Strengthening School-Based Health Centers in Maryland
A Study of Funding and Access Issues

Submitted to
The Maryland Community Health Resources Commission

Submitted by
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Executive Summary

School-based health centers (SBHCs) provide on-site preventive services, acute care, mental health services, and oral health care to students of all ages. These centers are an important safety net provider for children and adolescents who have limited access to the health care system. SBHCs are not intended to be a medical home; rather, they are a convenient place where students can access needed care and referrals in a familiar and non-threatening environment.

In Maryland, there are currently 62 SBHCs in 10 jurisdictions providing access to health services to the more than 50,000 students enrolled in affiliated schools. The SBHCs are sponsored by seven local health departments, two school systems, two Federally Qualified Health Centers (FQHCs), and one hospital. Forty-four percent of the centers serve high school students, 31 percent serve middle school students, and 44 percent serve elementary school students. In FY 2006, funding for Maryland's SBHCs approached an estimated $6.96 million. Funding sources include the federal government (approximately 12 percent of the total in FY 2006); state government (30 percent); local government (37 percent); patient care revenue, which is predominantly Medicaid revenue (11 percent); sponsor contributions (4 percent); and other support, such as United Way, in-kind support, and miscellaneous cash support (6 percent). In FY 2008, the state of Maryland will contribute $2.875 million in grant funding to subsidize the operation of SBHCs.

Despite broad-based support for SBHCs in Maryland, SBHCs report insufficient funding to finance current operations and to expand in order to meet the growing demand for their services. Advocates and policymakers alike agree that the long-term financial viability and the very survival of these important community health resources is dependent on developing new sources of support as well as the ability to bill for services and collect reimbursement from Medicaid and private insurers.

The Study

The Maryland Community Health Resources Commission (Commission) contracted with the Center for Health Program Development and Management at the University of Maryland, Baltimore County, to conduct a study of funding and access issues that have an impact on the financial viability and continued growth of Maryland's SBHCs. The legislation establishing the Commission—the *Community Health Care Access and Safety Net Act of 2005*—required that the study be carried out.

The objectives of the study were to 1) produce a financial portrait of Maryland's SBHCs; 2) assess barriers to reimbursement from Medicaid and other third party payers; 3) examine patient eligibility, fee schedules, reimbursement, and security issues; and 4) recommend directions the Commission might pursue to expand access to SBHCs, further develop the infrastructure and stabilize the financing of SBHCs, and promote increased reimbursement from Medicaid and other insurers. The study involved structured interviews with SBHC sponsors; structured interviews with Maryland Qualified Health Centers (MQHCs); interviews with managed care

organizations (MCOs); consultation with Maryland Medicaid; an examination of the legal and regulatory environment; and a review of best practices in other states.

Study Findings

1. **The survey, interviews, and other research confirm the value of SBHCs as a safety net provider for school children.** During the 2005-2006 school year, a total of 26,901 students enrolled in SBHC programs and 15,000 of those children visited their centers, accounting for 73,165 visits. SBHCs provide access to health care regardless of ability to pay for many children and adolescents who might not otherwise seek services or who do not have a regular source of health care.

2. **The state's SBHCs are operating on very limited budgets and with minimal staff.** Estimated FY 2006 revenue was $6.96 million and the state's SBHCs averaged just 2.89 full-time equivalent staff. All the centers reported need for services far greater than what the centers are able to provide, particularly oral health care and mental health services.

3. **Because the HealthChoice regulations place restrictions on reimbursement for self-referred services, there is limited potential for SBHCs to receive Medicaid reimbursement, even if SBHCs were to bill and receive payment for all eligible services.** Maryland's SBHCs reported that patient revenue accounted for about 11 percent of total revenues. This compares with 13 percent nationally, suggesting that Maryland's centers could increase patient revenue to some extent. Contracting with MCOs could provide additional Medicaid reimbursement to SBHCs, but a number of barriers must first be overcome. Even then, SBHCs are likely to require additional sources of revenue to survive and grow.

4. **All but one SBHC sponsor report billing for services to some extent, but there is wide variation.** The least frequently billed services are health promotion/prevention services, substance abuse treatment, and mental health care. Sponsors report difficulty maximizing third party reimbursement because of insufficient staffing, lack of staff training, lack of standardized billing policies and procedures, and difficulty complying with insurers' credentialing requirements. Many SBHCs question the cost-effectiveness of billing Medicaid given the limited number of "self-referred" services for which SBHCs may bill, the low Medicaid reimbursement rates, and the amount of staff time required in the billing process.

5. **SBHCs have not been very successful in contracting with HealthChoice MCOs.** Only one sponsor reports having an MCO contract. MCOs expressed varying levels of interest in contracting with SBHCs. MCOs are concerned that the concept of managed care and the medical home may be undermined; quality may be compromised, as well as the ability of the MCO to meet HEDIS standards; and reporting by SBHCs on encounters is not always timely or consistent.

6. **Accounting and fiscal management systems of SBHCs do not always produce reliable financial information.** The accounting systems of some sponsors do not have dedicated cost centers for SBHCs, so consistent and reliable reporting of revenue and expenses by center is not possible. Consequently, revenues and expenses reported in this study are only estimates. Better financial management systems will be required to monitor progress with any initiatives to increase billing by SBHCs.

7. **SBHCs report a need for expanded oral health services and mental health services.** Six sponsors reported providing dental services and all the sponsors reported providing mental health services. Expanding oral health services involves significant capital outlays for equipment, and the dearth of dental providers presents significant staffing challenges. With mental health services, the primary barrier to expanding services is lack of financing to pay additional salaries and fringe benefits to providers.

8. **The availability of professional liability coverage is not an issue for SBHCs or MQHCs.** Most SBHCs and MQHCs provide professional liability coverage to their full-time and part-time employees. Eight SBHC sponsors report that they are already covered by governmental immunity laws (i.e., the Federal Tort Claims Act, the Maryland Tort Claims Act, or the Local Government Tort Claims Act). SBHCs and MQHCs report that they do not anticipate hiring more part-time or contractual practitioners if the Maryland Tort Claims Act were to be extended to cover these groups of practitioners.

9. **Security does not seem to be a major issue at most SBHCs.** Few SBHCs provide services to non-students and most operate during school hours and/or immediately before and after school, so after-hours security is not a significant issue. Precautionary security measures, such as secure storage for medical supplies, drugs, and records and HIPAA-compliant procedures for sharing and storing medical records, are generally in place. Over 80 percent of SBHCs have not experienced any security incidents.

10. **SBHCs experience difficulty in recruiting, remunerating, and retaining qualified practitioners, especially dental providers.** Reconsidering and appropriately liberalizing scope of practice limitations could potentially result in a greater supply of practitioners available to SBHCs and/or expand the scope of services that existing practitioners can provide.

11. **Maryland's SBHCs are generally choosing to pursue the traditional SBHC model as opposed to the school-based *community* health center model, which involves serving a broader population in the community.** SBHCs report serving populations other than students, but it is usually confined to siblings, parents, and faculty and staff. Only one sponsor expressed interest in expanding services in the community.

12. **The survey of MQHCs had the unexpected result of highlighting the difficulty in identifying existing MQHCs in the state.** The numbers of MQHCs in the state appear to be declining. At the time of the survey, seven MQHCs were operating, but one of these will cease operations in November 2007.

13. **Initiatives in other states offer lessons for Maryland.** In New Mexico, the Medicaid reimbursement rules provide for reimbursement for a broader range of services than in Maryland, and a stakeholder summit and task force were instrumental in building ongoing, broad-based support for SBHCs. The Michigan initiative, which involves a centralized billing system and enhanced capitation payments to MCOs for SBHC outreach and education, is another promising model. New Hampshire, New York, and Ohio have innovative school-based dental programs.

Recommendations for a Commission Grants Program

Research findings point to three opportunities for grant-making by the Commission. However, in designing a grants program, it is important to note that SBHCs in Maryland vary tremendously—in sponsorship, size, scope of services, populations served, billing capacity, and perhaps most significantly, their location on the "continuum of growth and development" as organizations and safety net service providers. Recognizing this, a range of grant opportunities is presented so that there will be an appropriate opportunity for each SBHC and SBHC sponsor. In addition, the grant-making recommendations reflect the needs and desires of SBHCs and their sponsors as communicated in the survey and interviews conducted for this study.

SBHCs could benefit from grant opportunities in three program areas:

1. Enhancing the IT capability of SBHCs in order to streamline financial and clinical management information systems and function and maximize revenue from patient care.
2. Service expansion in preventive health care, oral health, and behavioral health.
3. Start-up support for new SBHCs.

In designing a grants program, the Commission should consider encouraging collaboration across sponsors and centers and building leadership from within. A program of technical assistance and training on financial management and billing made available to all SBHCs and sponsors in the state would be beneficial. Because centers are operating with minimal staff—many of whom are clinicians managing busy practices—sponsors and SBHCs urged that sufficient time be built into any Request for Proposals to enable them to explore new collaborations and prepare grant proposals.

General Recommendations

SBHCs are an important safety net provider for Maryland's school children and should be an integral part of any proposals for health reform put forth by the state. The long-term viability of SBHCs can be ensured only if the needs of these vital community health resources are addressed broadly and systematically. It is unlikely that SBHCs can ever be fully self-supporting through patient care revenue. Steps to improve billing and reimbursement will have a positive effect on revenue, but these efforts must be coupled with a broader consideration of policies that affect the financing and delivery of SBHC services. For example, the state might consider:

1. Revising the Medicaid regulations to allow "self-referred" reimbursement for a wider range of services, including more preventive services, and simplifying the reporting requirements.

2. Instituting incentives to encourage MCOs participating in the HealthChoice program to contract with SBHCs for the provision of preventive services.

3. Exploring the possibility of increasing Medicaid reimbursement rates for self-referred SBHC services in order to increase revenue to SBHCs.

4. Encouraging all of the local health department sponsors who are facing challenges with patient billing to apply for and enforce waivers allowing uninsured individuals to be "nonchargeable."

5. Providing ongoing training and technical assistance to SBHCs on Medicaid and MAPS-MD billing and reimbursement.

6. Collaborating with SBHCs and MCOs to find new ways to enhance electronic billing capacity and make claims processing and payment more efficient for all.

7. Encouraging measured expansion of SBHCs in the state with an emphasis on long-term sustainability.

8. Working with provider groups and training programs to explore new ways to train, credential, supervise, and finance practitioners for SBHCs—including nurse practitioners, physician assistants, oral health providers, and behavioral health practitioners—and establish appropriate linkages to students' primary care physicians and medical homes.

Introduction

Overview of Maryland's School-Based Health Centers

The National Assembly on School-Based Health Care defines school-based health centers (SBHCs) as follows:

> School-based health centers are partnerships created by schools and community health organizations to provide on-site medical and mental health services that promote the health and educational success of school-aged children and adolescents … The school-based health care team works in collaboration with the school nurse and other service providers in the school and the community … SBHCs are typically open every school day, and staffed by an interdisciplinary team of medical and mental health professionals that provide comprehensive medical, mental health, and health education services. SBHCs make provisions for care beyond the centers' operating hours or scope of service … Because of the unique vantage point and access to students, the health center team is able to reach out to students to emphasize prevention and early intervention.[1]

In Maryland, there are currently 62 SBHCs in ten jurisdictions providing access to health services for the more than 50,000 students enrolled in affiliated schools (Table 1).[2] The centers provide preventive services and treat acute and chronic conditions. Some centers provide oral health, mental health, and substance abuse services as well. SBHCs are not intended to be a medical home; rather, they are a convenient place where students can access needed care and referrals in a familiar and non-threatening environment. SBHCs are an important safety net provider for children and adolescents who have limited access to the health care system.

Maryland's SBHCs are sponsored by seven local health departments, two school systems, two Federally Qualified Health Centers (FQHCs), and one hospital. Forty-four percent of the centers serve high school students, 31 percent serve middle school students, and 44 percent serve elementary school students.[3] Funding for SBHCs in Maryland in FY 2006 approached an estimated $6.96 million. While the centers share a common mission, each center differs from the next. Developmental history, sponsorship, services provided, populations served, staffing arrangements, financing, and parental and community involvement can vary.

[1] National Assembly on School-Based Health Care. *School-Based Health Centers: A National Definition*. Position Statement of the National Assembly on School-Based Health Care, Adopted June 20, 2002.
[2] A complete listing of Maryland's SBHCs can be found in Appendix 1.
[3] Some SBHCs serve multiple schools and multiple grade levels. For example, an SBHC may serve one high school and two middle schools. For this reason, the percentages cited here add up to more than 100 percent.

Table 1
Number of School-Based Health Centers in Maryland by Sponsor
As of November 2007

Jurisdiction	Sponsor	Number of Centers
Baltimore City	Baltimore City Health Department	15
	Baltimore Medical System	2
	Maryland General Hospital	1
Baltimore County	Baltimore County Public Schools	14
Caroline County	Choptank Community Health System, Inc.	7
Dorchester County	Dorchester County Health Department	4
Harford County	Harford County Public Schools	4
Montgomery County	Montgomery County Department of Health and Human Services	3
Prince George's County	Prince George's County Health Department	4
Talbot County	Talbot County Health Department	4
Washington County	Washington County Health Department	3
Wicomico County	Wicomico County Health Department	1
Total		**62**[4]

Source: Maryland State Department of Education.

According to the Maryland Assembly on School-Based Health Care (MASBHC), approximately 27,000 children were enrolled by their parents in SBHCs in FY 2006 and almost 15,000 of those children visited their center at least once. As shown in Table 2, centers vary considerably in the number of hours they are open each week, as well as the hours of operation.

[4] The number of SBHCs in the state fluctuates from year to year as some centers close their doors and others open. Hence, the number of centers cited in this report will vary according to the year in which the data were collected. For example, in FY 2006, there were 63 SBHCs in Maryland, but as of the date of this report, there are 62.

Table 2
School-Based Health Centers in Maryland:
Number of Hours Open Each Week and Hours of Operation
FY 2006

No. of Hours Open Each Week	No. of Centers	Percent of Centers		Hours of Operation	No. of Centers	Percent of Centers
30-40 hours	24	38%		During School	59	94%
20-30 hours	10	16%		Before School	24	38%
10-20 hours	19	30%		After School	27	43%
Less than 10 hours	10	16%		Summer	17	27%

Source: Maryland Assembly on School-Based Health Care.

In FY 2008, the state of Maryland will contribute $2.875 million in grant funding to subsidize the operation of SBHCs. As shown in Table 3, the state has provided support for the centers since FY 2001. Funding was appropriated through the Governor's Office for Children, Youth, and Families from FY 2001 to FY 2005 and through the Governor's Office for Children in FY 2006. In FY 2007, the Maryland State Department of Education (MSDE) assumed responsibility for the state's SBHCs pursuant to House Bill 932 entitled *Education—Child Care Administration and Office for Children, Youth, and Families and Maryland Family Support Centers Network—Transfer to State Department of Education,* which was passed by the 2005 Maryland General Assembly and signed into law by the governor. MSDE manages the state's SBHC grants program and the School-Based Health Center Policy Advisory Council, charged with "coordinating the interagency effort to develop, sustain, and promote quality school-based health centers in Maryland."

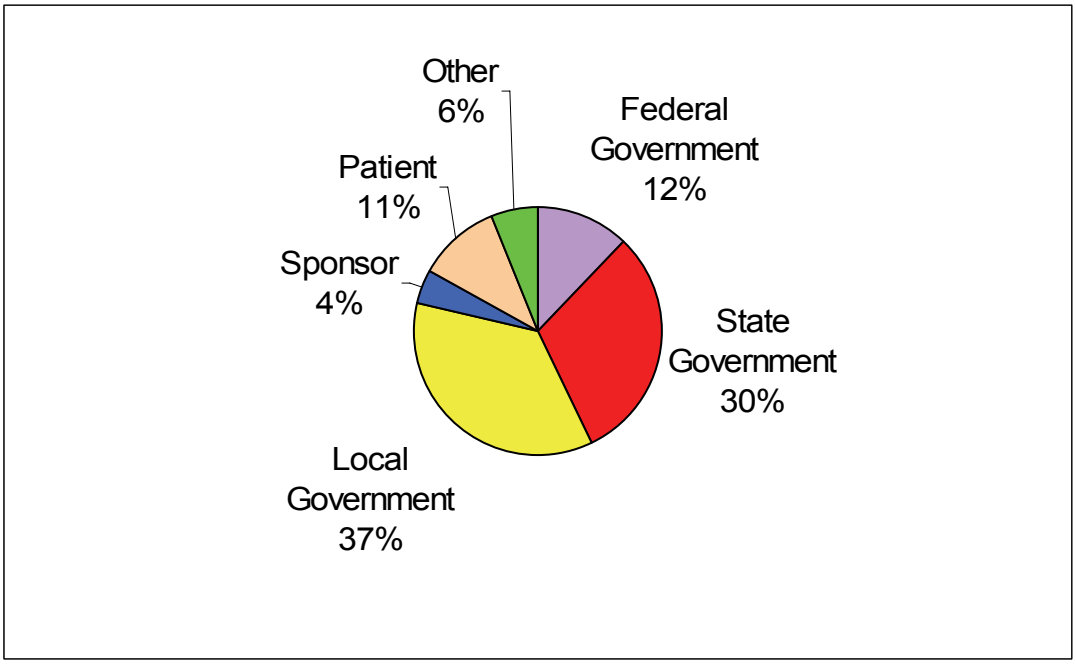
Table 3
State Funding for School-Based Health Centers
Maryland, FY 2001 – FY 2008

Fiscal Year	Funding
2001	$1,689,535
2002	--
2003	3,086,475
2004	--
2005	2,854,945
2006	2,175,206
2007	2,875,206
2008	2,875,206

Source: Maryland State Department of Education.

