The Colorado Health Foundation™

The Colorado Health Foundation's School-Based Health Care Initiative

Evaluation Case Studies: Generating Patient Revenue from Billing and Financing Services for the Uninsured

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About the Colorado Health Foundation

Our Vision

Together, we will make Colorado the healthiest state in the nation.

The Foundation works with its partners in three community outcomes to encourage Healthy Living, increase the number of Coloradans with Health Coverage, and ensure access to quality, coordinated Health Care.

Within these three community outcomes, we have mapped out the Funding Strategies that need to be employed in order for us to succeed. Through our work, we invest our resources to:

- Develop Healthy Schools
- Promote Healthy Communities
- Optimize Coverage in Public Programs
- Ensure Adequate and Affordable Coverage
- Improve Health Care Delivery
- Build Health Care Professionals Workforce
- Accelerate the Adoption of Health Information Technology

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Authors

Sara Geierstanger
Univeristy of California, San Francisco

Shelly Kaller
University of California, San Francisco

Sally Brown, PhD
Phillliber Research Associates

Background and Overview

School-Based Health Centers (SBHCs) represent a successful model of care that responds to the unique physical and mental health needs of children and adolescents by offering care in an accessible, youth-friendly environment. Studies have shown that they increase use of primary care services, and reduce emergency room use and hospitalization.[i, ii, iii, iv, v, vi] They can also result in a net social benefit through savings to the Medicaid system and society, and may help close health care disparity gaps.[vii]

Despite their popularity and proven success, SBHCs continue to face sustainability challenges. Factors that have been shown to support their sustainability include diversified funding sources, strong clinic record keeping, sponsors with the capacity and expertise to bill for services, Medicaid reimbursement, and state and federal government funding and support.[viii, ix, x]

Recognizing the important role that SBHCs play in the health and wellness of Colorado's children, the Colorado Health Foundation launched the $10.8 million School-Based Health Care Initiative in June 2009 to support SBHCs in communities throughout the state. As of July 2013, the Initiative has supported the planning and implementation of 36 new or expanded SBHCs in Colorado. As part of the grants, sites were required to complete a readiness assessment, a business plan and a financial template to guide their strategic development.

The Foundation contracted with an evaluation team to determine if the Initiative was effective in moving Colorado SBHCs toward increased self-sustainability. Mid-point evaluation results demonstrated that key strengths of the sites were their staffing, strong management, provision of services, facilities and funding strategies that have resulted in increased government insurance program enrollment and revenue. Challenges revolved around the level of integration within the schools, including partnering with the schools on programs and advocacy, having effective and efficient billing systems, and finding ongoing funding streams to serve the uninsured.

As part of the Initiative evaluation, two case studies were conducted to share best practices with the field: **Generating Patient Revenue from Billing** and **Financing Services for the Uninsured**. In May 2013, the evaluation team conducted in-person interviews with a main contact from each of the participating case study SBHC sites, as well as with at least two representatives of the lead agency with operational and billing expertise. The interviewees were asked in-depth questions related to the case study topics, and were audio-recorded for transcription by the evaluation team after the interviews for analysis. In addition, data points were included from the SBHC Sustainability Self-Assessment Tool, which was developed by the evaluation team for sites to assess their annual progress on items considered by the field to be key factors for sustainability. The sites last completed an assessment in January 2013. School level demographic data are from fall 2011, and Free and Reduced Lunch data are from fall 2010, based on figures reported by the Colorado Department of Education.

Case Study #1: Generating Patient Revenue from Billing

Background: Why is SBHC Billing Important?

Although the value of SBHCs is widely recognized, proponents increasingly believe that they can no longer rely upon outside grant funding to pay for their services; they must also bill for services to generate patient revenue. Of course, the SBHC model of care includes the provision of many services which may never be billable to a payer source, such as providing consultation with teachers, classroom health education, assisting with a school-wide health fair or even clinical services that are not billable or only partially reimbursed. However, SBHCs must now implement the infrastructure and operational changes necessary to maximize billing for their services to ensure financial sustainability. This case study describes strategies SBHCs are using to generate patient revenue, including having a supportive sponsoring agency, maximizing insurance and billing, monitoring coding and reimbursement, and educating the community and providers about billing.

Overview of Case Study Sites

Three SBHC sites are included in this case study. Two have large percentages of clients enrolled in Medicaid or CHP+, and nearly all of their patient revenue came from these sources in 2011-12. The third site overcame challenges in generating billing revenue through partnering with a new sponsor and implementing electronic health records.

