A Guide for School-Based
and School-Linked
Health Centers

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VOLUME VI

Introduction to
Managed Care

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VOLUME VI

Introduction to Managed Care

by

Donna Zimmerman, M.P.H.

ACKNOWLEDGMENTS

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CHAPTER 1:
INTRODUCTION

The school-based health center movement has grown significantly from only 40 centers in the early 1980's to 948 in 1997. (Fothergill, 1998) Designed to provide confidential, convenient, and comprehensive medical, mental health, and health education services on school grounds, school-based health centers (SBHCs) are valued for their ability to improve access to health care for children and youth. Now a recognized model of care, SBHCs must make themselves a fundamental part of the nation's health care system if they are to sustain themselves over time.

Securing funding is the primary challenge to institutionalizing SBHCs as a fundamental part of today's rapidly changing health care system. SBHCs' early reliance on funding from private foundations has been replaced over the years by increased reliance on public sources of funding, including federal Title V funds, state budgets, and local tax initiatives. More recently, SBHCs have begun to bill third party payers, including state medical assistance programs, insurance companies, and health maintenance organizations. Although third party revenue provides only a fraction of most SBHCs' budgets, program administrators are keenly aware of its importance. Many public and private funding sources require health centers to draw upon third party insurance payers prior to receiving grant funding. For some SBHCs, revenue from third party sources provides up to 20 percent of their budgets and is an important component of the total funding profile. In the future, as more students are covered through managed care, SBHCs' success at third party billing will depend largely on the ability of the health centers to work within the country's growing managed care system.

Managed care—including both health maintenance organizations (HMOs) and preferred provider organizations (PPOs)—experienced exponential growth during the time when the SBHC movement also grew. With its emphasis on prevention and cost reduction, managed care is now the premiere vehicle for health care delivery across the United States. Furthermore, the movement of state Medicaid programs into managed care has implications for SBHCs and other providers which serve Medicaid recipients.

SBHCs are now struggling to define their niche within this system. Most of the successful relationships, formed in the past several years, have been contractual agreements—between managed care organizations (MCOs) and the organizations that sponsor SBHCs—to serve the students who are members of health plans and also SBHC clients.

This volume of *The Guide to School-Based and School-Linked Health Centers* aims to help SBHC administrators gain a general understanding of managed care and learn to negotiate successful relationships with MCOs. It offers a thorough introduction to managed care concepts and terminology, and it provides guidance on establishing contractual relationships with MCOs. It also includes glossaries, a bibliography, and a listing of selected sources of information.

Introduction to Managed Care is designed to complement the five earlier volumes in the series. The first five volumes, also available from Advocates for Youth, provide guidance on SBHC advocacy, implementation, sources of federal funding, evaluation, and legal issues.

Background on School-Based Health Centers

During the late 1960's, increasing rates of adolescent pregnancy, substance abuse, sexually transmitted diseases, and other health problems among adolescents prompted health care professionals and policy makers to consider ways to improve health care for teens. Realizing that adolescents under used the traditional health care system because services were not confidential, convenient, comprehensive, affordable, or age-appropriate, community planners began to seek non-traditional approaches to adolescent health care.

SBHCs emerged as a promising model for improving adolescents' access to health care. The first SBHCs—established in Dallas, Texas, and St. Paul, Minnesota, during the late 1960's and early 1970's—began with a vision of increasing adolescents' access to health care while reducing teen pregnancy. Popular for their ability to deliver comprehensive primary care and counseling services in underserved communities, SBHCs quickly expanded beyond urban high schools to serve primary and middle schools in rural and suburban communities. Over the past 25 years, SBHCs have expanded services beyond reproductive health care to include primary care, health education, and behavioral health services. The most common sponsors of SBHCs are community health centers, health departments, hospitals, other health agencies, and, in a few cases, school districts.

Schools welcome SBHCs as guests because improving the health status of students is likely to improve school attendance and educational outcomes. The SBHC's multidisciplinary team collaborates with school staff to ensure coordination of care and prevent disruption of school systems. SBHCs are usually supported by multiple health care grants; education funds are seldom used for SBHCs' health services. School district contributions to SBHC operations normally come in the form of in-kind support, such as donated space or shared staff.

Extensive evaluation data indicate that health centers increase access to health care for adolescents and improve their use of services. For example, one study found that SBHCs improved students' health knowledge and increased their use of health care, especially among students with little other access to health care and/or with a greater need for health care. (Kisker, Brown, 1996) A study in nine SBHCs found that providing teens with school-based primary care resulted in increased use of some health services—including sports physicals, treatment for minor illnesses, and counseling—as well as decreased use of emergency rooms and fewer hospitalizations. (Santelli, Kouzis, 1996) In recognition of the ability of SBHCs to improve students' access to comprehensive services, more and more communities are establishing these centers across the country.

Review of School-Based Health Care Financing

SBHCs receive funding from a combination of private and public sources. As the number of private foundation grants decreased during the 1990's, SBHCs increased their reliance on public funds from federal, state, and local sources. According to a 1997 survey by Advocates for Youth, the three top funding sources reported by SBHCs were Medicaid, the Maternal and Child Health Block Grant, and the Early and Periodic Screening, Diagnostic, and Treatment program (EPSDT). Other sources of funding used by SBHCs included: preventive health and health services block grants, social services block grants, Special Projects of Regional and National Significance (SPRANS), elementary and secondary education funds, Indian Health Service funds, state and local funds, contributions from corporations and charities, and private insurance. (Fothergill, 1998)

In the early years of the movement, SBHCs seldom sought third party reimbursement for services. Since then, billing has been limited for several reasons. First, many SBHC users have neither private insurance nor Medicaid. Second, Medicaid benefits may not cover comprehensive services for children and adolescents. Third, most private insurance plans do not cover the preventive or counseling services which constitute a substantial portion of SBHC services. Finally, some SBHCs have not billed when the administrative costs of billing may be higher than the revenue collected. Despite these barriers, more than half of SBHCs are now billing Medicaid and other third party payers for services to enrolled students. Respondents to Advocates' latest survey reported, however, that on average, only 12 percent of their budgets came from third party billing. (Fothergill, 1998)

In the 1990's, state governments have played an increasingly important role in financing SBHCs. In addition to providing grants and other funding, many states have encouraged Medicaid reimbursement for SBHC services. While states have also moved with increasing speed to cover their Medicaid beneficiaries through managed care programs, some states are now working to encourage and facilitate strong relationships between SBHCs and MCOs as part of their Medicaid managed care programs. For example, in 1998, New York began requiring MCOs serving Medicaid populations to contract with SBHCs. State strategies for linking managed care and SBHCs are highlighted on the next page.

Similar efforts at local levels permit individual SBHCs and MCOs to develop operating agreements. Negotiating an operating agreement is challenging in that it involves finding agreement on several issues including mission, scope of services, coordination of care, communication systems, confidentiality protections, and reimbursement. Some SBHCs may find that their student clients are insured by different MCOs, requiring negotiations and sustained relationships with several MCOs simultaneously. Other SBHCs, which have no significant proportion of students insured through MCOs, are uncertain as to the value of working to develop and maintain these relationships. SBHCs in St. Paul, Boston, Denver, Multnomah County in Oregon, Stockton, and New York City have developed local approaches to contracting with MCOs. (Brellochs, Zimmerman, Zink, *et al.*, 1996; Zimmerman, 1998) Others follow state mandates when and as they are implemented.

**State Strategies for Linking SBHCs
with Managed Care Plans**

- Medicaid requests for proposals (RFPs) requiring contracts with SBHCs

- Development of model contracts

- Permission for MCO members to seek care from SBHCs without pre-authorization

- Financial incentive plans

- Statutes that require MCO action plans regarding adolescents

- Facilitative activities, such as state-sponsored meetings

- Development of common data exchange forms

- Accountability measures for SBHCs

- Drafts of benefits packages for SBHCs.