In addition to state funds, federal Section 330 funds help support SBHCs sponsored by two community health centers and one local health department. Local governments and school systems allocate substantial sums to centers as well. Figure 1 displays sources of funding for SBHCs in Maryland.

Figure 1
School-Based Health Center Revenue by Source
Maryland, FY 2006



Note: "Other" includes United Way, in-kind support, and miscellaneous cash support
Source: Center for Health Program Development and Management, UMBC.

Despite this broad-based support, SBHCs continue to report insufficient funding to finance current operations and meet the growing demand for their services. Advocates and policymakers alike agree that the long-term financial viability and the very survival of these important community health resources is dependent on developing new sources of support as well as the ability to bill for services and collect reimbursement from Medicaid and private insurers.

Study Purpose

The Maryland Community Health Resources Commission (Commission) contracted with the Center for Health Program Development and Management (Center) at the University of Maryland, Baltimore County, to conduct a study of funding and access issues that have an impact on the financial viability and continued growth of Maryland's SBHCs. The legislation establishing the Commission required that this study be carried out as specified below:[5]

[5] Community Health Care Access and Safety Net Act of 2005, codified as Health-Gen. Art., §19-2109(a)(15), (a)(17), and (d)(2).

(15) Study school-based health center funding and access issues including:
(i) Reimbursement of school-based health centers by managed care organizations, insurers, nonprofit health service plans, and health maintenance organizations; and
(ii) Methods to expand school-based health centers to provide primary care services; …

(17) Evaluate the feasibility of extending liability protection under the Maryland Tort Claims Act to health care practitioners who contract directly with a community health resource that is also a Maryland qualified health center or a school-based health center; and

(18) … (d) The Commission, in conducting the school-based health center study required under subsection (a)(15) of this section, shall:
(1) Solicit input from and consult with local governments that operate school-based health centers, the State Department of Education, the Maryland Insurance Commissioner, representatives from school-based health centers, providers, and insurers; and
(2) Identify the following:
(i) A fee schedule for individuals accessing a school-based community health center;
(ii) Reimbursement rates to be paid by managed care organizations and insurers, nonprofit health services plans, and health maintenance organizations to the school-based community health center;
(iii) Insurance payments owed to school-based community health centers and how much of the payments should be collected to offset any State subsidy;
(iv) Barriers to the reimbursement of licensed health care providers who provide services at school-based health centers, including nurse practitioners and physician assistants;
(v) A system of registering individuals who receive health care services from a school-based community health center that requires an individual to pay premiums and sliding scale fees; and
(vi) Security measures to be used by school-based community health centers.

Working within the legislative framework, the overarching focus of the study is to examine operational and policy options for increasing reimbursement and sustainability as a way to build self-sufficient, fiscally strong SBHCs. Specifically, the study has four objectives:

1. Produce a financial portrait of the state's SBHCs, including revenues, expenses, fee schedules, billing and collections practices, relationships with Medicaid and third-party payers, reimbursement, and professional liability issues.

2. Assess barriers to reimbursement by Medicaid and private insurers and present policy options for overcoming these barriers.

3. Examine patient eligibility, fee schedules, reimbursement, and security issues related to school-based community health centers as discussed in the Commission's enabling legislation (Health-General Article §19-2109(d)(2), Annotated Code of Maryland).

4. Recommend directions that the Commission might pursue to help expand access to SBHCs, further develop the infrastructure and stabilize the financing of these community health resources, and promote increased Medicaid and third party reimbursement for services.

Methods

The study involved six tasks as described below.

1. Structured Interviews with SBHC Sponsors

The Center conducted structured interviews with sponsors of Maryland's SBHCs. This involved developing a survey instrument; encouraging SBHC sponsors to participate in the survey; collecting, processing, and analyzing survey data; and conducting follow-up in-person or telephone interviews with a sample of sponsors.

The survey instrument, which consisted of two parts, is provided in Appendices 2 and 3. Part A was to be completed by the sponsoring organization; Part B requested SBHC-specific information and was to be completed by individual centers. Together, Part A and Part B requested information on:

- Populations served by SBHCs
- Billing practices
- Barriers to billing and reimbursement for services
- Fee schedules
- Staffing and practitioner contracting
- Appointment capacity
- Security
- Professional liability coverage
- Revenue and expenses

MASBHC and MSDE offered the Center assistance in identifying appropriate contact persons at each of the sponsoring agencies and encouraging the agencies to participate in the study.

In July 2007, the survey instrument was mailed to representatives of 12 agencies sponsoring SBHCs in Maryland: 7 local health departments, 2 FQHCs, 2 public school systems, and 1 hospital.[6] The Center followed up by telephone and e-mail with each sponsor to encourage completion of the survey, contacting non-respondents at least three times. Sponsors were permitted to respond either electronically or on paper. Despite repeated requests, one sponsor, representing less than 2 percent of the state's SBHCs, chose not to participate.[7] Completed surveys were received from the other 11 sponsors between July and September 2007.

[6] A survey was not sent to Cecil County Health Department, whose SBHCs were temporarily closed due to lack of funding.
[7] The non-respondent operates an SBHC that serves a specialized population.

Part B of the survey requested itemized data on revenues and expenses for FY 2006, as well as operating results for FY 2004 through FY 2007. The sponsors reported varying capacity to compile these data and some spent considerable time responding to this portion of the questionnaire. In some cases, sponsors were unable to provide SBHC-specific data as requested in Part B, so the Center accepted aggregate data. Because some of the reported data were incomplete and/or exhibited inconsistencies or possible inaccuracies, letters were sent to chief financial officers of sponsoring organizations requesting completion and verification of the financial information reported in the surveys.

The chief financial officers of three SBHC sponsors did not respond to the request for completion and verification of revenue and expense data. Among these is one sponsor who responded to the survey but was unable to report complete revenue data and did not report expenditure data at all. As a result, revenue and expense data provided in this report are incomplete. However, the estimates presented can provide a useful overview of major funding trends. Clearly, the inability of some sponsors to report financial information points to the need for improved cost accounting systems for SBHCs.

The Center entered data from the surveys into an electronic database, cleaned the data, and analyzed it to produce the findings presented in this report.

Follow-up interviews were conducted with six sponsors in October 2007. The interviewees represented both large and small networks of SBHCs and varied in their billing practices and success at reimbursement.

2. Interviews with Managed Care Organizations and Insurers

In October and November 2007, the Center conducted telephone interviews with the seven managed care organizations (MCOs) participating in the Maryland HealthChoice program, as well as one private insurer in Maryland. The purpose of the interviews was to obtain their perspectives on the opportunities and challenges to entering into relationships with SBHCs to provide health care services to children enrolled in their health plans. A list of discussion topics was sent to the MCO interviewees ahead of time.

3. Consultation with Maryland Medicaid

In September and October 2007, the Center consulted with the Maryland Department of Health and Mental Hygiene (DHMH) on Medicaid policy and rules related to reimbursement for SBHCs. Specifically, the Center examined rules that allow fee-for-service billing for self-referred services provide by SBHCs, as well as contracting between SBHCs and MCOs. In particular, barriers to reimbursement were examined.

4. Legal and Regulatory Environment

The Center examined existing laws and regulations that potentially could act as barriers to SBHC reimbursement, as well as those that could be helpful in reducing the effect of such barriers. The Maryland Tort Claims Act was also reviewed to analyze how it might be used to extend professional liability protection to practitioners in SBHCs.

5. Review of Best Practices

The Center reviewed initiatives in other states to promote improved billing and reimbursement for SBHCs, as well as programs and policies to promote dental services in SBHCs. This activity included a literature review and interviews with SBHC officials in other states.

6. Structured Interviews with Maryland Qualified Health Centers

The Center developed a survey instrument for Maryland Qualified Health Centers (MQHCs) on professional liability issues as directed in the legislation establishing the Commission. There are presently six MQHCs in the state. The MQHC survey instrument is provided in Appendix 4. Using a list of MQHCs and contact persons obtained from DHMH, the Center mailed the questionnaire in July 2007. Despite repeated follow-up telephone calls and e-mails, only three of the six MQHCs responded to the survey.

Findings from the surveys, interviews, and research described above are discussed in the following pages. The final chapter of this report provides a summary of findings, presents policy options and recommendations that would help strengthen SBHCs in Maryland, and provides suggestions for a Commission grants program that would complement these recommendations.

Study Findings

The research conducted for this report confirms the value of SBHCs as a safety net provider for Maryland's children and adolescents. Below is a discussion of the services provided by SBHCs in Maryland, the capacity of centers to meet both current demand and future need, and the financial outlook for the state's SBHCs. A discussion follows on the extent to which access to professional liability coverage limits the ability of SBHCs to recruit practitioners, whether security concerns affect the operation of SBHCs, the extent to which SBHCs are seeking to expand to serve the broader community, and practitioner-related reimbursement issues for SBHCs.

School-Based Health Center Services

Maryland's SBHCs provide a variety of services to their student populations. The scope of these services varies widely across sponsors, centers, and type of school. According to survey results, all of the sponsors reported that their centers provide acute care, chronic disease care, mental health services, and health promotion/prevention services. Half of the sponsors reported that their centers provide dental and reproductive health care services, and only three sponsors reported providing substance abuse treatment. While most of these services are provided to enrolled students, a small number of centers serve siblings, parents, and guardians of enrolled students; school faculty and staff; and/or other members of the community. The following table indicates the most prevalent somatic, mental health, and dental services provided onsite in SBHCs.

Table 4
Prevalent School-Based Health Center Services by Category
Maryland, FY 2006

Somatic	Dental	Mental Health
Acute Illness Treatment	Oral Hygiene Instructions	Assessment
Chronic Illness Treatment	Cleaning	Brief Therapy
Health Education		Grief Loss Therapy
Prescriptions for Medication		Case Management
Medication Administration in the Health Center		Conflict Resolution
		Skill Building

Source: Maryland Assembly on School-Based Health Care, School Year 2005-2006 Annual Survey.

The somatic care services provided by Maryland SBHCs are consistent across the state. All of the SBHC sponsors reported that their centers provide acute care services and most provide well-child exams and immunizations. The screening services provided by SBHCs can serve to identify previously untreated conditions that require follow-up by the student's primary care provider. One sponsor reported that offering sports physicals to their students serves that function; the SBHC providers then refer the child to a primary care provider for appropriate treatment. Several sponsors reported the need for additional funding to increase provider hours to meet demand, both in existing SBHCs and in new schools with at-risk student populations.

Follow-up interviews with a sample of SBHC sponsors revealed a great need for dental services. Six sponsors reported that their SBHCs provide dental services to students. The scope of these services varies widely, with the most prevalent services being preventive. Some centers offer minor restoration, but most refer out for more complex dental procedures. SBHCs are interested in expanding dental services, especially through connections to local health departments. Interest was also expressed in a mobile dental clinic, which could serve multiple sites with the same equipment. Major barriers to expanding dental services were the need for dental equipment, startup and continuing funding for the salaries and benefits of dental providers, and the dearth of licensed dental providers willing to work in public clinics.

While all of the SBHCs surveyed (11 sponsors) provide mental health services, there was once again wide variation in programs. While some SBHCs provide mental health services on a daily basis, others have more limited hours generally because of financial constraints. Typically, SBHCs employ or contract with social workers; few have psychologists or psychiatrists. For some schools, mental health accounts for a significant number of SBHC visits. In follow-up interviews, one sponsor reported that the need for mental health services is so great that its SBHCs could use the services of mental health professionals 40 hours per week if funds were available to support a service expansion. Clearly the greatest barrier to expanding mental health services is financing.

School-Based Health Center Capacity

Maryland's SBHCs serve a relatively large number of students with limited staff and resources. During the 2005-2006 school year, a total of 26,901 students were enrolled in SBHC programs and 15,000 of those children visited their center, accounting for 73,165 visits.[8]

Average staffing in Maryland's SBHCs during that same year was 2.89 full-time equivalents (FTEs). Most of the staff employed by SBHCs are medical staff, with nurse practitioners and registered nurses being the most common. None of the SBHCs reported employing any volunteer staff or licensed practical nurses, and the SBHCs hire few physician assistants, psychologists, or psychiatrists. On average, SBHCs reported clerical staff of only 0.3 FTE and practice management staff of 0.2 FTE. This has obvious implications for the ability of SBHCs to perform administrative and billing functions. Table 5 presents the average staffing per SBHC by type of employee.

[8] Maryland Assembly on School-Based Health Care. School Year 2005-2006 Annual Survey.

Table 5
Average Full-Time Equivalents Employed by School-Based Health Centers
Maryland, FY 2006

	Employees	Independent Contractual Workers	Volunteers
Licensed Health Care Practitioners*	.61	.44	--
Other Health Care Practitioners**	1.10	.16	--
Practice Management***	.20	--	--
Clerical Staff	.30	--	--
Other	.06	.02	--
Total**	**2.26**	**.63**	**--**

* Licensed practitioners who can practice independently, such as physicians, physician assistants, nurse practitioners, dentists, psychologists, and social workers.
** Practitioners such as registered nurses, licensed practical nurses, dental hygienists, health aides, and medical assistants who are not licensed to practice independently.
*** Non-health practitioners who are responsible for managing the operations of the SBHC (e.g., operations, fiscal management facilities management, school/sponsor relationships).
**** Totals may not add up due to rounding errors.
Source: Center for Health Program Development and Management, UMBC.

On average, SBHCs reported that 82 percent of appointment slots available in April 2007 were booked; of those appointments, four-fifths were kept by students. Despite the small staffs, 96 percent of patients with an appointment were seen within 15 minutes. For walk-ins, 69 percent were seen within 15 minutes and 99 percent within 30 minutes. Some SBHCs do not book appointments.

In the survey, SBHCs were asked if they were ever forced to suspend enrollment due to capacity or financial constraints. Only one sponsor reported suspending enrollment; this was necessary to do more than three times in the prior three years due to difficulty in recruiting staff because of lower-than-market-rate salary and fringe benefits.

Financial Portrait of School-Based Health Centers

Below is a discussion of SBHC revenues and expenses, third party billing and reimbursement, Medicaid regulations relevant to SBHCs, and barriers to reimbursement.

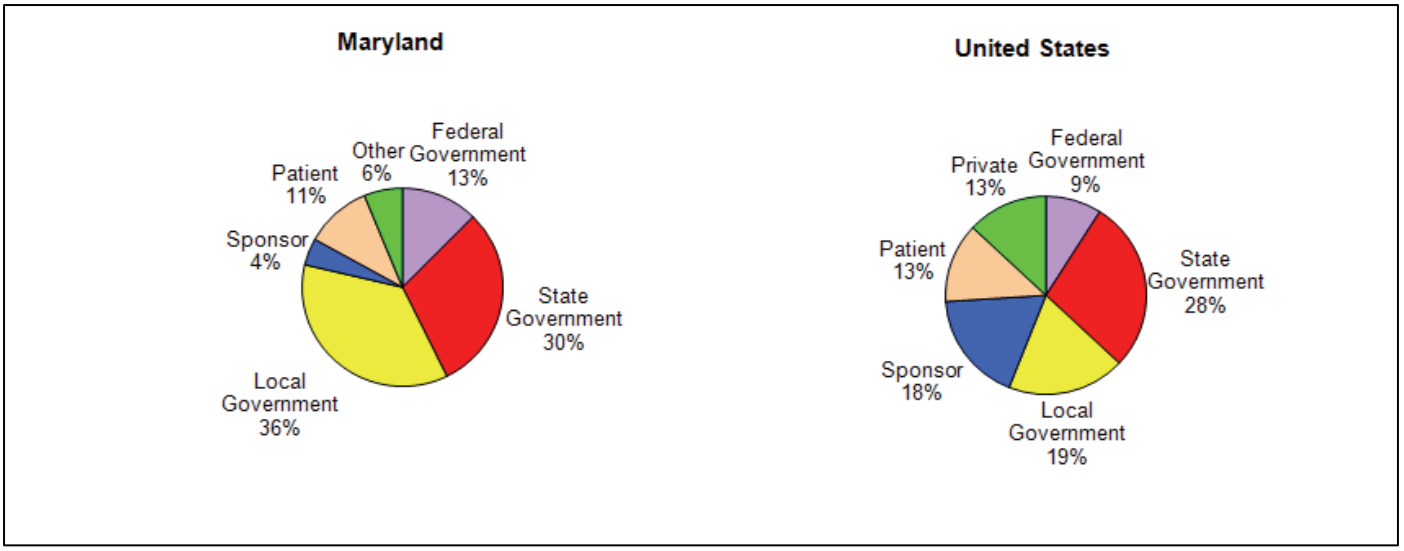
Revenues and Expenses

When conducting the survey of SBHC sponsors for this report, it became clear that the accounting and fiscal management systems of SBHC sponsors vary considerably in terms of their ability to produce reliable revenue and expense data at the health center level. Some of the sponsors do not maintain separate cost centers in their accounting systems for individual SBHCs and were only able to provide aggregate or estimated data for all of their SBHCs. One sponsor was able to provide only partial revenue and expense data. Consequently, revenue and expense data provided in this report are incomplete, yet the estimates presented can provide a useful overview of major funding trends.

