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Memorandum

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Subj: **Financing Options for School-Based Health Centers**

In the middle of a financial melt-down, the consequences of which are still to be determined, an exploration of future funding opportunities for school-based health centers (SBHCs) may seem the ultimate triumph of hope over reality. However, from another perspective, the timing may be about right. The typical timeframe for establishing centers and moving them to participation in the health care marketplace is between 2 – 4 years, suggesting that by the time the economy recovers, the centers to be funded by The Colorado Health Foundation will be ready to implement funding strategies that move them towards sustainability.

This memorandum reflects the insights of a diverse group of Coloradans whom we interviewed during the past several months as well as our experiences in working with school-based health center initiatives in other states. (See appendix 1)

### **Current funding of school-based health centers in Colorado**

In 2008 the Colorado Association for School-Based Health Care (CASBHC) summarized the revenue sources for the state's 38 SBHCs in 2006 – 2007. (See appendix 2 for full report). Drawing on its 2008 Survey of Colorado School-Based Health Centers, CASBHC reported total revenues as \$9,098,481, with per center costs averaging \$239, 500.<sup>1</sup> A diverse group of sources offered support: in-kind contributions represented 27% of the total; private grants and donations – 25%; patient revenue – 22%, federal dollars – 13%; state support – 11%, and local public dollars – 2%. (See appendix 2) While the state of Colorado has supported school-based health centers with Maternal and Child Health grant dollars since the 1980s, in 2006 the legislature authorized the first state general fund dollars of \$500,000 be directed to school-based health centers. The line item was increased to nearly \$1 million in 2008.

This diversity of funding is a strong foundation for Colorado's school-based health centers. With support coming from multiple sources, the centers are less likely to be reliant on a few, possibly

volatile, funding streams and more likely to be creative in thinking of new ways to sustain their efforts.

### **Advice from the experts: big picture issues**

The Colorado experts we spoke with consistently reflected a pragmatic view of the strategies required to build sustainable funding for the state's school-based health centers. While there was diversity among their opinions and priorities, they resisted overarching theories of whom the centers should serve or what their service packages should include. To some degree this puts them at odds with long-time SBHC proponents who have spent considerable energy hammering out the definition of a school-based health center. While our informants did not urge school-based health centers to narrow their focus, they did recommend that the centers move beyond their comfort zone and rethink their business plans and vision of what they do and whom they serve. Our informants advise the centers to maintain their diverse funding streams, but expand their reimbursable services and increase the types of persons served. If there were a consensus among our experts, it was that SBHCs too frequently leave money on the table and that closer attention to a business plan will result in healthier bottom lines.

***Don't leave money on the table –bill for the services provided.*** While much that is written about SBHC financing focuses on public and private grant funding, our advisors urged centers to begin by capturing the money due for services provided to insured children. That is, all our experts recommended looking for opportunities to bill insured students for covered services. As one expert emphasized, “tying SBHCs to patient care revenues is the best way to assure a continuous funding stream and thereby support sustainability.”

***Meet with insurers first.*** Just as working with insurers may be a new role for SBHCs, working with SBHCs will be new for some insurers. SBHCs will want to talk with the plans serving their community and learn about any issues or concerns. Prior to meeting with insurers, Chris Walker, senior counsel at Wellpoint, suggested talking with the school systems to learn which insurers they use to insure the school system employees. The school systems have substantial purchasing power with their insurers and, with school system collaboration, that purchasing power may create an opportunity to make a new friend in the insurance world. The school systems' insurers could be helpful allies in negotiating with these new business partners.

***Prepare to bill.*** Walker suggested there are five steps SBHCs can take to position themselves for billing third party payers: Credentialing staff, formally adopting non-discrimination policies, establishing a defined list of services, arranging to bill and collect for services, and selecting billing codes to align with those of insurers. These steps are key to setting the stage for securing third-party payments. Walker also suggests that meetings with the Vice President for provider contracting at Wellpoint (or with similar executives with other insurers) can be helpful to thinking through the barriers and challenges involved in linking SBHCs to the health care reimbursement system.