Source: Making the Grade, 1995

As managed care continues to expand in the United States, the SBHC's ability to negotiate a role within the managed care environment will largely determine the SBHC's ability to sustain itself. SBHCs must demonstrate that they provide a unique community service and meet the needs of a particular population. Gaining recognition by MCOs will allow SBHCs to obtain reimbursement for services and to establish their niche in the health care system.

Experience to date suggests that the SBHC is usually the initiator in discussions with MCOs. In planning such discussions, the SBHC will need to develop a plan to educate the MCO about the SBHC's services. In addition, the SBHC must understand as much as possible about the MCO and the local health care environment. The following pages should provide a better understanding of MCOs and the potential offered by a relationship between an SBHC and an MCO.

CHAPTER 2:
OVERVIEW OF MANAGED CARE

Managed Care Trends and Issues

Managed care is now a dominant force in health care services and financing in the United States. The term, **managed care**, refers to the blending of financial control and health services delivery to a specified set of individuals (or members) within a specified network of providers. Managed care emphasizes managing health services at the primary care level, controlling costs through financial arrangements with providers, and promoting good health in members. Managed care's objectives are to reduce unnecessary use of services, to lower health care costs, and to improve access to and quality of services.

The most popular form of MCO is the HMO. HMOs are typically paid a **capitated**, or monthly, fee from the purchaser to provide an enrollee with most medical services, which are usually coordinated through primary care physicians. Purchasers of health care services, such as employers or government, determine the **scope of benefits**, the services to be included in the package (or product). Fees paid to the HMO are negotiated between the HMO and the purchaser.

This model, with its fixed, prospective payment for a defined set of services, places the MCO **at risk** for all of the health care needed by enrolled members, regardless of the actual cost of providing those services. It creates an incentive for the HMO to provide preventive and primary care and to provide only needed medical services. Since this prospective payment mechanism also creates a disincentive to provide services, managed care involves an extensive array of mechanisms to ensure that the consumer receives high quality services. MCOs are also regulated by federal and state governments to ensure consumer protection and compliance with laws.

Another major managed care model is **fee-for-service** primary care case management (PCCM). In a PCCM plan, a provider—usually the patient's primary care physician—acts as a **gatekeeper**, approving and monitoring services to the patient. The gatekeeper assumes no financial risk for the provision of services and is paid a per-patient monthly case management fee.

Managed care gained popularity in the 1980's when purchasers, both private and public, began to look to various types of managed care organizations to help control costs. Following demonstration programs in the early 1990's, states began to move Medicaid beneficiaries into managed care programs.

In a large measure, MCOs meet the challenge of serving their members. MCOs have also improved access for vulnerable populations. As the nation enters the 21st Century, more public program enrollees—such as persons with disabilities and those institutionalized for long-term care, who were previously **carved out*** of many state managed care programs—will be moved

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*A **carve out** is an arrangement in which the purchaser of health care services (e.g., state or employer) contracts separately with providers for those specific, chosen services. In other words, this care is not included in health services contracts with MCOs and payment for the separate (carved out) services is also handled separately.

"Managed care" refers to the blending of financial control and health services delivery to a specified set of individuals (or members) within a specified network of providers.

into managed care arrangements. The public Child Health Insurance Program (CHIP), will also use managed care to extend coverage to more children. As these programs grow, MCOs will look for partnerships with organizations that can help them deliver health care to special populations.

HMOs are typically paid a capitated, or monthly, fee from the purchaser to provide an enrolled member with most medical services, which are usually coordinated through primary care physicians.

Issues for Managed Care Organizations and Implications for SBHCs

- Increasing regulatory supervision of MCOs for mandated benefits and provider inclusions —
  Will this help SBHCs? Will mandated benefits include services provided by SBHCs?

- Increased MCO monitoring by state and local governments of services for publicly funded enrollees, such as Medicaid participants —
  How will the states ensure that the needs of adolescents and children are being met?

- Regulatory oversight for fraud/abuse —
  Can the SBHC meet all provisions relating to billing and encounter data?

- Consumer protection provisions —
  How will the SBHC balance consumer protection and privacy for young clients with its interest in receiving reimbursement for confidential and sensitive services?

- Competition based on quality and cost among plans and providers —
  Is this an opportunity for the SBHC to help an MCO achieve quality measures?

- Movement of the private market into self-insured arrangements**—
  Since regulatory protections for providers do not apply to self-insured plans, how will SBHCs work in an environment without regulation?

While this list is not exhaustive, it illustrates the need for planners to understand some of the issues that affect the MCO / SBHC relationship. These issues will affect the negotiations and operations of contracts.


**When the employer directly assumes the risk for all of its employees' health care services, regulations that protect providers or mandate benefits for enrollees do not apply. Thus, in states where some services offered by SBHCs must be covered by MCOs, the regulatory mandate will not extend to SBHC enrollees whose coverage is through self-insured plans.

Introduction to Managed Care

Medicaid Managed Care

State Medicaid agencies around the country have turned to managed care programs as a potential solution to the spiraling costs of traditional state Medicaid fee-for-service programs and as a means to increase access to care for low income and vulnerable populations. Medicaid expenditures in 1996 reached $160 billion—nearly quadrupling fiscal year 1986 expenditures.

Medicaid managed care programs are experiencing exponential growth as a result of this movement. The percentage of Medicaid enrollees in managed care programs across the country increased from 9.5 percent in 1991 to 47.8 percent in 1997. As of June 30, 1997, 15.3 million Medicaid enrollees were in some form of managed care. By emphasizing prevention and primary care, MCOs aim to improve the health of Medicaid beneficiaries and control health care costs. (Henry J. Kaiser Family Foundation, 1998)

In primary care case management (PCCM) plan, the patient's primary care provider acts as a gatekeeper, approving and monitoring services to the patient.

Percentage & Numbers of Medicaid Beneficiaries Enrolled in Managed Care

1991	1992	1993	1994	1995	1996	1997
9.5%	11.8%	14.4%	23.2%	29.4%	40.1%	47.8%
2.7*	3.6*	4.8*	7.8*	9.8*	13.3*	15.3*
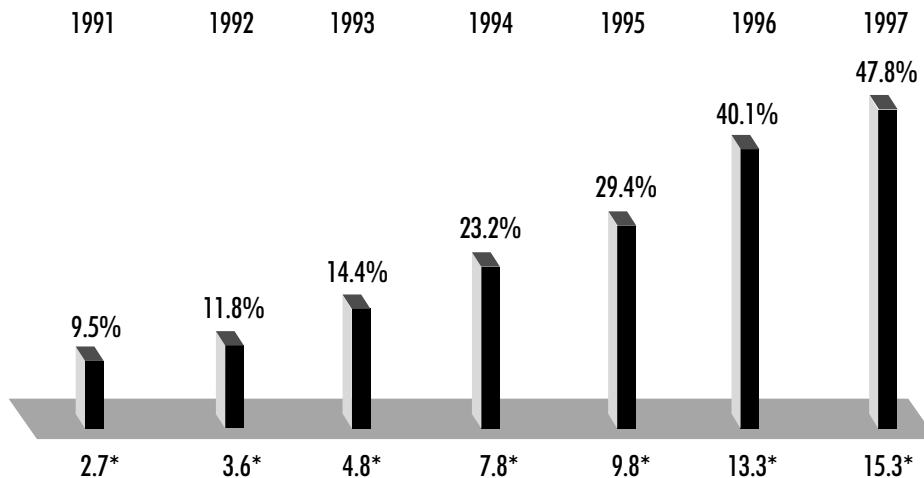
*Numbers in millions, Medicaid beneficiaries enrolled in MCOs.
Source: Henry J. Kaiser Family Foundation, 1998

In order to create Medicaid managed care programs, states must secure a 1915(b) freedom of choice waiver or an 1115 research and demonstration waiver from the federal government. These Medicaid waivers, obtained by states from the Health Care Financing Administration (HCFA), exempt states from some federal statutes and regulations that would otherwise hinder their efforts to create Medicaid managed care programs. Nearly all 50 states have either a 1915(b) waiver or an 1115 waiver, allowing flexibility to enroll Medicaid populations into managed care programs. (Henry J. Kaiser Family Foundation, 1998)

> The Balanced Budget Act of 1997 gives states new authority to mandate enrollment of Medicaid beneficiaries in MCOs without first obtaining a federal waiver—except for children with special needs, Medicare beneficiaries, and Native Americans. The law requires plans to demonstrate adequate capacity, including an appropriate range of services and access to preventive and primary care services as well as a sufficient number, mix, and geographic distribution of providers. (Henry J. Kaiser Family Foundation, 1998)

A common model for states implementing Medicaid managed care is to contract with full risk HMOs for Medicaid services. The health plans are at full risk for all services and receive a prospective payment per member, per month. Rates are based on actuarial tables, and the HMO provides the same benefits as those covered in the state's fee-for-service Medicaid program. On the other hand, some states employ a PCCM model for Medicaid managed care. The PCCM provider refers enrollees for necessary services and receives a fixed amount for case management. Providers bill for individual medical services on a fee-for-service basis.