Total reported SBHC revenues were $6.96 million in FY 2006. The primary revenue source for Maryland SBHCs is funding from federal, state, and local governments. The Governor's Office for Children[9] provided the largest share of funding in FY 2006—just under $2.2 million—through its grant program for SBHCs.[10] Maryland SBHCs received $863,570 in federal funding in the same year through the Health Resources and Services Administration (HRSA) Healthy Schools, Healthy Communities grants program and community health center funding available through Section 330 of the Public Health Services Act. The sponsors also reported local government funding from local management boards, health departments, and school systems. Third party billing revenue represented approximately 11 percent of SBHC revenue across the state. SBHCs also reported in-kind support, United Way funding, and funding from the sponsoring organizations. None of the SBHCs reported receiving any foundation funding. Funding for Maryland SBHCs is similar to that for SBHCs nationwide; however, patient care revenue (i.e., Medicaid, other third party revenue, and self-pay) in Maryland lags slightly behind the national average (11 percent compared to 13 percent), suggesting that this source of revenue might be increased (Figure 2).[11]

[9] The Governor's Office for Children was responsible for allocating state SBHC grant funding prior to MSDE.
[10] State general fund support for school-based health centers was $2.8 million in FY 2005 and FY 2007.
[11] Smith, V.K. (June 2002). *Opportunities to Use Medicaid in Support of School-Based Health Centers*. Health Management Associates. Retrieved August 2007 from http://www.nasbhc.org/atf/cf/%7BCD9949F2-2761-42FB-BC7A-CEE165C701D9%7D/Funding_Medicaid_Opportunities.pdf.

Figure 2
School-Based Health Center Revenue:
Maryland (2006) and the United States (2001)



Sources: Center for Health Program Development and Management, UMBC (Maryland); Smith, V.K. (June 2002). *Opportunities to Use Medicaid in Support of School-Based Health Centers*. Health Management Associates. (United States).

Approximately 88 percent of expenditures by Maryland SBHCs is for employee salaries and fringe benefits and fees for contractual staff. Remaining expenditures are for medical supplies and equipment, office supplies, translation services, utilities, and indirect costs. Local health department sponsors in particular reported difficulty hiring staff because they are unable to offer competitive salaries and benefits. Some of the survey respondents indicated that support from the sponsoring organization was critical to balancing the budget each year.

Third Party Billing and Reimbursement

In FY 2006, Maryland SBHCs received approximately 11 percent of their revenue from third party billing—most of it through HealthChoice, Maryland's Medicaid managed care program. SBHC sponsors reported negligible revenue from private insurers and fee-for-service Medicaid. Ten out of the eleven sponsors who responded to the survey reported that they bill for at least some of the services provided. The most frequently billed services include acute care, chronic disease care, and immunizations. Less frequently billed services include health promotion and prevention services, substance abuse treatment, and mental health care. The extent of billing for these services varies widely across centers and sponsors. For contracted services such as mental health, the contracting organization may bill for the services, not the health center/sponsor.

Of the sponsors who do bill, eight use a fee schedule based on Current Procedural Terminology (CPT) codes. The sponsors reported using eight different billing software products and a variety of billing arrangements. The software products include Vision PM, Misys, Medical Manager, Sage Software, Clinical Fusion, Patrac, Patient Care Management System, and a system

developed specifically for one sponsoring organization. Some of these products are designed to capture both clinical and financial data, while others are much more limited. Most SBHCs use their sponsor's billing system, and report that billing is a labor-intensive process.

All of the SBHCs collect information about student health insurance coverage at the time of enrollment and counsel students and/or families about enrolling in insurance programs for which they might be eligible (Medical Assistance, the Maryland Children's Health Program, etc). Nearly all of the health centers (91 percent) provide assistance and follow-up with families who choose to file applications for insurance coverage. It was clear from the survey and key informant interviews that the success of SBHCs' billing and collections from third parties varies considerably from sponsor to sponsor. Sponsors that reported difficulty maximizing third party reimbursement offered the following challenges: insufficient staffing, lack of staff training, lack of standardized billing policies and procedures, and difficulty complying with insurers' credentialing requirements. While most SBHCs (90 percent) have dedicated telephone and fax lines, 10 percent do not, which may pose a challenge to billing as well. One sponsor reported that it does not bill any third parties for the services that it provides, but that sponsor would be open to evaluating whether third party billing could help to improve the financial stability of its centers.

HealthChoice Regulations Affecting SBHCs

Over 90 percent of school-age children enrolled in Medicaid are in the HealthChoice program where the delivery of health care services is coordinated by one of seven participating MCOs.[12] Each child is enrolled in an MCO and assigned to a primary care provider (PCP), who is responsible for providing the child with preventive and acute care services. Although Maryland SBHCs can provide services to HealthChoice enrollees, they do not serve as PCPs. MCOs generally require PCPs to offer on-call services 24 hours per day and access to services year-round. Most Maryland SBHCs do not meet those requirements.

State regulations do stipulate, however, that HealthChoice enrollees may self-refer for specified services provided in designated SBHCs,[13] which are eligible for reimbursement from the MCOs for those services. The specified services include "diagnosis, treatment, and uncomplicated follow-up (limited to one follow-up visit to the SBHC) of acute or urgent somatic illness, and related prescribing of medications; and family planning services."[14] SBHCs are then required to refer the student to his or her PCP and transmit a report to the MCO within two business days about the services provided. If a student receives more than four acute or urgent visits in a semester, the SBHC must "notify the student's MCO to determine if the student's PCP wants to see the student for a thorough physical evaluation," and "assist the MCO in scheduling follow-up visits."[15] All of the MCOs reported that they reimburse SBHCs at the Medicaid fee schedule rate at a minimum for all self-referred services as required by regulation.[16]

[12] Source: Center for Health Program Development and Management, UMBC.
[13] COMAR 10.09.68.02 delineates the operating standards that must be met for school-based health center designation.
[14] COMAR 10.09.68.03A(1)-(2)
[15] COMAR 10.09.68.03 C(4)a-b.
[16] See Appendix 5 for a list of approved codes with current Medicaid fee schedule rates.

HealthChoice regulations do not preclude MCOs from contracting with SBHCs to provide services to MCO enrollees in addition to those allowed on a self-referral basis. Although a majority of SBHCs in the state offer preventive health services, only one SBHC sponsor reported having an agreement with an MCO to be reimbursed for providing preventive health services to its enrollees. Both parties appear to benefit from the agreement. The SBHC providers are credentialed providers in the MCO's provider network. The MCO reported that the presence of a contract increases the likelihood that they will receive encounter data from the SBHC reporting that preventive care services (e.g., immunizations) were provided to its members. This reporting is important because DHMH monitors the performance of the MCOs in providing preventive care services to their members. The SBHC sponsor is pleased to receive reimbursement for the services that it provides. Discussions are underway for a second SBHC contract with that MCO.

Mental Health Billing

All of the sponsors reported that they offer mental health services in at least some of their centers; however, the specific types of services vary from center to center. Some health centers contract with outside organizations (e.g., local health departments or outpatient mental health clinics) to provide mental health services in school. Under these arrangements, billing is generally handled by the contractor, so the SBHC sponsor is not responsible. In other cases, SBHC sponsors handle the mental health billing directly.

Mental health services are carved out of the HealthChoice program (i.e., these services are covered by the Medicaid program outside of its capitation contracts with MCOs). As a result, billing for mental health services for Medicaid enrollees occurs on a fee-for-service basis through an administrative service organization, MAPS-MD, rather than through the participating HealthChoice MCOs. Limited funds are also available to support mental health services provided to uninsured individuals.

Reimbursement Barriers

The most significant barrier to increasing billing revenue for SBHCs is the current restriction on reimbursement for self-referred services provided to HealthChoice enrollees and the lack of provider contracts with MCOs to provide preventive care services. While most SBHCs provide preventive care services, MCOs are not required to reimburse SBHCs for that care. Although the presence of an active insurance card from a HealthChoice MCO with the name of an assigned PCP suggests that a student should have access to preventive care services from a community provider, some SBHC officials reported that they are willing to provide preventive care to insured students without reimbursement in cases where they are concerned that existing barriers would prevent the child from receiving the care in a timely manner (e.g., parent unlikely to follow up with referral because of cognitive challenges, lack of transportation, or inability to take time off from work). Furthermore, students value the convenience of the SBHC and feel comfortable accessing services with providers they know.

State Medicaid officials reported two historical reasons for the lack of MCO contracts with SBHCs and the restrictions on self-referred services. First, when the HealthChoice program was implemented, most MCOs reimbursed their PCPs on a capitated basis. Therefore, the MCOs were concerned that if they had been required to reimburse SBHCs for preventive care services,

they might end up paying for the services twice: once through the monthly capitation to the PCP and again to the SBHCs at the time of service. The structure of PCP reimbursement has changed since HealthChoice was first implemented, however, and most PCPs are now reimbursed on a fee-for-service basis by the MCOs. As a result, that barrier to MCOs contracting with SBHCs has diminished. State Medicaid officials also suggested that MCOs wanted tight regulations on SBHC services for fear that the centers would bill for those school health services that are not reimbursable.[17]

Interviews with the MCO representatives revealed additional barriers to contracting with SBHCs. First, some MCOs expressed concern that contracting with SBHCs for preventive care services undermines the concept of managed care and the medical home provided by the PCP and could result in duplication of services. MCO representatives also felt that contracting with SBHCs might result in a loss of control over quality and that contracting might negatively affect the ability of the MCO to meet HEDIS[18] standards. Reporting by SBHCs on encounters with HealthChoice enrollees is not always timely and consistent. More than one MCO representative stated that they perceived their provider networks to be adequate and would need a compelling reason to add SBHCs as credentialed providers. Finally, some MCOs had a limited understanding of the scope of services that SBHCs are capable and credentialed to provide.

Many SBHC sponsors experience considerable difficulty billing HealthChoice MCOs, even for the covered self-referred services. They report frequent inappropriate claims denials that require additional staff time to appeal for proper reimbursement. For example, SBHCs report claims denials for ineligibility, even though the students are listed in the HealthChoice Eligibility Verification System on the date of service. Some report inappropriate denials for place of service codes on billing forms, even though the SBHCs use the place of service code for schools as directed. Identification numbers can cause other problems. All HealthChoice enrollees are provided with a Medical Assistance (i.e., Medicaid) identification number; however, some MCOs issue their own identification numbers and require these numbers on claims forms in addition to the Medical Assistance number. While the SBHC sponsors may eventually get the denied claims paid, many questioned whether the additional staff time spent following up on denials was worth the minimal reimbursement.

SBHCs reported very little difficulty billing fee-for-service Medicaid; however, since most Medicaid-eligible children served in SBHCs are enrolled in HealthChoice, the proportion of claims and revenue that fee-for-service Medicaid represents is minimal.

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[17] COMAR 10.09.68.03 specifies a limited number of services for which MCOs are required to reimburse SBHC providers who deliver services to MCO enrollees. COMAR 10.09.67.27B(11) establishes that the HealthChoice MCOs are not required to provide reimbursement for:
"Health-related services and targeted case management services provided to children when the services are:
(a) Specified in the enrollee's individualized family service plan (IFSP), or an individualized education program (IEP); and
(b) Delivered in the schools or through Children's Medical Services community-based providers."

[18] HealthChoice MCOs are required to submit selected HEDIS (Healthcare Effectiveness Data and Information Set) measures to DHMH annually as part of ongoing quality monitoring efforts.

As noted earlier, the provision of mental health services varies by sponsor. Some sponsors contract with an outpatient mental health clinic that both provides the services and coordinates the billing. Other sponsors provide their own mental health staff and bill directly. One sponsor stopped billing for mental health services shortly after the implementation of the HealthChoice program because they encountered so many problems with the billing requirements.

The SBHCs that currently bill MAPS-MD did not report major difficulties with billing for eligible mental health services. They did, however, cite two concerns. First, outpatient mental health clinics are reimbursed at higher rates by MAPS-MD than local health departments. State officials report that although local health departments can qualify as outpatient mental health clinics, most do not. If a local health department has the ability to meet those qualifications, this may represent an opportunity to increase the level of reimbursement that a health department receives for the mental health services they provide in their SBHCs.

The second concern expressed by SBHCs is that not all of the services they provide are eligible for reimbursement. Claims submitted to MAPS-MD must include a diagnosis of a mental disorder, but not all of the children who receive mental health services from SBHC providers have a diagnosis. SBHCs provide a range of counseling services for students who are experiencing difficulties, but whose symptoms do not meet diagnostic criteria. Examples include grief counseling and anger management. Furthermore, providers are reluctant to diagnose a child for the purpose of getting reimbursement for services because of their concern that the label will become a part of the child's permanent medical record. Despite the lack of third party reimbursement, SBHC providers are adamant that they must maintain the ability to provide services in a flexible manner to meet students' needs and to address behaviors that are affecting the educational process in the school.

Overcoming the reimbursement barriers faced by SBHCs will require considerable communication on the part of Medicaid officials, SBHC sponsors, and MCO representatives. SBHCs will need to demonstrate that they can increase access to preventive health care services for the MCO enrollees and help MCOs improve HEDIS scores. Provider contracting may also reduce the problems SBHCs are experiencing with billing for self-referred services. Interviews with MCO representatives revealed that they need a better understanding of the role that SBHCs can play in providing care to their enrollees. As Medicaid officials, MCOs, and SBHC sponsors examine these issues, however, they will need to carefully consider how to establish effective linkages between SBHC providers and students' medical homes. SBHCs can provide an additional access point for students in a familiar and non-threatening environment, yet the care provided in a SBHC should be carefully coordinated with students' PCPs in order to avoid duplication of services and ensure continuity of care.

Expanding the list of services eligible for reimbursement on a self-referral basis and increasing the number of contracts with MCOs to cover additional preventive care services may contribute significantly to improving SBHC reimbursement and long-term sustainability. It is important to note, however, that third party reimbursement will never fully sustain SBHCs. Their target population is children who do not have access to care in other settings, whether due to insurance status, immigration status, or other factors. Grant funding remains a critical piece of the funding

structure. Furthermore, each SBHC sponsor must evaluate whether billing is cost effective. For centers that provide few reimbursable services with inefficient billing capacity, the best choice might be not to bill at all. The lack of accurate financial data provided by the sponsors made it difficult to quantify the possible lost revenue from not maximizing billing potential. SBHCs also reported a concern about billing for services that students would prefer to access confidentially, such as family planning and mental health services. Sponsors strive to ensure access to these services by agreeing not to bill a student's insurance company so as to avoid the arrival of an explanation of benefits/bill at the student's home. This commitment to provide confidential services decreases the billing potential for any SBHC, but is arguably justifiable given the mission of SBHCs.

Private Insurance Plans

As mentioned earlier, reimbursement from private insurance represents a limited source of revenue for SBHCs. The sponsors reported varying success with billing private insurance for services rendered at the health center. Private insurance plan representatives reported that they reimburse SBHCs for services rendered to their members at rates comparable to those for community physicians as long as the health plan has a provision for reimbursing non-network providers. Not all private health plans have out-of-network coverage, however, so claims would be denied in those cases. One private insurance plan reported that it would entertain applications from SBHC providers to join their networks, assuming that the providers met their credentialing requirements. SBHCs pointed out, however, that contracting with multiple private insurance companies for the handful of students they might see from each one would likely cost more in staff time than it would yield in reimbursement. Furthermore, SBHCs find it difficult to keep up with changes in parents' private insurance coverage.

Patient Revenue and Sliding Fee Discount Schedules

Another limited source of revenue for SBHCs is payments from patients or their families for services rendered. All of the SBHCs sponsored by FQHCs and local health departments are required either by federal or state regulations[19] to offer a sliding fee discount schedule based on family income.[20] In effect, however, only two SBHC sponsors reported any collections from patients. Local health departments are eligible for a waiver of the requirement that they hold recipients of services and chargeable persons (e.g., parents) liable for the payment of services provided in SBHCs in order to decrease access barriers. The Nonchargeable Services Waiver Committee at DHMH has granted waivers to health departments in seven of the ten jurisdictions in Maryland with SBHCs that allows health departments to consider uninsured participants who receive SBHC services to be "nonchargeable." Discussions with DHMH indicate that the local health departments who do not have this waiver for SBHC services would likely receive one upon application.

Centralized Billing Function

One option for improving the efficiency of third party billing among SBHCs is to establish a centralized billing entity that would maintain responsibility for maximizing third party

[19] FQHCs must offer a sliding fee discount schedule per Section 330 of the Public Health Services Act and local health departments per COMAR 10.02.01.07B.

[20] A sample FQHC fee schedule is provided in Appendix 6.

reimbursement. A group of SBHCs in Michigan has created such an arrangement with some success (see the chapter of this report on "Best Practices in Other States"). While many SBHC sponsors agree that they could improve third party revenue by targeting additional resources to address some of the barriers discussed in this report, they did not overwhelmingly embrace the idea of creating a centralized billing function. SBHC sponsors are currently using several different billing systems, with a range of capabilities. While many SBHCs demonstrate a need for improved information technology, each sponsor's needs are unique. Moving to a centralized billing function would require a large investment of resources (both time and financial) and the sponsors place a higher priority on expanding services and addressing their individual needs in regards to information technology and electronic billing.

Maryland Tort Claims Act Immunity

Legislative Context

Issues concerning the cost and availability of medical malpractice coverage in Maryland came to a head in 2004. Consistent with the nationwide professional liability insurance crisis at that time, Maryland practitioners' medical malpractice liability insurance rates skyrocketed. The state's largest medical professional liability insurance carrier secured approval for a 28 percent increase for 2004 and a 33 percent increase for 2005. Annual premiums for obstetricians (the highest risk medical specialty) were expected to reach $150,000. Lawmakers, physicians, and the public shared grave concerns that Maryland health care practitioners would be forced to abandon their practices, reduce practice hours, move to another state, reduce their scope of practice, or retire.

