School-based Health Centers in New York State:
Ensuring Sustainability and Establishing Opportunities for Growth

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Executive Summary

A significant opportunity currently lies before us in New York State — to ensure that the important role of school-based health centers (Centers) in serving many of our most at-risk children is sustained, while also strategically achieving the goals established by the Medicaid Redesign initiative.

School-based health centers are invaluable service providers to children and youth in their communities. They provide cost-effective primary medical, dental, mental health and reproductive health care and education services to low-income communities. Additionally, Centers are a vehicle for eliminating racial and ethnic health disparities in the communities that they serve. In New York State, approximately 25% of Centers serve communities where more than one-third of the population lives below 100% of the Federal Poverty Level and 79% percent of students in schools with Centers are non-white with more than 30% identified as Black or African-American.[1] [2]

Furthermore, Centers lead to educational advancement and economic development for youth who are poor and underserved. In addition to being instruments for accessible, comprehensive primary care services that foster health equity for poor and minority youth, Centers have a proven record of impacting the health and education of children/youth in a profound way, improving classroom attendance and graduation rates. One study notes that children with asthma in elementary schools without Centers missed three more days on average compared to those in a school with a Center.[3] Another Bronx study showed that children with asthma in schools without a Center were 50% more likely to be hospitalized than those who attended a school with a Center.[4] Those students

[1] http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

[2] http://www.health.ny.gov/statistics/school/skfacts.htm

[3] McCord, M.T., Klein, J.D., Joy, J.M. and Fothergill, K. (1993). School-based Clinic Use and School Performance, *Journal of Adolescent Health,* 14, 1-98.

[4] Webber MP, Carpinellos KE, Oruwariye T, Lo Y, Burton WB, Appel DK. (2003). Burden of Asthma in inner-city Elementary Schoolchildren: Do School-Based Health Centers Make A Difference?" Arch. *Pediatric & Adolescent Medicine,* 157, 125-129.

who used their Center were more likely to graduate or be promoted than those who did not. They were less likely to be dismissed from school early due to illness and had three times less loss of academic seat time when compared to students not enrolled in a Center.[5] In this time of competitive learning, school attendance matters significantly. Centers are an important way of ensuring students can easily access comprehensive care without missing significant amounts of class time.

Medicaid Redesign — instituted by Governor Andrew Cuomo's Administration in 2010 — was created to develop a system of care that would improve health outcomes of Medicaid recipients in New York and, in turn, reduce the costs of care long-term. The concept of "coordinated care" via managed care organizations is the methodology upon which the administration plans to revise health care administration for Medicaid recipients and, ultimately, improve health outcomes. The redesign of Medicaid has birthed the need to determine how to fully transition all New York State Medicaid dollars to managed care organizations and, in turn, reimburse health care providers in a carefully crafted way that ensures adequate Medicaid payment levels and the sustainability of programs and services. Specifically, for school-based health centers (Centers) in New York, this is an enormous challenge. Over the past twenty years, Centers' financing has become significantly reliant on the program because their base consumers are children covered by Medicaid. Currently, Medicaid is the leading third-party payer, accounting for 89% of third-party revenue. Therefore, with the implementation of Medicaid Redesign, transitioning from a fee-for-service payment methodology to one involving managed care can impact whether or not Centers remain viable in New York State. Center viability is crucial to ensuring that children and youth in New York's high need areas have a secure means of comprehensive health care.

In comparing current Medicaid reimbursements received by Centers to those issued by managed care organizations for primary care services, it is projected that the transition from a fee-for-service to a managed care payment structure could result in program revenue loss of up to $16.2 million statewide. Collectively, among all Center providers, this represents 50% of current Medicaid revenues and 25% of the $63.3 million statewide program budget. It is important to note that this projection includes a reduction for federally-qualified health center (FQHC) sponsored centers, not taking into account the wraparound payment they receive. Excluding the FQHC rate reduction nets a statewide loss of $8.9 million.

This projected loss of up to $16.2 million is scheduled to take place on top of the existing statewide deficit of $1.5 million. Historically and currently, Centers have operated on a skeletal budget. The $1.5 million deficit is presently filled through the support of organizational sponsors. However, it is important to note that organizational sponsorship is not limited to $1.5 million in annual financing. Rather, it totals approximately $5.2 million a year, including in-kind revenue.[6] The actual amount of Centers' sustainability has been the result of piecing together a myriad of funding sources to create a budget that supports crucial services for children living in the poorest communities of New York State.

Given this projected revenue loss of up to $16.2 million, it is imperative that New York State construct a methodology for Medicaid managed care financing that guarantees a stable fiscal environment for Centers, in turn, providing continuity of care to school-aged children at existing sites and an opportunity for expansion. The goal of this report is to provide concrete, workable financing solutions and implementation methodologies for Centers in the environment of Medicaid managed care and beyond. New York State is a leader and innovator in providing children with access to health services. Committing to the sustainability of school-based health centers as providers for children and youth is necessary for New York to continue its dedication to the health and well-being of its youngest residents.

[5] Van Cura M. (2010). The Relationship between School-Based Health Centers Rates of Early Dismissal from School and Loss of Seat Time. *Journal of School Health,* 80 (8) 371-78.

[6] Data source for financing. Financial Expenditure Data gathered from the State Department of Health for Year 2011.

Methodologies for Research and Analysis

Surveying New York Providers

To accurately assess the financing structure of New York's school-based health center program, quantitative and qualitative analyses were completed. Quantitative financing data was amassed from 196 (of 223*) school-based health centers in New York State. Data was gathered cross-regionally and among the three existing sponsorship models — namely, hospitals, federally qualified health centers, and independent diagnostic and treatment centers. This data was examined by CohnReznick — a national firm with expertise in health center fiscal analysis and third-party reimbursement.

Qualitative data was collected and examined by the Children's Defense Fund – New York (CDF–NY). CDF-NY conducted individual interviews and convened two stakeholder forums, engaging more than sixty participants — twenty-five percent of whom were Center providers and administrators. Other interviewees and participants of stakeholder forums included government administrators, elected officials, and other veterans of school and children's health.

Examining Other States

Through data gathering on programs in California, Maryland, and Michigan, as well as from the National School-based Health Alliance, CDF-NY was able to gather valuable information that influenced the construction of policy recommendations in this report. For a summary on financing models in other states, see Appendix A.

All data representing the financial landscape of Centers in New York State is collectively and anonymously reported in this document.

Findings

The overarching findings from the research and analyses conducted were as follows:

- Transitioning Medicaid reimbursements from a fee-for-service to a managed care method could result in a statewide program loss of up to $16.2 million.

  In comparing current Medicaid reimbursements received by Centers to those issued by managed care organizations for primary care services, it is projected that the transition from a fee-for-service to a managed care payment structure could result in program revenue loss of up to $16.2 million statewide. This is because managed care organizations reimburse providers at lower rates than fee-for-service payments. The loss of $16.2 million is projected on top of an existing statewide program deficit of $1.5 million.

- The $16.2 million in Center revenue loss will become the profit of New York State and/or managed care organizations.

  A total of $16.2 million will either be kept by New York State or newly acquired by managed care organizations once Medicaid reimbursements to Centers transition to a system that involves managed care organizations.

- Medicaid is the leading third-party payer to Centers in New York State, accounting for 89% of third-party revenue.

  Of all children and youth who visit school-based health centers statewide, 44% of them are confirmed to have Medicaid as their health insurance. While only 44% of the membership uses Medicaid, the revenue gained by Centers is 89% of total third-party revenue.

* This number is based on data from December 2013.

Centers can accept health insurance other than Medicaid, however, these payers are not the primary sources of third-party revenue. This is true for a few reasons. Principally, the schools where Centers are placed have a large population of students who are publicly insured on Medicaid.[7] Secondly, Centers in New York are often precluded from receiving primary care reimbursement for children covered by Child Health Plus (CHPlus) and private health insurance plans. This is because payment is funneled through managed care organizations, which will not pay for primary care services to providers who are not designated providers for their patients.

While Medicaid beneficiaries who receive services at school-based health centers also need to enroll in managed care as part of their health insurance, Center providers are paid directly by the State for rendered services without managed care involvement due to an established waiver. This waiver does not apply for services rendered to beneficiaries of CHPlus and private health insurance.

- Medicaid reimbursements to Centers vary according to sponsorship.

The Medicaid reimbursement rate – either the ambulatory patient group (APG) rate methodology or the FQHC prospective payment system (PPS) rate – determines each program's Medicaid payment level. All centers are eligible to receive APG rates which are designed to take into account the amount and type of resources used in an ambulatory visit. Only Federally Qualified Health Centers (FQHCs) are eligible to receive PPS rates, which are generally higher than the APG rates and most FQHCs have "opted-out" of APGs. Hospitals and DTCs, by default, accept the APG rate. FQHCs receive, on average, reimbursements that are 14% higher than those received by hospitals and independent DTCs. Diagnostic and treatment centers fare the worst with respect to Medicaid reimbursements.

When transitioning to managed care with payment rates below these traditional rate systems, Hospitals and DTCs stand the most to lose as FQHCs are "held harmless" through a supplemental payment paying up to the PPS rate.

- Independent diagnostic and treatment centers (DTCs) are most vulnerable to adverse consequences of a Medicaid carve-in to managed care.