Pueblo Community Health Center (PCHC) received implementation grants from the Foundation to support reorganized staffing and improved billing procedures at their SBHCs at Central High School, East High School, Freed Middle School and Risley Middle School. Located two hours south of Denver, Pueblo first developed on railroads and the coal and steel industries, but has shifted to a services-oriented economy. The focus of the case study was on the **Central High SBHC**, which opened 15 years ago. A Title 1 school[1], 71 percent of the students are Hispanic and 66 percent are eligible for the Free and Reduced Lunch (FRL) program.[2] A mid-level provider is on-site several hours, with a school nurse covering the remainder of the 40-hour week. Nearly all of the services in 2011-12 were for immunizations, primary care or other services (89 percent). The SBHC primarily serves children from families who are enrolled in Medicaid, and who are existing clients of the sponsoring agency. A large percentage of the revenue was from billing (35 percent), and they reported slightly higher revenues than expenses in 2011-12. Nearly all services are billable; they provided few behavioral health, health education or other non-reimbursable services.

Summit Community Care Clinic (SCCC) received grants through the Initiative to expand SBHC services at Summit Middle and High Schools and at Dillon Valley Elementary School, and to create an SBHC at Silverthorne Elementary School. Located in the Rocky Mountains, the Summit School District serves the diverse resort communities of Breckenridge, Dillon, Frisco and Silverthorne.[xi] The focus of this case study was on **Dillon Valley Elementary SBHC**, which opened in 2005. Also a Title 1 school, 58 percent of the students are Hispanic and 40 percent are White; 53 percent are eligible for the FRL program. In 2011-12, the number of visits provided at the SBHC was small, with four hours per week of clinical services.

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[1] Title I provides federal funding to schools with high poverty levels to help students at risk of falling behind academically.
[2] Eligibility for the National Free and Reduced Lunch Program is based on family income levels.

Most services were for dental (66 percent), primarily school wide screenings. School front desk staff also saw students for immediate and first aid needs, but these did not count as SBHC encounters. Nearly all of the revenue was from non-patient sources (in-kind contributions, government and private grants). Although the SBHC site was not able to recoup much revenue through billing in 2011-12, it is now using a billing infrastructure through its new sponsoring agency that should soon turn this around.

Aurora Public Schools received an implementation grant through the Initiative to expand services at Crawford Elementary SBHC, and to create a new SBHC at Laredo Elementary School. Aurora Public Schools is one of the metropolitan Denver area's largest and most diverse school districts. The focus of this case study is **Crawford Elementary SBHC**, which opened in 2008. A Title 1 school, three-quarters (74 percent) of the students are Hispanic and 89 percent are eligible for the FRL program. With a high number of annual visits per user (3.8), the majority of services were for mental health (67 percent) in 2011-12, but also included immunizations and primary care services. Aurora Public Schools has 4.5 mental health therapists for each of their two SBHC school sites, but only one medical clinic at each site, with one practitioner serving the physical health needs of students. Crawford Elementary SBHC reported the largest net revenue of the three case study sites in 2011-12, thanks to large in-kind contributions from a local behavioral health provider, private donations and government grants. However, only 14 percent of its revenue came from billing because a large percentage (39 percent) of clients was not insured. While the clinic reported large in-kind contributions, a significant portion of the support covered the actual cost of direct services. Those costs will need to be sustained with additional monies in the future.

Keys to Billing Success

The following section describes key themes that emerged from the case study interviews to describe their best practices in billing for patient services.

#1: Have a Strong and Supportive Sponsoring Agency

After Parkview Medical Center had operated the Central High SBHC for 10 years, **Pueblo Community Health Center (PCHC)** became the medical sponsor in 2009. As the only safety-net health care provider in the county, PCHC is a Federally Qualified Health Center (FQHC)[3] and a 501(c)(3) private, nonprofit, full-service family practice provider whose mission is to serve every child regardless of their ability to pay, including the undocumented. PCHC serves as the lead agency, medical sponsor and fiscal agent for the SBHCs. Having an FQHC as the lead sponsor provides the SBHCs with a strong administrative structure and FQHC cost-based reimbursement rates. As one representative explained, "The secret, the magic for them being profitable here is Medicaid and the rate that they get as an FQHC is what allows them to be profitable in the schools. We are first and foremost a community health center, and we just happen to do business in a SBHC. School based health care is different, but the billing systems are the same."

