

Medicaid Reimbursement in School-Based Health Centers: State Association and Provider Perspectives

A report of the National Assembly on School-Based Health Care, June 2000

School-based health care is most often distinguished as a comprehensive package of services—typically encompassing the full range of preventive, early intervention and acute care—delivered by a community health care organization in an unparalleled access point: the child’s school setting. As a collaboration between health care agency and school, school-based health centers have as their primary mission to attend to unmet physical and emotional health needs that make children and youth unavailable for learning. In realizing this mission, the “health care in schools” model has evolved as a hybrid of mainstream pediatric practice, public health, and pupil support services. Practicing in a school setting, medical and mental health providers are afforded richer opportunities and greater flexibility in engaging students through a variety of modalities to decrease health risks and strengthen interpersonal assets.

For the majority of students who use the health centers, access to care in schools is consistent with public education’s access standard—open and free to all. There are, however, environmental shifts in the health care financing landscape that are creating challenges to school-based health care’s “open access to all” policy. Public and private grant dollars from federal, state and local levels, a critical mainstay of support to school-based health centers, are increasingly more competitive and in shorter supply. Program expansions, whether for existing or new sites, are constrained because grant funds are not keeping up with interest in school-based health care. Moreover, public health insurance expansions have prompted policy makers to turn a more critical eye toward health care safety net investments. The result is increasing pressure on providers such as school-based health centers to supplement grants with public insurance revenue from Medicaid and the states’ child health insurance programs (SCHIP). Limited infrastructure and resources, however, have tested the ability of school-based health centers to bill and collect from third-party payers, including Medicaid and SCHIP. There is growing sentiment within some ranks of the school-based health care field that the pursuit of revenue far outweighs the return, runs counter to the mission of open access to all (and in fact has restricted access), and diverts valuable energy and resources away from services to children (National Assembly on School-Based Health Care 1999).

The Survey

To assess the role Medicaid revenue plays in supporting school-based health care operations, in January 2000, two surveys

were conducted of: 1) the National Assembly’s fourteen state school-based health care associations and, 2) school-based health care providers. Thirteen associations, representing 674 school-based health centers (more than half the field) and an estimated 465,000 enrollees, described their collective experiences. An additional 40 programs running 129 school-based health centers completed the provider survey. (For a list of responding NASBHC affiliates, see the end of this report.)

Medicaid Enrollees in School-Based Health Care

The potential for Medicaid and state child health insurance as a source of patient care revenue to school-based health centers depends in great part on the volume of health center users who are enrolled in these public insurance programs. Because school-based health centers are strategically located in low-income, underserved communities, they are more likely to be in schools that have a disproportionately larger publicly insured population. The average proportion of school-based health center users enrolled in Medicaid and SCHIP, as estimated by *state affiliates*, ranged from a low of 15 percent in Colorado and Oregon to 60 percent in California (see table 1). The average across all states was 36 percent. *Providers* estimated Medicaid enrollment at 28 percent, with a range of 4-90 percent (see table 2).

As the data suggest, ranges vary across states, and even within state boundaries. Several factors account for these large

Table 1. Medicaid enrollees in School-Based Health Centers, Medicaid Billing Activity, and Medicaid Revenue as % of Operating Budget

State Affiliates	# of SBHCs	# of SBHC Enrollees	% of SBHC Enrollees in MA*	% of SBHCs that bill MA	% of SBHCs that bill MA			% billed visits reimbursed by MA			% of SBHC Budget covered by MA				% of SBHC involved in CHIP enroll
					On-site	Through sponsor	By indep. agent	<25%	25-50%	>50%	<5%	5-10%	10-20%	20-25%	
CA	70	80,000	40-60%	95%	60%	25%	15%		✓					✓	25-50%
CO	31	50,500	15-20%	58%	43%	43%	14%		✓		✓				>75%
CT	51	29,500	33%	100%	99%		1%		✓						>75%
IL	42	25,700	40%	100%	7%	93%			✓			✓			50-75%
LA	32	18,600	23%	94%	75%	25%						✓			50-75%
ME	15	4,600	20%	60%	66%	33%		✓				✓			>75%
MD	40	19,000	36%	85%	1%	99%		✓			✓				>75%
MI	34	21,000	49%	50%		100%		✓			✓				>75%
NY	163	116,300	85%		100%				✓					✓	80%
NC	41	25,000	40%	87%		88%	12%		✓					✓	>75%
OR	39	24,700	15%	<50%	25%	50%	10%			✓		✓			<25%
TX	82	35,000	20%	90%								✓			
WV	34	15,000	34%	100%		100%				✓				✓	>75%