In response to this crisis, the Maryland General Assembly unsuccessfully tried to reach agreement on legislation to address these problems in the 2004 regular session. Subsequently, the governor convened a special legislative session on December 28, 2004. The Maryland Patients' Access to Quality Health Care Act of 2004 (HB 2, SS 2004) passed on December 30, 2004, was vetoed on January 10, 2005, and the veto was overridden the next day. The law imposed a temporary 5 percent cap on annual increases of professional liability insurance rates, repealed exemption from the state's 2 percent premium tax for health maintenance organizations (HMOs) and MCOs (worth approximately $29 million in revenue), and established the Maryland Medicaid Professional Liability Rate Stabilization Fund (funded by the repeal of the HMO/MCO premium tax exemption). This rate stabilization fund would be used to buy down and stabilize medical professional liability insurance rates and increase Medicaid reimbursement for physician services.

The Maryland Community Health Resources Commission's enabling legislation was introduced in January 2005 during the regular session that began only days after the veto override of the Patients' Access to Quality Health Care Act. The Commission's statute requires an evaluation of "the feasibility of extending liability protection under the Maryland Tort Claims Act [(MTCA)] to health care practitioners who contract directly with a community health resource that is also a Maryland Qualified Health Center or a School-Based Health Center …"[21] In order to address this requirement, the SBHC survey that was part of this study included questions regarding the extent

[21] Community Health Care Access and Safety Net Act of 2005, §3, *codified as* Health-Gen. Art., §19-2109, Ann.

to which SBHCs provide liability coverage to full- and part-time employees, independent contractual practitioners, and volunteer practitioners. The questions also addressed the extent to which SBHCs experience obstacles related to the availability of such coverage. A survey instrument was developed with similar liability questions and disseminated to all of the MQHCs.

MTCA Background

When a tort action is brought against the state in a Maryland court, the MTCA[22] waives a portion of the state's sovereign immunity. Immunity from liability under the MTCA does not apply to the first $200,000 of liability, but immunity from liability above this amount remains in place. Therefore, even if the MTCA were to be extended so that it applied equally to MQHCs, SBHCs, and their practitioners (whether employed, contracted, or volunteer), wrap-around insurance would still be needed to cover the first $200,000 of liability. Additionally, the MTCA does not cover the following situations: punitive damages and pre-judgment interest; claims arising from the combatant activities of the state militia during a state of emergency; acts or omissions by state personnel that are outside the scope of their public duties or are made with malice or gross negligence; or a claim prohibited by law.

SBHC Survey Results

The SBHC survey questions and subsequent follow-up indicated that the availability of professional liability insurance is not an issue for SBHCs. The main reason is that most SBHC sponsors are already covered by governmental immunity laws: two sponsors are covered under the Federal Tort Claims Act (FTCA); five sponsors are covered by the MTCA; and one sponsor is covered by the Local Government Tort Claims Act (LGCTA). As such, most sponsors provide professional liability coverage to their full- and part-time employees.

Due to this coverage, none of the sponsors reported the availability of liability insurance coverage as an impediment to hiring full- or part-time practitioners. While few sponsors provide liability insurance for independent contractual practitioners, follow-up with some of these sponsors has indicated that liability insurance coverage is required of the practitioner in the contract. None of the sponsors reported employing volunteer health care practitioners. Only one sponsor reported that the unavailability of liability coverage was an impediment to hiring volunteer or contractual medical practitioners, but noted that it was an issue in recruiting dentists.

Given the hypothetical situation that the MTCA would be amended to extend immunity to health care practitioners working as independent contractors or volunteers in SBHCs, most sponsors did not report that they would be likely to hire new independent contractual or volunteer health care practitioners. Nearly all of the sponsors reported that they would not likely offer "wrap-around" coverage to these practitioners in this situation.

None of the sponsors reported encountering any of the following issues related to securing professional liability coverage: a limited choice of companies offering liability insurance, a limited choice of insurance products that meet the needs of the SBHC sponsors, or insurance

[22] MTCA is codified as State Government §12-101 *et seq*., and Cts. & Jud. Proc., §5-222(a), Md. Code Ann.

products that meet their needs but exceed their budget. Follow-up with a sample of sponsors further indicated that the availability of liability insurance is not an issue for their SBHCs.

MQHC Survey Results

The MQHC survey yielded similar findings regarding liability coverage. An unexpected result of the survey was the difficulty in identifying the number of existing MQHCs. The number of MQHCs in the state is declining, and there appears to be confusion among some of the centers about their designation as an MQHC. It was eventually determined that there are only seven MQHCs in operation, one of which is no longer operating as an MQHC as of November 2007. This center did not complete the survey. Of the remaining six, one reported that it was not an MQHC, although it was identified as one by DHMH. After numerous follow-up attempts, completed surveys were obtained from three of the six MQHCs.

The results of these three surveys proved to be similar to those of the SBHC survey. Two of the MQHCs provide liability insurance to all employees, and one does not provide it to any employees. All three centers reported that the availability of liability insurance is not an impediment to hiring health care practitioners.

Given the hypothetical situation that the MTCA would be amended to extend immunity to health care practitioners working as independent contractors or volunteers in MQHCs, two centers reported that they would not likely hire additional volunteer or contractual health care practitioners. One center would be somewhat likely to hire new volunteer or contractual practitioners. None of these centers have encountered obstacles related to securing professional liability coverage.

The survey results indicate that the availability of professional liability insurance is not a major impediment to the operations of SBHCs or MQHCs, suggesting that a revision to the MTCA is not necessary at this time.

Security Issues

Although the Commission's enabling legislation directs this study to examine security measures for SBHCs, the survey results and key informant interviews indicate that security is not a major issue for SBHCs. Precautionary security measures were reviewed, as well as incident reporting.

This study examined precautionary security measures related to medical equipment and records, as well as physical security of the SBHC building. All of the SBHCs reported having secure storage for medical supplies, drugs, and records. Additionally, they all reported having HIPAA-compliant procedures for sharing and storing medical records. As far as the physical security of the building, 80 percent of the SBHCs do not have an electronic security system with a direct call to security or police; 89 percent do not have a security officer or police presence during after-school hours; and 83 percent do not have a separate entrance for the SBHC. However, most SBHCs are not open to the public and are not open in the evening, so these security measures may be less applicable. All of the SBHCs reporting evening hours have night lighting in the parking lot.

In addition to examining these precautionary measures, the survey inventoried security incident reporting for the past three years. Over 80 percent of the SBHCs did not experience any security incidents, and none of the centers had stolen medical records or malpractice lawsuits. The most frequently reported incidents were situations necessitating a call to security or police. Many of these situations were related to disruptive student behavior.

School-Based Community Health Centers

SBHCs that have expanded their mission to serve a broader population in their community are sometimes referred to as school-based *community* health centers. In underserved communities and communities with a significant uninsured population, such centers can be an important safety net provider. However, this model has not been adopted broadly and many believe it would discourage families from establishing a medical home elsewhere. Providing care to infants, preschoolers, and/or adults in addition to school-aged children and teens requires additional services, different providers, and new referral networks. Other considerations include adequate clinic space, equipment, and staffing; access to the clinic outside of school hours; and security. Fee schedules and billing practices are also impacted. Adolescents, who tend to view SBHCs as their "own" place, are likely to feel that privacy and confidentiality are compromised if the clinic is opened up to the broader community. National literature indicates that service confidentiality affects SBHC utilization by adolescents.[23]

Nationally, an estimated 65 percent of SBHCs provide services to individuals other than enrolled students, although it is mostly confined to students' family members and faculty and school personnel.[24] Among the Maryland SBHCs responding to the survey for this study, 23 percent reported serving siblings of enrolled students, 18 percent served faculty and staff, 5 percent served parents and guardians, and 10 percent served other members of the community. Follow-up interviews with some of these sponsors indicated that service provision to non-students is a rare occurrence. Only one SBHC sponsor expressed interest in expanding services in the community.

The *Community Health Care Access and Safety Net Act of 2005* directed the Commission to identify fee schedules, reimbursement rates, insurance payments, patient registration systems, and security issues related to school-based *community* health centers. This report addresses these issues as they relate to existing SBHCs in Maryland. However, because there are no recognized national models for school-based *community* health centers, nor is the "community" model being actively pursued in Maryland, it is not possible to identify existing systems and practices at this time.

[23] Harvey, J., Vaquerano, L., Nolan, L., and Sonosky, C. (July 2002). *School-Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues*. The George Washington University Center for Health Services Research and Policy.
[24] Lear, J.G., Isaacs, S.L., Knickman, J.R. (2006). *School Health Services and Programs.* The Robert Wood Johnson Foundation Series on Health Policy.

Scope of Practice Law

The *Community Health Care Access and Safety Net Act of 2005* includes in its list of duties to be performed by the Commission a charge to "identify ... barriers to the reimbursement of licensed health care providers who provide services at school-based health centers, including certified nurse practitioners and physician assistants." [25] This section of the report explores the scope of practice of these health professionals in Maryland, examines how they benefit SBHCs, and addresses reimbursement issues faced by SBHCs in which nurse practitioners, physician assistants, and dental hygienists practice.

Nurse Practitioners

Medicaid, SCHIP, and Private Payers. The federal Medicaid program requires that state Medicaid programs cover pediatric, family nurse practitioner, and nurse-midwife services in order to qualify for federal matching funding.[26] Similarly, the State Children's Health Insurance Program (SCHIP)[27] provides matching funding for "nurse practitioner services," "nurse midwife services," "advanced practice nurse services," and "pediatric nurse services."[28] Federal Medicaid rules also allow, at the state's option, nurse practitioners, nurse-midwives, and physician assistants to serve as primary care case managers.[29]

Maryland's HealthChoice program, which insures children enrolled in both Medicaid and MCHP, provides for primary and preventive care access to occur through assigned PCPs. Program regulations provide that MCOs *may* appoint nurse practitioners to serve as PCPs,[30] but they are not *required* to do so. The private sector provides apparent contrasts. A law enacted in 2003 appears to guarantee members of HMOs an opportunity to choose nurse practitioners as PCPs, but this is illusory because it also limits a nurse practitioner's autonomy and scope of practice in the PCP role. Moreover, Maryland has no requirement that either MCOs or HMOs include nurse practitioners in their provider panels.[31] Maryland does, however, require that individual and group indemnity insurance policies issued in the state by insurers and nonprofit health service plans reimburse covered services provided by nurse practitioners.[32] Similarly, if a policy includes coverage for a service, the coverage must apply to the service regardless of the provider's license or certification category, so long as it is within the practitioner's scope of practice.[33]

Interviews with MCO representatives conducted for this report indicate that HealthChoice MCOs largely have elected to use only physicians as PCPs. HealthChoice regulations governing

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[25] Codified as Health-Gen. §19-2109(d)(2)(iv), Md. Code Ann.
[26] Social Security Act, §1905(a)(17) and (21).
[27] The Maryland Children's Health Program (MCHP) is Maryland's version of SCHIP.
[28] Social Security Act, §2110(a)(15).
[29] Social Security Act, §1905(t)(2)(B)(i); 42 CFR §§440.165, 440.166, and 440.168.
[30] COMAR 10.09.66.05A(5)(f) and (g). Nurse practitioners eligible to serve as HealthChoice PCPs must be certified in one of the following areas of specialization: certified nurse midwife or certified adult, pediatric, geriatric, OB/GYN, school nurse, or family nurse practitioner.
[31] House Bill 974 (2003), enacted and codified as Insur. Art., §19-705.1(c), Md. Code Ann.
[32] Insur. Art., §15–703, Md. Code Ann.
[33] Insur. Art., §15–701(a)(2), Md. Code Ann.

enrollee access to self-referred services provide that SBHCs are eligible for reimbursement only if they maintain staffing patterns that provide for a physician, nurse practitioner, or physician assistant to be onsite whenever comprehensive care services are being delivered.[34] A similar rule applies to Medicaid fee-for-service reimbursement for services delivered in freestanding clinics.[35]

Scope of Practice: Maryland. A certified nurse practitioner is authorized to practice independently, consistent with the terms of the nurse practitioner's written agreement with a physician. The certification agreement identifies practice areas and procedures that the parties agree are appropriate to the nurse practitioner's training and experience. In effect, the agreement tailors a nurse practitioner's authorized scope of practice to a specific nurse practitioner, setting the terms and conditions under which the nurse practitioner may independently carry out the following functions:

> "(a) Comprehensive physical assessment of patients;
> (b) Establishing medical diagnosis for common short-term or chronic stable health problems;
> (c) Ordering, performing, and interpreting laboratory tests;
> (d) Prescribing drugs;
> (e) Performing therapeutic or corrective measures;
> (f) Referring patients to appropriate licensed physicians or other health care providers; and
> (g) Providing emergency care."[36]

Nurse practitioners may be certified in specialty areas such as nurse midwife, pediatric nurse practitioner, and family nurse practitioner.[37] A nurse practitioner is authorized to practice only in the area of specialization in which the nurse practitioner is certified.[38]

Nurse practitioners are a key component of SBHC clinical staffing. Consistent with the permitted practice functions specified above, a nurse practitioner whose physician agreement specifies a broad practice authorization can provide most, if not all, primary care services that are likely to be required in an SBHC setting.

Physician Oversight. A physician who enters into a written agreement with a nurse practitioner takes on certain duties that must be specified in the agreement. In addition to specifying practice functions, the physician agreement must include the physician partner's agreement to discharge certain duties on a regularly scheduled basis. These include the duty to:

> "(a) Accept referrals,
> (b) Establish and review drug and other medical guidelines with the nurse practitioner,

[34] COMAR 10.09.68.02A(8). Regarding nurse practitioner specialty area limitation, see n. 30 above.
[35] COMAR 10.09.08.04A(1)(a). The freestanding clinic regulation does not include any specialty limitations for nurse practitioners.
[36] COMAR 10.27.07.02A.
[37] For specialty certification, a candidate must satisfy academic and examination requirements. These are administered by national bodies recognized by the Maryland Board of Nursing, e.g., the American Nurses Credentialing Center and the American Academy of Nurse Practitioners.
[38] COMAR 10.27.07.02C and .03B(2).

(c) Participate with the nurse practitioner in periodically reviewing and discussing medical diagnoses and the therapeutic or corrective measures employed in the practice setting,
(d) Jointly sign records if needed to document accountability of both the physician and nurse practitioner,
(e) Be available for consultation in person, by telephone, or by some other form of telecommunication, and
(f) Designate an alternate physician if the physician identified in the written agreement temporarily becomes unavailable."[39]

The oversight duties set out above are evocative of a collaborative partnership between physician and nurse practitioner that is more supportive, educational, and consultative than supervisory.

Physician Assistants

Medicaid, SCHIP, and Private Payers. Federal Medicaid and SCHIP programs do not extend the same level of acknowledgement and protection to physician assistants as they do to nurse practitioners. Although at state option they may serve as primary care case managers (in states with such programs), they may not serve as PCPs in the Maryland HealthChoice program.

Scope of Practice. Physician assistants are certified by the Maryland Board of Physicians and must practice under a delegation agreement with a supervising physician. The practice of a certified physician assistant is less independent and more limited than a nurse practitioner's. A physician assistant may perform medical acts that are:

"(b)… (1) Delegated by the supervising physician;
(2) Appropriate to the education, training, and experience of the physician assistant;
(3) Customary to the practice of the supervising physician; and
(4) Consistent with the delegation agreement submitted to the Board.

(c) Patient services that may be provided by a physician assistant include:
(1) (i) Taking complete, detailed, and accurate patient histories; and
(ii) Reviewing patient records to develop comprehensive medical status reports;
(2) Performing physical examinations and recording all pertinent patient data;
(3) Interpreting and evaluating patient data as authorized by the supervising physician for the purpose of determining management and treatment of patients;
(4) Initiating requests for or performing diagnostic procedures as indicated by pertinent data and as authorized by the supervising physician;
(5) Providing instructions and guidance regarding medical care matters to patients;
(6) Assisting the supervising physician in the delivery of services to patients who require medical care in the home and in health care institutions, including:

[39] COMAR 10.27.07.02B(2).

(i) Recording patient progress notes;
(ii) Issuing diagnostic orders; and
(iii) Transcribing or executing specific orders at the direction of the supervising physician; and

(7) Exercising prescriptive authority under an approved delegation agreement and in accordance with §15-302.2 of this subtitle."[40]

On the other hand, as discussed above, in some ways physician assistants are treated as equivalent to nurse practitioners. Federal Medicaid law allows nurse practitioners and physician assistants to serve as primary care case managers; Maryland law requires SBHCs and other freestanding clinics to have a physician, nurse practitioner, or physician assistant present when comprehensive care is being provided.[41]

Physician Oversight. The practice of a physician assistant is based on a physician's *delegation* of specifically identified medical duties, while maintaining a *supervisory* role. These supervisory functions can be transferred to another physician. In this event, the physician assistant may not practice beyond the alternate supervisory physician's scope of practice. (One cannot delegate authority one does not have.)

Dental Hygienists

Scope of Practice. Dental hygienists, with appropriate supervision by a licensed dentist, may perform a broad variety of functions, including, for example, performing preliminary dental exams and dental prophylaxis, applying sealants, taking impressions and X-rays, cementing temporary crowns, and "any duty that either a dental assistant, or a dental assistant who is listed on the roster of dental assistants recognized as qualified in orthodontics or general duties, may perform." A dental hygienist may not diagnose, perform extractions, correct tooth placement, perform surgical or anesthesia procedures, or cement permanent crowns. [42]

Dentist Oversight. Dental hygienists' authority to practice dental hygiene depends on a licensed dentist being responsible for and providing "general supervision," which need not include a supervising dentist being physically present on the premises when dental hygienist services are performed.