Prior to 2012, the lead sponsor for Dillon Valley Elementary SBHC had been a for-profit, private medical provider who staffed mid-level providers in the SBHCs through grant revenue. Separate billing,

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[3] Federally qualified health centers (FQHCs) include organizations receiving grants under Section 330 of the Public Health Service Act. FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. (Source: Health Resources and Services Organization, US Dept. of HHS)

health record and practice management systems made tracking and reporting of financial and patient information challenging. In 2012, the SBHC Management Team decided that **Summit Community Care Clinic (SCCC)** should serve as the lead agency, medical sponsor and fiscal agent for the SBHCs. This change resulted in all patient and financial information becoming part of one system, with the added benefit of enhanced Medicaid reimbursement because of their new FQHC Look Alike Designation.[4] Since 2008, Crawford Elementary SBHC's medical sponsor has been **Rocky Mountain Youth Clinics**, a private, nonprofit organization that provides pediatric care to children of Colorado regardless of their insurance status or family's ability to pay. Its mission is to provide services to the under-served and at-risk youth in their communities. As a pediatric practice, Rocky Mountain is not eligible to become an FQHC and receive the higher Medicaid reimbursement. However, it is a well-respected nonprofit medical services organization that believes in the SBHC model and supports six SBHCs in Colorado. Aurora Public Schools serves as the lead agency and fiscal agent for the SBHCs.

In sum, all three of the sites reported that they have open and collaborative relationships with their sponsoring agencies. As Crawford has found, having an FQHC or FQHC Look Alike medical sponsor is not essential. Recommendations for strong sponsors include sound fiscal management, support for and understanding of the SBHC model, established systems to handle medical records, savvy insurance billing capabilities and knowledge of government regulations.[xii]

#2: Maximize Medicaid/CHP+ Enrollment

The main sources of government billing revenue for Colorado SBHCs are Medicaid, a federal-state program that provides health insurance to low-income Americans, and Colorado Health Plan *Plus* (CHP+), a low-cost health insurance for Colorado's uninsured children whose families earn too much to qualify for Medicaid, but cannot afford private health insurance. Statewide there was a 10 percent increase in Medicaid enrollment from 2010-11 to 2011-12 due in part to "an increased population, a weak economy and employment environment, eligibility expansions and a greater awareness of the program. Colorado has received federal award bonuses for the past three years for improving outreach and removing barriers to enrollment into Medicaid and CHP+."[xiv]

Multiple methods of outreach are important to reach the children eligible for Medicaid/CHP+. For example, the case study sites noted that enrollment efforts have been aided by a new policy allowing the FRL application to integrate consent to be contacted by the local health agency for Medicaid/CHP+ enrollment. This has helped to streamline access to these Medicaid/CHP+ eligible families. The Foundation also provided grants for SBHCs to determine eligibility using County Health Department and County Social Services data. Finally, school district commitment and SBHC referrals were essential. Additional strategies are described below.

Over one-third (35 percent) of the reported total revenue from **Central High SBHC** came from patient sources, and most of this revenue came from Medicaid (91 percent). Given that there is widespread poverty in the Pueblo community, people are generally very aware and appreciative of the benefits of public insurance. Most of the SBHC students are from families who were already patients at Pueblo Community Health Center, facilitating the enrollment of the children in Medicaid/CHP+. In addition,

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[4] FQHC Look-Alikes are health centers that operate and provide services consistent with all requirements that apply to FQHCs, but do not receive funding under Section 330. (Source: Health Resources and Services Organization, US Dept. of HHS)

Pueblo Step Up, a local nonprofit, also provided their services in-kind to enroll youth in Medicaid and CHP+. Over half (52 percent) of the SBHC clients were enrolled in Medicaid by 2011-12.

Virtually none (5 percent) of **Dillon Valley Elementary SBHC's** total revenue came from patient sources in 2011-12 and only 12 percent of the clients were enrolled in Medicaid. However, this was the final year of their sponsorship by a private, for-profit medical sponsor who did not return Medicaid fees back into the SBHC. The new sponsor has reported that already in 2013, 13 percent of their revenue came from patient sources in a single month. The Family and Intercultural Resource Center (FIRC), a nonprofit working with families and individuals in Summit County, received grants from the Foundation in 2010 and again in 2012 to conduct Medicaid/CHP+ outreach and enrollment in the schools. Expanded CDPHE dollars have been requested to provide a half-time staff person to work as an Exchange Navigator to continue Medicaid and CHP+ enrollment through FIRC for 2013-14.

