State Policy Context for School-Based Health Centers
With Special Focus on Development of Mental Health and Dental Health Services

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There is widespread need for dental health and mental health services among all populations of American children and adolescents. Though the needs cut across socioeconomic and cultural demographics, those school-aged children with the lowest socioeconomic status are affected disproportionately by the shortage of available care, and indigent and minority youths bear the brunt of poor health status in our country today. Poor children suffer twice as much from dental caries as their more affluent peers, and their disease—indicative of their poor general health—is more likely to go untreated.[1] More than two-thirds of children and adolescents in need of mental health services receive none at all.[2]

This memorandum describes financing and other state policy issues that confront school-based health center (SBHC) staff and sponsors, and highlights special issues that affect centers seeking to initiate dental services and expand existing mental health services. Valuable lessons have been learned from those centers that have established their services over the past decade, and those that have expanded their dental health and mental health services. These lessons including the following:

- Multiple funding sources, carve-outs of mental health and dental services from state and other third party contract provisions, and low reimbursement rates are a reality that challenge school-based health centers to find sustainable funding for current and expanded services.

- State policies differ by state, and each state's particular licensure, certification, and public health insurance payment practices affect the way states reimburse SBHCs. Because centers that opt to expand mental health services and provide dental services for the first time may confront unique policies specific to those types of services, centers will need to pay particular attention to the rules affecting those services.

- The growth in Medicaid managed care, and the recently established State Child Health Insurance Programs (SCHIP), are significant forces that will shape the way school-based health centers can expand their programs. Centers may find themselves negotiating not with the state but with managed care plans that have enrolled Medicaid and SCHIP beneficiaries, and SBHCs will generally need to respond to managed care plan requirements to adhere to policies and practices that conform to plan reporting policies.

We offer the following examination of these issues, their impact, and their implications to guide center staffers and sponsors toward identifying and anticipating the policy and programmatic constraints that will affect the ways centers can meet the needs of the children and adolescents they serve.

The memorandum is organized in tripartite fashion. The first section, *Funding Sources and Financial Support for SBHCs*, provides an overview of funding sources supporting school-based health centers, and examines those sources of funding directed towards school-based health centers as a specific provider type and those sources of funding that result from securing third-party payment monies tied to individuals served by the centers. The second section, *State Functions and SBHCs*, looks at school-based health center program expansion from the perspective of state government licensure, certification, and payment functions, and how these practices, coupled with Medicaid managed care arrangements, may impact SBHC operations. The third section, *Implications of State Policy Environment on SBHC Practice*, examines the implications of state policy environment for the organization of SBHC program administration and the specific burdens placed on medical records management.

Funding Sources and Financial Support for SBHCs

Multiple funding sources typically contribute to any one particular school-based health center's health services programs.[3] Both public and private mechanisms generate the monies that make up a center's funding mix. Though an underutilized resource, some centers also receive reimbursement from third party payers, such as Medicaid and commercial insurance.[4] SBHCs operate in a defined funding landscape that must be explored and made familiar in order to understand the difficulties and manage the impact that multiple sources of funding may have on school-based health centers, especially those that seek to expand their mental health services and implement dental services.

With respect to financing, what sets SBHCs apart from private practice and most other outpatient settings is the large number of distinct funding streams the centers must tap for needed funds. School-based health centers—or rather, the community health centers, hospitals, health departments, and other institutions that own, operate, and fund SBHCs—potentially receive revenues from the following sources:

- Publicly funded grants from Federal, state, and local government administrations;
- Privately funded grants from foundations and corporations;
- In-kind contributions from school systems, community agencies, and other entities;
- Publicly funded patient care reimbursements from Early Periodic, Screening, Detection, and Treatment (EPSDT) programs, Medicaid, State Child Health Insurance Programs (SCHIP), and P.L. 94-142 and the Individuals with Disabilities Education Act (94-142/IDEA); and
- Privately funded patient care reimbursement from commercial insurance.

When school-based health centers provide dental and mental health services, the list of financing sources tends to shift, and even in cases such as Medicaid where the source remains the same, specific issues frequently complicate an already challenging situation.

For example, in the case of dental services, while many state public insurance programs cover a wide range of dental services, dental providers have been subject to low reimbursement rates that

ultimately discourage dentist participation in Medicaid,[5] and make it a challenge for dental programs sponsored by school-based health centers to secure significant payments for providing services to Medicaid and SCHIP beneficiaries. A shrinking pool of available dentists compounds the problems generated by historically low dentist participation in Medicaid. Additionally there have tended to be few Federal, state, and local grant programs directed toward the dental needs of children and adolescents, and dental health typically has not attracted much private or corporate support. Only recently, following the 2000 release of the Surgeon General's Report on Oral Health, has the situation begun to change.