Sum/Avg 674 464,900 36% 80% 38% 53% 6%

***MA=Medicaid/Medicaid managed care plans
SBHC Enrollees estimate based on NASBHC's 1998-99 census data**

differences: variability in public insurance income and age eligibility requirements, a disproportionate number of children from undocumented families, and families not enrolling their eligible children. Additionally, because obtaining accurate and current information from the student is difficult, it is not uncommon for school-based health centers to report a large number of users with unknown insurance status.

Medicaid/SCHIP patient volume alone is not sufficient to ensure revenue that warrants the effort to collect it. Increasingly, access to Medicaid and SCHIP reimbursement for health services

rendered to enrollees is becoming more constricted with the introduction of managed care into many states' public insurance programs. The latest national data from the federal Health Care Financing Administration estimated Medicaid managed care penetration at 54 percent of the total Medicaid population (National Summary of Medicaid Managed Care Programs and Enrollment, June 1998). More than half the school-based health care providers reported operating in a Medicaid managed care environment. Among all school-based health center registrants who were Medicaid-enrolled, an estimated 41 percent were in managed care plans.

What was once a billing transaction between provider and state Medicaid agency now involves multiple third-party organizations, each with its own criteria for who and what gets reimbursed.

Table 2. SBHC Provider Response to Medicaid Survey (n=129 SBHCs)

Average Medicaid Enrollees as Percent of SBHC Users	28%
Range of Responses	5-75%
Average SCHIP Enrollees as Percent of SBHC Users	6%
Range of Responses	0-40%
% SBHCs operating in mandatory Medicaid managed care	53%
% SBHC Medicaid enrollees in managed care	41%
Average Budget per SBHC	\$128,000
Average annual Medicaid Revenue	\$7,000
Medicaid as % of Operating Budget	5%

Billing in School-Based Health Centers

Eighty percent of centers represented in both the state and provider surveys report that Medicaid and Medicaid health plan billing does occur, either directly (38%), through their sponsoring agency (53%), or by an independent billing agent (6%). This finding is consistent with the 75 percent figure

identified in the National Assembly's 1998-99 census of more than 800 health centers.

There are advantages and disadvantages to each of the billing scenarios employed by school-based health centers. To establish a billing and collection system on site requires dedicated personnel and computer resources to organize and monitor billing activity. By using the system resources of the sponsoring agency, staff is freed from associated administrative tasks. It requires monitoring, however, to ensure that recovered revenue is re-invested in the school-based health center; some agencies may absorb collected revenue attributable to overhead and administrative costs. Independent third-party billing organizations afford greater billing efficiency and effectiveness but come at a cost: standard fees range from a percentage of recovered revenue to a flat "per claim" fee, regardless of what is collected on the claim. One program's experience was that the billing agent promptly changed their financial arrangement from a percentage cut to a "per claim" fee when it discovered that the overall recovery was minimal. Because centers will avoid charges for potentially denied bills, a "per claim" rate makes for very conservative billing.

Revenue Recovery in School-Based Health Care

An encounter between school-based health care provider and Medicaid enrollee is not always grounds for filing a claim. Many of the *state affiliates* reported that because of restrictions on the types of services or providers considered reimbursable by Medicaid or a Medicaid health plan, only those claims likely to be accepted are submitted. Except for a narrow range of diagnostic and treatment services, claims for a large scope of school-based health care services are deemed illegitimate or unnecessary by insurers. For example, a state Medicaid program may define a specific provider type for mental health services, rendering school-based health centers ineligible for reimbursement for mental health related claims. Similarly, a clinician might incorporate a comprehensive risk assessment and attendant health guidance that is not considered to be medically necessary. These services represent the hallmark of school-based health care.