Although only a small portion (14 percent) of **Crawford Elementary SBHC's** total revenue came from patient sources in 2011-12, nearly all of the patient revenue came from Medicaid (88 percent). The SBHC had large increases in Medicaid enrollment and revenue over the past year, with 59 percent of the clients enrolled in Medicaid in 2011-12. One of their most successful strategies has been the use of outreach enrollment staff paid for by Aurora Public Schools' Medicaid Program as governed by Colorado's School Health Services (SHS) Program, which allows districts to use the reimbursement received through the SHS program to provide additional and expanded health services. The SBHC will continue to work on increased Medicaid enrollment, and reported the potential for increased patient revenue in 2012-13 because of an increased Medicaid fee schedule.

In sum, the sites report that they are reaching their maximum potential to enroll clients in Medicaid thanks to the multiple strategies that they have employed. Crawford and Central have "finely tuned" their billing procedures and systems; with most of their patient revenue coming from Medicaid, they appear to be billing Medicaid as effectively as possibly. Dillon Valley has made great strides and seems to also be headed towards maximum billing efficiencies. The one area that appears to be less developed is enrollment in and billing for CHP+, perhaps due to limitations of funding for outreach.

#3: Become Credentialed to Bill Private Insurance

Although the process to seek reimbursement from commercial insurance companies and establish contracts with commercial payers is staff and resource intensive[xv], the three case study sites have gone through the necessary work to become credentialed to bill private insurance through the majority of local plans. In 2011-12, 16 percent of **Central High SBHC's** clients were enrolled in private insurance plans, compared with 2 percent at **Dillon Valley Elementary SBHC** and 1 percent at **Crawford Elementary SBHC**. Given low rates of private insurance at these sites, they are generating little revenue from private insurance.

One challenge of having private insurance is that often students or families cannot afford the copays or they have high deductibles. However, 2011 legislation (HB11-1019) allows SBHCs to waive copayments and deductibles. Anecdotal evidence from some Colorado SBHCs is that not all insurance companies are aware of this legislation, and have attempted to bill SBHC clients for the copay. SBHCs are working to educate their clients that they are not responsible for the copays.

Another challenge of private insurance is that some students do not want the SBHC to bill insurance for fear that the billing statements would be sent home, compromising their confidentiality especially for sensitive services. One option here is for an SBHC to charge the patient/family a flat fee for the service.

There is the potential that more clients will become enrolled in private insurance plans with the Accountable Care Act, and that these plans might reimburse more for the types of preventive services provided by SBHCs.

#4: Closely Monitor Coding and Reimbursement through Electronic Health Records

Through the infrastructure of their lead sponsors, each of the three sites has implemented Electronic Health Records (EHR) not only for clinical practice management, but also for billing purposes. Rocky Mountain Youth Clinics pays a third party biller to process the electronic patient claims, while Summit and Pueblo use in-house billing staff to do this. Each of the sites devotes administrative resources to monitoring the quality and consistency of the service and diagnostic codes, as well as reimbursements. As one site explained, "With so little revenue coming in, it is crucial to be savvy about billing." Another major advantage of EHRs is that the sites can more easily generate reports showing levels of patient care and outcomes, both important for internal quality improvement purposes, as well as for various accreditations and funders. In addition, EHRs can help health care organizations share data to better bill and receive reimbursement.[xvi]

Nearly all of the patient revenue from both Crawford Elementary School and Central High School came from Medicaid, while for Dillon Valley SBHC, 2012-13 was the first year that their SCCC has been able to recoup revenue from their billed services as the lead sponsor, generate billing reports and ensure that patient revenue is returned to the SBHCs.

#5: Educate the Community and Providers about Billing

Another key lesson has been the importance of educating the families of students and providers that, although meeting the health needs of clients is the most important priority, SBHCs will not be sustainable without patient revenue. Some patients and families who had become used to free services are often resistant at first to paying either insurance copays or fees for service. One site said that some patients complain, "If I have to pay the same amount, I might as well have to go to a 'real doctor'." To overcome this challenge, the SBHCs have worked to educate the community about the quality of care provided and the importance of generating patient revenue through participation in school and community events where they can explain the purpose and mission of SBHCs.