A Review of State Medicaid Managed Care Systems

State and local health officials can help SBHCs integrate with managed care systems. States can develop policies that require or encourage health plans to contract or coordinate with SBHCs. Some states have regulations that foster relationships between MCOs and SBHCs. Health Systems Research looked at waiver applications submitted to HCFA by state Medicaid agencies and grouped state protective provisions into four broad categories.

States may:

- **Require Contracts**—Using either waiver applications or Medicaid contracts with health plans, states may require plans to *contract* with SBHCs in their service area. States may require that MCOs contract for all Medicaid-eligible services provided by the center or may specify certain services.

- **Require Coordination**—States may require health plans to *coordinate* with SBHCs and may permit flexibility in the extent and form of the relationship.

- **Encourage Coordination**—Contracts with health plans may simply *encourage* plans to coordinate or work with SBHCs.

- **Make No Requirements**—States may not address the issue at all.

Source: Schwalberg, Hill, 1995

MCO Contracts with SBHCs

When the SBHC is a legal entity, the MCO may contract directly with it.

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│  MCO  │────────────────┼───▶│   SBHC   │
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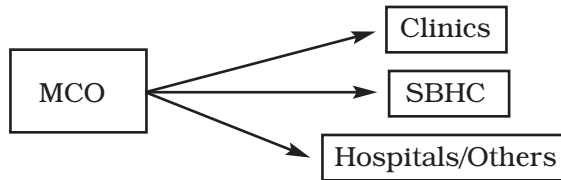
The MCO contracts directly with the sponsoring organization of the SBHC.

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┌───────┐     ┌───────────────┐     ┌────────┐
│  MCO  │────▶│  Sponsoring   │────▶│  SBHC  │
└───────┘     │ Organization  │     └────────┘
              └───────────────┘
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Even when SBHCs are not explicitly cited in regulations for contracts or coordination with MCOs, sponsoring organizations of SBHCs may have just such regulatory protection. For example, Minnesota health plans must offer contracts to community health centers and local public health agencies for Medicaid services. Health plans must also submit a collaboration plan and an action plan to the Minnesota Department of Health, outlining the health plan's activities to serve high risk populations and to collaborate with local public health agencies to achieve public health goals. These requirements provide opportunities for relationships between managed care organizations and SBHCs.

Regulations will not alleviate the need to work with MCOs and to negotiate mutually beneficial contractual relationships. Mandating a contract does not define the content or desirability of the contract. An SBHC might be offered a contract that has terms with which it cannot comply or that fails to meet regulatory requirements. Since states place the HMO at financial risk for health care services, states are unlikely to mandate details of contracts between an HMO and its providers.

CHAPTER 3:
EXPLORING POTENTIAL RELATIONSHIPS WITH MCOs

Fundamentals of Relationships with MCOs

The Benefits and Limitations of Working With MCOs

Any agreement has a cost-to-benefit ratio. SBHC administrators may want to consider the pros and cons of establishing working relationships with MCOs. Some common benefits and limitations—from the perspective of an SBHC administrator—appear below.

Benefits of Working with MCOs

- Increased revenue
- Enhanced sustainability
- Improved ability to meet requirements for billing third party sources
- Improved encounter reporting and accountability
- Enhanced coordination of services
- Less duplication of services
- Improved patient care processes through health plan's continuous quality management (CQI) programs
- Partnering on issues important to the SBHC

Drawbacks of Working with MCOs

- Limited revenue as a percent of budget
- Administrative costs for billing
- Differing expectations
- Potential for billing errors
- Potential compromise of student confidentiality

Relationship Options

Great potential exists to serve children and adolescents when SBHCs and MCOs work together. While the development of contractual relationships for health care services is important, SBHC administrators should consider different kinds of partnerships with MCOs—ranging from working almost entirely separately to a formal, signed agreement between the two.

Managed Care—SBHC Relationships

	No Relationship	
MCO	Coordination Collaboration Funding Relationship Formal Agreement	**SBHC**
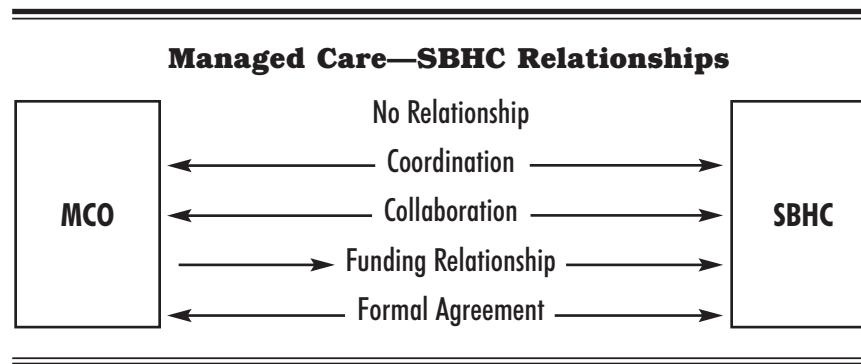
No relationship with an MCO may be best for a particular SBHC. For example, no relationship between the MCO and SBHC may be necessary if they have few common interests or responsibilities, if funding is not available, or if the SBHC will not bill for services. Analysis of immediate and long-term goals will determine whether the SBHC may benefit from relationships with MCOs. Does the SBHC expect a funding partner or a collaborator? Does it want a contractual agreement? What will the SBHC expect from the relationship in five years? In ten years?

Coordination exists when both parties are willing to share some information and to coordinate services. There is no monetary exchange. However, both parties reap advantages from exchanging information. Coordination may minimize duplication of services and may establish a basis for working together in the future. An SBHC's inviting a health plan representative to be on its community advisory committee is one example of coordination.

Collaboration exists when both parties provide resources toward a specific purpose. For example, an MCO or MCOs might collaborate with an SBHC on a smoking cessation program. The MCO could provide training and materials while the SBHC staff implements the program in the school. Mutual accountability for resources and the satisfaction in working toward a shared goal are two advantages of collaboration. Successful collaborations may lead to other such efforts. One collaborative effort is *School Connections*, in which Kaiser Permanente in Denver and the Denver Health and Hospitals' SBHC program collaborate to offer primary care services in SBHCs to uninsured children in Denver. (Guiden, 1998)

Funding relationships resemble grant programs. For example, an MCO may offer a specific grant for a specific purpose, including starting an SBHC. Indeed, many health plans establish foundations to provide community grants. Funding relationships can also include in-kind support. Advantages to the health plan may include good public relations, supporting a health initiative, or serving a hard-to-reach population. Although the funding relationship is temporary and seldom continues over time, the SBHC acquires cash needed for an activity. For example, four Twin Cities health plans provided funding for the start-up phase of the Andersen School Health Center in Minneapolis. (Brellochs, Zimmerman, Zink, *et al.*, 1996)

Formal agreements involve contracts between the MCO and the SBHC or its sponsoring organization. Contractual agreements outline what is expected by each party and how parties will be reimbursed for services, such as direct

patient care. The advantage of contracts is that they provide funding and endure over time. Health Start in St. Paul, Minnesota, and the SBHC program in Multnomah County, Oregon, have formal agreements with MCOs, whereby health plan members receive services in SBHCs, and the health plans pay SBHCs for this care. (Brellochs, Zimmerman, Zink, *et al.*, 1996) Much of the remainder of this volume addresses issues of contractual agreements.