Among the three Center models, independent diagnostic and treatment centers are the most at risk for financial hardship upon implementation of the carve-in to managed care. This is due to the fact that they are not eligible for the same enhanced Medicaid reimbursement received by FQHCs, nor do their sponsoring organizations have resources to backfill programs that fall at a deficit, as may be true with larger hospitals. Additionally, DTCs are sponsored by nonprofit organizations, which are already heavily reliant on government funding. This is most concerning given that New York's DTCs offer services in communities where 30%-41% of residents live below the poverty level.[8]

Recommendations

Based on the findings of CDF-NY's research and research and analyses, the following recommendations explicitly provide a concrete method for adequate reimbursement to Centers upon implementation of Medicaid Redesign and also provide mechanisms for financing outside of the realm of Medicaid managed care. These recommendations are made in the interest of preserving a system of health care that has proven effective for children and youth in New York State and nationally.

[7] http://ww2.nasbhc.org/RoadMap/Public/Funding_IB_MedicaidReimbursement.pdf.

[8] www.usa.com

Within the Medicaid Managed Care Environment:

- Transitioning Centers to receive Medicaid reimbursements via managed care should be phased in prior to full implementation.

  Handling the transition of Medicaid reimbursements from a fee-for-service model to a managed care model with great precision and accuracy is paramount to securing that Center doors remain open in the months and years ahead. Centers, for the first time, will need to implement a completely new reimbursement system. Phased-in implementation will afford an opportunity for assessment and identification of any errors and systemic glitches that can be effectively addressed and rectified on a smaller scale. This will, ultimately, aid in ensuring ultimate success for the "carve in" methodology — a common goal of the State Administration and Center providers in the interest of uninterrupted services to children and youth.

- Workgroup meetings among the State Department of Health, Center providers, and managed care organizations should commence prior to and continue through the implementation process.

  As experienced by other populations undergoing the transition from a fee-for-service reimbursement methodology to one involving managed care, it is expected that situations will arise that will negatively impact the utilization of Centers by children and youth. Workgroup meetings inclusive of the State Department of Health, Center providers, and managed care organizations would serve a critical purpose — to ensure effective planning and negotiation for implementation of the "carve in" with the ultimate goal of sustaining an effective health care model for children and youth. Prior to implementation, it is critical for all parties to agree to specific dollar amounts for financing Centers via managed care organizations. Ongoing workgroup meetings would monitor trends concerning managed care recognition and reimbursement, effectively resolving systemic issues that impact utilization — ultimately, guaranteeing uninterrupted services to children and youth dependent on Centers' care.

- After being carved in to managed care, school-based health centers should receive Medicaid financing inclusive of a per-member-per-month rate.

  Reinvesting additional Medicaid savings — acquired via managed care involvement — back into school-based health centers is the only way that the program can survive and continue to offer optimal care to low-income families. This PMPM payment would cover the cost of school-based enabling and support services not covered by traditional payment models and rates. Re-investing this additional Medicaid savings back into Centers can be done using a methodology that pays Center providers per member on a monthly basis.

- School-based health centers should not be required to complete credentialing and automatically be recognized by managed care organizations as designated providers for specified services.

  Completing non-standardized credentialing applications for various managed care entities to ensure third-party insurance reimbursement is a process that would add administrative burden and costs on Centers. Non-standardized credentialing is a cumbersome, overwhelming, and costly process for organizations with low administrative capacity. In order to successfully complete the process, organizations would need to add to administrative overhead costs that would create further deficit.

  Instead, as in the state of Michigan, Centers should be automatically recognized by managed care as designated providers to avoid excess expenditure on the credentialing process.

- School-based health centers should have a specified designation in managed care that permits them to receive reimbursement.

In order for school-based health centers to receive Medicaid dollars administered by managed care organizations, they need to have a specified, recognized designation in the managed care system. Other states — namely, Michigan and Maryland — have arranged for school-based health centers to have a recognized designation and, in turn, are entitled to Medicaid reimbursements administered via managed care. This eliminates unnecessary competition for reimbursement between community providers and school-based health centers, allowing each to have a designated role and recognized status within managed care.

This designation would require Center providers to:

- meet specific standards for comprehensive service provision to children/youth;
- report on quality outcome measures pre-determined via negotiations with managed care organizations; and
- effectively integrate with community providers to ensure quality health care.

- School-based health centers need to use a streamlined, centralized billing system.

  In order to create a fluid process for reimbursement to providers that optimizes the potential for expeditious processing and revenue generation, New York State needs to create and support a simplified, streamlined, and centralized system that Centers can use to bill managed care organizations. Given the skeletal budget by which Centers operate, ensuring timely, adequate reimbursement is necessary to guaranteeing program viability and sustainability.

  Additionally, such a system could serve as a clearinghouse of information for the State Administration. Data gathered through this tool could provide critical information on how the program can be administered moving forward to ensure optimal, cost-effective care to children and youth.

Beyond Medicaid Managed Care

- School-based health centers should receive funding for specialized care and public health education services.

  Currently, New York State operates federally-subsidized programs that offer interventions and support for areas related to reproductive health, childhood obesity, substance abuse and mental health. Allocating some of the public funds used to finance these programs to Centers that currently offer these services will allow for a new opportunity to enhance program revenue and services to the same target population.

- School-based health centers should designate clinic hours to serve the community, at large.

  Making Centers available to the community, at large, for primary care services would optimize the potential of the facility to serve patients beyond the limitations of school hours, which would create additional revenue and guarantee sustainability. Additionally, creating community access would also meet a growing demand in New York State for expansion of primary care services given the implementation of the Affordable Care Act.

Introduction

Access to affordable primary health care has posed one of the most difficult challenges in our health care system. Specifically, for low-income communities, residents are often medically disenfranchised, not having access to affordable, comprehensive, and quality health services. Lack of access leads to other consequences — namely, disproportionate health outcomes for low-income individuals — that can hamper quality of life and opportunities for advancement.

School-based health centers — facilities housed in schools that provide on-site primary care, ancillary care, reproductive health care and education, and mental health services — offer a means for remediating the shortage of medical service provision for children and youth, particularly in low-income communities.[9] Securing these facilities as critical access points for care is essential to creating a fastened pathway for children and youth to have a healthy start in life.

The Current Challenge

At this time, New York State's school-based health centers are facing an enormous challenge. As providers that have become heavily reliant on Medicaid dollars, they have been sustainable due to a fee-for-service financing methodology. However, as of October 2014, Centers are being directed by the state's administration to involve managed care organizations as an intermediary for issuing Medicaid reimbursements. This shift in financing is part of the Medicaid Redesign initiative issued by Governor Andrew Cuomo in 2010. This initiative has birthed the need to determine how to fully transition Medicaid reimbursements from a fee-for-service methodology to one that involves managed care organizations for various beneficiaries and providers. For school-based health centers, guaranteeing their continued viability means crafting a Medicaid reimbursement methodology that offers adequate levels of payment, ultimately ensuring the sustainability of programs and services.

[9] http://ww2.nasbhc.org/RoadMap/PUBLIC/Advocacy_SBHCdefinition.pdf.

History

Providing medical services in schools to achieve both child health and school performance objectives has a deep and long history in the United States. The first school-based health centers (Centers) emerged in Cambridge, MA in the 1960s, following President Lyndon B. Johnson's War on Poverty, which acknowledged the need to focus on health issues among impoverished school-age children.[10] Since 1970, school-based health centers have grown from just a handful to more than 1,900 in 45 states. Currently, New York State, which houses 223 centers statewide, is one of three states — along with California and Florida — with the greatest volume of centers.

Who and Where Centers Serve

Nationally, Centers serve all school levels, but have the greatest presence in high schools at 30 percent, followed by elementary schools (20%), middle schools (15%), elementary with middle schools (14%), schools offering K-12 (14%), and middle with high schools (7%). The majority are co-located in school buildings in urban communities (59%), followed by rural (27%) and suburban (14%) communities. Seventy percent of the students in schools with Centers are non-White. They include Hispanic/Latino (36%), Black non-Hispanic/Latino (26%), Asian/Pacific Islander (4%), Native American/Alaskan Native (1%), and "Other" (1%).[11]

In New York State, almost 25% of Centers serve communities where more than one-third of the population lives below 100% of the Federal Poverty Level.[12] Additionally, 79% percent of students in schools with Centers are non-white with more than 30% identified as Black or African-American.[13]

Parallel to the premise on which Centers were birthed — to focus on addressing health issues among poor children — they remain critical in providing health care for school-age children living in poverty who are racial and ethnic minorities.

Service Provision and Staffing

School-based health centers provide a range of primary care and ancillary care services. Namely, these include: first aid; diagnosis and treatment for pediatric and adolescent health needs; assessments and examinations for sports physicals and working papers; chronic disease monitoring and treatment; laboratory testing; reproductive health services; STI/HIV testing, treatment, and counseling; vaccinations; mental health services; and dental care.

Centers are staffed by a multi-disciplinary team of licensed health care professionals and support staff. By and large, they are staffed by Nurse Practitioners (NPs) or Physician Assistants (PAs). One NP or PA is designated to serve between 700 and 1,500 students. A supervising physician from the center's sponsoring agency is required to be accessible to the NP or PA at all times during operating hours. Mental health needs may be addressed at the school site or by referral. If services are provided on-site, one full-time licensed mental health provider should be available for every 700-1,500 students enrolled in the program. Lastly, all Centers have a medical or health assistant on site who schedules appointments, conducts data entry, and assists the NP and PA in patient care. Centers that offer expanded services may have additional staff on-site which may include a health educator, a community outreach worker, registered nurses, or a nutritionist. If dental services are provided

[10] Wolfe, B. (2012). The Legacy of the War on Poverty. Retrieved from http://npc.umich.edu/news/events/war-on-poverty-june-conference/wolfe.pdf.