For services that are billed, reimbursement is often significantly less than the cost of providing the visit. The majority of states report that, of all visits billed, only a small portion is actually recovered. Two states (Oregon and West Virginia) report being reimbursed for more than 50 percent of billable services; the rest received significantly less.

Successful Billing

School-based health centers that succeed at billing are characterized by two attributes: a strong business orientation

similar to private medicine, and a philosophy that no care is given for free - that for students and their families, billing places a value on services. Capacity is critical. Considered most necessary is an accounts receivable infrastructure for billing and collecting. This includes: 1) encounter forms that support billing; 2) dedicated staff to conduct data entry, obtain insurance information, and track claims, denials, payments and follow up; and 3) clinical staff who are knowledgeable coders.

The sponsoring health care organization also affects the school-based health center's billing success. Greatest success comes from sponsoring organizations with a history of billing, an existing infrastructure, and a commitment to reinvesting revenue back to the school-based program. Some *state affiliates* reported that the sponsoring organization's institutional reimbursement rate can make a difference in the revenue return. In New York, for example, licensed health care facilities that sponsor school-based health centers are entitled to bill at their institution's rate structure, which based on visit and provider type can range from \$65-125 per visit. West Virginia's school-based health centers, sponsored by federally qualified health centers, are entitled to reimbursement based on cost of delivering the service, instead of standard fee for service rates.

Medicaid as Revenue Source

Despite serving children and adolescents most likely to be covered by public health insurance, school-based health centers do not recover costs in proportion to their Medicaid-enrolled population. At best, school-based health centers from four *state affiliates* are able to capture almost one-quarter of their operating budget from Medicaid and SCHIP revenue. The majority, however, barely achieve 10 percent.

Among the *provider* respondents, data for both annual budget and Medicaid revenue was available for 71 health centers. On average, the centers collected \$7,000 annually in Medicaid revenue. With an average operating budget of \$128,000, this represents five percent of the health centers' budget.

State policies preventing adequate reimbursement

State school-based health care associations were asked to identify state Medicaid and health plan policies that prevent adequate reimbursement. The issue raised most frequently by the state affiliates was that many services delivered by school-based health centers are not considered reimbursable under their state Medicaid plan (see page 7). Restriction to Medicaid revenue by the assignment of Medicaid enrollees to managed care plans was also identified by a majority of states. The inability to bill for services provided by the center's mental health staff was identified by six of the eleven affiliates. The Medicaid policy to forward

an explanation of benefits (EOB) to the home, which is thought to comprise adolescents' confidentiality, was also considered to be a billing barrier. One state reported that difficulty in accessing information about who among school-based health care users were either Medicaid eligible or enrolled complicated revenue collection. Colorado, which has an on-site physician requirement for reimbursement to nurse practitioners and physician assistants, identified this policy as a barrier.

State SBHC chapter efforts to increase Medicaid support

State school-based health care associations have placed reimbursement policies as a high priority for their advocacy and technical assistance agendas. Proposed policies to establish school-based health centers as safety net providers, or to support school-based health centers as CHIP-eligible providers, is being advanced in Oregon, California and North Carolina. Data collection on the experiences of mental health reimbursement is being conducted statewide in Maryland. State affiliates and state Medicaid agencies are partnering to provide training on billing, coding, managed care contracting, and Medicaid enrollment. Many are also providing statewide networking opportunities so that program successes can be shared across the school-based health care provider community.