Larry Hay concurred in the importance of billing. Once the centers begin billing, he believes they will begin to look for opportunities to increase revenues – becoming open to serving new populations or offering new services. He emphasized that “If SBHCs can generate a

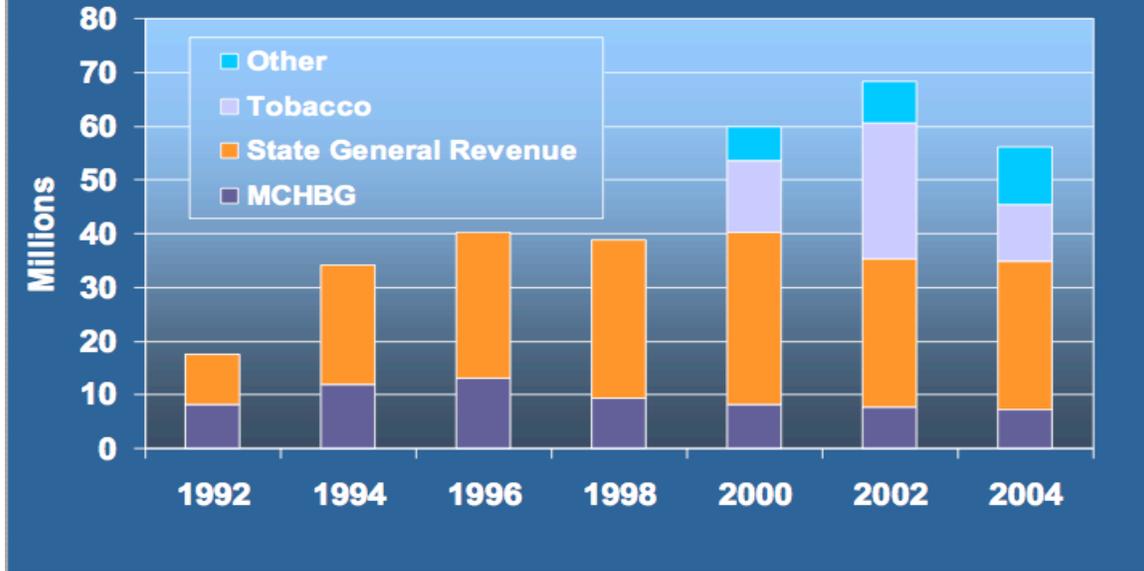
profit in some areas, that profit can be used to cover services given to the uninsured and the non-reimbursable services that are provided to all health center users. To reduce the number of uninsured students, Hay also argues for aggressive Medicaid and CHP+ enrollment services at the centers.

*Co-payments and cash payment for services.* SBHCs historically have not pursued collection of co-payments from students and/or their families for services delivered in a school based health center. In positioning centers to pursue private third party payments, there needs to be some thought as to how SBHCs will be deal with any requirements around the collection of co-payments. Additionally, some uninsured families, especially those who may be undocumented, will want to pay for services delivered. SBHCs should explore the possibility of accepting cash for services on site.

***Pursue expanded state funding – or maybe not.*** In looking to the state as a key source for SBHC funding, the paramount caution voiced was that the Tabor Amendment, adopted by Colorado voters in 1992, places serious constraints on this strategy. The Tabor legislation limits revenue increases for state and local governments to an inflation-rate increase plus a percentage adjustment equal to the percentage growth in population. While voters may approve revenue increases exceeding this amount, in general, Tabor creates a restrictive financial environment for those hoping to create new state-funded initiatives.