[11] Zimmerman et. al. (December 2011). The School-Based Health Care Policy Program: Capstone Program, Center for School, Health, and Education. Retrieved from http://www.schoolbasedhealthcare.org/wp-content/uploads/2011/01/SBHCPP-Capstone-Evaluation-ATTACHMENTS-Dec-20111.pdf.

[12] http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml#none

[13] http://www.health.ny.gov/statistics/school/skfacts.htm

on-site, a dental assistant, a dental hygienist, and a supervising dentist will be part of the center's staff. One full time dental hygienist can provide services for approximately 2,500 enrollees.

It is required that all staff are trained in child abuse, infection control, emergency care, including general first aid, basic life support, and in the use of an automated external defibrillator. Centers are also required to have a presence during all normal school hours.[14]

Facility Requirements

The school space designated to the Center must include adequate space to provide services. Space is needed for exam room(s), counseling room(s), a reception area, professional office space, a storage area and locked space for medical records and pharmaceuticals, bathroom(s), an infirmary area, clean and dirty prep areas, hand washing sinks, and a laboratory area. Approximately 1,500 to 2,000 square feet is recommended by the New York State Department of Health (NYSDOH), School Health Program for a site with an enrollment of 700 students. However, typically, space allocation is determined by availability and resources within the school building.[15]

Invaluable Service at Minimal Cost: Implications on Public Health and Academic Performance

By providing accessible, quality health education and services for high-need children and youth, school-based health centers provide an enormous benefit to communities and greater society, as compared with their low expense. Primarily, their benefit outweighs cost due to their "one-stop shop" approach to prevention and early detection/treatment for children and youth who are most at risk. Costs, as well as administrative burdens experienced by providers and families, are dramatically reduced given their capacity to have multi-disciplinary teams serve school-age youth without the need for referrals and outsourcing of services. This is most relevant to Centers with robust models of care that offer primary and ancillary care services. Centers save money for the taxpayer and for low-income families by offering children access to health care — ultimately fostering disease prevention and early detection/treatment.[16]

Centers also serve as a vehicle for eliminating racial and ethnic health disparities in preventive primary, dental, mental health and reproductive health care and education. Geographic placement of school-based health centers in communities where the demographic make-up consists of racial and ethnic minorities who are at or below 133 percent of the federal poverty level (FPL) gives opportunity for minority children in low-income families to access primary and specialty care prevention and treatment services. History and data have shown that access to such care in schools by qualified professionals is a fundamentally effective model to guarantee disease prevention and service intervention.[17]

Moreover, Centers lead to educational advancement and economic development for youth who are poor and underserved. Studies have shown improved school attendance, grades and graduation rates as a result of Center intervention.[18] Improving the health of a child in poverty enhances his or her chance of educational achievement and advancement out of poverty.[19]

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[14] Horton, J.M. and Lima-Negron, J. (2009). School-based Health Centers: Expanding the Knowledge and Vision. Retrieved from http://www.nystatesbhc.org/images/stories/CHFWCNY%20FINAL%20DOCUMENT%208.5.pdf.

[15] Horton, J.M. and Lima-Negron, J. (2009). School-based Health Centers: Expanding the Knowledge and Vision. Retrieved from http://www.nystatesbhc.org/images/stories/CHFWCNY%20FINAL%20DOCUMENT%208.5.pdf.

[16] Webber et. al. (2005). Impact of Asthma Intervention in Two Elementary School Based Health Centers in the Bronx. *Pediatric Pulmonology*: 40 (6), 497-493.

[17] Jeff J. Guo, Terrance J. Wade, Wei Pan, and Kathryn N. Keller (2010). School-Based Health Centers: Cost–Benefit Analysis and Impact on Health Care Disparities. *American Journal of Public Health*: 100 (9), 1617-1623.

[18] http://www.eric.ed.gov/PDFS/ED539815.pdf.

[19] Webber MP, Carpinellos KE, Oruwariye T, Lo Y, Burton WB, Appel DK. (2003). Burden of Asthma in inner-city Elementary Schoolchildren: Do School-Based Health Centers Make A Difference?" Arch. *Pediatric & Adolescent Medicine,* 157, 125-129.

Financing and Sponsorship

School-based health centers are financed by myriad sources. Government grants and subsidies, organizational sponsorship, and third-party reimbursements all support the 223 centers throughout New York State.

New York State's school-based health center program costs $63.3 million. This cost includes direct and indirect expenses. Of the $63.3 million budget: 42% is covered by state grants; 54% is covered by third-party revenue; and, the balance is covered by in-kind support from sponsor organizations.

Government Grants

In the initial years of the program, public financing for centers across the United States began with local and state investments of the federal maternal and child health (MCH) block grant. Between the years 1994-2004, funding through the Public Health Services Act appropriation featured the first-ever federal grant program dedicated exclusively to Centers: the Healthy Schools/Healthy Communities (HSHC) program. The program, operated by the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services, funded 80 Centers across the country, including nine in New York. By the late 1990s, financing by MCH block grant began to diminish because of federal budget cuts, and the HSHC funding was consolidated with other federal health care safety net program funds, forcing states to determine other means for center viability and sustainability. In addition to continued funding by the MCH block grant, New York State carved out public monies via tax dollars from the Health Care Reform Act (HCRA). These monies provided financial support for a number of public health programs, including school-based health centers, from tax dollars levied from the Tobacco Settlement. Currently, government grants comprise 42% of the Center program budget statewide.

Sponsors

Over the past twenty years, organizations establishing school-based health center programs in their designated communities have become critical entities for sponsorship and financial support. These organizations include: hospitals, public health departments, federally-qualified health centers (FQHCs), and nonprofit healthcare and social service agencies. In New York State, school-based health centers are identified according to sponsorship as hospital-sponsored Centers, federally-qualified health center-sponsored centers, or independent diagnostic and treatment centers (sponsored by public health departments and non-profit agencies). Implications for financial support vary based on the organizational sponsorship designation. Larger and wealthier institutions are in the position to allot more finances to centers, ensuring program sustainability independent of government financing. Less affluent institutional sponsors, like federally-qualified health centers and non-profit agencies, are more reliant on government financing and third-party reimbursements in order to maintain services. See Appendix B for a listing of Centers and sponsors in New York State.

Third-Party Payments

Third-party payments via health insurance reimbursements (including Medicaid) have become significant sources of income for centers since the 1990's. Originally, Centers began to bill health insurances for service reimbursement to supplement their revenue stream. Currently, these third-party reimbursements constitute 54% of revenues generated by Centers in New York.[20]

Additionally, since school-based health centers are strategically located in impoverished communities, students who receive care at these facilities are largely insured by Medicaid, making it the primary third-party payer. As a result, Centers are heavily reliant on Medicaid financing for program sustainability. More specifically, in New

[20] Fiscal Data gathered from the State Department of Health for Year 2011.

York State, Medicaid reimbursements supply 89% of third-party revenue, making it the most significant third-party payer for the program.[21]

Reliance on the Medicaid program for financial support is significant for New York State's School-based Health Center program, overall. However, Center sponsorship and geographic location also influence the degree by which a program is reliant on Medicaid funding. For example, diagnostic and treatment centers (DTCs) in downstate New York are the most reliant on Medicaid financing, making them significantly more susceptible to program closure if state Medicaid funding is adversely impacted.

In addition to center payer mix varying by sponsorship and region, Medicaid reimbursement levels to centers in New York State also differ by sponsorship and region. From a geographic rate-setting perspective, New York State Medicaid rates are segregated between upstate and downstate, with differing rates established taking into account the differences in the cost of living and other factors by region. The sponsoring entity's identity also affects the Medicaid rate. Hospital outpatient clinics, FQHCs and free-standing diagnostic and treatment centers each have differing reimbursement rates. Centers sponsored by FQHCs receive the prospective payment system (PPS) rate. This rate was created by federal legislation — the Consolidated Appropriations Act of 2001, and includes a provision establishing a minimum Medicaid per visit rate for FQHCs using a specific methodology.[23] Through the PPS methodology, an enhanced Medicaid reimbursement rate to FQHCs is established to cover the cost of federally-mandated services. Centers sponsored by all other entities are reimbursed under the ambulatory patient group (APG) rate methodology, which is designed to take into account the amount and type of resources used in an ambulatory visit. While FQHCs can qualify to receive APG reimbursement, they often opt for the PPS rate since it offers higher compensation, reflective of the actual cost of care.

Medicaid Redesign in New York State: The Impact on School-based Health Centers

In 2010, Governor Andrew Cuomo issued an executive order, instituting Medicaid Redesign — an initiative purposed to provide "care coordination" for all program beneficiaries in New York and avoid duplication in expenditures. This, in turn, is expected to reform the Medicaid system and reduce costs. The Governor's action was taken to address the uptick in Medicaid expenditures within the past five years. The reconfiguration of Medicaid spending in New York is a necessary step towards preserving the program long-term. However, it is critically important that careful planning and administration ensue in the overhaul of a program that provides critical health services for underserved children and other populations.