Another potential challenge pointed out by one of the sites is that SBHC providers have a strong passion to serve clients, but they might not necessarily have a business sense or motivation for billing. Ongoing education, not only in the importance of billing, but also in how to effectively use the EHR and how to code for services and diagnoses, is vital to maximizing reimbursement. The sites train providers at staff meetings and through individual coaching. One sponsoring agency representative explained that although EHRs have built-in drop down boxes with the various codes, providers need to understand the software, how to enter data correctly, and of course the correct vernacular and medical terminology. Recently, Pueblo Community Health Care hired an auditing company to compare provider coding from sites that were still using paper charts with those that had implemented EHRs to ensure that they are coding properly.

Case Study #2: Best Practices in Financing Services for the Uninsured

Background: Serving the Uninsured

School-Based Health Centers (SBHCs) have been shown to be successful throughout the country and are well-received because they increase access to care, provide appropriate, effective services and can contribute to cost savings and disparity reductions. However, they face major financial sustainability challenges stemming not only from their mission to serve all students regardless of ability to pay, but also from the large volume of non-reimbursable services they provide.

In the last five years, Colorado has made real progress toward ensuring that all children have health insurance and access to the care they need, with over 40,000 children gaining insurance between 2008 and 2010. However, in 2012, approximately 10 percent of Colorado children still did not have health insurance coverage.[xvii] Of those without coverage, more than half (58 percent) were eligible for public insurance benefits but were not participating. In addition, 14 percent were not eligible at all due to citizenship status.

This case study describes how SBHCs are able to cover the services provided to uninsured clients. Strategies discussed include charging a sliding fee scale, limiting non-billable services, generating non-patient revenue and reducing the total number of uninsured through enrollment outreach efforts.

Overview of Case Study Sites

The SBHCs chosen for this case are the three with the highest percentage of clients in 2010-11 with no insurance. Two were fairly successful at generating patient revenue, including fee for service from the uninsured. The third site partners with an FQHC that absorbs the costs of serving the uninsured.

Aurora Public Schools received an implementation grant from the Foundation to expand the quantity of health care services provided to students at Crawford Elementary School Health Center and to create a new SBHC at Laredo Elementary School. The focus of the case study is on the **Laredo Kids Clinic**, which opened in 2010 to serve students and families in eleven nearby schools. The population of this school is 60 percent Hispanic and 19 percent African-American. It is a Title 1 school, with 88 percent of the students qualifying for the FRL program in 2011-12.[xix] In that same year, half of the clients served by the SBHC were uninsured.

The Cripple Creek-Victor School District RE-1 received a grant from the Foundation for the **Cripple Creek-Victor School-Based Health Center** at Cresson Elementary School. Starting in 2009, the SBHC services at this site were delivered two days a week through an extremely small (285 sq. ft.) room in the school nurse's office. With Foundation funding, they opened a 2,582 square foot clinic on the school grounds in 2012, enabling them to expand services. Most of Cresson Elementary students are white (83 percent). The elementary school is a Title 1 school and 61percent of the students qualify for the FRL program. About half (53 percent) of the services delivered in 2011-12 were primary care and immunizations and 45 percent were mental health services. Just over a quarter (27 percent) of SBHC clients in 2011-12 were uninsured.

The **Northside Child Health Center**, which operates an SBHC through the Montrose County School District RE-1J School District, received a grant from the Foundation to implement an Electronic Health

Record (EHR) system and improve their billing practices. This SBHC, opened in 2007, is located on the grounds of Northside Elementary School; it serves all youth (birth to 18) and their families, including adults, in the Montrose community. This Title 1 school has a diverse student population with 52 percent being white and 45 percent Hispanic. Just over three-quarters (77 percent) of the school population qualifies for the FRL program. More than half of the 2011-12 services (53 percent) were primary care and immunizations and just over a third (37 percent) were for mental health. Fifty-nine percent of those served in 2011-12 were uninsured.

Keys to Success at Financing Services for the Uninsured

The following section describes key themes that emerged from the case study interviews to describe their best practices in financing services for the uninsured.

#1: Charge a Sliding Fee Scale

Two of the three SBHC case study sites have policies to charge sliding fees for uninsured clients. Not only does this generate some cash revenue, but the sites believe that clients better appreciate services that they pay for, even if the fee is small.