Although recent data on state funding for SBHCs nationwide is unavailable, in 2004 a report from the National Assembly on School-Based Health Care (NASBHC) reported a drop in state allocations from nearly \$70 million in state-directed funding for the centers in 2002 to \$56 million in 2004. While this decline was likely accompanied by an increase in state Medicaid and SCHIP expenditures directed to the centers, the NASBHC chart on state funding from 1992 – 2004 does not provide encouragement for a funding strategy built primarily on state-directed spending.

## Total State-Directed Funding 1992-2004



Larry Hay also weighed in on the limitations of state funding and private grants. Relying on “the kindness of strangers” as offered by private and public grants and in-kind contributions, he argued, is not a good strategy. Because SBHCs do not need to make a profit, he is confident that SBHCs can ‘get close’ to being self-sustaining.

*A state pilot program to increase private provider participation in CHP+ and Medicaid,* the Colorado Children’s Healthcare Access Program (CCHAP), may be a promising model for school based health centers. CCHAP, a non-profit organization formed 2 1/2 years ago, is working to increase the number of private providers willing to serve children covered by public insurance. Since it began, CCHAP has negotiated an enhanced reimbursement rate for participating providers. CCHAP also provides or secures access to support services that help Medicaid and CHP+ families access health care. These include transportation, eligibility determination, case management, and links to mental health services, to name a few. Initial outcome data from CCHAP has been promising: Participating children are much more likely to receive preventive care than Medicaid children in general; are more likely to receive required immunizations, and their average cost is significantly lower than that associated with children who do not have a medical home. Steve Poole, the founder of CCHAP, is interested in potential partnerships between private providers and local schools. His vision is that a private practice could locate a mid-level provider in a school based health center. The private practices would bill for services and, in return, deliver the needed infrastructure required by school-based health centers. The mid-level providers would see children at school and refer them back to their practice for follow up or more complicated services.

***Keep an eye on federal opportunities.*** There are several things to watch on the federal level. Introduced in 2007, the School-Based Health Clinic Establishment Act would have authorized a federal grant-based program for the operation and development of SBHCs. There are 22 Senate co-sponsors and 29 House co-sponsors. The National Assembly on School Based Health Care plans to pursue sponsorship and re-introduction in the Congress in 2009.

**On February 4, 2009, President Obama signed the SCHIP reauthorization legislation, H.R.2, which became Public Law 111-003. Section 505 of the act includes an explicit recognition of SBHCs as a potential provider of SCHIP-covered services by defining an SBHC as a provider of primary care services within the meaning of the legislation.**

The final things to watch for will be implementation of the President's fiscal stimulus package, as well as the work of the health care reform teams associated with Senator Kennedy (Senate Committee on Health, Education, Labor and Pensions) and Senator Baucus (Finance Committee). All these efforts have the potential to change the current health care finance landscape. Senator Baucus has published a white paper on health care reform Call To Action, Senate Health Care Reform 2009. In this document, the medical home concept, increased reimbursement for primary care, and reimbursement for early intervention and prevention are highlighted.

#### **Advice from the experts: strategic decisions that could benefit SBHC finances**

***Abandon the “safety net” only strategy.*** While SBHCs have targeted low-income communities to assure that uninsured and publicly insured children have access to care, one expert argued that the more SBHCs are seen as “for everyone,” the less stigma and the more funds will be associated with the centers. Similar to the strategies used by the burgeoning retail health care clinics, this expert urged the centers to market services that are of particular interest to parents. Sports physicals and immunizations are a way to create income that offsets the costs of providing care to uninsured or underinsured students or offering early intervention and health promotion services.<sup>2</sup>

***Encourage state to move to pay-for-performance reimbursement.*** While acknowledging that Colorado has not been in the forefront of this movement, another advisor noted that Colorado providers' performance measured against HEDIS standards for Medicaid MCOs are lower than they should be. If the state moves to pay for performance, SBHCs would be in a good position to receive bonus payments for their high rates of providing health promotion/disease prevention services.