Dental Assistants

Scope of Practice and Dentist Oversight. A dental assistant's scope of practice is more limited than a dental hygienist's. A dental assistant may perform a limited set of duties under the general supervision of a licensed dentist in the context of a dental sealant program, including oral hygiene instruction, cleaning environmental surfaces, performing retraction, preparing sealant materials, rinsing and aspirating, and sterilizing instruments.[43] Direct supervision is required for these and an array of additional dental procedures that may be performed by a dental assistant outside the auspices of a sealant program; direct supervision means that the supervising dentist

[40] Health Occ. Art. §15-301 Ann Code, Md.
[41] See text corresponding to n. 35 above.
[42] COMAR 10.44.04.02 and .03.
[43] COMAR 10.44.01.02A.

diagnoses the condition, authorizes the procedure, is physically present in the dental office when the dental assistant performs the procedure, and evaluates the dental assistant's performance before dismissing the patient.[44]

Experimental Programs. The scope of practice of both licensed dental hygienists and qualified dental assistants may be expanded in the context of an academically-sponsored experimental program that is approved by the Dental Board. Under these circumstances, procedures must be performed under the direct supervision of a full time faculty member of the dental school or college who is responsible for informing the dental hygienist or dental assistant in writing that the delegation of such duties is limited to the experimental program. Such a delegation is subject to review and approval by the Board of Dental Examiners and the Maryland State Dental Association.[45]

Reimbursement Barriers for Health Professionals in SBHCs

The SBHCs and sponsors surveyed for this report voiced concern about the challenges involved in recruiting, remunerating, and retaining qualified practitioners for SBHCs. Dental practitioners are especially in short supply. The health professionals discussed above can help meet the practitioner needs of SBHCs within the current regulatory framework, at lower cost compared to physicians and dentists, and with built-in quality safeguards (e.g., the requirements for supervision by a licensed physician or dentist). In particular, federal Medicaid rules and Maryland law are friendly to the reimbursement of nurse practitioners and physician assistants. Reconsidering and appropriately liberalizing scope of practice limitations could potentially result in a greater supply of practitioners available to SBHCs or expand the scope of services that existing practitioners can provide. For example, some SBHC sponsors suggested revising scope of practice laws to allow nurse practitioners to perform dental cleanings or to apply dental sealants. Some states are considering allowing dental therapists to drill and fill cavities in children.[46] It is possible under current Maryland law to expand the scope of practice for dental assistants and dental hygienists through experimental programs. Options such as these merit careful consideration if SBHCs are to be adequately and affordably staffed with providers in coming years.

[44] COMAR 10.44.01-.03 and .05.
[45] COMAR 10.44.03.01-.02.
[46] Berenson, A. (October 11, 2007). "Boom Times for Dentists, but Not for Teeth." *The New York Times*.

Best Practices in Other States

Issues related to SBHC financing and sustainability are not unique to Maryland. A variety of initiatives are underway in other states to address these barriers and to promote the growth and sustainability of SBHCs. This section of the report will focus on the experiences of Michigan and New Mexico as examples of innovative practices in SBHC financing, followed by a review of reimbursement models used in other states. A review of best practices in school-based dental program financing and delivery concludes this section of the report.

Michigan

Michigan is home to 86 school-based and school-linked health centers as of school year 2006-2007, 63 of which are state-funded.[47] These centers are sponsored by 40 organizations, including hospitals and health systems, local health departments, community health centers, and school systems. Michigan's SBHC program is notable for two major financial initiatives: the Medicaid Matching Initiative and a centralized billing system.

Medicaid Matching Initiative[48]
In 2003, a coalition of SBHC and Medicaid officials was established to explore methods of maximizing SBHC funds. After reviewing several strategies, the coalition decided to leverage federal funds through Medicaid managed care by using state budget appropriations for SBHCs ($3.74 million) to draw down $5.5 million in federal Medicaid funds. The intent of this new revenue stream was to support outreach and health education services for students enrolled in or eligible for Medicaid.

Realizing that an amendment to their Medicaid waiver would be necessary, the Michigan Public Health Institute, a health policy and research organization, facilitated stakeholder meetings, which included representatives from the state Medicaid agency, the state education agency, and advocates for SBHCs and health plans. With input from these meetings, a concept paper was drafted and sent to the Centers for Medicare and Medicaid Services (CMS). Following this submission, with CMS' encouragement, the Medicaid agency formally requested a capitation rate adjustment for school-aged children in December 2003. Several months later, CMS determined that this type of arrangement is an appropriate use of Medicaid funds and approved the request.

With the request approved, each of the 14 Medicaid MCOs in the state make monthly contributions to a fiduciary intermediary, the Michigan Primary Care Association. These contributions are similar to the amount of the capitation rate increase. The intermediary then allocates this funding to state-sanctioned SBHC programs.

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[47] School-Community Health Alliance of Michigan. *School-Based and School-Linked Health Centers & Programs in Michigan: 2006-2007 Directory*. Retrieved September 2007 from http://www.scha-mi.org/HealthCenters/2006Directory.pdf.
[48] Brinson, D., Murdock, R., and Reinhart, P. (September 2005). *Effective Practices: Michigan's Medicaid Matching Initiative.* Prepared for the W. K. Kellogg Foundation.

As a result of this program, SBHC funding doubled, allowing for a two-fold increase in the number of centers in the state. Other reported results include improved relations between SBHCs and MCOs and increased enrollment as a result of the enhanced outreach. A formal evaluation is being conducted by Michigan State University and results are expected in early 2008. In addition, this project is testing a new arrangement for securing enhanced federal matching funds, and it has encouraged the state to test matching initiatives in other venues.

Centralized Billing[49]

Like Maryland, there is wide variation in the billing capacity of SBHCs in Michigan and billing has historically posed a challenge to many of Michigan's SBHCs. In January 2007, the W.K. Kellogg Foundation awarded the School-Community Health Alliance of Michigan (SCHA-MI) a three-year, $578,075 grant to establish a centralized billing and reporting system, which will allow SBHCs to bill both public and private insurers for covered services. The Blue Cross Blue Shield Foundation of Michigan and Blue Cross Blue Shield of Michigan are contributing $125,000 to this project as well. This initiative builds on a Kellogg-funded pilot project that provided centralized billing to 18 SBHCs in Michigan from 2003 through 2005. This pilot was successful in earning over $90,000 in additional revenues for the participating centers and in streamlining the billing process.

Grant funds have been used for software purchasing and licensing fees, hiring billing staff, and training SBHC staff. The SCHA-MI is coordinating the new billing system and is responsible for returning the revenues to the centers. This billing system has the capacity to track both financial and clinical data. The SCHA-MI has recently acquired a full-time billing staff member to provide technical and billing assistance to the SBHCs.[50] Annual program costs are estimated to be approximately $250,000.

The SCHA-MI, along with a committee of SBHC staff members, has developed a common encounter form and reporting elements to be used with the new billing system.[51] This way, each center may enter their own billing charges, while the SCHA-MI transmits the claims and handles remittance posting. It is hoped that this arrangement will alleviate some of the administrative burden associated with billing for the SBHCs. While participation in the billing system is not mandatory, 18 SBHCs have elected to use it and others are interested.

For both the Medicaid matching initiative and the centralized billing system, program staff report that strong support from the state Medicaid agency as well as active community involvement have been critical to their success. Staff also note that efforts such as these require strong leadership and ongoing commitment by all involved.

[49] W.K. Kellogg Foundation. (January 22, 2007). Press Release. "Michigan School-Based Health Centers get Boost. Funding Will Develop Billing System to Help Sustain Health Care Access for Underserved Youth."
[50] School Community Health Alliance of Michigan Website. Retrieved July 2006 from http://scha-mi.org/BillingInfo/billinginfo.html.
[51] Ibid.

New Mexico

In New Mexico, *Salud! Comes to Your School* began as a pilot with three participating SBHCs. Broadly, the program addressed the financing, quality of care, and future viability of SBHCs. More specifically, the project aimed to develop the technical, collaborative, and administrative expertise needed to link SBHCs with New Mexico's Medicaid managed care program, which is called Salud!.[52] Historically, SBHCs were excluded from the Medicaid program and did not receive any type of Medicaid reimbursement for covered students. The state recognized that if SBHCs were to achieve long-term viability and sustainability, participation in the broader delivery system and specifically Medicaid managed care would be essential.

The project resulted from a 1999 School Health Summit, which convened health care leaders in the state and representatives of SBHCs and MCOs. On the agenda was how SHBCs might participate in Salud!. The summit was key to rallying support across different constituencies in order to build consensus to move forward.

Following the summit, the Center for Health Care Strategies, Inc., awarded the state a three-year grant of $500,000 to launch *Salud! Comes to Your School.* The grant not only provided needed resources, but recognition of the importance of the undertaking as well. The state selected pilot sites in two elementary schools, four middle schools, and nine high schools.

Crucial to the success of *Salud! Comes to Your School* was understanding and accommodating the needs of key partners—SBHCs, MCOs, primary care physicians, and students. Challenges included determining which SBHC services would be covered and how the services would be reimbursed; preparing SBHCs to meet MCO credentialing and quality improvement requirements; developing practice guidelines for disease management, prevention, care coordination, and communication; integrating primary and behavioral health care; and ensuring confidentiality in the provision of services for which adolescents could consent on their own. In addition, the project addressed SBHC administrative responsibilities, including claims payment issues and the education and training of practitioners. The project emphasized cultivating strong interagency relationships among those agencies in the state who serve the student population.

At the conclusion of the pilot project, New Mexico reported better communication among the SBHCs, MCOs, and primary care physicians related to the care of students. The pilot sites implemented clinical practice guidelines, integrated primary and behavioral health care, and improved communication, charting, and billing practices. The MCOs increased EPSDT data collection and contracted with SBHCs to provide more primary care services. Sports physicals for adolescents were changed to include all the components of a wellness check. The pilot sites developed more sophisticated billing systems and increased billing revenue. Technical assistance provided directly by the MCOs was key to streamlining billing systems and processes. Data documenting increased reimbursement are currently being collected.

[52] Salud!, which means "to your health" in Spanish, is New Mexico's Medicaid managed care program, implemented in 1997. Salud! is administered through contracts with three MCOs.

Building on the success of *Salud! Comes to Your School*, in 2005 Governor Bill Richardson initiated an expansion of SBHCs, doubling the number in the state. As of 2007, the state has 80 SBHCs.

Salud! Comes to Your School has now been institutionalized as part of the state's Medicaid managed care program. To bill Salud! or the state's Medicaid behavioral health provider, SBHCs must become contracted providers. The state has developed a standardized process for this, which involves submission of a letter of interest, a demonstration of readiness (e.g., compliance with OSHA standards, ability to bill, satisfactory enrollment policies, compliance with minor consent and confidentiality laws), credentialing, and a facility site visit. SBHCs must also comply with ongoing clinical and quality standards. New Mexico has also developed a model contract for SBHCs and MCOs. As of 2007, 25 SBHCs in New Mexico have established these contracts. A list of services billable through MCO contracts is provided in Appendix 7. Additional resources on the New Mexico program can be found at *www.hsd.state.nm.us/mad/schoolhealth.html.*

Other School-Based Health Center Managed Care Models

A review of SBHC literature indicates that SBHCs play a variety of roles in the health care delivery system across the country. A review of Medicaid managed care reimbursement conducted by the George Washington University Center for Health Services Research and Policy has indicated three models for SBHCs: carve-out, contractual, and self-referred.[53] In addition to Medicaid, SBHCs may forge partnerships with private HMOs.

The carve-out model allows fee-for-service reimbursement for services provided in SBHCs, regardless of managed care enrollment. This may be used as both a permanent and temporary reimbursement strategy. This model is employed in Illinois, where all non-FQHC SBHCs are carved out of the managed care program for a limited number of services.

In a contract-required model, exemplified in Connecticut, Medicaid MCOs are mandated to contract with SBHCs. When Connecticut was implementing its Medicaid mandatory managed care program, the state required the health plans to contract with SBHCs as safety-net providers. Initially, the MCOs were permitted to limit the number of reimbursable services in the contract. During renegotiations, however, this restriction was relaxed, requiring MCOs to pay for all reimbursable services. It should be noted that this contracting process was not easy for the SBHCs, as they had to negotiate separate contracts with each of the MCOs and their sub-contractors.

Related to the contract-required model, some states have polices that directly and indirectly encourage Medicaid MCOs to contract with SBHCs. In Minnesota, for example, Medicaid providers are required to offer contracts to community clinics and local health departments, which may be sponsors of SBHCs. Similarly, West Virginia has established financial incentives

[53]Harvey, J., Vaquerano, L. , Nolan, L., and Sonosky, C. (July 2002). *School-Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues*. Center for Health Services Research and Policy, George Washington University School of Public Health and Health Services.

of up to two percent in additional capitation payments for plans that contract with public health providers, such as SBHCs.

The self-referred model allows Medicaid managed care enrollees to self-refer to SBHCs for a limited amount and type of services. The SBHC is reimbursed by the MCO on a fee-for-service basis. This is the model used in Maryland, which is described previously in this report.

In addition to relationships with Medicaid MCOs, SBHCs may establish partnerships with private HMOs. While this does not appear to be a common arrangement, some of Colorado's SBHCs established a contract with Kaiser Permanente, entitled "Colorado's Kaiser School Connections Program." Initially, Kaiser Permanente participated in a pilot program with ten SBHCs. As a result of this program, Kaiser created a new product, which allowed participants free choice in selecting their SBHC. A key lesson learned from this initiative was that a critical mass is necessary to create an incentive for collaboration and to produce quality outcome data.

Dental Programs

As indicated earlier in the report, six SBHC sponsors in Maryland provide dental services to their students. Recognizing the tremendous need for these services, many of the sponsors expressed interest in dental program expansion. This section of the report focuses on New Hampshire, Ohio, and New York as examples of different school-based dental program financing schemes and delivery models. The New York and Ohio models operate within SBHC programs; the New Hampshire model does not, but could be adapted into an SBHC program.

New Hampshire[54]

New Hampshire is an example of a state that has successfully integrated Medicaid revenue into its school-based dental programs. This state has leveraged Medicaid funds to create sustainable school-based preventive dental programs. In addition to Medicaid, funding is also provided by regional community sources and the New Hampshire Oral Health Program in the Department of Health and Human Services. Funders continue to encourage increased integration of Medicaid billing into school programs. Data sources do not indicate what percentage of revenue is generated through Medicaid billing.

A key component of these programs is that schools partner with a sponsoring organization with Medicaid billing experience (e.g., a community health center or hospital). Program eligibility is limited to children who have not seen a dentist in the past year, thus minimizing competition with private insurers or private practice. Many of these programs have begun by treating children only one or two days per week, or by limiting access to certain grades or schools, in order to gain acceptance in the school system gradually.

A dental hygienist operates as the primary advocate for the program, responsible for raising funds, managing Medicaid enrollment, obtaining parental permission and medical/dental histories, and providing treatment. Despite a perceived shortage of dental hygienists in the state,

[54] School-Based Preventive Dental Programs, New Hampshire. (2002). Dental Public Health Activities & Practices Series, Practice #32003. Association of State and Territorial Dental Directories.

community-based dental coalitions initiating these programs have not encountered difficulty in hiring dental hygienists to fill positions, and these hygienists report enjoying working with children during school hours. A dental hygienist can be contracted for approximately $25 per hour.

Supporting state policy allows registered dental hygienists to provide preventive dental services in schools without direct supervision from a dentist. Services provided by dental hygienists in schools include dental screenings, prophylaxis, topical fluoride treatments, dental sealants, oral health education, fluoride mouth rinses, and data collection activities to support the state's oral health surveillance system. Children are referred to dentists in the community willing to serve vulnerable children, and hygienists serve as case managers. This case management reduces no-shows and behavioral problems, which increases the willingness of dentists to participate.

Ohio[55]

Ohio, on the other hand, has not integrated Medicaid revenue into its school-based dental programs, which are predominantly grant-funded. The Ohio Department of Health sustains school-based dental sealant programs (funded in 2002) through a Maternal and Child Health Block Grant, tobacco settlement monies, local governments, and charitable foundations. Grants target the Appalachian counties and large urban schools with 50 percent or more students participating in the Free/Reduced Meals program. Grant awards are allocated based on the number of children projected to receive sealants, rather than retrospective reimbursement for children actually receiving sealants.

The delivery model includes a dentist to examine and prescribe sealants, and dental hygienists working with dental assistants to place sealants. Programs typically serve students in the second and sixth grades, screening approximately 30 children per hour and placing sealants for 15 to 18 children per day. The average cost per child receiving sealants is $35 to $40. One-year follow up is provided to sealant participants in the third and seventh grades to replace lost sealants or to add sealants to newly erupted teeth. Schools employ portable dental equipment for these programs.

The state believes school-based programs are a very effective approach to identifying students most likely to benefit from sealants. For example, all racial and income groups of Ohio third graders at schools with the sealant programs exceed the Healthy People 2010 objective of 50 percent prevalence of sealants. While programs focus on sealant application, supplemental grants have funded demonstration programs using different models to assure restorative dental care for children with dental needs found in the course of examination. Improved follow-up and referral for treatment appear necessary as 30 percent of children seen are identified as needing dental care, and 25 percent of participants examined one year later still need dental care.