Of the three case study sites, the **Northside Child Health Center** had the clearest policy on sliding scale billing for uninsured and self-pay patients. Its governing body, made up of members from the school district, lead medical provider and mental health partner, based its sliding fee scale on the Federal Poverty Guidelines. This six-tier fee structure requires only a donation for those at the lowest level, which are families who would otherwise qualify for Medicaid but are not enrolled. At somewhat higher tiers, the fees are modest ($12 for a sick visit and $18 for a well check) and the fees increase at the highest tier ($50 for a sick visit and $65 for a well check). Patients are expected to pay at time of service, but if they don't have the funds on hand they are expected to return with the payment. They do not send bills, as most of their patients do pay. Since instituting this fee structure, the SBHC went from collecting approximately $2,500 in the first few years the clinic was open to nearly $10,000 in 2011-12.

Laredo Kids Clinic charges a sliding scale fee from $2-$7 for self-pay clients. The goal of the sliding fee scale is to give families some ownership of their care without creating another hurdle by making it unaffordable. These self-pay fees, along with copays, generated just under $1,000 for this clinic in 2011-12.

The **Cripple Creek-Victor School-Based Health Center** has a policy not to charge fees for service to uninsured patients. While just over a quarter (27 percent) of their patients were uninsured in 2011-12, the SBHC recouped very little patient revenue from them. They are able to deliver services to the uninsured without fees as their providers, Peak Vista for primary care services and Aspen Pointe for mental health services, absorb the costs. Peak Vista, an FQHC, does not set a limit on the number of uninsured patients they will serve, but Aspen Pointe limits these services to two students a month.

Although some in the SBHC field have cautioned that sliding fee scales might prevent clients from using the SBHCs, two of the sites in this case study have found success in generating some revenue from the uninsured by providing a sliding scale fee for service. Their experience has been that most of these patients are willing to pay these modest amounts at time of service, so that they do not need to set up a billing and collection system. While these fees do not cover the complete cost of the services, they do offset the amount that is unbillable.

#2: Reduce the Number of Uninsured Clients through Enrollment Outreach Efforts

All three SBHCs in this case study have made concerted efforts to reduce the number of uninsured patients by referring these families to enrollment specialists.

Two of the three case study sites, **Laredo Kids Clinic** and **Northside Child Health Center**, have enrollment specialists who are certified for Presumptive Eligibility (PE) determination, a key advantage to enrolling children and families for Medicaid and CHP+. PE provides immediate temporary medical overage for children under age 19 whose families have applied for Medicaid or CHP+ using the Colorado Public Health Insurance for Families application and who appear to be eligible. This allows immediate access to services for eligible clients, while they are waiting for eligibility determination.[xx]

Another effective practice was having outreach workers who are school district employees or otherwise have access to school record data. Aurora Public Schools was one of three pilot programs under HB1270, funded in 2006. This program used three methods to increase referrals for Medicaid insurance outreach screening: FRL application forms, self-referrals and school staff referrals. **Laredo Kids Clinic** staff have access to eligibility information through the APS Medicaid outreach staff. At **Northside Child Health Center**, the enrollment specialist is a school district employee, giving her access to the campus school record system. When families register their children for school they must answer a question about health insurance. Any family lacking health insurance is immediately referred to the enrollment specialist. As one SBHC partner explained, "The families know that she is a school district employee. She is very trusted."

Through access to funding from a Children's Health Insurance Program Reauthorization Act (CHIPRA) grant, the **Cripple Creek-Victor School-Based Health Center** supports an enrollment specialist on-site four days a week. She actively conducts outreach, attending many school functions including back-to-school night and family fun nights, making her well known in the community. The enrollment efforts at this clinic have been very successful as the percent of their uninsured clients dropped from over half (55 percent) in 2010-11 to just over a quarter (27 percent) in 2011-12. They expect the percent of uninsured to continue to drop as they continue their outreach efforts. It is important to note, however, that this community has very few undocumented families.

All three case study sites believe that more families will qualify for insurance once the Affordable Care Act's health insurance exchange, Connect for Health Colorado, is in effect, although they felt that it is too early to really know the impact.

#3: Reduce Expenses, Increase Patient Revenue and Limit Non-Billable Services

All three case study sites are incorporating practices to reduce their expenses, increase billable patient revenue and/or limit the delivery of non-billable services in order to keep non-reimbursable costs as low as possible.