Relationships with MCOs need not be viewed as a one-way continuum. SBHCs may develop more than one type of relationship with the same plan for different activities or they may have different relationships with different MCOs. The relationship models are offered to help the SBHC administrator consider the most effective, long- and short-term relationships. The most important point is that relationships between MCOs and SBHCs offer rich possibilities for improving the health of student populations.

Considerations in Developing Managed Care Contract Relationships

The structure of SBHC/MCO relationships varies considerably across states. Administrators must understand the overall managed care environment in the state and community as well as regulatory provisions and market trends before they begin negotiations with health plans. Much of the information presented here will apply to managed care contracting both for commercially enrolled members and for state public program (*i.e.*, Medicaid) participants. Since most SBHCs serve more students receiving medical assistance than students who are commercially insured, this volume places more emphasis on the elements of contracting for Medicaid services.

SBHC administrators usually feel an interest in developing relationships with MCOs because the SBHC loses revenue if it is unable to contract and bill for services. Consequently, administrators usually emphasize negotiating a formal contract for payment of services. When the prospective relationship will be primarily contractual, SBHC administrators should first consider the following questions:

- What percentage of SBHC users are enrolled in MCOs? What percentage are enrolled in the targeted MCO?

- What are the relative percentages of insured and uninsured users among the SBHC's clients?

- What plans has the state for enrolling Medicaid recipients into managed care plans? Will the state use the 1115 waiver, CHIP, or other provisions?

- Will failing to pursue a contractual relationship have a financial impact on the SBHC?

- What relationships currently exist between the SBHC's sponsoring organization and managed care plans?

- Does the state provide any regulatory protections to SBHCs or sponsoring organizations? For example, must MCOs include certain providers in their network?

- Does the SBHC offer a comprehensive array of primary care services?

- Does the SBHC play a significant role in primary care for children and/or adolescents in the community?

- How many health plans are targeted?

- What is the market share of each health plan in the student population?

- What are the current utilization patterns for health plan members who are SBHC clients?

SBHCs most commonly enter into contractual relationships to serve Medicaid recipients when states plan to move them into managed care. Since Medicaid revenue is an important funding source for SBHCs, an SBHC lacking contractual agreements with participating MCOs might find its continued existence in jeopardy.

CHAPTER 4:
GETTING STARTED

SBHCs should undertake a number of activities in preparation for contracting with health plans. One of the first of those activities is identifying SBHC staff—the internal managed care team— who will work with the MCO on behalf of the health center. For example, an internal managed care team might include the clinic or medical director, the lead specialist in mental health services, and staff responsible for billing/finance. The SBHC's sponsoring organization will probably identify one person—such as the clinic executive director, finance/business manager, hospital managed care liaison, or public health agency director—who will directly negotiate with the MCO or MCOs.

The internal managed care team should comprehensively assess the SBHC's internal and external environment for managed care contracting. Gathering this information is critical for understanding the SBHC's opportunities and capacity for working in a managed care environment.

External Assessment

Understanding the external (managed care) environment is the purpose of the external assessment which identifies regulations, participating MCOs, populations served by the MCOs, and special requirements of specific programs, such as Medicaid. A checklist is provided on the next page.

Since one primary interest of the SBHC will be in contracting for medical assistance services, the team should obtain a copy of the state's 1115 waiver— the state's blueprint, submitted to HCFA, for enrolling Medicaid recipients in managed care. The 1115 waiver will identify essential state requirements and program structures. Waivers contain a wealth of information, including provisions relating to *essential community providers*, state reporting requirements, benefits, and how EPSDT will be delivered. Waivers also note any services or special populations specifically excluded from managed care, or *carved out*. These *carved out* services or groups will remain in the fee-for-service Medicaid system. SBHCs which are sponsored by a Federally Qualified Health Center (FQHC) should note provisions relating to cost-based reimbursement for services provided to Medicaid recipients.

The team should also acquire and thoroughly understand the state's RFP for Medicaid managed care plans and any existing state contracts with managed care to serve Medicaid enrollees. The RFP and/or contracts will delineate those services for which the state is or will contract. The exact set of services depends upon what services the state covers under Medicaid and whether a service *carve out* exists, such as behavioral health care or EPSDT services. These *carved out* services may be subcontracted to other providers, be left in the fee-for-service program, or be administered by the state. Carved out groups or services may be significant for SBHCs. For example, the SBHC may need to have contracts with MCOs and subcontractors as well as bill the state under fee-for-service.

External Assessment Checklist

❑ Identify relevant regulations.

❑ List participating MCOs.

❑ List populations served by MCOs.

❑ Note any special Medicaid requirements.

❑ Note special requirements of other special programs.

❑ Review documents such as the Medicaid waiver, the state's RFP, and current contracts between the state and MCOs.

Using the following questions, include information about area MCOs.

❑ What is the primary care network for the plan? Where are the primary care providers located?

❑ Who are the plan's specialist providers and which hospitals does it use?

❑ What network has the plan for behavioral health services? Are the services provided by an identified group of behavioral health providers? How do members access these services? Do members need a referral?

❑ Does the plan require each member to select one primary care provider to manage his/her health care services *(closed panel)*, or can members go to any provider in the network *(open access network)*?

❑ Does the plan have contracts with any public health or community clinics in the SBHC's service area?

❑ How is the plan structured? Is it a staff model health plan in which the physicians are hired directly by the health plan, or is it a health plan with affiliated, or contracting, physicians?

❑ How does the health plan normally reimburse providers for primary care services?

State/MCO contracts for medical assistance will contain information about possible requirements that health plans contract with certain types of providers, such as community clinics, public health agencies, and SBHCs. Even when SBHCs are not specifically cited in a ***must contract*** provision, the sponsoring organization for the health center may be. These contracts may also extend various incentives to MCOs for contracting with community-based providers.

Further, state/MCO contracts include reporting and performance requirements which the team must thoroughly understand. The SBHC may be able to assert its ability to help the health plan comply with these requirements. For example, the contract may require health plans to demonstrate progress toward a threshold of 80 percent EPSDT participation. SBHCs can help the MCO meet this requirement. Contracts also contain other requirements pertaining to quality assurance.

Internal Assessment

The SBHC's internal assessment will reveal its capacity to engage in a contractual relationship with an MCO. A major component of the internal assessment pertains to the SBHC's information systems and financial management capability. SBHCs which are able to bill third parties and have billed for Medicaid services should already have most of the needed systems. The team should begin its internal assessment by completing the checklist provided on the next page.

The SBHC will need a program capable of basic billing per encounter and tracking utilization data by diagnoses and CPT (current procedural terminology) codes. The system should be able to produce bills on standard forms, such as the HCFA 1500, and to track information by payer. Most MCOs accept, and some require, electronic submission of claims.

The managed care team should evaluate the cost/benefits of hiring or training staff and investing in a billing system vs. contracting with a billing service company. Often, the SBHC's billing can be done by the sponsoring organization.

Some types of reimbursement, such as capitation, require additional information. The SBHC team will need to capture the costs of providing services to enrollees. Then, the SBHC's accounting and information system will need to allocate costs so that the SBHC can identify the total costs associated with providing specific services on a per unit basis. Also important is the ability to track revenues by payer, including self-pay, private insurance, and managed care plans. Before the SBHC and its sponsoring organization enter any contract negotiations for rates, the center needs to know whether current fee-for-service reimbursement will cover the cost of providing individual services. Without this information, the SBHC cannot determine whether to accept capitated payment for services. If information is not available on the total per unit costs of providing services, the SBHC administrator should immediately retain the services of an accountant or other qualified financial management expert to analyze existing cost information and to recommend a software package to support billing/cost accounting.

Internal Assessment Checklist: Is Your SBHC Program Ready for Managed Care?

What is the current scope of primary care services available in your health center?

Do you currently bill for services rendered in the health center?

If yes, for which services do you bill?