[55] The Ohio Department of Health School-Based Dental Sealant Program. (2002). Dental Public Health Activities & Practices Series, Practice #32002. 2002. Association of State and Territorial Dental Directories.

New York[56]

The Community DentCare Network in Northern Manhattan was initiated by the Columbia University School of Dental and Oral Surgery, in partnership with community-based organizations, and is funded through a variety of sources, including foundation grants, city outlays for construction, state grants, and grants and support from educational institutions. This program provides a model for linking SBHCs to community dental services.

The network includes components to respond to dental health needs across the life span in Northern Manhattan, and includes seven public middle school dental programs; one mobile dental clinic serving the Head Start population during the school year (and the elderly during the summer); and four community health center sites offering comprehensive dental services. These freestanding clinics operate in close proximity to school-based health center sites, and serve to link school-based dental services to additional services in the community through an anchor concept delivery model. Dental professionals retain cross-appointments at both school and community sites, and a system of communication and referrals link the school and its student population to community services.

Schools within the network employ different delivery models that were designed based on consensus-building activities between providers, educators, community members, and policymakers. However, all delivery models were built based on existing infrastructure of safety net services and provider capacities, and integrated oral health into primary care services. For example, one school operates a school-based clinic off school premises in a community health center, and escorts students between sites. The clinic provides preventive and primary restorative dental services using dentists, dental hygienists, and dental assistants. Another school operates a freestanding clinic in the school and provides comprehensive dental care, including endodontics, and fabrication of mouth guards (for sports). In addition, outreach is conducted to Head Start and day care facilities to provide screening and prevention with referrals to the school clinic when needed. An alternative model employs a dental van that visits schools without comprehensive school-based health services, providing a more limited set of dental services.

All programs retain bilingual staff and communicate daily with teachers and school administrators. Some encourage children to participate as volunteers in the clinics, and staff members function as mentors. Patient escorts are used to bring children from the classroom to the clinic and to assist staff with clerical tasks. This alleviates wait times and minimizes hassle for teachers and school administrators. Where possible, programs maintain extended hours and serve students, siblings, and children in the community.

[56] Albert, D., McManus, J.M., and Mitchell, D.A. Models for Delivering School-Based Dental Care. (May 2005). *Journal of School Health* 75(5): 157-161; and Formicola, A. J., Ro, M., et al. *Strengthening the Oral Health Safety Net: Delivery Models that Improve Access to Oral Health Care for Uninsured and Underserved Populations*.

Conclusions and Recommendations

Maryland's SBHCs are an important community health resource, providing access to preventive services, acute care, mental health services, and oral health care to more than 50,000 children and adolescents in schools across the state. The findings from this study are summarized below, followed by recommendations for a Commission grants program and general recommendations.

Findings

1. **The survey, interviews, and other research confirm the value of SBHCs as a safety net provider for school children.** During the 2005-2006 school year, a total of 26,901 students enrolled in SBHC programs and 15,000 of those children visited their centers, accounting for 73,165 visits. SBHCs provide access to health care regardless of ability to pay for many children and adolescents who might not otherwise seek services or who do not have a regular source of health care.

2. **The state's SBHCs are operating on very limited budgets and with minimal staff.** Estimated FY 2006 revenue was $6.96 million and the state's SBHCs averaged just 2.89 full-time equivalent staff. All the centers reported a need for services far greater than what the centers are able to provide, particularly oral health care and mental health services.

3. **Because the HealthChoice regulations place restrictions on reimbursement for self-referred services, there is limited potential for SBHCs to receive Medicaid reimbursement, even if SBHCs were to bill and receive payment for all eligible services.** Maryland's SBHCs reported that patient revenue accounted for about 11 percent of total revenues. This compares with 13 percent nationally, suggesting that Maryland's centers could increase patient revenue to some extent. Contracting with MCOs could provide additional Medicaid reimbursement to SBHCs, but a number of barriers must first be overcome. Even then, SBHCs are likely to require additional sources of revenue to survive and grow.

4. **All but one SBHC sponsor report billing for services to some extent, but there is wide variation.** The least frequently billed services are health promotion/prevention services, substance abuse treatment, and mental health care. Sponsors report difficulty maximizing third party reimbursement because of insufficient staffing, lack of staff training, lack of standardized billing policies and procedures, and difficulty complying with insurers' credentialing requirements. Many SBHCs question the cost-effectiveness of billing Medicaid given the limited number of "self-referred" services for which SBHCs may bill, the low Medicaid reimbursement rates, and the amount of staff time required in the billing process.

5. **SBHCs have not been very successful in contracting with HealthChoice MCOs.** Only one sponsor reports having an MCO contract. MCOs expressed varying levels of interest in contracting with SBHCs. MCOs are concerned that the concept of managed care and

the medical home may be undermined; quality may be compromised, as well as the ability of the MCO to meet HEDIS standards; and reporting by SBHCs on encounters is not always timely or consistent.

6. **Accounting and fiscal management systems of SBHCs do not always produce reliable financial information.** The accounting systems of some sponsors do not have dedicated cost centers for SBHCs, so consistent and reliable reporting of revenue and expenses by center is not possible. Consequently, revenues and expenses reported in this study are only estimates. Better financial management systems will be required to monitor progress with any initiatives to increase billing by SBHCs.

7. **SBHCs report a need for expanded oral health services and mental health services.** Six sponsors reported providing dental services and all the sponsors reported providing mental health services. Expanding oral health services involves significant capital outlays for equipment, and the dearth of dental providers presents significant staffing challenges. With mental health services, the primary barrier to expanding services is lack of financing to pay additional salaries and fringe benefits to providers.

8. **The availability of professional liability coverage is not an issue for SBHCs or MQHCs.** Most SBHCs and MQHCs provide professional liability coverage to their full-time and part-time employees. Eight SBHC sponsors report that they are already covered by governmental immunity laws (i.e., the Federal Tort Claims Act, the Maryland Tort Claims Act, or the Local Government Tort Claims Act). SBHCs and MQHCs report that they do not anticipate hiring more part-time or contractual practitioners if the Maryland Tort Claims Act were to be extended to cover these groups of practitioners.

9. **Security does not seem to be a major issue at most SBHCs.** Few SBHCs provide services to non-students and most operate during school hours and/or immediately before and after school, so after-hours security is not a significant issue. Precautionary security measures, such as secure storage for medical supplies, drugs, and records, and HIPAA-compliant procedures for sharing and storing medical records, are generally in place. Over 80 percent of SBHCs have not experienced any security incidents.

10. **SBHCs experience difficulty in recruiting, remunerating, and retaining qualified practitioners, especially dental providers.** Reconsidering and appropriately liberalizing scope of practice limitations could potentially result in a greater supply of practitioners available to SBHCs and/or expand the scope of services that existing practitioners can provide.

11. **Maryland's SBHCs are generally choosing to pursue the traditional SBHC model as opposed to the school-based *community* health center model, which involves serving a broader population in the community.** SBHCs report serving populations other than students, but it is usually confined to siblings, parents, and faculty and staff. Only one sponsor expressed interest in expanding services in the community.

12. **The survey of MQHCs had the unexpected result of highlighting the difficulty in identifying existing MQHCs in the state.** The numbers of MQHCs in the state appear to be declining. At the time of the survey, seven MQHCs were operating, but one of these will cease operations in November 2007.

13. **Initiatives in other states offer lessons for Maryland.** In New Mexico, the Medicaid reimbursement rules provide for reimbursement for a broader range of services than in Maryland, and a stakeholder summit and task force were instrumental in building ongoing, broad-based support for SBHCs. The Michigan initiative, which involves a centralized billing system and enhanced capitation payments to MCOs for SBHC outreach and education, is another promising model. New Hampshire, New York, and Ohio have innovative school-based dental programs.

Recommendations for a Commission Grants Program

Research findings point to three opportunities for grant-making by the Commission. However, in designing a grants program, it is important to note that SBHCs in Maryland vary tremendously—in sponsorship, size, scope of services, populations served, billing capacity, and perhaps most significantly, their location on the "continuum of growth and development" as organizations and safety net service providers. Recognizing this, a range of grant opportunities is presented so that there will be an appropriate opportunity for each SBHC and SBHC sponsor. In addition, the grant-making recommendations reflect the needs and desires of SBHCs and their sponsors as communicated in the survey and interviews conducted for this study.

SBHCs could benefit from grant opportunities in three program areas:

1. Enhancing the IT capability of SBHCs in order to streamline financial and clinical management information systems and function and maximize revenue from patient care.
2. Service expansion in preventive health care, oral health, and behavioral health.
3. Start-up support for new SBHCs.

In designing a grants program, the Commission should consider encouraging collaboration across sponsors and centers and building leadership from within. A program of technical assistance and training on financial management and billing made available to all SBHCs and sponsors in the state would be beneficial. Because centers are operating with minimal staff—many of whom are clinicians managing busy practices—sponsors and SBHCs urged that sufficient time be built into any Request for Proposals to enable them to explore new collaborations and prepare grant proposals.

General Recommendations

SBHCs are an important safety net provider for Maryland's school children and should be an integral part of any proposals for health reform put forth by the state. The long-term viability of SBHCs can be ensured only if the needs of these vital community health resources are addressed broadly and systematically. It is unlikely that SBHCs can ever be fully self-supporting through

patient care revenue. Steps to improve billing and reimbursement will have a positive effect on revenue, but these efforts must be coupled with a broader consideration of policies that affect the financing and delivery of SBHC services. For example, the state might consider:

1. Revising the Medicaid regulations to allow "self-referred" reimbursement for a wider range of services, including more preventive services, and simplifying the reporting requirements.

2. Instituting incentives to encourage MCOs participating in the HealthChoice program to contract with SBHCs for the provision of preventive services.

3. Exploring the possibility of increasing Medicaid reimbursement rates for self-referred SBHC services in order to increase revenue to SBHCs.

4. Encouraging all of the local health department sponsors who are facing challenges with patient billing to apply for and enforce waivers allowing uninsured individuals to be "nonchargeable."

5. Providing ongoing training and technical assistance to SBHCs on Medicaid and MAPS-MD billing and reimbursement.

6. Collaborating with SBHCs and MCOs to find new ways to enhance electronic billing capacity and make claims processing and payment more efficient for all.

7. Encouraging measured expansion of SBHCs in the state with an emphasis on long-term sustainability.

8. Working with provider groups and training programs to explore new ways to train, credential, supervise, and finance practitioners for SBHCs—including nurse practitioners, physician assistants, oral health providers, and behavioral health practitioners—and establish appropriate linkages to students' primary care physicians and medical homes.

Appendices

Appendix 1
Maryland's School-Based Health Centers

Jurisdiction	Sponsor	SBHC[57]
Baltimore City	Baltimore City Health Department	William S. Baer
		Carter Woodson K-8
		City Springs K-8
		Roland Patterson
		Harford Heights
		Harlem Park MS/Baltimore Talent Development
		Lombard Middle School/Baltimore Freedom Academy
		Digital South High School
		Southside Academy/New Era Academy
		Dunbar High School
		Southwestern High School
		Northwestern
		Patterson High School
		Heritage High School
		Wallbrook High School
Baltimore City	Baltimore Medical System	CATCH
		THAT Place
Baltimore City	Maryland General Hospital	Laurence G. Paquin School
Baltimore County	Baltimore County Public Schools	Hawthorne Elementary School
		Chesapeake High School
		Glenmar Elementary School
		Martin Boulevard Elementary School
		Middlesex Elementary School
		Mars Estate/Deep Creek
		Riverview Elementary School
		Winfield Elementary School
		Deep Creek Middle School/Sandalwood
		Kenwood High School
		Woodlawn High School
		Lansdowne High School
		Lansdowne Middle School
		Bridge Center

[57] The Cecil County Health Department anticipates re-opening one if its centers in December 2007. This center is not included because it is not yet operational.

Jurisdiction	Sponsor	SBHC
Caroline County	Choptank Community Health System	Colonel Richardson Middle School
		Colonel Richardson High School
		Federalsburg Elementary School
		Greensboro Elementary School
		Lockerman Middle School
		Ridgely Elementary School
		North Caroline High School
Dorchester County	Dorchester County Health Department	Cambridge South Dorchester High School
		Maces Lane Middle School
		North Dorchester High School
		North Dorchester Middle School
Harford County	Harford County Public Schools	Edgewood Elementary School
		Halls Crossroad Elementary School
		Magnolia Elementary School
		William Paca/Old Post Road Elementary School
Montgomery County	Montgomery County Department of Health and Human Services	Gaithersburg Elementary School
		Broad Acres Elementary School
		Harmony Hills Elementary School
Prince George's County	Prince George's County Health Department	Bladensburg High School
		Fairmont Heights High School
		Northwestern High School
		Oxon Hill High School
Talbot County	Talbot County Health Department	St. Michael's
		Easton Elementary School
		Easton High School
		Easton Middle School
Washington County	Washington County Health Department	Western Heights Middle School
		South Hagerstown High School
		Williamsport High School
Wicomico County	Wicomico County Health Department	Wicomico Middle School

Source: Maryland State Department of Education.

Appendix 2

School-Based Health Center Survey

PART A: To be completed by the school-based health center Sponsor.

Return completed survey to the Center for Health Program Development and Management, UMBC, Sondheim Hall—3rd Floor, 1000 Hilltop Circle, Baltimore, MD 21250.

Sponsoring Organization: _____

Survey Completed by: _____
Name

Telephone: _____ E-mail: _____

1. What is the sponsoring organization's fiscal year?
   - ☐ July 1-June 30
   - ☐ January 1-December 31
   - ☐ Other (specify) _____

2. Do the school-based health centers sponsored by your organization bill for at least some of the services provided?
   - ☐ Yes
   - ☐ No. The centers do not bill for the reason(s) indicated below. *(Check all that apply and skip to Question 8.)*
     - ☐ Sponsoring organization's policy is that school-based health centers are free clinics.
     - ☐ Adequate revenue from other sources (i.e., government funding, grants, donations) to cover expenses.
     - ☐ Limited or no access to billing software.
     - ☐ Limited or no access to a computer.
     - ☐ Limited or no access to a fax machine.
     - ☐ Limited or no access to the internet.
     - ☐ Not enough staff time.
     - ☐ Staff do not have adequate training in billing.
     - ☐ Cannot comply with managed care plans' credentialing requirements.

☐ Managed care plans are not willing to contract with our school-based health centers.

3. Which of the following services do the school-based health centers sponsored by your organization provide, and how frequently do the centers bill for these services?

	Service Provided?	**Billing Frequency**			
		Always	Frequently	Sometimes	Never
Immunizations	☐ Yes ☐ No	☐	☐	☐	☐
Well-child exams	☐ Yes ☐ No	☐	☐	☐	☐
Acute care	☐ Yes ☐ No	☐	☐	☐	☐
Chronic disease care	☐ Yes ☐ No	☐	☐	☐	☐
Dental services	☐ Yes ☐ No	☐	☐	☐	☐
Mental health care	☐ Yes ☐ No	☐	☐	☐	☐
Substance abuse treatment	☐ Yes ☐ No	☐	☐	☐	☐
Reproductive/sexual health services	☐ Yes ☐ No	☐	☐	☐	☐
Health promotion/ prevention services	☐ Yes ☐ No	☐	☐	☐	☐
Other (specify):	☐ Yes ☐ No	☐	☐	☐	☐

4. How often do the school-based health centers sponsored by your organization encounter the following barriers to billing for services?

	Always	Frequently	Sometimes	Never
Insufficient staffing	☐	☐	☐	☐
Lack of staff training	☐	☐	☐	☐
Lack of standardized billing policies and procedures	☐	☐	☐	☐
Difficulty complying with insurers' credentialing requirements	☐	☐	☐	☐
Limited or no access to billing software	☐	☐	☐	☐
Limited or no access to a computer	☐	☐	☐	☐
Limited or no access to a fax machine	☐	☐	☐	☐
Limited or no access to the internet	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐

5. Do the school-based health centers sponsored by your organization use a fee schedule with established charges for services?

   ☐ Yes. Our fee schedule is based on (*check all that apply*):

   ☐ Current Procedural Terminology (CPT) codes

   ☐ Length of visit/appointment

   ☐ Other (specify): _____

   ☐ No. *Skip to Question 7*.

6. Do the school-based health centers sponsored by your organization have a sliding fee discount schedule? That is, do fees vary based on a patient's family income or ability to pay?

   ☐ Yes

   ☐ No

7. What billing software system is used by the school-based health centers sponsored by your organization?

Yes	No	
☐	☐	The sponsoring organization's billing software system.
☐	☐	The school-based health centers have their own billing software systems.
☐	☐	Other (specify):_____

Please provide the name and manufacturer of the billing software used:

8. When a student enrolls in a school-based health center sponsored by your organization, does the school-based health center:

Yes	No	
☐	☐	Request information about the student's health insurance coverage?
☐	☐	If the student is uninsured, counsel the student and/or family about enrolling in insurance programs for which the student and/or family might be eligible (e.g., private insurance, Medical Assistance (Medicaid), the Maryland Children's Health Program, other public programs)?
☐	☐	Assist the student and/or family in completing and filing an application for public programs such as Medical Assistance (Medicaid) or the Maryland Children's Health Program?
☐	☐	Follow up to ensure that the student and/or family satisfactorily completes applications for public programs such as Medical Assistance (Medicaid) or the Maryland Children's Health Program application process?

9. Specify whether health care practitioners working in the sponsoring organization's school-based health centers work as full-time employees, part-time employees, contractual practitioners, and/or volunteers (*see definitions below*.)