On the other hand, while public insurance programs also cover a wide range of mental health services, certain states may prohibit payment for mental health and other services rendered by particular practitioners serving at school-based health centers, making the challenges surrounding mental health for some SBHCs related to utilizing available resources more successfully. The increase of child and adolescent enrollment in public insurance programs represents an opportunity for SBHCs to meet needs and capture increased amounts of payment simultaneously. Unlike issues in dental health, mental health problems and the services that respond to those issues have generated a fair amount of Federal, state, and local grants and have attracted more private and corporate grants, as well as an emphasis on the role of community agencies in providing those services. However, at the conceptual level, these grantors historically may not have thought about schools as a delivery site and school-based health centers as a delivery mechanism, so that in some cases grant resources may be developed and used for mental and/or dental health.

One way for SBHCs to evaluate potential revenue sources and make sense of different funding streams may be for centers to assess the potential benefits of these streams by grouping them into two categories: monies available to SBHCs by virtue of their organizational or provider type, and monies potentially available by virtue of the insurance coverage of the young people they serve.

Monies directed toward SBHCs or the services they provide. Certain public monies are designated for use by organizations that typically own and operate school-based health centers, either specifically to support centers or the types of services provided by centers. Most commonly, these funds are tax dollars levied by elected bodies at the Federal, state, and local levels, and administered and disbursed by agencies in the form of grants to the health centers, hospitals, and public health departments that sponsor SBHCs.[6] In-kind contributions from various hospitals and community agencies also fund SBHC operations; such contributions frequently consist of facility space and full-time equivalent (FTE) practitioner and support staff hours. Private foundations also award and distribute grant dollars to health centers, hospitals, and public health departments for the operation of SBHCs, but because of their limited terms, are less stable sources of funding.

Monies tied to individuals served by SBHCs. In addition to monies tied to the SBHC organization-type, SBHCs receive funds according to individuals they may serve. Fees for primary care services rendered are paid—with the appropriate Medicaid, State Child Health Insurance Program, and/or Early Periodic, Screening, Detection, and Treatment funds—by the state and/or its managed care contractor(s) to the agencies that sponsor SBHCs. Also, to the extent a school-based health center's scope of service includes services provided to children and

adolescents with special needs, an SBHC may receive funds from the district made available by P.L. 94-142 and the Individuals with Disabilities Education Act for providing those behavioral, mental health, and counseling services covered by the program and specified in the Individual Education Plan (IEP).

Financing issues associated with expanded services. School-based health centers planning to provide expanded mental health and dental services stand to enter into the thickets of more complicated funding terrain. This is due to several reasons:

- their scopes of service are more likely to include services provided to children and adolescents with special needs;
- mental health and dental services are carved out of managed primary care plans; and
- adequate third party billing practices are required to collect third party reimbursement revenue successfully and consistently.

More than sixty percent of school-based health centers provide mental and behavioral health services. A smaller percentage of centers offer "related" health services, when written into an Individual Education Plan, to children and adolescents qualifying for special education services.[7] The most common related services an SBHC would deliver are mental health related. Theoretically, an SBHC can consider whether it wishes to include those services in its scope of practice and negotiate with the school district to become formally authorized and funded providers of special needs services. To encompass those services creates a financing challenge; but leaving them to the school and/or the district is the prototypical scenario, and also creates a delivery challenge that puts pressure on SBHC budgets and practitioners. Although school districts vary considerably in terms of the systems they put in place to assure that these required services are delivered, such services are sometimes provided by SBHCs despite being neither required nor paid to do so.

The SBHC considering an expansion of its scope of practice may also be challenged by the Medicaid issues involved in billing for mental health and dental services. Most states have carved out the provision of mental health and dental services from the provision of primary care services in the structuring of their Medicaid programs. These carve-outs require sponsoring organizations to enter into additional contracts to secure payment for mental health and dental services.

Medicaid managed care reimbursement represents an underutilized source of funds for many centers. Historically, reimbursement from Medicaid and private insurance companies has been an insignificant funding source for SBHCs.[8] In part, this has been due to a general reluctance on the part of centers to bill out of concern that billing would become a barrier to care; this, coupled with small staff sizes and a shortage of billing skills, has slowed adoption of third party billing practices. Small Medicaid revenues are also a function of consistently low rates of reimbursement for mental health and dental services. And while low rates present difficulties for all mental health care providers, the issues are particularly problematic for SBHCs because their mental health client population consists predominantly of Medicaid recipients and uninsured children and adolescents. The combination of absent or inadequate third party billing practices

and low reimbursement rates ultimately results in failure to collect funds for covered services provided in SBHCs, and can stymie program expansion.