- ❏ Primary care?
- ❏ Reproductive health care, including confidential services?
- ❏ Preventive health care services?
- ❏ EPSDT screenings?
- ❏ Immunizations?
- ❏ Mental health care?

Does the financial/billing staff have current knowledge of third party reimbursement procedures?

Is your billing system automated? Can you make electronic submissions?

Do you know the insurance status of all SBHC users?

Are you able to obtain information on primary care clinic selection for students?

What percent of users are covered by Medical Assistance?

Does SBHC staff meet the criteria necessary for credentials?

- ❏ Physician?
- ❏ Nurse Practitioner?
- ❏ Physician's Assistant?
- ❏ Social Worker?
- ❏ Psychologist?

Who is responsible for case management? Who monitors referrals?

Does the SBHC have an identified Medical Director?

Is the CLIA (Clinical Laboratory Improvement Act) registration up to date?

Does the SBHC have an established quality improvement program and audit schedule?

Can you identify your cost per unit of service?

Contract Negotiation Objectives

The SBHC should establish its overall objectives for the negotiations with the MCO and clarify what will constitute a successful arrangement. In addition to specific language relevant to the individual SBHC, the sponsoring organization may prioritize the following objectives:

- **Negotiating for provision of all of the SBHC's services.** Ideally, the contract will permit some payment for services that are not usually billable, such as group counseling and education. However, the contract should include, at a minimum, all billable services. Contracting for a smaller subset of SBHC services—such as, EPSDT exams only—limits potential reimbursement and creates administrative difficulties.

- **Negotiating for both Medicaid and commercially insured members.** Negotiations with health plans that serve both commercially insured and Medicaid members should be for services to all covered members. Initially, health plans may be more interested in contracting for services to Medicaid members due to the SBHC's ability to help the health plan fulfill its requirements to serve the Medicaid population. Service to commercially insured members raises questions, such as whether the purchaser of insurance chose services that the SBHC offers, whether billing may compromise student confidentiality, and how the SBHC will fit into the network. The SBHC's negotiator should focus initially on the type of coverage common to the largest number of student users, which is often Medicaid.

- **Protecting student confidentiality.** The confidentiality of adolescents who are seeking sensitive services in the SBHC must be protected even when the SBHC exchanges information with the MCO. The SBHC must understand how claims data are handled by the MCO and negotiate protections for students. Are *Explanation of Benefits* (EOB) statements sent to the member or parent/policy holder?

- **Negotiating a favorable rate of reimbursement for services.** Most SBHCs begin with a fee-for-service arrangement which minimizes risk, especially in a new contractual arrangement. The specific rate may be based on the health plan's fee schedule or on the published medical assistance fee schedule. The SBHC should not accept a lower rate than is paid to other providers for similar services. Nor should the rate be lower than the fee the SBHC would receive under the fee-for-service option with the state Medicaid agency.

- **Simplifying data exchange.** The managed care contract will require some exchange of billing and encounter information. The MCO may require that the SBHC send encounter information and clinical data to other providers in the health plan network. The contract should delineate how and within what amount of time the data will be exchanged. The negotiator should explore electronic submission of billing data.

- **Focusing on the most important health plan partner.** SBHC administrators can experience great frustration in trying to negotiate

contracts with multiple health plans. While administrators will want as many consistent contracts as possible, initial negotiations should focus on the one or two health plans with the highest enrollment potential in the school. If these negotiations do not succeed, contracting with at least one other plan will demonstrate the SBHC's benefits to other plans. Health plans will often follow others health plans when meeting new requirements or when unique providers in the community serve target populations.

CHAPTER 5:
NEGOTIATION ISSUES

Types of Contracts

Contracts between SBHCs and health plans vary greatly in program design, services covered, health plan type, and local factors. The contract should meet the needs of both the SBHC and the MCO and should accurately reflect the relationship between them. All contracts will contain the following types of information:

- Descriptions of the contracting parties, including their legal status;

- Definitions of covered services, standards of care, emergency services, out-of-plan services, primary and specialty care, and other types of care;

- Contractual obligations, such as number and locations of service sites, hours of operations, credentials required, quality management procedures, facilities maintenance, and CLIA designation.

An SBHC under contract with health plans will usually be designated as a provider of either primary care or specialty care. The latter is sometimes called a *referral* provider. Many contractual requirements will remain the same regardless of the SBHC's designation. However, essential differences distinguish a provider of primary care from a specialty/referral care provider. Such differences include whether a student may *select* the SBHC provider as his/her primary care provider, how authorizations for service are handled, and the services covered under the agreement.

In their 1995-96 meetings, the School Health Policy Initiative's working groups on managed care and SBHCs reached consensus on several relationship models around which contracts may be developed. The working groups emphasized the mutual benefits accruing to MCOs and SBHCs from entering into partnerships agreements. The relationship models, described in *A Partnership for Quality and Access* (Brellochs, Zimmerman, Zink, *et al.*,1996), include primary care provider or "gatekeeper," specialty provider, and co-manager of health care.

- **Primary Care Provider or "Gatekeeper"**—The SBHC is a primary care provider in the health plan's network, on a par with other primary care providers or clinics. The relationship may or may not include financial risk for primary care and for specialty (referral) services. Students do not need prior authorization to use the SBHC's services.

- **Specialty Provider**—The SBHC provides some primary care services to enrollees of the health plan, such as family planning, physicals, or immunizations. Since the SBHC does not provide a full set of primary care services to enrollees, students must have prior authorization from their primary care provider or from the plan to use the SBHC services. Prior authorization is required because

An SBHC under contract with health plans will usually be designated as a provider of either primary care or specialty (referral) care.

another entity, such as the primary care provider or the health plan itself, is at financial risk for the services.

- **Co-Manager of Health Care**—The SBHC provides a complete array of available SBHC services which complement services of the primary care provider or clinic to which the student is assigned. The SBHC shares clinical information with the health plan and/or primary care provider. Students need prior authorization to use the SBHC's services.

The negotiations should clarify which type of contract will best suit the needs of both the SBHC and the MCO. The SBHC's ability to comply with various requirements may, in fact, determine the contractual relationship. However, most contract issues are negotiable. For example, an MCO might designate an SBHC as a referral provider but waive prior authorization.

Usually SBHCs with Primary Care Agreements

- Provide a full spectrum of primary care services;

- Hold daily clinic hours for regular clinic access;

- Have staff available daily, including M.D., nurse practitioner, or physician's assistant;

- Provide after-hours services (not just an emergency phone number).

Generally, SBHCs with Specialty Agreements

- Provide specialized services in certain areas, such as mental health, reproductive health care, or EPSDT;

- Hold less than daily clinic hours for clinic access;

- Have staffing patterns that may not include daily access to an M.D., nurse practitioner, or physician's assistant;

- Seldom provide after hours care or a full spectrum of services.

In general, the more comprehensive its range of services, the more success an SBHC will have negotiating a contract.

Scope of Services

Contractual agreements delineate the scope of services to be provided. In general, the more comprehensive its range of services, the more success an SBHC will have in negotiating a contract. When SBHCs offer only a few services, MCOs become concerned about possible fragmentation of care. Thus, SBHCs offering limited services may have difficulty marketing themselves to MCOs. For these SBHCs, establishing links and coordinating services with other clinics will be first step in marketing themselves to MCOs.

Confidentiality and Information Exchange

The ability to exchange information and coordinate care for health plan and SBHC enrollees is a critical component of a managed care contractual relationship. Information exchanged between the MCO and the SBHC must include clinical information, especially since the SBHC may not be acting as the sole primary care provider for the enrolled student. The contract delineates the exact vehicle for information exchange. For example, some information—such as immunizations—may need to go directly to the student's primary care provider rather than to the plan. When it is not the primary care provider, the SBHC must make sure to supply primary care providers with all relevant information because provider clinical records are audited for Health Plan Employer Data and Information Set (HEDIS) reporting purposes.