"Care coordination" for all Medicaid beneficiaries will entail eliminating the fee-for-service payment structure by re-allocating $26 billion in fee-for-service spending to managed care organizations that will coordinate patient care for all Medicaid beneficiaries.[23] The reallocation of spending through managed care organizations will require that school-based health centers transform the way they acquire Medicaid reimbursement dollars. To date, New York State has implemented a "carve out" methodology for Medicaid reimbursement to Centers. The "carve out" was authorized via a waiver in the Pataki Administration in 1998 and allowed Center providers to directly bill New York State for services provided to children on Medicaid.[24] The "carve out" has offered Center providers a streamlined, simplified billing methodology that allowed reimbursements to occur expeditiously and at an adequate rate, as approved by the State Department of Health.

Shifting to a billing method that would involve processing claims through a large pool of managed care organizations will involve a more complex structure and may not guarantee reimbursement rates at a level that

[21] Fiscal Data gathered from the State Department of Health for Year 2011.

[22] Koppen, C. (2001). Understanding the Medicaid Payment Prospective System for Federally Qualified Health Centers. Retrieved from http://www.nachc.com/client//IB69%20PPS%20Complete.pdf.

[23] http://www.health.ny.gov/health_care/medicaid/redesign/docs/care_manage_for_all.pdf.

[24] State Department of Health (letter to school-based health centers, April 22, 2004).

will sustain Centers. This is true for two reasons: (1) managed care reimbursements to providers are contracted on a payment schedule that is negotiated between the provider and managed care organization, often not allowing the provider much flexibility in rate determination; (2) managed care organizations have organized payment rates that are lower than the existing rates that Center providers receive via the fee-for-service payment methodology.

Since Medicaid reimbursements comprise more than 89% of Centers' third-party revenue in New York, ensuring that reimbursements to Center providers are timely and do not decline is crucial to their sustainability moving forward. Without a thoughtful plan that accounts for operating costs, Centers will close.

An Analysis: The Financial Performance of Centers – Current and Prospective

Surveying New York Providers

In order to accurately assess the financing structure of New York's school-based health center program for this report, quantitative and qualitative analyses were completed. The quantitative analysis was completed by CohnReznick — a national firm with expertise in health center fiscal analysis and third party reimbursement. Quantitative financing data was amassed from 196 (of 223) school-based health centers in New York State. Of the 196 sites, 72 are located in the Upstate Region and 124 in the Downstate Region. Fifty percent are hospital-sponsored; 35% are FQHC-sponsored; and 15% are DTC-sponsored.

Qualitative data was collected and examined by the Children's Defense Fund – New York (CDF–NY). CDF–NY conducted individual interviews and convened two stakeholder forums, engaging more than sixty participants. Interviewees and participants of stakeholder forums included Center providers, government administrators, elected officials, and other veterans of school health.

Looking at Other States

An important step in the development of this report's recommendations for sustainability and growth of school-based health centers included researching and examining models from other states. Through research and a host of communications with other state and program officials, as well as the National School-based Health Alliance, we were able to gather valuable information that influenced the construction of the policy recommendations in this report. For a summary on financing models in other states, see Appendix A.

All data representing the financial landscape of Centers in New York State is collectively and anonymously reported in this document.

Findings

Initial research and assessment of Center financing in New York State revealed the following:

- Medicaid is the leading third-party payer to Centers in New York State, accounting for 89% of third-party revenue.

  Of all children and youth who visit school-based health centers statewide, 44% of them are confirmed to have Medicaid as their health insurance while the remainder of the population consists of children/youth: with private coverage (10%), with Child Health Plus (4%), without insurance (29%), and with an unknown insurance status (13%). See Table with Graph A. Of the subgroups identified as "uninsured" or "unknown", it is likely that a large portion of these members have Medicaid, yet this information is not recorded by Centers based on the fact that the visits represent confidential encounters for reproductive health or mental health services. However, while only 44% of the membership uses Medicaid, the revenue gained by Centers is 89% of total third-party revenue. See Table with Graph B.

- Medicaid reimbursements to Centers vary according to sponsorship.

  Based on fiscal and year end data reports for the school-based health center program in New York State, Medicaid reimbursements cover 89% of the cost per visit, on average. Medicaid reimbursements range from covering 44% to 123% of a visit cost. Diagnostic and treatment centers fare the worst with respect to Medicaid reimbursements. Data shows that Medicaid reimbursements cover 44% to 63% of a visit cost, on average. The balance is covered by grant dollars and in-kind organizational support.

  New York State's school-based health centers currently accept Medicaid reimbursements for services provided to enrolled consumers. The payment is issued directly from New York State to the Center. Rates vary according to sponsorship type. FQHCs receive, on average, reimbursements that are 14% higher than those received by hospitals and independent DTCs. By statute, the PPS reimbursement methodology offers FQHCs protection by providing a guaranteed baseline for payment regardless of whether the Medicaid beneficiary is covered under fee-for-service or enrolled in managed care.

Table with Graph A.

NYS Center Statewide Third Party Enrollment

Third Party Payer Type	% Enrollment by Center Membership
Medicaid	44
Private Insurance	10
Uninsured	29
Unknown	13
CHP	4

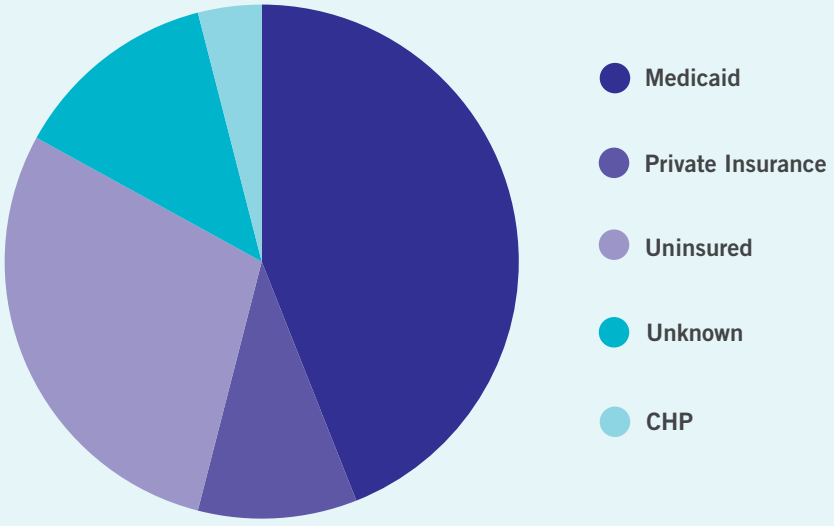
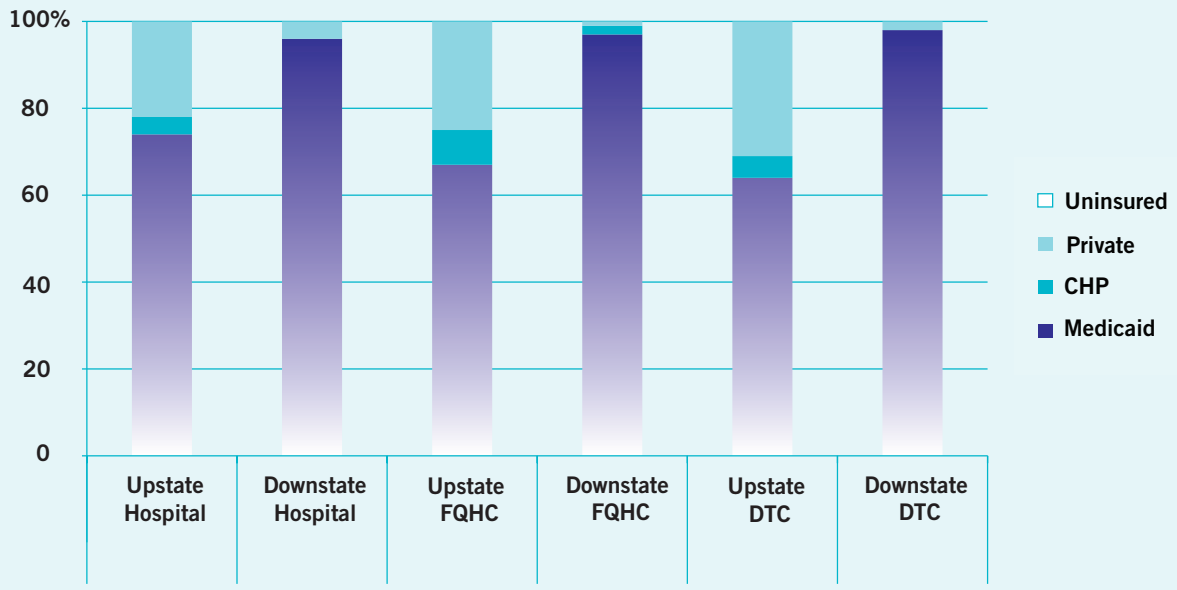


Table with Graph B.
Distribution of Statewide Center Revenue Generated by Third Party Payer

		Medicaid	CHP	Private	Uninsured/ Unknown	TOTAL
Upstate Hospital	**$**	5,583,577.00	296,570.00	1,700,299.00	None	**7,580,446.00**
	%	74	4	22	None	**100%**
Downstate Hospital	**$**	12,002,756.00	58,177.00	482,106.00	None	**12,543,039.00**
	%	96	0	4	None	**100%**
Upstate FQHC	**$**	1,495,446.00	184,113.00	546,263.00	None	**2,225,822.00**
	%	67	8	25	None	**100%**
Downstate FQHC	**$**	9,200,032.00	230,789.00	105,900.00	None	**9,536,721.00**
	%	96	2	1	None	**100%**
Upstate DTC	**$**	573,139.00	47,473.00	275,118.00	None	**895,730.00**
	%	64	5	31	None	**100%**
Downstate DTC	**$**	1,697,459.00	2,957.00	37,816.00	None	**1,738,232.00**
	%	98	0	2	None	**100%**
TOTAL	**$**	30,552,412.97	820,079.20	3,147,502.83	None	**34,519,995.00**
	%	89	2	9	None	**100%**



For Medicaid patients enrolled in managed care, FQHCs receive a supplemental payment from the State for the difference between their Medicaid PPS rate and the payment they receive from the managed care plan. This rate protection is rooted in the essential safety net provider status of FQHCs. The legislative history of the FQHC Medicaid program notes:

The role of [health centers] . . . is to deliver comprehensive primary care services to underserved populations or areas without regard to ability to pay. To the extent that the Medicaid program is not covering the cost of treating its own beneficiaries, it is compromising the ability of the centers to meet the primary care needs of those without any public or private coverage whatsoever. See Table with Graph C.