	Full-Time Employee	**Part-Time Employee**	**Independent Contractual Practitioner**	**Volunteer**
Physicians	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nurse Practitioners	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physician Assistants	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dentists	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Hygienists	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Assistants	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Registered Nurses	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Licensed Practical Nurses	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Psychologists/ Psychiatrists	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Counselors/ Social Workers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (specify):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Definitions:
Employees: *Salaried health care practitioners or contractual employees of the sponsoring organization.*
Independent Contractual Practitioners: *Independent health care practitioners who provide services under a fee-based contract with the sponsoring organization.*
Volunteers: *Health care practitioners who donate their time spent providing health care services.*

10. Does the sponsoring organization provide **professional liability insurance for health care practitioners** working in the sponsor's school-based health centers? Indicate below whether professional liability insurance is provided for full-time employees, part-time employees, independent contractual practitioners, and volunteers.

Full-Time Employees	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A**. No full-time employees at our school-based health centers **If no**, has this been an impediment to hiring health care practitioners as full-time employees? ☐ Yes ☐ No
Part-Time Employees	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A.** No part-time employees at our school-based health centers **If no**, has this been an impediment to hiring health care practitioners as part-time employees? ☐ Yes ☐ No
Independent Contractual Practitioners	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A**. No independent contractual practitioners at our school-based health centers. **If no**, has this been an impediment to hiring health care practitioners as independent contractual practitioners? ☐ Yes ☐ No
Volunteers	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A.** No volunteers at our school-based health centers. **If no**, has this been an impediment to hiring health care practitioners as volunteers? ☐ Yes ☐ No

11. Under certain circumstances, federal, state, and local laws apply to confer on school-based health centers' health care practitioners limited immunity from professional liability claims to the extent the claims exceed $200,000. Which, if any, of these programs provides the sponsoring organization with limited immunity for its health care practitioners working in school-based health centers?

Yes	No	
☐	☐	Federal Tort Claims Act (FTCA)
☐	☐	Maryland Tort Claims Act (MTCA)
☐	☐	Local Government Tort Claims Act (LGTA)

12. If the Maryland Tort Claims Act were amended to extend limited immunity from professional liability claims over $200,000 to **health care practitioners working as <u>independent contractual practitioners</u> in school-based health centers:**

    a. How likely would your organization be to **employ new independent contractual health care practitioners** in your school-based health centers?

Very at All		**Not Likely**		**Likely**	
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

    b. How likely is it that your organization would provide **"wrap-around" professional liability insurance** to protect independent contractual health care practitioners in your school-based health centers against the first $200,000 of professional liability?

Very at All		**Not Likely**		**Likely**	
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

13. If the Maryland Tort Claims Act were amended to extend limited immunity from professional liability claims over $200,000 to **health care practitioners working as <u>volunteers</u> in school-based health centers:**

    a. How likely would your organization be to **use new volunteer health care practitioners** in your school-based health centers?

Very at All		**Not Likely**		**Likely**	
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

    b. How likely is it that your organization would provide **"wrap-around" professional liability insurance** to protect volunteer health care practitioners in your school-based health centers against the first $200,000 of professional liability?

Very at All		**Not Likely**		**Likely**	
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

14. When securing professional liability insurance for its school-based health centers and the centers' health care practitioners during the last three years, has the sponsor encountered:

Yes	No	
☐	☐	A limited choice of companies offering professional liability insurance in Maryland?
☐	☐	A limited choice of insurance products that meets the needs of the sponsor's school-based health centers?
☐	☐	Insurance products that meet the sponsor's needs but exceed the sponsor's budget for professional liability insurance?

Please specify any other difficulties encountered in securing professional liability insurance:

15. During the past three years, has the cost or availability of professional liability insurance caused the sponsor to:

Yes	No	
☐	☐	Discontinue any school-based health center services?
☐	☐	Limit the hours of service of school-based health center(s)?
☐	☐	Limit the number of students served by school-based health center(s)?
☐	☐	Discontinue plans to expand the services offered at school-based health center(s)?
☐	☐	Discontinue plans to open a new school-based health center(s)?
☐	☐	Refrain from hiring health care practitioners as employees?
☐	☐	Refrain from contracting with health care practitioners as independent contractual practitioners?
☐	☐	Refrain from using health care practitioners in an unpaid volunteer role?
☐	☐	Close a school-based health center(s)?

If you answered "yes" to any of the preceding questions, please explain below:

THANK YOU!

Appendix 3

School-Based Health Center Survey

PART B: To be completed by the school-based health center Sponsor. The sponsor should complete a separate form for each school-based health center.

Return completed survey to the Center for Health Program Development and Management, UMBC, Sondheim Hall—3rd Floor, 1000 Hilltop Circle, Baltimore, MD 21250.

Sponsoring Organization:_____

School(s) Served: _____

Survey Completed by: _____
Name

Telephone: _____ E-mail: _____

1. What populations does the school-based health center serve?

Yes	No	
☐	☐	Students enrolled in the school(s) with which the center is affiliated.
☐	☐	Siblings of enrolled students.
☐	☐	Parents and guardians of enrolled students.
☐	☐	Faculty and staff of the school with which the center is affiliated.
☐	☐	Other members of the community.

2. Does the school-based health center have:

Yes	No	N/A	
☐	☐		A phone line dedicated to the school-based health center?
☐	☐		A fax line dedicated to the school-based health center?
☐	☐		Identification cards for students enrolled in the center?
☐	☐		Secure storage area for medical supplies and drugs?
☐	☐		Secure and confidential storage area for medical records?
☐	☐		HIPAA-compliant procedures for sharing/storing medical records?
☐	☐		An electronic security system with direct call to security or police?
☐	☐		Entrance separate from the school entrance that can be accessed after school hours?
☐	☐	☐	Night lighting in the parking lot if open in the evening?
☐	☐	☐	Security officer or police presence during after-school hours?

3. In the past three years, has the school-based health center experienced:

Yes	No	
☐	☐	A situation necessitating a call to security or the police?
☐	☐	An unauthorized intruder or break-in?
☐	☐	Stolen medical records?
☐	☐	Stolen or intentionally damaged medical equipment?
☐	☐	Stolen medical supplies or drugs?
☐	☐	A lawsuit alleging medical malpractice?

If you responded "yes" to any of the above questions, please explain:

4. In the past three years, has the school-based health center ever had to **suspend new enrollment** for a period of time because the number of individuals seeking services could not be accommodated by the center? *Check one.*

   ☐ Enrollment has **never** been suspended in the past three years.

   ☐ Enrollment was suspended **once** in the past three years.

   ☐ Enrollment was suspended **twice** in the past three years.

   ☐ Enrollment was suspended **three or more times** in the past three years as follows (*give approximate dates and duration of suspended enrollment periods, as well as reasons for suspending enrollment –e.g., insufficient staffing, funding, space*):

   _____

   _____

   _____

   _____

   _____

5. Looking back to the month of April 2007, approximately what percentage of available appointment slots were booked, and approximately what percentage of booked appointments were kept by patients?

   _____% of appointment slots were booked in April 2007

   _____% of booked appointments were kept by patients in April 2007

6. On a typical school day in April 2007, about how long did a **patient with an appointment** have to wait to see a health care practitioner? *Check one box for each service.*

Service	0-15 minutes	16-30 minutes	31-45 minutes	More than 45 minutes	Service Not Provided
Immunizations	☐	☐	☐	☐	☐
Well-child exams	☐	☐	☐	☐	☐
Acute care	☐	☐	☐	☐	☐
Chronic disease care	☐	☐	☐	☐	☐
Dental services	☐	☐	☐	☐	☐
Mental health care	☐	☐	☐	☐	☐
Substance abuse treatment	☐	☐	☐	☐	☐
Reproductive/sexual health services	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐

7. On a typical school day in April 2007, about how long did a **"walk-in" patient presenting with a non-emergency condition** have to wait to see a health care practitioner? *Check one box for each service.*

Service	0-15 minutes	16-30 minutes	31-45 minutes	More than 45 minutes	Walk-ins Not Accepted	Service Not Provided
Immunizations	☐	☐	☐	☐	☐	☐
Well-child exams	☐	☐	☐	☐	☐	☐
Acute care	☐	☐	☐	☐	☐	☐
Chronic disease care	☐	☐	☐	☐	☐	☐
Dental services	☐	☐	☐	☐	☐	☐
Mental health care	☐	☐	☐	☐	☐	☐
Substance abuse treatment	☐	☐	☐	☐	☐	☐
Reproductive/sexual health services	☐	☐	☐	☐	☐	☐
Other (specify):	☐	☐	☐	☐	☐	☐

8. **Staffing:** How many full-time equivalents (FTEs) worked at the school-based health center during the 2005-2006 school year (July 1, 2005, to June 30, 2006)? *See definitions below.*

Number of Full-Time Equivalents (FTEs)—FY 2006			
	Employees	**Independent Contractual Workers**	**Volunteers**
Licensed Health Care Practitioners			
Other Health Care Practitioners			
Practice Management			
Clerical Staff			
Other			
TOTAL			

Definitions:
Full-Time Equivalent (FTE): *One full-time worker is equal to 1.0 FTE. Full-time is defined as 35-40 hours per week. If the center is open only nine or ten months a year, consider a nine- or ten-month employee who worked full time (i.e., 35-40 hours per week) to be 1.0 FTE.*
Licensed Health Care Practitioners: *Licensed practitioners who can practice independently, such as physicians, physician assistants, nurse practitioners, dentists, psychologists, and social workers.*
Other Health Care Practitioners: *Practitioners such as registered nurses, licensed practical nurses, dental hygienists, health aides, and medical assistants who are not licensed to practice independently.*
Practice Management: *Non-health care practitioners who are responsible for managing the operations of the school-based health center (e.g., operations, fiscal management, facilities management, school/sponsor relationships).*
Clerical Staff: *Staff responsible for administrative, billing, and clerical support functions.*
Employees: *Salaried workers or contractual employees of the sponsoring organization.*
Independent Contractual Workers: *Independent workers who provide services under a fee-based contract with the sponsoring organization.*
Volunteers: *Workers who donate their time.*

9. **Revenue:** For Fiscal Year 2006 (school year 2005-06), list revenue and in-kind contributions for the school-based health center.

REVENUE—FY 2006			
Federal Funding:			
Section 330 Community Health Centers			$
Healthy Schools/Healthy Communities			$
Other			$
State Funding:			
MSDE			$
Other			$
Local Funding:			
Local Management Board			$
Local Health Department			$
School System			$
Other			$
Patient Revenue:	Billed	Adjustments, Contractual Allowances, and Write-offs for Bad Debts	Net Received
Medicaid/MCHP*	$	$	$
Private Insurance	$	$	$
Self-Pay (fees, copays)	$	$	$
Other Patient Revenue	$	$	$
Other Revenue:			
Sponsoring Agency			$
Foundations			$
Corporate Donations			$
United Way/Community Support			$
Other Cash Support			$
In-Kind Contributions			$
TOTAL REVENUE			$

* Maryland Children's Health Program.

10. **Expenses:** For Fiscal Year 2006 (school year 2005-06), list all expenses for the school-based health center.

EXPENSES, FY 2006	
Employees (salaries and fringe benefits):*	
Licensed Health Care Practitioners	$
Other Health Care Practitioners	$
Practice Management	$
Clerical Staff	$
Other Employees	$
Fees for Contractual Staff	$
Insurance (general liability, malpractice, other)	$
Medical Supplies/Equipment/Drugs	$
Translation Services	$
Office Expenses/Supplies	$
Office Space/Utilities	$
Other Direct Costs	$
Indirect Allowance	$
TOTAL EXPENSES	$

* See definitions under Question 8.

11. Did the school-based health center receive revenue from Maryland Medicaid (Medical Assistance) or the Maryland Children's Health Program (MCHP) in Fiscal Year 2006 (school year 2005-06)?

☐ No

☐ Yes. If yes, approximately what percentage of Medicaid revenue came from the each of the following sources in that year?

_____% Medicaid MCO Contract[58]

_____% Medicaid Self Referred[59]

_____% Medicaid Fee-for-Service[60]

100%

12. **Operating Results:** How would you characterize the school-based health center's expected operating results in FY 2007 and actual operating results in each of the previous three fiscal years? Did the center finish the year with a surplus, break even, or incur a loss? *Check the appropriate box for each fiscal year.*

Fiscal Year	Operating Surplus	Break Even	Operating Loss
FY 2004	☐	☐	☐
FY 2005	☐	☐	☐
FY 2006	☐	☐	☐
FY 2007 (Estimated)	☐	☐	☐

THANK YOU!

[58] Revenue from contracts with HealthChoice managed care organizations (MCOs) to provide services to HealthChoice enrollees. HealthChoice is Maryland's Medicaid managed care program.

[59] Revenue from HealthChoice MCOs for acute and urgent care services to HealthChoice enrollees in the absence of a contractual relationship with the MCO.

[60] Medicaid fee-for-service revenue (no involvement with HealthChoice MCOs).

Appendix 4

Survey of Maryland Qualified Health Centers

Please return the completed survey to the Center for Health Program Development and Management, UMBC, Sondheim Hall - 3rd Floor, 1000 Hilltop Circle, Baltimore, MD 21250.

Maryland-Qualified Health Center _____

Survey Completed by: _____
Name

Telephone: _____ E-mail: _____

1. What is the fiscal year for your Maryland Qualified Health Center (MQHC)?
   - ☐ July 1-June 30
   - ☐ January 1-December 31
   - ☐ Other (specify) _____

2. For FY 2006, list the MQHC's annual budget, patient visits, and unique patient count.

FY 2006	
Annual Budget	$
Number of Patient Visits	
Unique Patient Count	

3. In the chart below, estimate the percentage distribution of patient care revenue received in FY 2006 by type of insurance. (*Note: Percentages should add up to 100%.)*

Type of Insurance	Percent of Patient Care Revenue, FY 2006
Medicare	%
Medicaid*	%
Private Insurance	%
Uninsured	%
Other (specify):	%
Total	100%

* Includes fee-for-service Medicaid or Medical Assistance, HealthChoice, the Maryland Children's Health Program (MCHP), and the Primary Adult Care Program (PAC).

4. Specify whether health care practitioners providing services through the MQHC are full-time employees, part-time employees, independent contractor-practitioners, or volunteers (*definitions below*.)

	Full-Time Employee	**Part-Time Employee**	**Independent Contractor-Practitioner**	**Volunteer**
Physicians	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Nurse Practitioners	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Physician Assistants	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dentists	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Hygienists	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dental Assistants	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Registered Nurses	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Licensed Practical Nurses	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Psychologists/ Psychiatrists	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Counselors/ Social Workers	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other (specify):	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Definitions:
Employee: *A health care practitioner who provides health care services through an MQHC and whose payment is on a salaried basis, with or without a formal employment contract.*
Independent Contractor-Practitioner: *An independent health care practitioner who provides services through the MQHC under a contractual arrangement that provides for payment on a fee-for-service basis.*
Volunteers: *Health care practitioners who donate services through an MQHC.*

5. Does the MQHC provide professional liability insurance for its health care practitioners? Indicate below whether professional liability coverage is provided for full-time employees, part-time employees, independent contractor-practitioners, or volunteers.

Full-Time Employees	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A**. No full-time employees **If no**, has this been an impediment to hiring health care practitioners as full-time employees? ☐ Yes ☐ No
Part-Time Employees	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A.** No part-time employees **If no**, has this been an impediment to hiring health care practitioners as part-time employees? ☐ Yes ☐ No
Independent Contractor-Practitioners	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A**. No independent contractual practitioners **If no**, has this been an impediment to contracting with health care practitioners to work at the center? ☐ Yes ☐ No
Volunteers	☐ **Yes**, professional liability insurance provided ☐ **No**, professional liability insurance not provided ☐ **N/A.** No volunteers **If no**, has this been an impediment to using health care practitioners as volunteers? ☐ Yes ☐ No

6. To the extent that the MQHC provides professional liability insurance for its health care practitioners:

   a. What type of coverage is provided? (see definitions below)

      ☐ Occurrence coverage

      ☐ Claims made coverage

   b. If claims made coverage is provided, does the MQHC purchase "tail" coverage for a health care practitioner who leaves the MQHC?

      ☐ Yes

      ☐ No

      ☐ Whether or not the MQHC provides "tail" coverage for a health care practitioner who ceases to practice at the MQHC is determined on a case-by-case basis.

Comments (Optional):

Definitions (for question 6)

"Claims made coverage" means the coverage of claims made during the policy period concerning incidents occurring during the policy period.

"Occurrence coverage" means the coverage of claims arising from incidents occurring during the policy period, regardless of when claims relating to such incidents are made.

"Tail coverage" means an endorsement added to a "claims made" policy that extends *beyond the policy termination date* the time for reporting claims resulting from incidents taking place during the policy period

7. Does the MQHC provide obstetrical services?

   ☐ Yes. *Proceed to Question 8*.

   ☐ No. *Skip to Question 9.*

8. Are obstetrical services provided on-site or through formal arrangements with other providers?

   Yes No

   ☐ ☐ Obstetrical services are provided **through formal arrangements with other providers.**

   ☐ ☐ Obstetrical services are provided **on-site**. *If yes*, are health care practitioners providing obstetrical services employed as:

Full-Time Employee	Part-Time Employee	Independent Contractor-Practitioner	Volunteer
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

9. The Maryland Tort Claims Act (MTCA) provides MQHC-employed health care practitioners limited immunity from that portion of a professional liability award that exceeds $200,000. If the MTCA were amended to apply not only to health care practitioners *employed* by the MQHC, but also to **independent contractor-practitioners** providing health care services through the MQHC:

   a. How likely is it that the MQHC would **contract with additional independent contractor-practitioners** to provide services through the MQHC?