State Functions and SBHCs

The way a center is regulated by state policies and practices will differ from state to state, just as its financing schema will differ by state. But each state performs three important functions that shape the way a school-based health center can be organized: each licenses professionals, certifies providers, and sets payment policies. An examination of these state functions follows, and points out some of the broader policy issues—and real implications—that affect how a center will change and grow, especially in a managed care environment. In particular, state regulatory policies and payment practices can have a noticeable impact on the composition of school-based health center provider staff.

States regulate health care provision in a variety of ways. Each version, however, is based on the same three functions, described below. SBHCs looking to maximize reimbursements revenues without sacrificing desired service arrangements do well to know how to minimize undesired effects and maximize their potential benefits.

- ***Licensure***. A license enables a health care professional to practice legally in a state, and states license such professionals and determine the scopes of their practices. Typically, licensure is conducted and administered through highly regulated application and examination procedures exclusive to that State, although reciprocity agreements between certain states allow concurrent practice in more than one state.

- ***Certification.*** Once licensed, states determine which providers are eligible to receive payment for providing health care services. The process is known as certification, and it allows providers—individuals as well as institutions—to receive state funds for services delivered to enrolled Medicaid and SCHIP beneficiaries, as well as those enrolled in commercial insurance plans.[9]

- ***Payment.*** States establish eligibility, payment structures, and rates for Medicaid and SCHIP payments; they pay for covered services, provided by licensed personnel in certified provider locations, on behalf of eligible beneficiaries.

SBHCs are very sensitive to and greatly impacted by state licensure, certification, and payment policies and practices, partly because their commitment to meeting the mental and dental health care needs of their communities generally means a commitment to their low-income and uninsured students and participation in state sponsored insurance programs. As more children and adolescents are enrolling in public insurance programs and receiving health care services in SBHCs, centers need to remain aware of how state Medicaid and managed care practices can impact their own organizational structures.

States and Medicaid Managed Care. The past decade's growth in managed care—particularly the shift to Medicaid managed care—has potentially significant impact on the way SBHCs receive payments. In 1994, the percentage of the total Medicaid population enrolled in managed care plans was 23.17%; by 2000, it had grown to 55.76%, including primary care case management arrangements.[10] During the same period of time, SBHCs were embarking on efforts to expand their funding bases from government, foundation, and community grant sources by seeking reimbursements from third party payers, which increasingly were turning out to be managed care entities. The trend promises to continue as health insurance coverage expands for low-income and uninsured children through the State Child Health Insurance Program. As enrollment efforts improve and the number of SCHIP enrollees increases, the client base of SBHCs who receive services under managed care is likely to expand as well.[11]

States have made the move to sponsor managed care, in part, to improve the health status of Medicaid plan beneficiaries by providing comprehensive and preventive care, rather than episodic care. Various states have recognized that a large portion of those beneficiaries are children and adolescents, and are either carving SBHCs out of Medicaid managed care plans to allow for unrestricted access to those services, or—in order to make school-based health centers essential providers of comprehensive and preventive care services—are forcing managed care organizations to contract with them.[12]

But at the same time, in order to attract bids from third party payers—a necessity for states seeking to move from a fee-for-service to a managed care environment—states have had to carve out mental and dental health services from their managed care physical health contracts.[13] Accordingly, to avoid a "woodwork" phenomenon[*], significant barriers that work to limit access to dental and mental health services have materialized, and they are directly related to the financing of mental and dental health care for children and adolescents. In the case of dental care, financing barriers typically assume the form of very low Medicaid reimbursement rates; in the case of mental health care, those barriers are usually a lack of incentive for managed care organizations providing mental health services to identify cases.

States have two main options of meeting Federal obligations to pay for services on behalf of Medicaid beneficiaries, while at the same time controlling cost. States can delegate their payment responsibility and the associated risk to a managed care organization by providing that MCO with a capitated rate of monthly payment for covered services per enrollee. The MCO can then choose whether to pass risk further downstream by capitating providers, or it can choose to pay providers on a fee-for-service (FFS) basis, or it can even choose to mix and match, and provide a capitation rate for certain provider-types while paying other provider-types on a fee-for service basis. Alternatively, states can choose to bear all risk, in which case it typically sets up a primary care case management (PCCM) program, in which a primary care practitioner serves as a gatekeeper (for which they typically receive an extra $2 to $3 dollars per enrollee per month), and all providers are paid on a fee-for-service basis. In either case, the rule of thumb is that the risk-bearing entity sets payment rates.