Assuring client confidentiality is the major concern of SBHCs in regard to exchanging information, particularly about sensitive services for adolescents. Negotiators must learn what services, or CPT codes, the MCO considers "confidential." The MCO may have certain designated codes that protect confidentiality during the claims process. Or, the MCO may identify certain services, such as family planning, that may be paid out-of-network to any provider. A solution that might work for the SBHC would be to send no information on those services to the health plan or its primary care clinics.

Confidentiality remains a concern when SBHCs bill MCOs by using standard claims forms. The SBHC must know the policies of an MCO in regard to EOB statements sent to the insured party. These MCO policies can vary from health plan to health plan and can vary within plans by employer group policies. In order to prevent billing fraud and to verify that services were received, some commercially insured groups require health plans to send these statements to the policy holder. To protect against fraud and abuse, states may also require EOB statements under the Medicaid program. When the policy holder is not the student using the SBHC, the student's confidentiality is jeopardized. MCOs may be able to suppress EOBs for a category of services, such as care deemed confidential.

The ability to exchange information and coordinate care for health plan and SBHC enrollees is a critical component of a managed care contractual relationship.

Reimbursement

The contract should specify how and when the provider will be reimbursed. Most SBHCs that work with MCOs have negotiated contracts which permit paying the SBHCs on a fee-for-service basis—usually according to a published fee schedule such as a state's Medicaid fee schedule. SBHCs may negotiate for a higher rate of reimbursement than a Medicaid fee schedule but should not agree to accept less. Some states prohibit health plans from paying SBHCs less than is paid other providers in their networks for the same services.

Sometimes contracts include bonuses for achieving specified outcomes, such as targets on immunizations or well child visits. SBHCs should negotiate a higher level of payment for achieving mutually established targets. Plans may also provide incentives to clinics offering special programs—such as outreach, language interpretation, and transportation—for populations that are hard to reach. When an SBHC offers these special services, it should

The contractual agreement should specify how and when the provider will be reimbursed.

negotiate a higher fee-for-service across all services. Otherwise, it should negotiate a separate reimbursement for the special services. Some states include these services in MCO capitation rates for medical assistance. The state's contract with MCOs will provide this information.

SBHCS and Financial Risk

SBHCs and their sponsoring organizations must determine whether the SBHC is able to accept a measure of financial risk in the contractual arrangements with managed care. Since SBHCs have limited experience in contracting with MCOs, little data exists on any SBHC's accepting genuine financial risk in a contract with a health plan. Still, the SBHC administrator and sponsoring agency should understand the issues associated with financial risk in order to make an informed choice on behalf of the SBHC.

Capitation means that the health plan passes risk to, or shares risk with, the provider.

The capitation reimbursement methodology extends financial risk to the provider of services. *Capitation* means that the health plan passes risk to, or shares risk with, the provider—usually expressed as a single, per member per month rate paid to the provider regardless of the actual cost of services provided. Providers who are at *full risk* in a contract agree to provide all required health care services for the member for the fixed fee.

Capitation has both advantages and disadvantages for the health care industry. The major advantage is that financial responsibility shifts to the provider organization which makes decisions about the care and treatment of the patient. Capitation, thus, creates an incentive for the provider to deliver care as cost effectively as possible. The major disadvantage to the provider is that the provider organization may not be large enough to contract for a sound patient risk pool. That is, the provider may be unable to assume care for enough healthy patients to cover the costs of care for seriously ill or chronically ill patients. (Patterson, Wendel, 1996)

To succeed with capitation, the provider organization must know the full cost it incurs for providing services on a per member per month basis. It must use this cost to negotiate an adequate capitation rate for services. The provider organization must have excellent data systems to monitor both utilization and costs. Working successfully with capitation requires the expert management of a patient population, sometimes termed as a patient risk pool.

Critical Strategies for Successful Management of a Patient Risk Pool:

- Increase the pool size by increasing the numbers served or merging with another pool.

- Deliver effective care and develop process and outcome measures of performance.

- Define the resources required to deliver care.

- Define relevant characteristics of the patient pool. Use population-based data to identify the stability and health care needs of the patient pool.

(Patterson, Wendel, 1996)

An SBHC will face major challenges in negotiating a true risk contract, and many SBHCs may determine that risk contracts are not in their best interests.

Health centers should consider the following factors when considering whether to pursue a capitation (risk-based) relationship.

What services are covered under the capitation agreement? Some capitation agreements place the provider at 100 percent risk for all services, including primary, specialty, emergency, and ancillary care. Claims for any and all of these services would be paid out of the provider's capitation. In this arrangement, the provider must provide the fullest possible scope of services and must control as many as possible of the referral services. For example, an SBHC would need to control which referral services a student uses in order to ensure that the student uses in-network service providers, since the SBHC would be financially responsible for that care. The most comprehensive models of SBHCs normally provide primary care and mental health services, but they do not usually provide specialty or ancillary services. Thus, SBHCs have diminished control over those services. In addition, the SBHC would have to provide—or be financially responsible for care provided—outside its clinic hours, including emergency and other after-hours services.

What is the full cost of services, and where will students receive them? An SBHC at full risk would need to control where students go for services outside of the center and to account for the cost of theses extra services. Such services—which it may have no experience managing—could include radiology, surgery, and various therapies, such as physical therapy.

Will the patient "risk pool" be large enough? Sometimes an SBHC is included in a larger risk arrangement through its sponsoring organization which also provides for other population groups. An SBHC alone, especially one offering a limited panel of services, is extremely unlikely to attract enough students to constitute a large enough patient risk pool to enable to SBHC to assume full financial risk.

What are the characteristics of the risk pool? If an SBHC serves a population at higher risk than is served by the typical primary care provider in the community, the SBHC should negotiate for a higher capitation rate as well. A higher risk population might include frequent users of care, a large group of low-income persons, or a large population on medical assistance. Tracking data about the patient population is essential.

Does the SBHC have adequate performance measures and outcome data? SBHCs in a risk-based managed care relationship would need to measure both effectiveness and efficiency. This suggests that few SBHCs could or should enter into full risk contracts—which place the health center at 100 percent risk for all services provided to students who choose the health center as their provider. However, those SBHCs which are part of a large community health center or hospital may find it easier to work through the many issues associated with risk contracting. Or, an SBHC might consider affiliation with a network of providers which shares potential risk and a larger and diverse patient pool.

Variations to full risk contracting, however, may afford an opportunity for an

> **Many SBHCs may determine that risk contracts are not in their best interests.**

SBHC to accept capitated payment for services. Most simply, the MCO might offer a straight capitation payment, based on utilization data, for all enrolled students the SBHC serves. The SBHC would receive a capitated payment for providing primary care to those students, but would not be at financial risk for any other services. While this may sound simpler than fee-for-service billing, the SBHC must still submit encounter data for the ongoing utilization analysis which is used to set or adjust the capitation rate.

Another variation in capitation might be the SBHC's agreement to share risk with the managed care plan, but to accept risk only for services delivered in the SBHC. A third variation might make the SBHC part of a withhold program, in which a percentage of the reimbursement is withheld, pending overall financial performance of the plan. Health plans differ in their approaches to capitation contracts. For example, some would place primary care providers, including SBHCs, at risk for more than just primary care services to maximize their financial incentive to manage referrals to specialists.

What should an SBHC do if it is not ready to share risk with an MCO? A prudent approach to contracting for the majority of SBHCs is to begin with a fee-for-service contract. The SBHC administrator can gather cost and utilization data after one to two years of experience, ensure that systems are firmly in place, and evaluate whether risk-based contracting is feasible. Managed care plans can assist SBHCs with MCO data on services utilization, frequency and types of referrals, etc., which will assist the center in making sound financial decisions.

Delta HealthCare at Edison High School

One SBHC with a capitated approach to health plan payment is Delta HealthCare, a California nonprofit organization which manages the SBHC at Edison High School in Stockton, California. This organization negotiated a capitated rate from the Health Plan of San Joaquin County for students who choose the Edison SBHC as their primary care clinic. Delta HealthCare is not at risk for specialty care, hospitalizations, or any other services not provided in the SBHC; instead San Joaquin County provides the specialty and hospital services. Delta participates in a 2.5 percent withhold (or reserve of its capitation) which means Delta participates in the risk pool for inpatient and specialty care. In other words, if the plan performs well financially in these areas, this withheld capitation, or a portion of it, is disbursed to Delta at the end of the contract year.