To ensure that Federal PHS Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries, States would be required to make payment for these [FQHC] services at 100 percent of the costs which are reasonable and related to the cost of furnishing these services. [H.R. Rep. No. 101-247, at 392-93, reprinted in 1989 U.S.C.C.A.N. 2118-19 (emphasis added)]

Therefore, given this Federal protection, any potential reductions in state financing of Medicaid do not adversely impact the reimbursement rates received by FQHCs. See Table with Graph D.

Table with Graph C.
Average Medicaid Reimbursement Rate for Centers Per Claim

Sponsorship Type	Average Medicaid Reimbursement Rate for SBHCs Per Claim
FQHCs (PPS Rate)	$160.86
Hospitals (APG Rate)	$153.97
DTCs (APG Rate)	$130.54

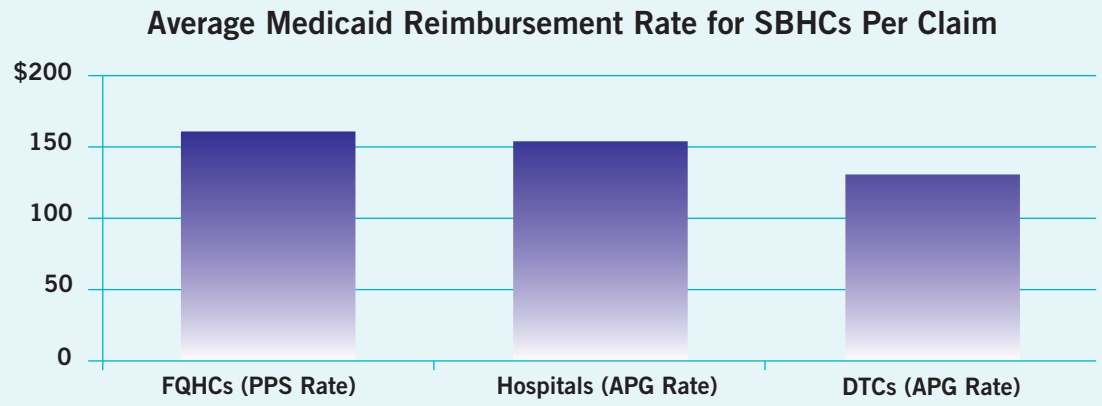
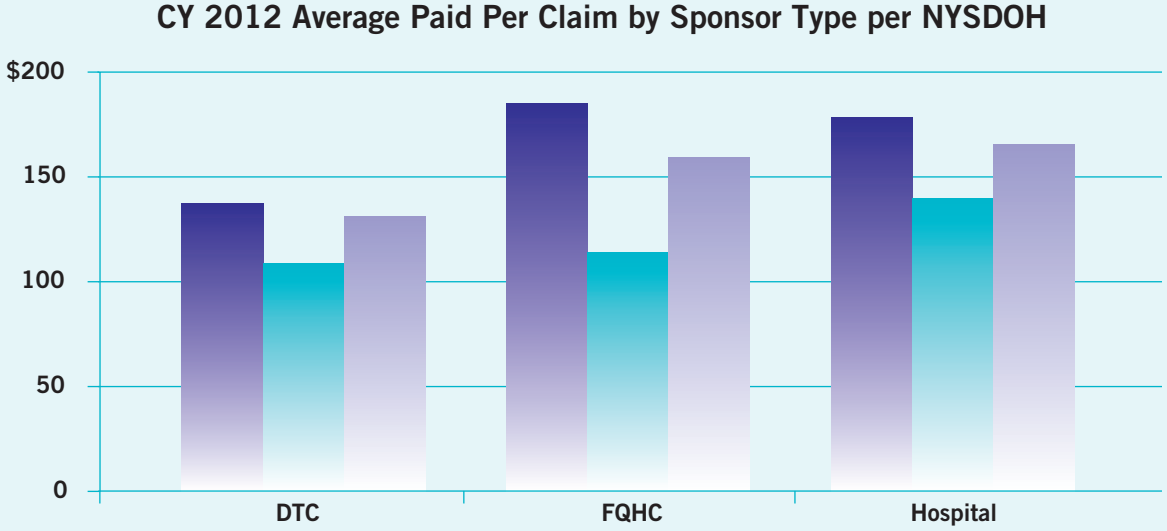


Table with Graph D.
Average Medicaid Reimbursement Rate for Centers Per Claim

Region	SBHC Sponsor DTC	FQHC	Hospital
Downstate	$137.52	$180.49	$175.68
Upstate	$106.22	$112.80	$141.07
Grand Total	$130.64	$160.18	$165.18

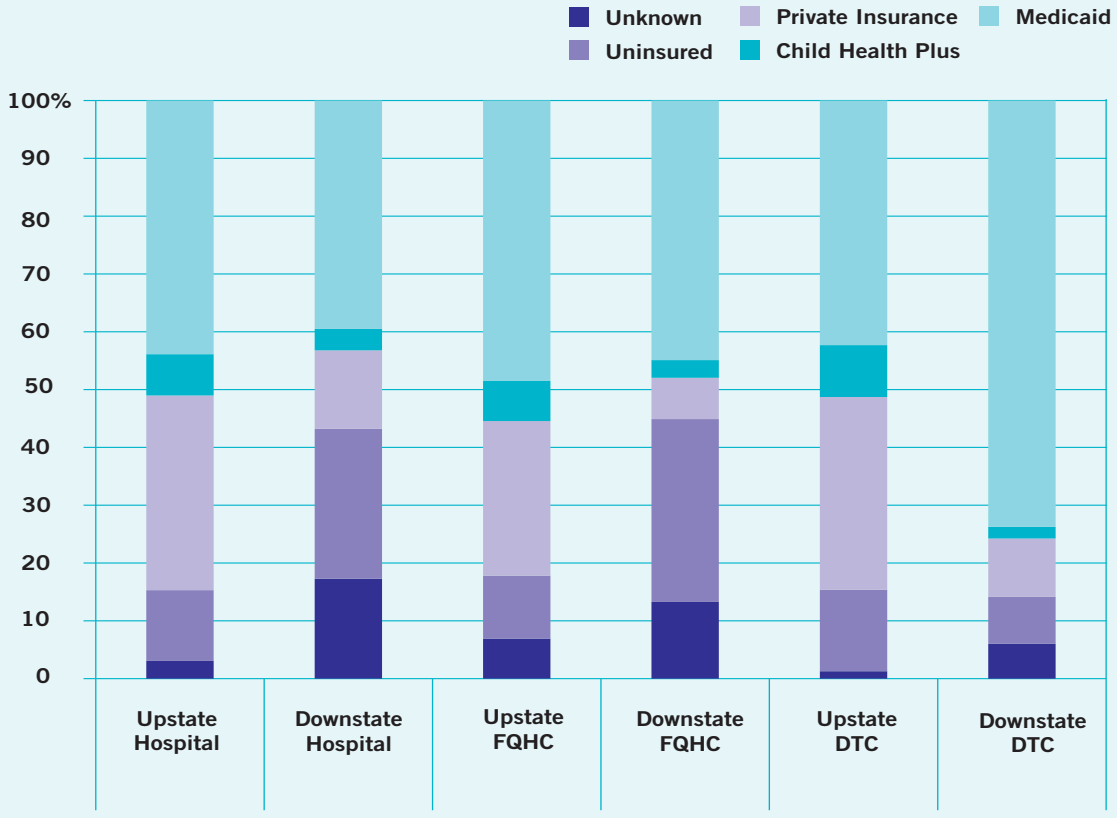


- Independent diagnostic and treatment centers are most vulnerable to adverse consequences of a Medicaid carve-in to managed care.

Additionally, when examining the payer mix by sponsorship and region for all Centers, diagnostic and treatment centers (DTCs) in downstate New York demonstrate to be the most reliant on Medicaid financing. DTCs show through financial reporting that Medicaid visits comprise 73% of all patient visits. Meanwhile, the range of percentages by which Medicaid finances the other sponsors and regions stretched from 32% to 49%, making downstate DTCs significantly more susceptible to program closure if state Medicaid funding is adversely impacted. See Table with Graph E.