Very Likely					Not Likely At All
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

b. How likely is it that the MQHC would **provide "wrap-around" professional liability coverage to independent-contractor practitioners** in order to extend practitioners' limited immunity by providing "first-dollar" coverage of the first $200,000 of professional liability (for which there is currently no immunity under MTCA)?

Very Likely					**Not Likely At All**
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

10. If the Maryland Tort Claims Act were amended to extend the existing statutory immunity from professional liability claims over $200,000 to health care practitioners working as **<u>volunteers</u>** in MQHCs:

a. How likely would your MQHC be to **increase the use of volunteer health care practitioners**?

Very Likely					**Not Likely At All**
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

b. How likely is it that your MQHC would **provide "wrap-around" professional liability coverage to volunteer practitioners** in order to extend volunteer practitioners' limited immunity by providing "first-dollar" coverage of the first $200,000 of professional liability (for which there is currently no immunity under MTCA)?

Very Likely					**Not Likely At All**
6	5	4	3	2	1
☐	☐	☐	☐	☐	☐

11. When securing professional liability insurance for the MQHC and its health care practitioners during the last three years, has the MQHC encountered:

Yes	No	
☐	☐	A limited choice of companies offering professional liability insurance in Maryland?
☐	☐	A limited choice of insurance products that meets the needs of the MQHC?
☐	☐	Insurance products that meet the MQHC's needs but exceed its budget for professional liability insurance coverage?

Please specify any other difficulties encountered in securing professional liability insurance:

12. During the past three years, has the cost or unavailability of professional liability insurance caused the MQHC to:

Yes	No	
☐	☐	Discontinue any services that it had previously offered?
☐	☐	Limit its hours of service?
☐	☐	Limit the number of patients served?
☐	☐	Discontinue plans to expand the services offered?
☐	☐	Refrain from hiring health care practitioners as employees?
☐	☐	Refrain from contracting with health care practitioners as independent contractor-practitioners?
☐	☐	Refrain from using health care practitioners as unpaid volunteers?
☐	☐	Consider closing the MQHC?

If you answered "yes" to any of the preceding questions, please explain below:

Appendix 5

Maryland Medicaid Fee Schedule for Self-Referral Services Provided by School-Based Health Centers in the HealthChoice Program

CPT Codes	Description	Rate
99201	Office visit, new patient, minimal	$30.27
99202	Office visit, new patient, moderate	$53.50
99203	Office visit, new patient, extended	$79.45
99204	Office visit, new patient, comprehensive	$116.02
99205	Office visit, new patient, complicated	$145.36
99211	Office visit, established patient, minimal	$18.07
99212	Office visit, established patient, moderate	$31.90
99213	Office visit, established patient, extended	$49.56
99214	Office visit, established patient, comprehensive	$75.06
99215	Office visit, established patient, complicated	$101.36
57170	Diaphragm fitting with instructions	$99.15
J7300	IUD Kit	$377.00
J7302	Mirena System	$468.71
58300	Insert Intrauterine Device	$100.89
58301	Remove Intrauterine Device	$107.84
11976	Remove Contraceptive Capsules	$118.14
J1055	Depo-Provera-FP	$48.19
J7303	Vaginal Ring Contraceptive Supply-hormone containing	At cost—must submit invoice
J7304	Patch Contraceptive Supply-hormone containing	At cost—must submit invoice
99070	Special contraceptive supplies not listed above; attach invoice	At cost—must submit invoice

Rates effective: July 2007

Source: Maryland Department of Health and Mental Hygiene.

Appendix 6

Sample FQHC Sliding Fee Schedule

	One Person Family		
	From	To	Discount
	0	10,210	90%/MA
100%	10,211	12,252	90%
120%	12,253	14,294	85%
140%	14,295	16,337	80%
160%	16,338	18,379	70%
180%	18,380	20,422	60%
200%	20,422	25,527	50%
250%	25,528	30,633	NA
300%	Over	30,633	0%

Two Person Family		
From	To	Discount
0	13,890	90%/MA
13,691	16,428	90%
16,429	19,166	85%
19,167	21,905	80%
21,906	24,643	70%
24,644	27,382	60%
27,382	34,227	50%
34,228	41,073	NA
Over	41,073	0%

Three Person Family		
From	To	Discount
0	17,170	90%/MA
17,171	20,604	90%
20,605	24,038	85%
24,039	27,473	80%
27,474	30,907	70%
30,908	34,342	60%
34,342	42,927	50%
42,928	51,513	NA
Over	51,513	0%

Four Person Family		
From	To	Discount
-	20,650	90%/MA
20,651	24,780	90%
24,781	28,910	85%
28,911	33,041	80%
33,042	37,171	70%
37,172	41,302	60%
41,302	51,627	50%
51,628	61,953	NA
Over	61,953	0%

Five Person Family		
From	To	Discount
0	24,130	90%/MA
24,131	28,956	90%
28,957	33,782	85%
33,783	38,609	80%
38,610	43,435	70%
43,436	48,262	60%
48,262	60,327	50%
60,328	72,393	NA
Over	72,393	0%

Six Person Family		
From	To	Discount
0	27,610	90%/MA
27,611	33,132	90%
33,133	38,654	85%
38,655	44,177	80%
44,178	49,699	70%
49,700	55,222	60%
55,222	69,027	50%
69,028	82,833	NA
Over	82,833	0%

Seven Person Family		
From	To	Discount
0	31,090	90%/MA
31,091	37,308	90%
37,309	43,526	85%
43,527	49,745	80%
49,746	55,963	70%
55,964	62,182	60%
62,182	77,727	50%
77,728	93,273	NA
Over	93,273	0%

Eight Person Family		
From	To	Discount
-	34,570	90%/MA
34,571	41,484	90%
41,485	48,398	85%
48,399	55,313	80%
55,314	62,227	70%
62,228	69,142	60%
69,142	86,427	50%
86,428	103,713	NA
Over	103,713	0%

For each additional person add $3,480

Source: Center for Health Program Development and Management, UMBC.

Appendix 7

New Mexico: School-Based Health Center Scope of Service

Evaluation and Management			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
99201	New Patient	Office or other outpatient visit (problem focused)	$35.90
99202	New Patient	Office or other outpatient visit (expanded problem focused)	$64.02
99203	New Patient	Office or other outpatient visit (detailed)	$95.43
99204	New Patient	Office or other outpatient visit (comprehensive, moderate)	$135.41
99205	New Patient	Office or other outpatient visit (comprehensive, high)	$172.64
99211	Established Patient	Office or other outpatient visit (minimal)	$20.67
99212	Established Patient	Office or other outpatient visit (problem focused)	$37.64
99213	Established Patient	Office or other outpatient visit (expanded)	$51.55
99214	Established Patient	Office or other outpatient visit (detailed)	$81.08
99215	Established Patient	Office or other outpatient visit (comprehensive, high)	$118.65
99354	Prolonged Services	Prolonged physician service; face-to-face pt. contact; beyond usual services	$99.44

Preventive Medicine Services (EPSDT)			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
99381	New Patient	Initial comprehensive preventive medicine (age under 1 year)	$144.00
99382	New Patient	Early childhood (age 1 through 4 years)	$144.00
99383	New Patient	Late childhood (age 5 through 11 years)	$144.00
99384	New Patient	Adolescent (age 12 through 17 years)	$144.00
99385	New Patient	Age 18 through 39 years	$144.00
99391	Established Patient	Periodic comprehensive preventive medicine (age under 1 year)	$85.92
99392	Established Patient	Early childhood (age 1 through 4 years)	$85.92
99393	Established Patient	Late childhood (age 5 through 11 years)	$85.92
99394	Established Patient	Adolescent (age 12 through 17 years)	$85.92
99395	Established Patient	Age 18 through 39 years	$85.92

Counseling and/or Risk Factor Reduction Intervention			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
99401	New or established patient	Preventive medicine counseling to an individual, approx. 15 minutes	Managed care only
99402	New or established patient	Preventive medicine counseling to an individual, approx. 30 minutes	Managed care only
99403	New or established patient	Preventive medicine counseling to an individual, approx. 45 minutes	Managed care only
99404	New or established patient	Preventive medicine counseling to an individual, approx. 60 minutes	Managed care only
99411	New or established patient	Preventive medicine, group counseling, approx. 30 minutes	Managed care only
99412	New or established patient	Preventive medicine, group counseling, approx. 60 minutes	Managed care only

Behavioral Health Services				
CPT Code	**Service Type**	**Service Description**	**MD/DO Rate**	**Mid-Lev Rate**
90801	Psychiatric diagnostic or evaluative	Psychiatric diagnostic interview examination	$135.00	$50.00
90804	Office or other outpatient facility	Individual psychotherapy, 20-30 minutes	$58.00	$25.00
90805	Office or other outpatient facility	Individual psychotherapy, 20-30 minutes, with med, eval, & management	$64.00	N/A
90806	Office or other outpatient facility	Individual psychotherapy, 45-50 minutes	$88.00	$50.00
90807	Office or other outpatient facility	Individual psychotherapy, 45-50 minutes, with med, eval, & management	$93.00	N/A
90808	Office or other outpatient facility	Individual psychotherapy, 75-80 minutes	$129.65	$75.00
90847	Other Psychotherapy	Family Psychotherapy	$104.00	$50.00
90853	Other Psychotherapy	Group Psychotherapy	$29.83	$20.00
90862	Other psychiatric services	Pharmacologic management	$50.00	N/A
T1016	Behavioral health enhanced	Behavioral health enhanced	Managed	Care only

Procedures and Laboratory			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
10060	Integumentary system/surgery	I&D of abscess (simple)	$92.58
11730	Integumentary system/surgery	Avulsion of nail plate (simple)	$85.43
12001	Integumentary system/surgery	Simple repair of superficial wounds	$141.77
17110	Integumentary system/surgery	Destruction of flat warts	$83.97
36415	Cardiovacular system.surgery	Routine venipuncture	$3.12
54050	Male genital system/surgery	Destruction of lesion(s), penis	$109.66
56501	Female genital system/surgery	Destruction of lesion(s), vulva	$129.14
57170	Female genital system/surgery	Diaphragm or cervical cap fitting with instructions	$91.43
58300	Female genital system/surgery	Insertion of intrauterine device (IUD)	$40.92
58301	Female genital system/surgery	Removal of intrauterine device (IUD)	$101.43
69200	Auditory system/surgery	Removal of foreign body from external auditory canal	$115.94
69210	Auditory system/surgery	Removal impacted cerumen (one or both ears)	$47.80
80061	Pathology & lab	Lipid panels	$17.16

Procedures and Laboratory (cont.)			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
81000	Pathology & lab	Urinalysis by dipstick or tablet reagent	$4.43
81001	Pathology & lab	Urinalysis, automated-with microscopy	$4.43
81002	Pathology & lab	Urinalysis, non-automated-without microscopy	$3.57
81003	Pathology & lab	Urinalysis, automated-without microscopy	$3.14
81015	Pathology & lab	Urinalysis, microscopic only	$4.24
81025	Pathology & lab	Urine pregnancy test – by visual color	$8.84
82270	Pathology & lab	Blood, occult, guaiac, qualitative, feces	$4.54
82465	Pathology & lab	Cholesterol, serum, or whole blood, total	$6.08
82947	Pathology & lab	Glucose, blood, quantitative	$5.48
82948	Pathology & lab	Glucose, blood, reagent strip	$4.43
82962	Pathology & lab	Glucose, blood by glucose monitoring device	$3.27
84703	Pathology & lab	hCG pregnancy test (urine) – qualitative	$10.49
85013	Pathology & lab	Spun microhematocrit	$3.31
85018	Pathology & lab	Hemoglobin (Hgb)	$3.31
86308	Pathology & lab	Heterophile antibodies; screening (Mono-spot)	$7.23
86318	Pathology & lab	Immunoassay for infectious agent antibody, qualitative or semi quantitative (H. pylori)	$18.09
87210	Pathology & lab	Wet mount (e.g., saline) for infectious agents	$5.96
87220	Pathology & lab	Tissue examination	$5.96
87430	Pathology & lab	Streptococcus, group A	$16.76
Q0091	Pathology & lab	PAP smear, obtaining/preparation, conveyance to laboratory	Managed care only
Q0111	Pathology & lab	Wet prep, obtaining/preparation	$5.66
90772	Therapeutic/prophylactic injections	Therapeutic, prophylactic or diagnostic injection, subcutaneous or intramuscular	$17.88
92567	Audiologic function testing	Tympanometry (impedance testing)	$20.28
94640	Pulmonary	Nonpressurized inhalation treatment for acute airway obstruction	$11.18
Immunizations			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
90471	Immunization administration	Immunization administration; one vaccine	Managed care only
90472	Immunization administration	Immunization administration; each additional vaccine	Managed care only
90633	Vaccines, toxoids	Hepatitis A vaccine, pediatric /adolescent	$10.94
90645	Vaccines	Hemophilius influenza b vaccine (HIB), HbOC conjugate	$10.94
90646	Vaccines	Hemophilius influenza b vaccine (HIB), PRP-D conjugate	$10.94
90647	Vaccines	Hemophilius influenza b vaccine (HIB), PRP-OMP conjugate	$10.94
90648	Vaccines	Hemophilius influenza b vaccine (HIB), PRP-T conjugate	$10.94
90649 HB	Vaccines	Human Papilloma Virus (HPV) vaccine – females 9-10 and 19-26 years if age	$130.00
90649	Vaccines	Human Papilloma Virus (HPV) vaccine – females 11-18 years if age	$10.00
90657	Vaccines	Influenza virus vaccine, split virus, 6-35 months of age	$10.94
90658	Vaccines	Influenza virus vaccine, split virus, 3 years and above	$10.94
90659	Vaccines	Influenza virus vaccine, whole virus	Managed care only
90669	Vaccines	Pneumococcal conjugate vaccine, polyvalent, children under 5 years	$26.60
90702	Vaccines	Diptheria, tetanus toxoids	$10.94

Immunizations (cont.)			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
90700	Vaccines	Diptheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)	$10.94
90701	Vaccines	Diptheria, tetanus toxoids, and whole cell pertussis vaccine (DTP)	$21.93
90707	Vaccines	Measles. Mumps, rubella vaccine (MMR)	$10.94
90712	Vaccines	Polivirus vaccine (OPV) for oral use	$10.94
90713	Vaccines	Poliovirus (IPV) for subcutaneous or intramuscular use	$10.94
90715	Vaccines	Tetanus, diphtheria toxoids and acellular pertussis vaccine (TdaP)	$10.94
90716	Vaccines	Varicella virus vaccine	$10.94
90718	Vaccines	Tetanus and diphtheria toxoids (Td)	$10.94
90732	Vaccines	Pneumococcal polysaccharide vaccine 23-valent	$27.03
90733	Vaccines	Meningococcal polysaccharide vaccine	$84.46
90734	Vaccines	Meningococcal conjugate vaccine, serogroups A, C, Y, and W-135 (tetravalent)	$10.94
90744	Vaccines	Hepatitis B vaccine, pediatric/adolescent dosage	$10.94
90748	Vaccines	Hepatitis B and hemophillius influenza b vaccine (HepB/Hib) combination	$45.62
Medications, Supplies, & Durable Medical Equipment			
CPT Code	**Service Type**	**Service Description**	**Medicaid FFS Rate**
A4266	Supplies/DME	Diaphragm for contraceptive use	$29.90
A4614	Supplies/DME	Peak flow meter, hand held	$23.78
J0696	Drugs administered other than oral	Injection, Ceftriaxone 250 mg. IM per vial	$1.76
J1055	Drugs administered other than oral	Injection, Depo Provera 150 mg. IM	$58.12
J7300	Drugs administered other than oral	Intrauterine copper contraceptive	$377.00
J7618	Drugs administered other than oral	Albuterol, all formulations	Managed care only
Q0144	Drugs administered other than oral	Azithromycin oral powder 1 gm	Managed care only
Q3014	Telehealth	Telehealth originating site facility fee	$22.47

Source: New Mexico Human Services Department. Retrieved at http://www.hsd.state.nm.us/mad/schoolhealth.html.

Appendix 8

Key Informants

Representatives from the following organizations were contacted for this study:

AMERIGROUP Community Care
APS Healthcare
Baltimore City Health Department
Baltimore County Public Schools
Baltimore Medical System
Baltimore Mental Health Systems, Inc.
CareFirst BlueCross Blue Shield
Center for Health and Health Care in Schools, The George Washington University
Choptank Community Health System, Inc.
Coppin State University Community Health Center
Diamond Plan, Coventry Health Care of Delaware, Inc.
Dorchester County Health Department
Harbor Family Care
Harford County Public Schools
Jai Medical System, Inc.
Johns Hopkins Bayview Children's Medical Practice
Johns Hopkins Community Physicians East Baltimore Medical Center
Johns Hopkins Community Physicians Tindeco Health Center
Maryland Assembly on School-Based Health Care
Maryland Department of Health and Mental Hygiene
Maryland General Hospital
Maryland Physicians Care
Maryland State Department of Education
MedStar Family Choice
Montgomery County Department of Health and Human Services
National Assembly on School-Based Health Care
New Mexico Assembly on School-Based Health Care
New Mexico Human Services Department
Prince George's County Health Department
Priority Partners MCO
School-Community Health Alliance of Michigan
Talbot County Health Department
UnitedHealthcare
University of Maryland Family Medicine Associates
University of Maryland Pediatric Ambulatory Center
Washington County Health Department
Wicomico County Health Department

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