The challenges Delta faced in the contract's first year included 1) gaining enough enrolled students and 2) helping families understand how to choose Edison SBHC as a primary care provider for the family's youth. Delta HealthCare receives reimbursement only for students who choose the SBHC as their primary care provider and not for all of the health plan members who use the SBHC. Delta appears to receive more reimbursement under this agreement than it would have under a fee-for-service arrangement. Delta's risk-free arrangement with the county enables Delta to manage a capitated reimbursement.

CHAPTER 6:
MARKETING THE SBHC TO MANAGED CARE ORGANIZATIONS

The Managed Care Perspective

When organizations have limited experience working together, relationships take time to evolve. Building a strong relationship will require that SBHC administrators and staff understand the perspectives and concerns of the health plan partner.

Health plans are accountable for the quality of services their members receive and for the premiums paid by the federal government, state, commercial groups, and members. Member benefits are the services which the member receives. Member benefits are determined by the purchaser, which may be the employer, employer group, or—in the case of medical assistance—the state and HCFA.

The role of the purchaser in the equation is often misunderstood and overlooked, but it is central to SBHC and MCO relationships. Although SBHC proponents are often critical of MCOs for not "covering" preventive health, counseling, and/or some behavioral health services, whether these services are covered is actually determined, not by the MCO, but by the purchaser. Health plans provide members with **chosen** benefits (services). In other words, purchasers must **choose** those benefits, or they will not be **covered**. Helping the purchaser understand the value of SBHC services is critical to these services being chosen and, thus, covered. Educating purchasers about the value of SBHC services is critical to improving MCO/SBHC relationships.

The questions that health plans frequently pose during negotiations mirror their concerns about working with SBHCs.

- Will an arrangement with an SBHC fragment the plan's commitment to primary care? For example, if the SBHC performs EPSDT physicals, how will that information get into the member's chart if the SBHC is not a full primary care provider?

- Will this arrangement increase costs? To the commercially insured group? To the health plan? To individual providers? To the consumer?

- If staff in the SBHC do not meet credentialing criteria, will it threaten the health plan's NCQA (National Committee for Quality Assurance) accreditation?

- Will the SBHC really help students who are plan members to understand how to identify and use primary care providers? If the SBHC is a primary care provider, will it help students to understand and use it as their primary care provider?

- Will primary care providers be concerned if their capitation decreases in order to pay the SBHC out of the capitation? Will providers be unwilling to work with SBHCs or to contract with the plan?

> **Purchasers must choose benefits, or they will not be covered. Educating the purchaser about the value of SBHC services is critical to improving MCO/SBHC relationships.**

- Can the SBHC bill accurately, or will inadvertent billing errors require more plan oversight in order to prevent billing fraud or abuse and to comply with requirements the MCO must meet?
- Will the SBHC's documentation comply with HEDIS requirements?
- Will the contract require more health plan administrative resources than is desirable if the SBHC covers only a small number of health plan members?

These are valid questions, and the SBHC's ability to anticipate and answer them as they arise will greatly facilitate the contract process.

Marketing the SBHC

In marketing the SBHC program to a prospective MCO partner, administrators should keep some principles in mind. The first step is to identify and target the groups vested in the MCO, such as employers, providers, members, policy makers, and regulators. Marketing strategies should target all of these essential stakeholder groups:

• Employers and Other Purchasers of Health Care
Employers and other purchasers determine benefits and pay the MCO. They determine which services the MCO will cover. Purchasers are particularly important groups with which discuss issues such as care for hard to reach groups (such as teens), assuring adolescent confidentiality, and including preventive services in benefits packages.

• Members—Parents and Students
Satisfaction surveys conducted among student users and parents are powerful tools for the SBHC to employ when marketing services to MCOs. Parents and students have a stake in, and are important to, both MCOs and SBHCs.

• Policy Makers
MCOs work closely with policy makers on all aspects of health care policy formation, legislation, regulation, and standards. They share concern about issues of quality and access.

• Regulators
Principle regulators of health plans are the federal HCFA and the state's departments of health, human services, and commerce. These departments oversee the contractual obligations of plans and enforce federal and state regulatory provisions. MCOs work closely with regulators when implementing, or considering implementation of, programs.

• Providers
The MCO listens to its health care providers because they are critical to the MCO's success. An SBHC should ensure that it has good working relationships with area health care providers—including providers of primary care, mental health care, and behavioral health care. For example, primary care providers may have concerns about how and whether an SBHC will communicate pertinent patient information to the primary care provider. The

SBHC should hold discussions with the main provider groups within the health plan, offer on-site tours, and present its plan for communicating with providers. Positive relationships with network providers will largely alleviate many MCO concerns.

Health Start Works to Convince Providers

One example of the importance of provider input comes from the experience of Health Start, a nonprofit organization operating several SBHCs in St. Paul, Minnesota. When Health Start began negotiating with several plans in 1994, one of the health plans responded with a survey to assess its providers' knowledge and opinions about the SBHC program. The health plan intended to use survey results to determine whether to lift its requirement that providers give prior authorization for primary care services in SBHCs Interestingly, although providers had no direct links with SBHC staff, many were familiar with Health Start, either through what they had either heard or read in the community. Health Start responded to the survey with SBHC tours for providers of this health plan. As a result, the MCO waived its requirement for prior authorization for primary care services in Health Start's SBHCs.

The MCO listens to its health care providers because they are critical to the MCO's success. Positive relationships between SBHCs and network providers will largely alleviate many of the MCO's concerns.

SBHCs have assets that they should market to health plans and the major groups vested in the health plans. The SBHC's marketing plan should stress the following:

- **Access to health care**—Health plans which serve Medicaid children must demonstrate special access for certain target populations in their networks, such as adolescents or low income children. SBHCs often serve the target populations and can help MCOs meet this requirement.

- **Ability to serve hard-to-reach populations**—Health plans must demonstrate that they tailor services and manage care for hard-to-reach target populations, such as adolescents, pregnant women, or children with special health care needs. SBHC services can help MCOs meet this requirement.

- **Culturally competent services**—Health plans often must demonstrate cultural competence in the design of provider networks, in member communications, and in special services. Many SBHCs provide culturally appropriate services for the young people they serve.

- **Outreach services**—Many MCOs do not employ outreach workers, but they recognize the value of outreach to obtain new members and to keep existing members enrolled with the health plan. Outreach services for special populations, such as teens, are often necessary for health plans that work with Medicaid populations.

- **Ability to improve immunizations, well child measures, entry into prenatal care**—Health plans must demonstrate HEDIS results, which include several measures pertinent to service delivery in

SBHCs, such as immunizations and well child visits. SBHCs which provide prenatal care can demonstrate improved results with the hard-to-reach adolescent population.

- **Ability to attract new enrollees to the health plan via the SBHC**—Health plans are interested in how SBHCs, through their access to families and students, can help them retain and increase membership.

- **Outcome evaluation data**—Outcome data, when available, is important because health plans want evidence that interventions work. However, the SBHC that lacks outcome data should not underestimate the value of the other assets listed in this section.

One final note—

Administrators should attempt to highlight the promotional value to the MCO of working with the SBHC, especially opportunities for positive public relations in the community. Working with the SBHC on a specific health promotion activity can give the MCO excellent publicity in the community. Working together on the health promotion activity will provide the SBHC an opportunity to build a relationship with the MCO, even if there is little or no monetary commitment other than in-kind support. An MCO is often very willing to invest in community initiatives that are in line with its mission.

CHAPTER 7:
CONCLUSIONS

Managed care organizations and school-based health centers have gained experience working together in recent years. As MCOs expand to provide care for new populations—such as persons on medical assistance and children with special health care needs—a tremendous opportunity arises for MCOs to join forces with SBHCs to improve services integration across the educational, medical, and public health sectors. In addition, MCOs, policy makers, and SBHCs share some common concerns—access to care, reimbursement, and adequate funding for services. Advocates for Youth hopes this guide will help stimulate practical discussions on how MCOs and SBHCs can work together to serve children and youth in the states and in communities.