Table with Graph E.
Payer Mix for Visits (by region and sponsorship)

	Upstate Hospital	Downstate Hospital	Upstate FQHC	Downstate FQHC	Upstate DTC	Downstate DTC
Unknown	3%	14%	7%	13%	1%	6%
Uninsured	12%	21%	11%	31%	11%	8%
Private Insurance	33%	11%	27%	7%	26%	10%
Child Health Plus	7%	3%	7%	3%	7%	2%
Medicaid	43%	32%	49%	44%	33%	73%



The implementation of Medicaid Redesign and the "carve in" of Medicaid dollars to managed care will, however, adversely affect non-FQHC providers by causing reductions in their reimbursement rates. An illustration of how providers are projected to fare with the institution of the "carve in" is provided in Table 1. Data is organized by geography (Upstate, Downstate) and sponsorship type (Hospital, FQHC, and DTC).

Table 1. Estimated Medicaid Revenue Impact Post- Medicaid Redesign Implementation

	Existing Medicaid Rate Per Visit	Estimated Average Medicaid Managed Care Rate Per Visit**	Rate Differential	Number of Annual Projected Medicaid Visits***	Medicaid Revenue Impact	Estimated Prospective Payment Rate Per Visit****	Medicaid Revenue Generated by Prospective Payment Rate	Medicaid Revenue Impact
Upstate								
Hospital-sponsored	$141.07	$77.44	($63.63)	8,567	($545,118)			($545,118)
FQHC-sponsored	$112.80	$77.44	($35.36)	26,378	($932,726)	$35.36	$932,726	$0
D&TC-sponsored	$106.22	$77.44	($28.78)	5,343	($153,772)			($153,772)
Total Upstate				**40,288**	**($1,631,616)**			**($698,890)**
Downstate								
Hospital-sponsored	$175.68	$81.38	($94.30)	76,023	($7,168,969)			($7,168,969)
FQHC-sponsored	$180.49	$81.38	($99.11)	64,594	($6,401,911)	$99.11	$6,401,911	$0
D&TC-sponsored	$137.52	$81.38	($56.14)	18,614	($1,044,990)			($1,044,990)
Total Downstate				**159,231**	**($14,615,870)**			**($8,213,959)**
Grand Total				**199,519**	**($16,247,486)**			**($8,912,849)**

* Per SDOH 2/28/2013 – Statewide Average Payment
** Per SDOH 3/4/2013 – Based on 2011 FQHC MCVRs
***Per SDOH 2/28/2013 – Paid visits 2011
****Applies to Federally-Qualified Heath Centers only

The data shows that the "carve in" is projected to bring a loss of $0 to FQHCs, $7.7 million to Hospitals, and $1.2 million to DTCs. While the projected loss to DTCs is less than the loss to Hospitals, DTCs do not have the monetary backing in-house to fill the gap loss, making them most vulnerable to closing. In turn, this would impact communities with more than one-third of their population living below the poverty level.[25]

Further analysis of Center financing elicited the following additional findings:

- Transitioning Medicaid reimbursements from a fee-for-service to a managed care method could result in a statewide program loss of up to $16.2 million.

[25] www.usa.com

It is projected that the transition from a fee-for-service to a managed care payment structure could result in a program revenue loss of up to $16.2 million statewide, most adversely affecting Centers in the downstate region. Since FQHCs are protected by statute to receive federal dollars that would subsidize state Medicaid financing and guarantee payment levels at a rate comparable to the average cost per visit (pre-determined by data from the previous fiscal year), we conducted an analysis (see Table 1) to show the impact on Medicaid revenue statewide. The projected net loss for Medicaid is reduced to $8.9 million when FQHCs are excluded. This is still a significant dollar amount and would, ultimately, unfavorably impact program viability throughout New York State.

With managed care organizations serving as the intermediary between New York State and school-based health centers, Center providers are slated to lose Medicaid revenue. The remaining revenue lost by Centers becomes savings to New York State and/or managed care organizations. See Table 2 for more details.

Table 2. Estimated Medicaid Savings by Managed Care Organizations Post-Medicaid Redesign Implementation

	Existing Medicaid Rate Per Visit	Estimated Average Medicaid Managed Care Rate Per Visit**	Rate Differential	Number of Annual Projected Medicaid Visits***	Current Medicaid Cost	Medicaid Managed Care Cost	Total Medicaid Savings by Managed Care
	Upstate						
Hospital-sponsored	$141.07	$77.44	($63.63)	8,567	$1,208,547	$663.43	$545,118
FQHC-sponsored	$112.80	$77.44	($35.36)	26,378	$2,975,438	$2,042,712	$932,726
D&TC-sponsored	$106.22	$77.44	($28.78)	5,343	$567,533	$413,762	$153,722
Total Upstate				**40,288**	**$4,751,519**	**$3,119,903**	**$1,631,616**
	Downstate						
Hospital-sponsored	$175.68	$81.38	($94.30)	76,023	$13,355,721	$6,186,752	$7,168,969
FQHC-sponsored	$180.49	$81.38	($99.11)	64,594	$11,658,571	$5,256,660	$6,401,911
D&TC-sponsored	$137.52	$81.38	($56.14)	18,614	$2,559,797	$1,514,807	$1,044,990
Total Downstate				**159,231**	**$27,574,089**	**$12,958,219**	**$14,615,870**
Grand Total				**199,519**	**$32,325,608**	**$16,078,122**	**$16,247,486**

* Per SDOH 2/28/2013 – Statewide Average Payment

** Per SDOH 3/4/2013 – Based on 2011 FQHC MCVRs

***Per SDOH 2/28/2013 – Paid visits 2011

****Applies to Federally-Qualified Heath Centers only

- The $16.2 million in Center revenue loss will become the profit of New York State and/or managed care organizations.

  A total of $16.2 million will either be kept by New York State or newly acquired by managed care organizations. Simultaneously, Centers will be adversely impacted by this new structure of management, losing up to 50% ($16.2 million) of their current Medicaid revenues. Centers are expected to provide the same level of service with a 50% average reduction in their reimbursement. This not only threatens their viability, but clearly disincentivizes them from providing comprehensive services to a vulnerable population.

Ensuring Sustainability

Recommendations for the Managed Care Environment

Preserving the $16.2 million loss of Medicaid revenues to Centers post the carve-in to managed care is critical to maintaining program viability and ensuring fiscal sustainability. This section addresses how the $16.2 million can remain in the school-based health center system and be used to support comprehensive services provided by the program for children and youth who benefit from these services.

Recommendation: Transitioning Centers to receive Medicaid reimbursements via managed care should be phased in prior to full implementation.

Managed care organizations will embark on a massive undertaking in becoming responsible for the effective administration of Medicaid dollars to Centers. Given that Medicaid is the primary source of revenue for Centers, the program cannot sustain systemic glitches in the forthcoming administration of Medicaid dollars. Handling the Medicaid "carve in" with great precision and accuracy is paramount to securing that center doors remain open in the months and years ahead.

As is sensible with most vast undertakings, the "carve in" should be phased in prior to full implementation. The phase-in is needed because Centers, for the first time, will need to implement a completely new reimbursement system. This will afford an opportunity for assessment and identification of any errors and systemic glitches that can be effectively addressed and rectified on a smaller scale. This will, ultimately, aid in ensuring ultimate success for the "carve in" methodology.

There is precedent for the phased in approach in how previous populations have transitioned into managed care. The homeless population, for instance, was transitioned into managed care over a six month period, beginning in April 2012. This transition impacted 206 sites that served 50,000 people statewide. The phased in approach was found to be necessary in order to minimize decreases in productivity and utilization of health services by this population. Given that there are 223 school-based health centers statewide that serve close to 200,000 children and youth, there is all the more cause for there to be a phased in transition from a fee-for-service reimbursement methodology to one that involves managed care organizations.

Recommendation: Workgroup meetings among the State Department of Health, Center providers, and managed care organizations should commence prior to and continue through the implementation process.

Anticipating that the transition from fee-for-service to managed care will, inevitably, lead to situations that could negatively impact the utilization of Centers by children and youth, workgroup meetings among the State Department of Health, Center providers, and managed care organizations should commence prior to implementation to set a baseline for contracted payments to Centers from managed care organizations. Post-implementation, ongoing workgroup meetings should occur to monitor trends concerning managed care recognition of Centers

and adequate reimbursement. The transition to managed care for the homeless population included ongoing workgroup meetings through the conversion period, which afforded the opportunity to track and monitor systemic glitches that, in turn, could be rectified expeditiously by the State Department of Health.

Recommendation: After being carved in to managed care, school-based health centers should receive Medicaid financing inclusive of a per-member-per-month rate.

The analysis completed in this report clearly demonstrates that of the $32 million currently allotted for Medicaid reimbursement to school-based health centers, it is estimated that lower reimbursement rates issued by managed care organizations to providers would result in a 50% ($16.2 million) reduction in Medicaid revenue statewide.

This savings of $16.2 million by managed care organizations can be reinvested back to school-based health centers to ensure that providers across New York State remain whole, in turn, allowing for critical health services — namely, first aid; diagnosis and treatment for pediatric and adolescent health needs; assessments and examinations for sports physicals and working papers; chronic disease monitoring and treatment; laboratory testing; reproductive health services; STI/HIV testing, treatment, and counseling; vaccinations; mental health services; and dental care — to be covered for children and youth in high need communities. The reinvested payment would be for services provided not covered in traditional payment models issued per patient member of the center on a monthly basis. Table 3 illustrates how monthly payments for members can be configured and issued to providers. Using a total reinvestment amount of $16.2 million for 65,441 patient members, the monthly reinvestment to Centers per patient member per month equals $20.69. Table 4 illustrates how reinvesting $20.69 per patient member per month will result in keeping centers fiscally whole.

