managed care arrangements in their communities.<sup>29</sup>

Surveys indicate that most SBHCs offer a range of mental health services. Mental health and counseling services offered by SBHCs include: crisis intervention (79% of SBHCs), case management (70%), comprehensive evaluation and treatment (69%), substance abuse (57%), and the assessment and treatment of learning problems (39%). Group counseling was used by SBHCs for peer support (59%), classroom behavior modification (49%), substance use prevention and treatment (41%) and gang intervention (26%).<sup>30</sup>

SBHCs have found that pursuit of reimbursement of mental health services through managed care organizations has been difficult. Arrangements are being tried in several States, but a single model of “best practice” is yet to emerge. Sponsoring agencies, State Medicaid agencies, MCOs and other providers are still learning about the role of school-

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*Primary Care Case Management Programs*, National Academy for State Health Policy for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, June 2001; and: Vernon Smith, Terrisca Des Jardins and Karin Peterson-Hoyt, *Exemplary Practices in Primary Care Case Management Programs*, Center for Health Care Strategies, July 2000.

<sup>29</sup> Gail Robinson, Marihelen Barrett, Traci Tunkelrott and John Kim, *School-Based Mental Health Services under Medicaid Managed Care*, (DHHS Publication No. [SMA] 00-3456). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2000.

<sup>30</sup> “Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999,” National Assembly on School-Based Health Care. June 2000.

based mental health services and their value. North Carolina is a current example of a State that has made special arrangements for services provided by a SBHC, including the creation of specific billing codes for behavioral health services provided in a SBHC. This reimbursement methodology recognizes the importance of mental health services and supports their timely availability. The Medicaid agency also has the option of a “carve out” that would allow SBHCs to bill Medicaid directly for these services.

## **VI. State Children’s Health Insurance Program and SBHCs**

The State Children’s Health Insurance Program (SCHIP) was established as Title XXI of the Social Security Act in the Balanced Budget Act of 1997. States began immediately to develop and begin implementing their SCHIP programs. Many States began enrolling children and adolescents in 1998. By the end of 1998 enrollment had reached about 800,000. By December 2000 enrollment had increased to 2.7 million.<sup>31</sup> During Federal fiscal year 2000 a total of over 3.3 million children and adolescents were enrolled during all or part of the year.<sup>32</sup> As enrollment increases, the number of children and adolescents in schools whose health services are covered by SCHIP will continue to increase.

SCHIP and Medicaid are distinct programs, yet they are closely inter-related. SCHIP programs are of two types: a Medicaid expansion program and a separate program. A State can choose to have either or both. As of December 2000, about one-third of the States (16 States and the District of Columbia) have a Medicaid-expansion only, a third (17 States) have a separate program only and a third (17 States) have both.<sup>33</sup> Under a Medicaid-expansion program, all the Medicaid rules apply, including the entitlement nature of the program. Separate SCHIP programs are not entitlement programs and may have a benefit package that is different from Medicaid.<sup>34</sup>

SCHIP may have eligibility rules and enrollment methods that differ from Medicaid and may be administered by an agency different from the one that administers Medicaid. SCHIP generally covers children and adolescents in households with incomes just higher

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<sup>31</sup> Smith, Rousseau and Guyer, *CHIP Program Enrollment: December 2000*, Kaiser Commission on Medicaid and the Uninsured, August 2001. Publication #4005.

<sup>32</sup> CMS reported that over 3.3 million children were enrolled at some point in time, for any length of time during Federal fiscal year 2000 (the year ending 9/30/2000). See: [www.hcfa.gov/init/fy2000.pdf](http://www.hcfa.gov/init/fy2000.pdf).

<sup>33</sup> Smith, Rousseau and Guyer, *CHIP Program Enrollment: December 2000*, Kaiser Commission on Medicaid and the Uninsured, August 2001. Publication #4005.