[*] As was seen in long term care, when services are made more convenient and accessible, costs are actually driven up by people "coming out of the woodwork" to take advantage of them. As school-based health centers expand services and increase access and utilization, costs for caring for children and adolescents could exceed projections, and therefore costs to managed care plans would exceed their capitation rate in some cases.

Concerning dental health, almost all states bear the risk of payment for covered Medicaid dental services, and pay providers on a fee-for-service basis for dental services based on rates that each state sets. Frequently, states themselves (or a state-designated fiscal intermediary) determine the appropriateness of specialized dental services through a treatment authorization review process. For mental health, many states are using a capitated model of payment, in which a mental health managed care organization receives a fixed amount per beneficiary per month from the state, and then pays providers on either a capitated or fee-for-service basis. Other states may still be using a fee-for-service model to pay for covered mental health services, with or without a case management component.

SBHCs and the Impact of State Functions. The alliance of states and managed care organizations shapes the way states pay for mental health and dental services. And consequently, Medicaid managed care practices—coupled with state certification practices, in particular—will shape the way SBHCs can expand their mental health programs and implement dental health care services.

Consider that SBHCs may not be able to achieve ideal mental health staff composition as they expand. Centers in the State of New York, for instance, must choose between providing the mental health services of a clinical social worker and receiving no payment from Medicaid, or providing the mental health services of a clinical psychologist and receiving reimbursement from Medicaid. The salaries of both professions are roughly equivalent.[14] While a social worker may provide services within the scope of his or her practice at an SBHC, and while social work services are reimbursable as an allowable cost in the calculation of Medicaid rates, a claim for a social work visit will not be paid under current policy. For centers that find it easier to recruit Master's level social workers, or find the clinical competences a better fit with the center's needs, such state policies represent an important challenge.

Those school-based health centers aiming to initiate a dental program must also figure logistics in relation to state certification policies. Only certain states, for example, allow dental hygienists to receive payment for the services they deliver.[15] The matter presents even more of a challenge for centers located in states such as North Carolina and Virginia that do not certify dental hygienists: claims cannot be submitted for services provided solely by a hygienist, making the demand even greater for already scarce dentists.[16, 17] Even in states where hygienists are certified to perform a limited number of procedures, Medicaid dental reimbursement rates are so low that a high volume of patient visits is necessary to secure significant funding.[18, 19]

In light of state certification and payment practices, SBHCs aiming to maximize their third party revenues should consider whether organizational restructuring (for example, to a Federally Qualified Health Center or Rural Health Clinic) is a possible and/or worthwhile pursuit. Medicaid rates—based on the prior reporting year's client visits—are generally higher and tend to benefit larger institutions with more client visits. In some cases, such as in New York, sponsoring organizations have been allowed to add SBHC sites to their operating certificates as satellite clinics, and are able to bill for SBHC services and capitalize on higher reimbursement rates. However, not every state parallels the payment structure of New York, and the feasibility of such restructuring is a function of a state's particular constellation of policies.

Expanding mental health and dental services entails that school-based health centers and their sponsors become familiar enough with their state licensure, certification, and payment policies to compose staff which allow the capture of a maximum of reimbursement dollars without sacrificing "best practice" in meeting the needs of children and adolescents.

Implications of State Policy Environment on SBHC Practice

Schools are a particularly good place to deliver health care to children and adolescents, as the biggest supporters of school-based health centers have known for years. Simply citing the potentials for positive health outcomes, however, is not sufficient to resolve funding challenges, especially in negotiations with managed care organizations. For the most part, there is no protocol or magic formula for sitting down and negotiating with managed care organizations. But SBHCs can court and garner their attention by getting the basics right. This section aims to guide centers and sponsors toward getting a maximum of third party reimbursement dollars, and examines the proper handling of medical records as the cornerstone of solid relationships and mutually beneficial dialogue with state managed care contractors. Proper documentation of the services a center provides ensures a higher probability of increasing payment revenues and sustaining expanded services, and requires increased focus on a center's administrative capacity and capability.

School-based health center officials know much about managed care organizations and the way they do business. MCOs have a large national presence, and are a growing presence in many lives, including their students' and their own. To overcome the barriers that prevent billing state managed care contractors for reimbursable services, school-based health center staffers must examine what they already know about managed care practices:

- Managed care organizations have formalized, internal procedures for determining whether a claim is valid and complete; for all practical purposes, it is the plan that will determine whether a submitted claim gets rejected or approved for reimbursement.

- Managed care organizations use medical records information for purposes of monitoring payment, utilization, quality, and risk of liability.

- Managed care organizations—aiming to increase and ensure the quality of health care services while struggling to contain the costs of delivery—use statistics such as annual visits per service type and average provider time spent per visit as criteria for gauging success, and as a basis for action.