Table 3. Configuring How to Reinvest Medicaid Savings into School-based Health Centers

	Number of Annual Visit***	Current Medicaid Cost	Medicaid Managed Care Cost	Total Medicaid Savings by Managed Care	Number of Patient Members****	Reinvestment Per Patient Member Per Year	Reinvestment Patient Member Per Month
Upstate							
Hospital-sponsored	8,567	$1,208,547	$663.43	$545,118	9,874		
FQHC-sponsored	26,378	$2,975,438	$2,042,712	$932,726	3,484		
D&TC-sponsored	5,343	$567,533	$413,762	$153,722	1,748		
Total Upstate	40,288	$4,751,519	$3,119,903	$1,631,616	15,106		
Downstate							
Hospital-sponsored	76,023	$13,355,721	$6,186,752	$7,168,969	23,724		
FQHC-sponsored	64,594	$11,658,571	$5,256,660	$6,401,911	17,671		
D&TC-sponsored	18,614	$2,559,797	$1,514,807	$1,044,990	8,940		
Total Downstate	159,231	$27,574,089	$12,958,219	$14,615,870	50,335		
Grand Total	**199,519**	**$32,325,608**	**$16,078,122**	**$16,247,486**	/ **65,441**	**$248.28**	= **$20.69**
				Total Amount to Reinvest	Divided by No. of Patient Members	Annual Amount to Reinvest Per Patient Member	Monthly Amount to Reinvest Per Patient Member

* Per SDOH 2/28/2013 – Statewide Average Payment
** Per SDOH 3/4/2013 – Based on 2011 FQHC MCVRs
***Per SDOH 2/28/2013 – Paid visits 2011
****Applies to Federally-Qualified Heath Centers only

Table 4. Demonstrating Reinvestment of Medicaid Savings Per Member Per Month

	Number of Annual Projected Medicaid Visits	Number of Patient Members	Reinvestment of $20.69 Per Member Per Month	Total Medicaid Savings by Managed Reimbursement	Medicaid Managed Care Reimbursement + PMPM Add On
Upstate					
Hospital-sponsored	8,567	9,874	$2,251,486	$663,428	$3,114,914
FQHC-sponsored	26,378	3,484	$864,997	$2,042,712	$2,907,709
D&TC-sponsored	5,343	1,748	$433,988	$413,762	$847,750
Total Upstate	**40,288**	**15,106**	**$3,750,470**	**$3,119,903**	**$6,870,373**
Downstate					
Hospital-sponsored	76,023	23,724	$5,890,120	$6,186,752	$12,076,872
FQHC-sponsored	64,594	17,671	$4,387,300	$5,256,660	$9,643,960
D&TC-sponsored	18,614	8,940	$2,219,595	$1,514,807	$3,734,402
Total Downstate	**159,231**	**50,335**	**$12,497,016**	**$12,958,219**	**$25,455,235**
Grand Total	**199,519**	**65,441**	**$16,247,486** +	**$16,078,122** =	**$32,325,608**

* Per SDOH 2/28/2013 – Statewide Average Payment
** Per SDOH 3/4/2013 – Based on 2011 FQHC MCVRs
***Per SDOH 2/28/2013 – Paid visits 2011
****Applies to Federally-Qualified Heath Centers only

The per-member-per-month add-on methodology is currently being used in other health sub-sectors in New York State. Namely, Patient-Centered Medical Homes receive payment incentives in this form for Medicaid patients covered by managed care.[26] Given that Centers provide valuable and critical services for children/youth, they should be granted permission to receive per-member-per-month payment add-ons, as well.

Recommendation: School-based health centers should not be required to complete credentialing and automatically be recognized by managed care organizations as designated providers for specified services.

New York City counties have a total of 21 managed care organizations that can act as third-party payers for medical care. While this variation exists to a lesser extent in upstate counties, completing non-standardized credentialing applications for various managed care entities to ensure third-party insurance reimbursement is a cumbersome, overwhelming, and costly process for organizations with low administrative capacity. Furthermore, beyond the initial process, credentialing requires maintenance beyond the scope of what is reasonable for Centers' slim administrative staffing.

In the state of Michigan, Centers are reimbursed by managed care organizations for services without individualized credentialing and contracts with managed care organizations or prior authorization. Instead, Centers are automatically recognized as designated providers that should be reimbursed for specific services after completing a simplified certification form. This was done for two reasons: (1) to alleviate administrative burden on Centers already contending with low administrative support; and, (2) to ensure that Center providers

[26] http://www.pcdc.org/resources/patient-centered-medical-home/.

could receive reimbursement via managed care for services rendered. For these same reasons, New York State should create a system that mirrors the Michigan model.

Further, New York State could require plans to reimburse Center providers under a fee-for-service methodology. Doing so would avoid potential instances of duplicate payments. Under this system, Center providers would offer care that falls in to two broad categories — services requiring prior authorization, and presumptively authorized services. Preventive and primary care services would require authorization from the patient's plan. Since these services can be scheduled in advance, providers would have sufficient time to obtain authorization before offering care. Ancillary and specialty services, such as reproductive health, dental and urgent care services would not require pre-authorization. Center providers could offer these services to students with confidence that they would be reimbursed by managed care. Such a system would retain the care coordination aspects of managed care that eliminate inefficiencies, while preserving the SBHC comprehensive model of care that has been shown to improve access to and quality of care.

Recommendation: School-based health centers should have a specified designation in managed care that permits them to receive reimbursement.

In order for school-based health centers to receive Medicaid dollars administered by managed care organizations, they need to have a specified designation in the managed care system. Given that they currently receive Medicaid reimbursement outside of managed care, Center providers do not have a designation within managed care that permits reimbursement.

The new designation would be warranted by Center providers meeting specific criteria in order to ensure quality care to children and youth. Namely, Centers would:

- meet specific standards for comprehensive service provision to children/youth;
- report on quality outcome measures pre-determined via negotiations with managed care organizations; and
- effectively integrate with community providers to ensure quality health care.

Other states — namely Michigan and Maryland — with school-based health centers have arranged for Centers to be recognized as designated providers who are entitled to Medicaid reimbursements administered via managed care. This eliminates unnecessary competition for reimbursement between community providers and school-based health centers, allowing each to have a designated role and recognized status within managed care.

Recommendation: School-based health centers need to use a streamlined, centralized billing system.

In order to create a fluid process for reimbursement to providers that optimizes the potential for expeditious processing and revenue generation, New York State needs to create and support a simplified, streamlined, and centralized system that Centers can use to bill managed care organizations. Such a model is successfully used in the state of Michigan and financed by The Kellogg Foundation and the state's Department of Health. This investment by the Kellogg Foundation and the Department of Health is based on the understanding that Centers can better thrive when mechanisms for financing are streamlined and simplified to ensure timely payment and fluid administration.

Given the skeletal budget by which Centers operate, ensuring reimbursements that are timely and adequate is necessary to guaranteeing program viability and sustainability. Such a system could be dual-purposed and also serve as a clearinghouse of information for the State Administration. Data gathered through this tool could provide critical information on how the program can be administered moving forward to ensure optimal, cost-effective care to children and youth.

Recommendations beyond Managed Care

The transition to managed care not only comes fraught with the possibility that Centers could close if steps are not taken to ensure sustained funding streams; it also represents an opportunity to consider how we can use Centers in new and practical ways, ultimately benefitting children, youth, and families in their communities.

Recommendation: School-based health centers should receive funding for specialized care and public health education services.

In addition to offering primary care services, Centers have been long-standing providers of reproductive health services and education, mental health services and dental care. Currently, New York State operates federally-subsidized programs that offer interventions and support for areas related to reproductive health, childhood obesity, substance abuse and mental health. Blending public funds used to finance these programs with the existing monies allocated for Center providers would enhance the statewide budget for these services and create opportunities for Centers and the specialized services to remain viable and whole. Additionally, channeling these specialized services through school-based providers in high need/risk areas achieves the goals of these programs. This model is used in the state of California, whereby government funding for ancillary and specialized care is allocated to Centers that offer the corresponding services.

Recommendation: School-based health centers should designate primary care clinic hours to serve the community, at large.

With the implementation of the Patient Protection and Affordable Care Act (ACA), it is estimated that approximately 1.1 million New Yorkers will be newly insured in Year 2014 and will be seeking medical care.[27] Therefore, it is timely for primary care access points to grow and expand across New York State.

Historically, school-based health centers have provided services to school-aged youth within specified hours and days of the week. Center facilities are typically not used during hours when the school building is closed. Making Centers available to the community, at large, for primary care services would optimize the potential of the facility to serve patients beyond the limitations of school hours, which would create additional revenue and guarantee sustainability. Additionally, creating community access would also meet a growing demand in New York State for expansion of primary care services.

Examining Opportunities for Growth

In 2011, the Patient Protection and Affordable Care Act (ACA) authorized a new program and appropriated $200 million in funding from 2010 – 2013 to address significant and pressing capital needs to improve delivery and support expansion of services at school-based health centers. The U.S. Department of Health and Human Services awarded these funds under the School-Based Health Center Capital (SBHCC) Program in fiscal years (FYs) 2011, 2012 and 2013 to 470 school-based health center programs to create new school-based health center sites in medically underserved areas; and expand preventive and primary health care services at existing school-based health center sites.[28] This investment is intentionally targeted to increase children's access to health services offered at school-based health centers.