<sup>34</sup> Sara Rosenbaum and Barbara Smith, *State SCHIP Design and the Right to Coverage*, (SCHIP Policy Brief #1, 2001). Available at: [http://www.gwuhealthpolicy.org/downloads/issue\\_brief\\_1.pdf](http://www.gwuhealthpolicy.org/downloads/issue_brief_1.pdf). Also see: Sara Rosenbaum, et al., *State Benefit Design Choices under SCHIP: Implications for Pediatric Health Care*, (SCHIP Policy Brief #2, 2001). Available at: [http://www.gwuhealthpolicy.org/downloads/issue\\_brief\\_2.pdf](http://www.gwuhealthpolicy.org/downloads/issue_brief_2.pdf).

than Medicaid eligibility levels.<sup>35</sup> The Federal matching rate to the State is higher for SCHIP than Medicaid.<sup>36</sup>

Federal law specifies that SCHIP is limited to children and adolescents who are not eligible for Medicaid and who have no other health insurance. The brief experience with SCHIP since 1998 has shown that many children and adolescents move from one program to the other and sometimes back again, as situations change in their families. As a result, Medicaid and SCHIP programs over time serve many of the same children and adolescents.

A key focus of SCHIP is finding and enrolling uninsured children and adolescents. The outreach, promotion and enrollment activities sometimes involve providers and schools, and SBHCs can play a significant role in assisting in these activities. In States with presumptive eligibility, Federal law includes SBHCs among providers who can determine eligibility for Medicaid and SCHIP. When a child or adolescent is made eligible under presumptive eligibility, the provider can receive payment for services rendered that day.

The rules for obtaining payment for services for SCHIP are similar to those for Medicaid. In the case of a State with a Medicaid expansion SCHIP program, the methodology is likely indistinguishable from Medicaid. For States with separate SCHIP programs, the method may be similar to Medicaid or to commercial health insurance, depending on how the State has chosen to administer its program.

The key message is that many children and adolescents have Medicaid or SCHIP coverage. Medical services provided in SBHCs may be reimbursable from either source.

## VII. Conclusion

School-based health care can be an appropriate and cost-effective way to provide necessary medical care to Medicaid-eligible children and youth. SBHCs in particular can provide primary care and preventive medical services, mental health, dental hearing and

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<sup>35</sup> SCHIP generally covers children in households in the next higher 50 percentage points of the income distribution, compared to Medicaid. E.g., where Medicaid covers children up to 185% of the Federal poverty level, SCHIP might cover children from 185% to 235% of the Federal poverty level. However, a State can use Section 1115 waivers or can adopt policies that disregard specific amounts of income to increase the eligibility levels for children up to 300% or 350% of the Federal poverty level. Some States are also covering the parents of these children under SCHIP. States use of these options is described at: [www.hcfa.gov/init/1115waiv.pdf](http://www.hcfa.gov/init/1115waiv.pdf).

<sup>36</sup> The SCHIP Federal matching rate is the Medicaid FMAP plus 0.3 times the difference between 100% and the FMAP, not to exceed 85%. For example, a State with a 50% FMAP has a SCHIP matching rate of 65% (50% + [0.3 x 50%]); a State with a 60% FMAP for Medicaid has a SCHIP matching rate of 72% (60% + [0.3 x 40%]).

vision services to beneficiaries in a setting with ideal access. Medicaid presents an opportunity for funding these services when they are provided by SBHCs.

SBHCs will want to work with their State Title V agency and Primary Care Association to be sure that all requirements for Medicaid and SCHIP reimbursement are met.

SBHCs are advantageously positioned to provide needed services to children and adolescents. In addition, they are ideally situated to assist Medicaid (and SCHIP) in marketing, promotion, outreach and enrollment activities. When the arrangements are worked out carefully with the State Medicaid agency, the services that are provided in SBHCs can be reimbursed by Medicaid, and these reimbursements can help the SBHCs offer better care for all the children and adolescents they serve.

#### Other Opportunities to Use Medicaid

Medicaid is a potential source of financing for a number of State and local health services. Specific areas where Medicaid can be a source of funding include maternal and youth health services, oral health services, rural health services, services for persons with HIV/AIDS and mental health and substance abuse services. A periodic review is useful to identify new ways for a State to qualify for Medicaid as a source of funding to support these services.

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