Despite this knowledge, agencies that sponsor school-based health have not been able to do much business with managed care organizations.[20] MCOs know little about SBHCs, and for the most part, this means that MCOs have not been able to calculate the risk of liability involved in contracting. In part, this is because providing services is the foremost priority and information about what SBHCs do and data documenting their effectiveness require a significant amount of

time and resources to organize and share, suggesting that more conscious planning, attention, and outreach is required.[21]

While state payment relationships and only a certain amount involve risk contracting, relationships with state managed care contractors are on the rise and becoming more crucial to be able to have in place. In some cases, state carve-outs may remain or be put or in place, but may also expire and drive the shift to Medicaid managed care by making it impossible for centers to bill states directly, on a fee-for-service basis. The shift to managed care forces SBHCs to learn to bill regularly and reliably for covered services they already offer and are preparing to provide, regardless of a state's particular payment arrangement. And, upping the stakes, poor paperwork communication with these organizations has typically resulted in managed care outfits unwilling to authorize school-based services. A center's policies and procedures must follow suit with its funding; staffers and sponsors must learn how to show the information required by managed care organizations to get their reimbursements.

Medical Records and Managed Care. Medical records are the source of most information a managed care organization requires for doing business. Whether a school-based health center maintains an electronic or manual records system, and whether a given state's payment arrangement is based on capitation or fee-for-service, medical records are the basis for claims paperwork and information that plans generally require for reimbursement. More frequently than they conduct other kinds of reviews, managed care entities will follow-up claims, and request photocopies of such things as chart notes and a patient history to support its merits, such as when a claim is not "clean" and lacks sufficient documentation of diagnosis, referral, services provided, and/or medications prescribed. "If it isn't documented, it wasn't done," is the general rule of thumb with medical records: the claims adjudication process—managed care's way of controlling how much is paid out in reimbursements—makes following this rule really worth something.

Medical records information is also used by MCOs to conduct reviews of patient encounters. Managed care organizations track everything from the coding of a procedure to the amount of staff time spent per encounter, and will even conduct patient surveys, in order to monitor the utilization of covered services, ensure the quality of care delivered, and assess their risk of liability. The information they collect is then worked up into data used to inform business decisions, ranging from which services their managed care plan should cover, to whether a particular claim is reasonable and should be approved.

A plan's medical records and data requirements may make certain procedures mandatory which SBHCs considering programmatic expansion may not yet be able to provide, or provide regularly. Significant research into these requirements and communication with state contracted plans is necessary to prevent poor records handling practices that can range from benign clerical errors to infractions worthy of litigation. The hospitals and public health departments that sponsor and run SBHCs, and generally enter into agreements with managed care entities, typically own their centers' medical records. With the ownership of medical records comes responsibility, ultimately, to their funders and the public they work to serve well: they are obligated by contract to provide MCOs with access to those records, and by Federal and state law to maintain client privacy rights.[22, 23] Accidental disclosures frequently result from ad hoc and

situational procedures, and the potential for liability may become significant and real when centers do not base administrative operations on a full appreciation of the importance of maintaining good medical records, properly.

Maintaining records properly becomes particularly important for centers that seek to expand mental health services and implement dental services. Typically, centers maintain separate mental health and dental records independent of a child or adolescent's general medical record. In the case of dental records, a center's logistics and/or physical space may necessitate that those records be kept physically separate from the general medical record. Care must be taken to coordinate the updating of charts, coding of services, and submission of claims in such cases. Such care must also be taken in the case of mental health records. However, because mental health diagnoses are protected by law as confidential information, care must also be taken to prevent accidental disclosures of such confidential information. This task may be made more difficult by the practice of maintaining a child's mental health record as a distinct section attached to the general medical record.

SBHC Administration and Managed Care. Determining the appropriate staff for a center will consist of choosing providers, but it will also mean making available the administrative resources and personnel that will allow a sound choice of provider staff to translate into increased reimbursement dollars. Medicaid managed care generally means that the administrative side of SBHC operations must be made ready to support any new programs, including mental health or dental services. Properly organized and functional administration—from educated providers and administrators to a procedures manual—is the necessary support any center needs, and sponsoring organizations need to have in place in order to implement or expand any services. Part of a center's goal should be to capture a maximum of third party reimbursements while providing the care services their children and adolescents need; the bar for sponsors and staffers is to be able to prove and justify what that center is doing, and that its operations are conformant to applicable laws.

SBHC administrative functions are classically underfunded. Tight budgets and financial constraints still force the choice between providing care and providing administrative support in some centers. Oftentimes, the result is a shortage of know-how in clerical procedures, such as Medicaid coding and billing, and medical records systems that ultimately cannot expand to meet the needs and demands for mental health and dental health care in their schools.