[27] Blavin et. al. (2012). The Coverage and Cost Effects of Implementation of the Affordable Care Act in New York State. Retrieved from http://www.urban.org/UploadedPDF/412534-Affordable-Care-Act-in-New-York-State.pdf.

[28] http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf.

These funds are projected to expand services by more than 50 percent and allow for the establishment of new centers and improved infrastructure. Thus far, forty-seven Centers across New York State have been awarded approximately $17 million in such capital expenses.[29] Stakeholders of children's health celebrate action taken by the Obama Administration to invest in Center infrastructure and technology. While these funds are time-limited, they offer an opportunity for investment in infrastructure and new systems that will help the expansion of services statewide.

There is opportunity to leverage these capital investments further. As recommended earlier in this report, Center facilities could be qualified to serve the greater community with primary and ancillary care services during non-school hours (i.e. evenings and weekends). Doing so would not only sustain Centers' viability, it would create a means for growth and expansion. Financing opportunities available to organizations that are working to expand primary care in communities could be blended with school-based health center financing mechanisms to establish more sites across New York State.

Conclusion

In order for school-based health centers to successfully grow and expand, they must first be sustained. Making certain that New York's Centers are financially viable under a Medicaid Redesign is paramount to ensuring that they remain critical access points for children and youth receiving primary and preventive care. Taking the steps necessary to do the following in the environment of managed care will enable Center sustainability:

- Phase in Center transition to managed care;
- Convene workgroup meetings among the State Department of Health, Center providers, and managed care organizations through the implementation process;
- Reinvest Medicaid savings back into Centers;
- Give Centers a specified provider and reimbursement designation within managed care;
- Require that managed care organizations automatically recognize Centers as designated providers;
- Develop a simplified, streamlined billing system.

Beyond the scope of managed care, Centers can generate additional revenue that would further enhance their sustainability by:

- Receiving funding for specialized care and public health education services;
- Designating clinic hours to serve the community, at large.

Funding allotted for capital expenses by the Patient Protection and Affordable Care Act (ACA) is a great example of how investments made to Centers provide the opportunity for improved and expanded facilities, which, in turn, lead to service growth. With continuing investments designated for Centers, there can be more growth and program development.

It is important to note, however, that administering funds to achieve expansion is a pointless act without first securing program viability post-implementation of Medicaid Redesign. Securing funds for operating and program expenses needs to be a top priority. For existing Centers, this needs to be done by ensuring adequate reimbursement for services. For newly established Centers, this can be done by relying on FQHC sponsors to develop new programs in untouched communities across New York State given their existing sustainable model.

CDF–NY firmly stands on the notion that all children deserve the right to affordable, quality, and comprehensive health care. School-based health centers are a mechanism for children's access to such care. Therefore, their sustainability and growth is priority in order to ensure that youth in communities are provided with the resources to be healthy and productive students who can thrive academically and socially.

We encourage all stakeholders of children's health to endure and stand in support of school-based health centers as they face this crossroads in financing. As stakeholders, we have a responsibility to support valuable services and programs that enrich the lives of our children and promote their well-being.

Appendix A

California

Analogous to New York, California has a large statewide SBHC program inclusive of 191 sites. When looking to build a fiscally sustainable school-based health program in New York, examining what works in California is an important step.

The most common organizations serving as the health care providers and sponsors of Centers in California are federally-qualified community health centers and school districts. Other sponsoring organizations include county health departments, hospitals/medical centers, mental health agencies, nonprofit community-based organizations and private physician groups.

Children and youth treated in Centers that are sponsored by federally-qualified community health centers can opt for the Center provider to be their designated primary care provider. The potential that these Centers have to be the designated primary care providers for children and youth gives Center providers recognized designation in the managed care system.

California's model also offers potential reimbursement for specialized services. Most recently, a bill has been drafted to provide reimbursement for services to children impacted by trauma. Additionally, their Family PACT Program provides funding for the delivery of reproductive health services. These additional funding streams designated for specialized health services enhance the program's fiscal viability and ensure an array of services beyond primary care.

> **Best Practice:** *Government funding for specialized care via the Family PACT Program is allocated to school-based health centers that offer designated services.*

Maryland

A large cohort (90%) of children and youth who are enrolled in school-based health centers are also enrolled in HealthChoice – the state's mandatory Medicaid managed care program. These enrollees may self-refer themselves to school-based health centers for specified services. These services are eligible for reimbursement from managed care organizations. The specified services include "diagnosis, treatment, and uncomplicated follow-up (limited to one follow-up visit) of acute or urgent somatic illness, and related prescribing of medications; and family planning services." Center providers are then required to refer the student to his or her primary care provider.

Given this regulation in the state of Maryland, all managed care organizations reported that they reimburse Centers at the Medicaid fee schedule rate for all required self-referred services. These regulations, however, do not preclude managed care organizations from contracting with Centers to provide services to managed care enrollees in addition to those allowed on a self-referral basis.[1]

Best Practice: *School-based health centers can receive reimbursement for designated health services by managed care organizations without contract or prior authorization.*

Michigan

Michigan Medicaid Services Administration allows for reimbursement by managed care organizations to Centers for services without contract or prior authorization. Centers do not need to be the primary care provider to receive reimbursement for primary care or mental health services rendered to a child. All state funded centers bill Medicaid and private insurance for services rendered, but no child is turned away if they are uninsured or for a confidential service. The state association provides access for centers to a streamlined, centralized billing and practice management system financed originally with grants from the Kellogg Foundation, the Department of Community Health, and Blue Cross Blue Shield of Michigan. Additionally, state funding for centers is federally matched by Medicaid through a waiver to CMS to provide outreach and enrollment assistance for eligible but uninsured children to enroll in Medicaid or the Child Health Insurance Program (CHIP). The primary sources of revenue for centers in Michigan come from billing managed care and private insurance, state funding which is federally matched, and private support including philanthropic, donated space from schools, and community benefit from health systems.

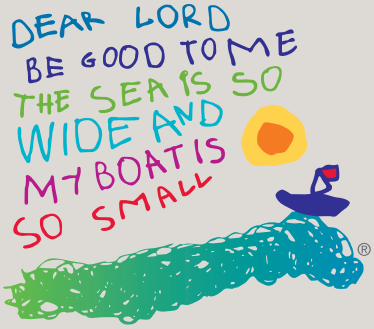
Best Practice: *School-based health centers can receive reimbursement by managed care organizations without contract or prior authorization.*

Best Practice: *School-based health centers use a streamlined, centralized billing system for all billing claims, which enables them to receive payment fluidly from managed care plans.*

Appendix B.
List of Organizations and Types of Sponsorship

Organization	Sponsorship Designation	Organization	Sponsorship Designation	Organization	Sponsorship Designation	Organization	Sponsorship Designation
Bedford Stuyvesant Family Health Center, Inc.	FQHC	Institute for Family Health	FQHC	New York Presbyterian Hospital	Hospital	Staten Island University Hospital	Hospital
Bellevue Hospital Center	Hospital	Jamaica Hospital Medical Center	Hospital	North Country Childrens Clinic	FQHC	Syracuse Community Health Center	FQHC
Brook-haven Memorial Hospital Medical Center	Hospital	Kaleida Health	Hospital	Northern Oswego County Health Services, Inc.	FQHC	The Resource Center	FQHC
Brooklyn Plaza Medical Center, Inc.	FQHC	Long Island Jewish Medical Center	Hospital	Open Door Family Medical Center	FQHC	Threshold Center for Alternative	DTC
Brownsville Multi-Service Family Health Center	FQHC	Lutheran Medical Center	FQHC	Queens Hospital Center - Queens Health Network	Hospital	United Health Hospitals, Inc.	Hospital
Carthage Area Hospital		Mary Imogene Bassett Hospital	Hospital	Renaissance Health Care	FQHC	University of Rochester	Hospital
Childrens Aid Society	DTC	Middle-town Community Health Center	FQHC	Research Foundation of SUNY	Hospital	Upstate Cerebral Palsy, Inc.	DTC
East Harlem Council for Human Services, Inc.	FQHC	Montefiore Medical Center	Hospital	Rochester General Health System	FQHC	Urban Health Plan, Inc.	FQHC
East New York Diagnostic & Treatment Ctr.	DTC	Morris Heights Health Center	FQHC	Saint Elizabeth Medical Center	Hospital	Whitney M. Young, Jr. Health Center, Inc.	FQHC
Elmhurst Hospital - Queens Health Network	Hospital	Morrisania Diagnostic & Treatment Center	DTC	Saint Josephs Hospital	Hospital	William F. Ryan Community Health Center	FQHC
Family Health Network of Central New York, Inc.	FQHC	Mount Sinai Hospital	Hospital	Saint Lukes-Roosevelt Hospital Center, Inc.	Hospital	Winthrop University Hospital	Hospital
Glens Falls Hospital	Hospital	Mount Vernon Neighborhood Health Center	FQHC	Saint Regis Mohawk Tribe Health Services	FQHC	Woodhull Medical & Mental Health Center	FQHC
Heritage Health Care Center	FQHC	Nassau Health Care Corp.	Hospital	Sisters of Charity Hospital	FQHC		

Key of Terms: **FQHC** = Federally Qualified Health Center **DTC** = Independent Diagnostic & Treatment Center



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