Strategies to Improve Billing and Collection

State school-based health care associations were asked to identify strategies that might improve school-based health centers' Medicaid billing and collection. Strongest support was for advocacy to broaden and enhance federal and state policies on Medicaid eligibility and visit rates for preventive services that are currently not part of, or under-funded by, existing reimbursement structures. Many of the state respondents sounded universal themes around the need for recognition and acknowledgement of the unique role played by school-based health centers. Through early intervention and prevention services, school-based health centers provide an opportunity to consistently address child and adolescent health issues that will impact health outcomes in students' adult years. They are a first line of defense against disease and discomfort. Functions that challenge mainstream health care, crisis intervention, acute counseling, and the engagement of harder-to-reach youth, are successfully met by health centers in schools. Public health insurance models, however, have not placed financial value on these services.

School-based health care providers, while questioning the energy required to bill and collect patient care revenues, understand its value in being recognized as a mainstream provider. Many reinforce the urgency of maximizing reimbursement as essential to the survival of this innovative model. The reimbursement process, however, is administratively taxing and heretofore has not justified the staff time required to collect the funds. Several respondents argued that it be simplified.

Specific policy recommendations included:

Free Care Provision Exemption. Exempting school-based health centers from Medicaid's "free care provision" policy, as has been done for the federal and state funded Title V agencies, would obviate the need to document family income and institute sliding scale fees. Experience suggests that the process is time consuming, provides little return, and runs counter to culture of the education setting.

SBHCs in Managed Care Networks. Several respondents suggested the federal Medicaid agency require (or encourage) states' managed care contracts to include school-based health centers within HMOs and other provider networks. The obstacles to using school-based health centers as health plans' primary care providers are too great, the burden on centers too onerous. School-based health centers cannot compete with well financed managed care organizations.

Cost-based Reimbursement. Special reimbursement mechanisms exist for federally qualified health centers so that compensation more accurately reflects the full cost of providing health care. This option should be explored by state and federal Medicaid agencies for financing visits made to school-based health centers. Because of enhanced Medicaid reimbursement rates, school-based health centers under the sponsorship of historically recognized Medicaid providers such as hospitals and community health centers are perceived to be less threatened by Medicaid cost controls.

School-Based Health Care Carve Out

Illinois and New York school-based health care advocates negotiated a carve out (temporary in the case of New York) under their respective states' Medicaid managed care plans, allowing health centers to bill the state Medicaid agency directly for services provided to Medicaid enrollees, regardless of the student's assigned managed care home. It creates a unique Medicaid provider type for school-based health centers under the state's Medicaid plan, and serves to protect the centers from uncompensated visits by Medicaid enrollees in health plans that refuse to pay for out of plan visits.

Many of the suggestions focused on policy operations. Several *state affiliates* acknowledged that the establishment and enhancement of effective billing and collections system might improve revenue collection. A few states argued that a centralized, statewide billing system through an intermediary agent might enhance the centers' billing efficiencies. So too could the improvement of visit and diagnostic coding by school-based health care providers help to realize greater Medicaid reimbursement. Other strategies suggested by the *state affiliates* include: learning specific authorization and credentialing requirements of managed care organizations; collecting data on cost benefits; and enforcing existing state reimbursement policies.

SUMMARY

Is school-based health care's future tied to third-party payer reimbursement? Reports from school-based health care providers and their respective state associations suggest that the field is making earnest strides to create sustainable funding through public insurance mechanisms. This represents a significant shift from earlier years when there were few compelling reasons for school-based health centers to bill. In spite of federal and state efforts to increase the number of insured low-income children and youth, school-based health care providers seem not to be yielding any new resources from these efforts. The exploration of capacity and policy issues and their solutions by state school-based health care associations, Medicaid agencies and state public health departments provides optimism that policy makers share the view that this unique health care access strategy is worth protecting, and that mutual interests can be achieved.

Many of the solutions to sustaining school-based health centers through Medicaid and CHIP will come from broader advocacy and technical efforts that urge greater accountability among insurers and providers for meeting the health and mental health needs of children and youth. Through the adoption of child and adolescent-specific performance measures, on-going quality assurance monitoring, and compensation that supports early identification and preventive care, including anticipatory guidance, Medicaid and CHIP programs can create important incentives for school-based health care partnerships.