***Encourage SBHC interest in the “social entrepreneur” model for future operations.*** Many of the experts spoke of the need to develop a new model or new frame for school based health centers. Historically SBHCs have resisted billing mandates for fear that this will divert SBHCs from their mission-driven approach to organizing and delivering care. The Colorado Association of School-Based Health Centers may be in a pivotal position to bring the state's SBHCs together to explore how adapting some of the business strategies described in this memo

create not only new funding opportunities but offer a way to maximize mission impact. Some of the innovative suggestions made include: providing flu shots to adults on back to school night, negotiating with the major insurer of the teachers to provide on site wellness and health promotion services to the teachers in the school, marketing immunizations and sports physicals to the entire student body, providing newborn nursery physicals for unassigned babies at the local hospital. This ‘social entrepreneurial’ approach will require considerable reflection and planning by the SBHCs as they work to build a secure financial future while reinforcing their commitment to improving children’s health through school-connected care.

***Investigate developing partnerships with business and financial partners who have the skills to support the SBHCs evolution into social entrepreneurial ventures.*** Two of the experts, Larry Hay and Christopher Castilian, suggested exploring partnership opportunities with organizations and associations that represent the health care industry. They both felt that there might be opportunities to tap into the health care industry’s expertise/technical advise as well as to educate these organizations about the work of the school based health centers. Some of the suggested organizations and associations to be targeted included the Convenience Care Association, the Colorado Association of Health Plans, and the Colorado Business Health Forum.

***Build on voter support for change (but recognize voter resistance to higher taxes).*** Health care reform is a real possibility – whether it is presented as “change we can believe in” or as part of a stimulus package. Thinking about where SBHCs would fit into a reformed health system for kids should be part of our planning for the future. One specific benefit of potential universal coverage for kids is that, in theory, there would be an insurer for every child. This would be an opportunity for SBHCs to make their case as being the most effective mechanism for reaching low-income kids. *To be noted:* Health care reform will not touch the challenge of uninsured undocumented children. Also note that while federal officials may see SCHIP as a coverage strategy, they may not be sufficiently tuned in to the state budgetary limitations. A 10% match is still a state match and the state coffers are near to empty.

***Capitalize on SBHCs’ acknowledged skills:*** (1) SBHCs can make the case that they have the skills to serve harder-to-serve populations – those whose parents are not native-English speakers and those who are very low income, and (2) centers can also make the case that they have advantages in providing health promoting and chronic disease management services. If MCOs play a role in health care expansion, SBHCs should plan how they can negotiate enhanced payment rates.

***Build partnerships between community physicians and school-based health care as part of a collaborative effort*** to assure safe hand-offs if the SBHC is co-managing clinical care for kids with chronic diseases.

***You gotta have volume to survive and grow!*** If an SBHC does not have scale, that is, multiple service locations, it needs to generate large volume at a single site. Thus, consolidated services make sense as a foundation for administrative services. CASBHC is taking advantage of that principle by building back-office services (billing) for multiple SBHCs in the Colorado.

***Risk adjustment in Medicaid is not going away*** and MCOs will need to collect data from their providers to secure appropriate reimbursement from Medicaid. While a number of states have had difficulties weighting Medicaid reimbursement according to risk, one of our key informants felt strongly the concept is not going away and that SBHCs need to start talking with MCOs about how the centers will fit into the MCO network requirements.

## **Challenges to sustainability**

***Schools and SBHCs are on the front-line of providing services to undocumented kids.*** Health care reform will not solve the problem of uncompensated care. How can SBHCs secure funding from charitable sources to help support this care? Alternatively, how can SBHCs develop patient care revenues sufficient to help pay for the burden of providing uncompensated care?

***SBHCs will always need some form of direct public or private funds.*** There will always be a percentage of students who will not have health insurance or a means to pay for their care. To offset the cost of uncompensated care, SBHCs need to develop strategies to bring in funding sources beyond patient care revenues.