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APPENDIX A:
GLOSSARY OF MANAGED CARE TERMS

Authorization—Approval for certain health care services, typically those outside the realm of primary care services. Authorization is usually made by the primary care physician, or the health plan, for services such as home health care, therapy services, referral to specialists, and hospital admissions.

Capitation—A payment methodology in which a provider, clinic, or health plan is paid a fixed, prospective amount—usually per member per month—for each individual who selects the provider, clinic, or plan. Capitation can refer to the amount paid by the purchaser to the plan or to the amount paid by the plan to the providers. Capitation rates are determined using actuarial tables.

Carve Out—An arrangement in which the purchaser of health care services (e.g., the state or the employer) chooses a set of services, such as behavioral health services, chiropractic care, etc., and contracts separately with a set of providers for those specific services. Payment may be made either under a capitation or fee-for-service arrangement. In other words, the payment for this portion of care is not included in the MCO contract for the rest of the health care services.

Essential Community Provider—ECPs are defined in the statutes of states with regulatory provisions relating to this designation. ECPs may be community or rural health clinics, public health agencies, or primary care or behavioral health providers. They provide services in underserved areas, to low income persons, or to high risk individuals. ECP designation may be temporary or for a definite period of time and is intended to assure a relationship between the MCO and the ECP to serve the defined target population.

Fee-for-Service—Billing and payment methodology in which the provider of services bills and is reimbursed for each encounter at which service is rendered. Usually, fees are based on a predetermined fee schedule or as a percentage of the charges actually billed. The state sets the fee-for-service rate for the medical assistance program.

Health Maintenance Organization (HMO)—A licensed health care organization that has the following characteristics:

- It is a system of health care services, organized in a geographic region.
- It provides comprehensive health care based on a set of benefits.
- It serves a defined population or membership.
- Its services are usually prepaid on a per member per month basis. Payment is fixed without regard to the actual volume of services provided.

In addition, group model plans or individual practice associations (IPAs) may be included under the definition of an HMO.

HEDIS—HEDIS is the Health Plan Employer Data and Information Set, which measures health plans in the areas of access, satisfaction with care, quality of service, membership, utilization, and finance. The National Committee for Quality Assurance (NCQA), a national organization repre-

senting consumers, purchasers and providers of managed care, developed **HEDIS** to help employers and purchasers compare health plans using uniform criteria. HEDIS 3.0, developed in 1996, includes new measures specific to Medicaid and Medicare enrollees.

Medicaid HEDIS measures provide state Medicaid agencies with comparative performance information on Medicaid contractors and inform beneficiaries about health plan performance. The measures also promote standardization of health plan reporting across public and private sectors.

Managed Care—Managed care refers to a delivery system that blends financial control and provision of health care services to covered individuals, or members, by various arrangements with a specified network of providers. Managed care is characterized by using specific criteria in selecting providers, financial incentives for members to use the providers in the health plan's network, a system of care management, and formal programs for quality assurance and utilization review. Other key features of managed care include an emphasis on primary and preventive care for patients, prior authorization for services, and some measure of risk sharing among providers.

Medicaid—Established in 1965 as title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), Medicaid is a state/federally funded health financing program for low income people, administered by the states, with federal oversight by Health Care Financing Administration within the Department of Health and Human Services (HHS).

Primary Care Provider—Usually the first entry point into the health care system in a managed health care plan. The PCP provides care management and assumes responsibility for coordinating the health care services needed by an enrollee/member. The primary care provider is sometimes referred to as a "gatekeeper" in the health care system. Physicians, nurse practitioners, and physician assistants may all provide elements of the care management/coordination role.

Prior Authorization—Prior authorization is a review conducted prior to the delivery of a service and may include any outpatient service as well as scheduled hospitalization.

Risk Sharing—The level or distribution of financial risk between contracting parties. A health plan may share risk with a contracting clinic or hospital, or it may place the clinic or hospital at full risk for the services.

Stop-Loss Insurance—Insurance purchased by a health plan to reimburse the plan for the cost of benefits paid out to an individual or account that exceeded what the plan expected to pay. It is also called *reinsurance*.

Utilization—The use of services, commonly expressed in terms of rates of use of a single type of service, such as visits to a specialist or hospital emergency room admissions. An example is the number of hospital inpatient days per 1000 members.

Waivers—Medicaid waivers obtained by states from the Health Care Financing Administration (HCFA), that exempt states from some federal statutes and regulations that would otherwise hinder their efforts to create Medicaid managed care programs. Nearly all 50 states have either a 1915(b) waiver or an 1115 waiver, allowing them flexibility in enrolling Medicaid

populations into managed care programs.

APPENDIX B:
GLOSSARY OF ACRONYMS

CHIP   Child Health Insurance Program

CLIA   Clinical Laboratory Improvement Act

CPT   Current procedural terminology

CQI   Continuous Quality Improvement

ECP   Essential Community Provider

EOB   Explanation of Benefits

EPSDT   Early and Periodic Screening, Diagnostic, and Treatment

FQHC   Federally Qualified Health Center

HCFA   Health Care Financing Administration

HEDIS   Health Plan Employer Data and Information Set

HHS   U.S. Department of Health and Human Services

HMO   Health Maintenance Organization

IPA   Individual Practice Association

MCO   Managed Care Organization

NCQA   National Committee for Quality Assurance

PCP   Primary Care Provider

PCCM   Primary Care Case Manager

PPO   Preferred Provider Organization

RFP   Request for Proposal

SBHC   School-Based Health Center

SPRANS   Special Regional Projects of Regional and National Significance

APPENDIX C:
SBHCS AND MANAGED CARE: A SELECTED BIBLIOGRAPHY

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APPENDIX D:
SELECTED SOURCES OF FURTHER INFORMATION

Advocates for Youth
1025 Vermont Avenue NW, Suite 200
Washington, DC 20005
202-347-5700
www.advocatesforyouth.org

American Association of Health Plans
1129 20th Street, NE, Suite 600
Washington, DC 20036
202-778-3200
www.aahp.org

American Public Health Association
1015 15th Street
Washington, DC 20005
202-289-3200
www.apha.org

Center for Adolescent Health and the Law—Advocates for Youth
211 North Columbia Street
Chapel Hill, North Carolina 27514
919-968-8870
www.adolescenthealthlaw.org

Center on Budget and Policy Priorities
820 First Street, NW, Suite 510
Washington, DC 20002
202-408-1080
www.cbpp.org

Center for Health Policy Research
George Washington University
2021 K Street, NW
Washington, DC 20052
202-296-6922

Health Care Finance Administration (HCFA)
7500 Security Boulevard
Baltimore, MD 21244
410-786-3000
www.hcfa.gov

Health Resources and Services Administration
U.S. Public Health Service
5600 Fishers Lane
Rockville, MD 20857
301-443-8041
www.hrsa.gov

Kaiser Commission on the Future of Medicaid
1450 G Street, NW, Suite 250
Washington, DC 20005
202-347-5270

Making the Grade
1350 Connecticut Avenue, NW
Washington, DC 20036
202-466-3396
www.gwu.edu/~mtg/

National Assembly on School-Based Health Care
1522 K Street, NW, Suit 600
Washington, DC 20005
202-289-5400
www.nasbhc.org

National Conference of State Legislatures
1560 Broadway, Suite 700
Denver, CO 80202
303-830-2200
www.ncsl.org

National Governors' Association
Hall of States
444 North Capitol Street
Washington, DC 20001-1512
www.nga.org

National Maternal and Child Health Clearinghouse
2070 Chain Bridge Road, Suite 450
Vienna, VA 22181-2536
703-821-2098
www.nmchc.org

Support Center for School-Based and School-Linked Health Care
Advocates for Youth
Suite 200
1025 Vermont Avenue NW
Washington DC 20005
202-347-5700
www.advocatesforyouth.org

The Urban Institute
2100 M Street, NW
Washington, DC 20037
202-833-7200
www.urban.org