Setting up billing procedures and juggling an increased administrative load are not the only challenges SBHCs can expect to face. Those SBHCs that have successfully begun to bill for third party reimbursement—and which in a number of cases are using electronic billing through sponsors—have found themselves in a culture clash with certain philosophies underlying managed care,[24] including the high importance of data and documentation. Lost claims revenue can result when SBHCs misrecognize what they already know about managed care: MCOs base their operations on data information related to medical records and related paperwork, and most often require such data and/or documentation to communicate in doing business, even in the appeals process. Attention to detail in the deluge of data information and documentation requirements becomes practically invaluable.

Medicaid managed care's impact is evident in the need for greater and more skilled administration staff. In some centers, additions to the staff are needed; in others, training seminars and in-services are required. Additional physical space and equipment to support expanded systems (computers, DSL lines, fax machines) are needed in most. While the burdens on space and staff can be reduced by generous and substantial support from a sponsoring agency, school-based health centers are unlikely to avoid confronting a remainder of burden and responsibility.

Most centers will need to assure that staff at either the center or the center's sponsor are providing at least three roles: Medicaid biller, charges clerk, and billing supervisor. In a larger collection of centers, these functions will require several dedicated staff. For example, in one city, a group of 10 centers that in the aggregate covers roughly 25% of its costs through billing can expect to utilize the services of a minimum of three FTE administration staffers.[25]

As noted previously, Medicaid managed care requires that SBHCs develop sophisticated, well organized medical records systems. Billing and records management go hand in hand; in many cases, billing errors are an extension of poor records management. Poor records management has an additional downside, in that breeches of a child's or adolescent's privacy can result. Schools are held utlimately liable for breaches of confidentiality under the Federal Educational Rights and Privacy Act (FERPA) and a myriad of other state and Federal laws, which most recently includes the Health Insurance Portability and Accountabilty Act of 1996 (HIPAA) and related regulations under the *Standards for Privacy of Individually Indentifiable Health Information* (the Privacy Rule), furnished in April 2001 by the Department of Health and Human Services. Accordingly, SBHC practitioners and administrative staff must have procedures in place to assure secure handling of medical records and avoidance of unintentional disclosures.[26]

Only after a staff and administration procedures are sufficiently able to handle a center's administrative requirements can expanded services be implemented. For example, to ensure compliance with FERPA and complementary state privacy laws, problem sheets—typically of the facing pages in a medical record—can be assigned internal codes to guard against accidental disclosures of sensitive information, such as a person's HIV status or mental health diagnosis. While de-identified data may not be protected under certain privacy laws and regulations, such as the case is with HIPAA, protected health information (PHI)—individually identifiable health information in any form (written, printed, electronic, and oral) that is held or transmitted by a covered entity such as a school-based health center—may not be disclosed unless the disclosure is specifically permitted by the individual through consent or authorization, or specifically permitted under HIPAA regulations.

Additionally, daily chart reviews might be formally assigned to a clerical staffer to ensure physicians have signed off on orders, charts are dated and their components updated, and referrals are coordinated. Such measures can be made to satisfy HIPAA and Privacy Rule requirements in tandem with FERPA requirements by designating that one task of an administrative employee or any other SBHC staff member be to serve as a privacy official that is responsible for implementing and/or development of privacy policies and procedures. In certain cases, SBHC sponsors and staff considering whether to add a dental component in particular to

their school-based services may find help where in-kind medical records support is available from a sponsoring organization.

Conclusion

Ultimately, school-based health centers seeking to expand mental health services or implement a dental component will need to review carefully the policy environment of their particular state. Such SBHCs will need to determine the relevant regulatory obligations and constraints of their particular state, and examine the potential to bill their state and/or state managed care contractor(s). Centers may very well identify certain regulations in their state that change the shape of general plans to implement expanded services or new components, and by identifying such potential barriers, may be able to plan their operations around such regulations. Those centers that weigh their options carefully will most likely find, in planning to implement certain measures, that the process of expanding service programs will ultimately increase billing potential, enhance administrative functionality, ensure compliance with various state and Federal laws, and promote sound basic operations. In summary:

- Increased child and adolescent enrollments in Medicaid, SCHIP, and other public insurance programs represent an opportunity to meet mental and dental health care needs and capture increased amounts of payment from such programs. Though billing for mental health and dental services may be a challenge in light of state carve-outs, the shift to Medicaid managed care means centers increasingly need to bill on a regular basis for services they already offer and are planning to provide, and billing states and/or their managed care contractor(s) may in some cases be a viable and productive way to increase payment revenues.