***SBHCs are affected by shortages of primary care, mental health, and dental health providers available and willing to serve uninsured or publicly-insured students.*** The health care delivery system needs professionals to deliver the care and there are not enough of them. These are longer-term issues that need to be addressed at the state policy level. A related issue is the limited network of providers who will see Medicaid and CHP+-enrolled kids, especially in rural parts of the state. While the absence of providers creates an opportunity for SBHCs, without nearby community-based providers, the SBHCs have difficulty functioning.

***Negotiating the politics involved in SBHC relationships with private practices and other institutional providers is fraught with downsides for SBHCs.*** In the main, these politics reflect the mutual concerns of community-based providers and SBHCs as to who will serve as gate-keepers for public and private reimbursement for primary care services. Larry Hay acknowledged the anxiety associated with negotiating with insurers as well as with the pushback from medical providers “who do not want anyone to rock the revenue boat.” On the other hand, our experts also pointed out several examples of win-win relationships. Larry Wolk described a Rocky Mountain Youth Clinic effort that contracted with community providers to provide back-up and on-call services to its SBHCs. This arrangement enables the SBHCs to have access to the pediatricians’ networks of sub-specialists as well as the pediatricians’ privileges to admit patients to the local hospital. In another instance, a local practice provides both the medical director and the part-time PA for the SBHC.

***Changes affecting school systems will affect SBHCs.*** It’s unclear where schools will be in 10 years but it is clear that current trends involving charter schools, smaller schools and school choice all tend to disperse kids into a variety of locations. Neighborhood clusters are less common and that makes it difficult for SBHCs to team up with neighborhood leaders to create mutually reinforcing school-community partnerships.

*It's time to increase the evidence base.* With a handful of exceptions, much of the research on SBHC effectiveness was published more than 5 – 10 years ago. While there is some good research (much of it published by the Denver SBHCs), it is time to update the evidence. (See appendix 3 for best-quality research publications.)

## **Financing and School-Based Health Centers 2.0**

This memorandum on financing school-based health centers focuses on patient care revenues and linkages between the centers and community-based patient care. Nationwide and in Colorado this has *not* been the primary strategy pursued by centers as they have sought to stabilize their funding. Becoming more business-like and, as suggested by our experts, exploring the possibilities associated with social entrepreneurship will be challenging for the school-based health center field and its many supporters.

In part, the centers were created *because* traditional health care did not meet the needs of adolescents and many low-income children and youth. Not surprisingly, health center staff, public health officials and others are sometimes concerned about the willingness of the private sector to support a service model that emphasizes prevention and early intervention as well as universal access for students in the school. It is also true that a number of SBHCs are small and ill-prepared to implement cost-efficient billing. That said, the consultants we spoke with and our field experience persuade us that patient care revenue may be the most currently-promising building block for long-term health center sustainability. The Colorado Health Foundation and the Colorado Association for School-Based Health Care are taking an important step in exploring the creation of a central billing service for the centers. Assisting the SBHCs assess their capacity to collect needed data and participate in third party billing should be a technical assistance priority. On a parallel track, an initiative might be developed that would enable Colorado SBHC stakeholders discuss their concerns about raising the importance of patient care revenues in sustaining the centers. As noted earlier, many of the centers long-time supporters worry that a focus on patient care revenue could undercut the historic mission and vision of the school-based centers. Their concerns will need to be addressed.

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<sup>1</sup> Colorado Association for School-Based Health Care, *Financing School-Based Health Care*. Colorado Association for School-Based Health Care, Denver, CO, 2008. Accessed on the web at <http://www.casbhc.org/publications/index.asp> on December 16, 2008.

<sup>2</sup> Historically, limited funds have led most funders to prioritize low-income communities as locations for SBHCs. (Only Delaware which as pursued a policy of placing an SBHC in every high school has side-stepped a “means testing” for SBHCs.) A consequence of this targeting strategy is the perception (both within and outside the centers) that SBHCs are *only* for the low income and underserved students.

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