End Notes

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Non-Reimbursable Services: Anecdotes from the Field

We keep necessities such as safety pins and band-aids at the reception desk. This informal set up has served us very well in having students come in for items and to check us out. It often provides opportunities for health education and counseling. The students come in, get their questions answered and become “engaged” with the services. None of this is billable.

A morbidly obese 16 year old male student was referred to us for “diet counseling.” After three non-reimbursable visits to build a relationship and obtain some health history, the student disclosed some significant health problems that led to a diagnosis of encopresis, nocturnal enuresis and depression. Thereafter, visits were billed for treatment of those problems.

A 15 year old female student came to us with “embarrassing questions” to ask. She insisted that she not be examined. After a lengthy counseling session, and with questions answered, the student departed relieved. Non-billable.

A student on the baseball team died suddenly as he walked off the field. The health center staff from three area schools spent most of one week working with groups of students and teachers as part of the crisis team. All of this was not billable.

A student, told by her mother that she might have an eating disorder, visited the health center to learn more. After a 30-minute discussion she agreed to come back to fill out a risk screen and discuss her eating habits in more depth. Because she does not meet the criteria for anorexia or bulimia at present, no diagnosis was made for the initial intervention, which included several preventive visits that are not reimbursable.

Non-Reimbursable Services in School-Based Health Centers

Prevention Services and Wellness Activities

- Individual health education and anticipatory guidance
- Classroom-based health promotion
- Engagement activities
- Parent education
- Risk reduction counseling
- Nutrition counseling and weight management

Mental Health

- Individual counseling
- Group counseling
- Pre-diagnostic services
- Prevention
- Substance abuse counseling

Administrative/Non-Direct

- Case management
- Social work services
- Insurance enrollment
- Referrals
- Classroom observation
- Teacher consultation
- Physical Health
- Immunizations
- Laboratory tests/cultures
- Sports physicals
- EPSDT screenings
- Nursing services

Recent problems with openly gay and lesbian students have caused difficulty for the school personnel. The health center staff have scheduled a series of meetings with academic departments and peer mediation teams to discuss appropriate policy. This is important—but not reimbursable.

The school based health center sent a student with suspected active tuberculosis to the hospital. Although the student's condition was confidential rumors quickly spread through the school. During the time that the student's laboratory results were pending, the staff met with administrative staff, faculty, students and parents to calm anxious parties down and to educate regarding the risks of transmission. In addition, center staff worked closely with the Department of Health to plan a school wide screening for tuberculosis once it was determined that the student did have active disease. None of these activities were reimbursable.

Staff are frequently asked to attend and participate in school-based support team meetings on students who are being evaluated for special education services.

A student comes to the center in the morning to talk with the social worker and reports that she has been physically abused. She is seen by the social worker and the nurse practitioner. It is determined that it is not safe for her to go home that day and protective services is notified. At this point the student's needs required the attention of two staff members for several hours and because of the urgency of the problem other appointments for that time are canceled. The student spends the day in the center waiting for protective services. The center is reimbursed for a single visit.

Responding NASBHC Affiliates

California Association of School-Based and School-Linked Health Programs

Irwin Staller, President

Colorado Association of School-Based Health Centers

Betty Pepin, President

Connecticut Association of School-Based Health Centers

Jesse White-Fresé, President

Illinois Coalition for School-Based Health Centers

Brenda Banner, Chair

Louisiana Assembly on School-Based Health Care

JoAnn Derbonne, President

Maryland Assembly on School-Based Health Care

Kathleen Wise, President

Maine School-Based Health Care Assembly

Lisa Belanger, President

School Community Health Alliance of Michigan

Kathleen Conway, President

North Carolina Association of School-Based and School-Linked Health Centers

Cathy DeMason, President

Oregon Coalition of School-Based Health Centers

Sister Barbara Haase, President

Texas Association of School-Based Health Centers

Jenni Jennings, President

West Virginia School-Based Health Assembly

Carol Whetzel, President



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