- Expanding mental health services and implementing dental services requires school-based health center staff and sponsors to research and understand state licensure, certification, and payment policies. To gauge whether desired program components are permissible and feasible to implement, given a particular state's policy environment, centers must determine whether their current provider and administrative staff composition will be able to support those components and make appropriate, informed decisions based on those findings.

- Proper handling of medical records increases the likelihood of receiving a maximum amount of third party payment dollars. Though a center currently may not have the administrative capacity to handle state and/or managed care plan requirements, centers can work concurrently to satisfy medical records and data requirements and meet privacy and confidentiality standards laws sets by FERPA, HIPAA, and other applicable Federal and state laws by devoting appropriate resources (billing, privacy, and confidentiality training and electronic systems equipment, for instance) to the management of medical records and medical information.

Notes

[1] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.
[2] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.
[3] National Assembly on School-Based Health Care. "SBHC Finance Survey." Preliminary data, June 2001.
[4] Koppelman, Jane, and Julia Graham Lear. "The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?" *Journal of School Health*, 68(10): 441-446 (1998).
[5] According to a September 2000 GAO Report on oral health and the factors contributing to low use of dental services by low-income populations, dentists cite as the primary reason for their not treating more Medicaid patients that payment rates are too low (U.S. General Accounting Office. *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*. http://www.gao.gov/new.items/he00149.pdf. September 11, 2000).
[6] Seattle, Washington is an example of how good lobbying efforts and legislative support translate into direct money gains: that city's SBHCs receive direct tax dollars, as schools do. Similarly, Connecticut has allotted its SBHCs a $6 Million line-item in the state budget. The danger in each case: the funding stream is subject to political winds of fortune.
[7] When it comes to children and adolescents with special needs with mental health disabilities in schools, 94-142/IDEA funds—supplied by districts, not the state for those children not enrolled in Medicaid—are not capped, as Federal law under IDEA mandates districts to finance all services children and adolescents with special needs require to get an education. But the 94-142/IDEA requirement is written so that, once a child or adolescent is identified as having a special need, the district's responsibilities are financially open-ended in terms of providing needed resources. The unintended result—districts that are reluctant to formally identify children and adolescents with special needs—transforms a body of legislated funds to meet the special needs of children and adolescents into a mechanism that occasionally can work to limit access to those funded services.
[8] Mason, Michael J. "School-Based Clinics and the Role of Mental Health Services: A Review of the Literature." *Journal of Health & Social Policy*, 10(2): 1-13 (1998).
[9] But because states also tend to certify provider participation in the Medicare program, their separate role in state provider certification is frequently misunderstood and collapsed into the part states play in certification at the Federal level. For example, licensed clinical social workers (LCSWs) are eligible for certification under the Medicare program. States, however, may not have developed a licensure category for clinical social workers, and/or they may certify other types of social workers as eligible to receive payment in their State. In addition, states may have special certification categories for various types of outpatient services, including those delivered in free clinics, community-based clinics, hospital-based clinics, and specialty services delivered in sites such as ambulatory surgical centers. Some of these certification categories may overlap with Federal certification categories, such as FQHCs, rural health clinics, or provider-based clinics; others may not.
[10] Health Care Financing Administration. *National Summary of Medicaid Managed Care Programs and Enrollment*. http://www.hcfa.gov/medicaid/trends99.pdf . June 30, 1999. Also published by that Administration, see *2000 Medicaid Managed Care Enrollment Report: Penetration Rates from 1996-2000*. http://www.hcfa.gov/medicaid/trends00.pdf. June 30, 2000.
[11] Koppelman and Lear (1998).
[12] Connecticut is the prototypical example of a state that has passed laws requiring linkage between SBHCs and MCOs.
[13] Many states have also entered into separate contracts for managed mental health care. But while there has been some shakeout in the physical health Medicaid managed care marketplace, the nature of the physical health needs of Medicaid beneficiaries tends to be such that cases in need can be readily identified and treated. In the mental health marketplace, however, needs cannot be so easily identified and treated.
[14] A possible solution comes in the form of a partial phase-out of social workers, along with a careful integration of state certified and plan-covered practitioners in the kinds of cases and situations where a social worker's expertise is not required.

[15] A chart detailing the states that certify the independent practice of dental hygienists—including which procedures hygienists are certified to perform independent of a dentist's supervision—is available as a PDF download at the following site: forthcoming.
[16] In a less restrictive state that certifies hygienists for limited number of procedures, such as New York, a dental program can expect to utilize at least one full-time dentist and two hygienists, irrespective of support staff size and the number of chairs.
[17] For more on the shortage of dentists see the Surgeon General's first-ever report on oral health (U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.)
[18] A recent unpublished study comparing a sample of dentists' fees in the private sector to Medicaid fees for the same services, cited by GAO investigators in their April 2000 Report, indicates that "the level of Medicaid dental reimbursement in 1999, nationally and in most States, was about equal to or less than the dental fees normally charged by the lowest 10th percentile of dentists, i.e., 90 percent of dentists charged more, and usually substantially more, than the Medicaid fee." (From a January 2001 HCFA letter to State Medicaid Directors, posted on the Center for Health and Health Care in Schools website at http://www.healthinschools.org/tabaref.asp.)
[19] According to one sponsoring organization's estimates, however, approximately two-thirds of their SBHC dental programs revenue comes from Medicaid reimbursements, demonstrating the possibility of success despite poor reimbursement rates.
[20] Relationships between SBHC sponsors and managed care entities, while on the rise in number and quality, have been absent traditionally. They are rare enough still. The percentage of total revenue SBHCs receive from managed care and other third party reimbursements varies widely—from nothing in cases where plans are unwilling to contract with SBHCs or their sponsors, to very high percentages of the total school-based budget, such as in the case of Montefiore Ambulatory Care Center in New York, which in 1997 reported 69% of its total budget came from Medicaid fee-for-service revenues. Typically, those school-based systems that do receive third party payments, and Medicaid funding in particular, receive a very small percentage of their total budget from such reimbursement (data from Koppelman and Lear [1998]).
[21] Armbruster, Paula, Ellen Andrews, Jesse Couenhoven, and Gary Blau. "Collision or Collaboration? School-Based Health Services Meet Managed Care." *Clinical Psychology Review*, 19(2): 221-237 (1999).
[22] There are instances where school districts, or even SBHCs themselves, own the official medical records; in any case, the agency that contracts with a managed care organization is generally required to provide the risk-bearing entity—managed care organizations, in most cases—with access to medical records.
[23] Students' sensitive health status, care and treatment information are protected by Federal and state legislation. The Federal Educational Rights and Privacy Act (FERPA) protects "education records," and strictly defines such records to include a range of information a school collects about a student, including: guardian contact and date of birth information; grades and academic information; special education records; medical and health records the school creates or collects and maintains; and student personal information such as social security numbers. Personal notes made by teachers or other officials are not considered protected. Schools and local education agencies may release student information without the prior written consent of parents under limited conditions specified by law, and as stated in the school's or agency's student record policies. The same rules restricting disclosure apply to records maintained by third parties acting on behalf of a school, such as psychologists or medical practitioners who work for or are working under contract with a school. Outside parties receiving records must receive a written explanation of the restrictions on the re-release of information. Most states also have privacy protection laws that reinforce and supplement FERPA. This has significant implications for mental health staff and practitioners that, for example, are employees of an outside clinic-system licensed by the state and insured through that clinic system, who must make sure to uphold state and agency confidentiality and consent restrictions which are often more stringent than FERPA requirements. In other words, state confidentiality laws in some states may possibly supercede FERPA to prohibit the kind of internal sharing FERPA allows. For more general background and information on FERPA see Policy Studies Associates, Inc. "Protecting the Privacy of Student Education Records." *Journal of School Health*, 67(4): 139-140 (1997).
[24] Morone, James A., Elizabeth H. Kilbreth, and Kathryn M. Langwell. "Back To School: A Health Care Strategy For Youth." *Health Affairs*, 20(1): 122-136 (January/February 2001).
[25] As evidenced by some of the SBHCs which have already expanded their mental health services and implemented dental services, additional contracts need to be negotiated with a whole new set of entities. Once contracts are in

place, these SBHCs have had to modify billing systems and data collection on top of what they have developed on the primary care side of their operations to adhere to their new contracts.

[26] HIPAA provides for privacy and confidentiality standards specific to mental health. All covered entities, including school-based health centers, must obtain an authorization for any use or disclosure of psychotherapy notes except in situations of direct provider-client interactions (use of notes by originating provider for treatment, use or disclosure by the covered entity in training programs to improve skills in counseling; to defend legal action brought by the individual; and as required with respect to oversight of the originator of the notes.) (Adapted from Rankin, Kaye L. *Demystifying the Privacy Regulations: Health Insurance Portability and Accountability Act of 1996.* 2001: unpublished presentation.) For more on HIPAA visit the U.S. Department of Health and Human Services' website for their HHS Fact Sheet of May 9, 2001, entitled "Protecting the Privacy of Patients' Health Information," at http://www.hhs.gov/news/press/2001pres/01fsprivacy.html, as well as the Department's Office for Civil Rights publication entitled "Standards for Privacy of Individually Identifiable Health Information" at http://www.hhs.gov/ocr/hipaa/finalmaster.html.

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