Peak Vista, the fiscal and medical sponsor for the Cripple Creek-Victor School-Based Health Center, reports that when they set their budget for the SBHC, they plan for 50 percent of patients being uninsured. While they hope that assumption will be too high, they feel that it is the best strategy for budget planning. The **Northside Child Health Center** has worked hard in recent years to minimize their costs. As a relatively small clinic that sees about 2,000 patients a year, the primary care provider not only provides clinical services but is also the clinic director. They have trimmed unessential costs, such as travel to meetings, from their budget and strive to ensure that all of their direct services are billable.

As noted in Case Study #1 (focused on billing), SBHC sites need to improve their capacity to bill Medicaid, CHP+ and private health insurance providers. All three of these uninsured client case study sites reported having that capacity. At **Laredo Kids Clinic** and **Cripple Creek-Victor School-Based Health Center**, billing for primary care services is handled by their lead medical agencies, Rocky Mountain Youth Clinics and Peak Vista. At **Northside Child Health Center**, an outside agency handles the billing, although the clinic director does all the coding, in part because she is also the primary care provider. She works to ensure coding is accurate, and stays abreast of which procedures are billable and which are not to maximize revenue. The director of Community Health Programs for Rocky Mountain Youth Clinics, that serves **Laredo Kids Clinic**, is also a "stickler for coding appropriately." She analyzes reimbursements each month to determine if staff are coding properly and provides technical assistance when improvement is needed.

Behavioral health services appear to be a category of services that can be more difficult to bill, and the sites report that paying for these services is a key challenge to SBHC sustainability. In each region only one behavioral health organization (BHO) is designated as the Medicaid behavioral health provider, with just five BHO's in Colorado. There are also 17 community mental health centers (CMHC) and six specialty clinics, all of which receive revenue from the BHOs for their Medicaid clients. While it would be strategically best for the SBHCs to partner with one of these providers, that is not always possible. Without the ability to bill Medicaid or CHP+ for behavioral health services, the SBHCs rely on grant funding or in-kind service from their local behavioral health providers in order to make these services available to their student population.

Laredo Kids Clinic mental health services are provided by Aurora Mental Health (AMS), the BHO for their region and thus they are able to bill Medicaid and CHP+. **Northside Child Health Center's** behavioral health services are provided through a CMHC, the Center for Mental Health. While their behavioral health clinician is on-site five days a week and is able to bill for most of the services she delivers, none of the patient revenue is returned to the SBHC and only half of the clinician's salary is covered by her agency, necessitating grant funding to cover the difference.

The primary behavioral health contractor for **Cripple Creek-Victor School-Based Health Center** is Aspen Pointe, which is included in the regional BHO, Colorado Health Partnerships. However, because the demand for mental health services is so great, the SBHC also contracts with several other independent Colorado licensed professional counselors. While these other therapists are able to bill CHP+, only one is able to bill some private insurance carriers and neither can bill for Medicaid. The SBHC relies on the Foundation grant funding to make up the difference and is unsure how they will continue to provide these services when this funding stream ends.

#4: Generate Non-Patient Revenue

All three of the case study sites acknowledged that in addition to their strategies for generating patient revenue and cutting costs that they must also rely in part on non-patient revenue to cover costs for the uninsured. Each has had to develop the capacity to effectively seek grant funding.

At **Cripple Creek-Victor School-Based Health Center**, the clinic coordinator receives mentoring and support from their medical provider, Peak Vista, to seek grant funding. Their nonprofit foundation, Peak Vista Community Health Centers Foundation, works to ensure the sustainability of the medical and dental services provided by Peak Vista Community Health Centers. The clinic director at **Northside Child Health Center** also has development support by collaborating with the school district grant writer on

joint projects. The **Laredo Kids Clinic** benefits from a large staff of 25 in the development department for Aurora Public Schools. The grant coordinator admits that it is rare to have a department as large as this. While Rocky Mountain Youth Clinics provides all the health services, they need assistance to cover their costs. The district values the important services the clinic provides and recognizes the vital role good health plays in a student's overall academic success, but has the challenge of allocating dwindling resources to the many competing needs across the district.

There are inherent challenges in relying on private or public grant funding, however. Many funders will only provide grant funding for a limited amount of time. One SBHC grant writer worries, "Once we've worn out our welcome with foundations it will be interesting to see what happens. We need operational support." There are opportunities in Colorado for SBHCs to express their funding needs, including the forums such as Rural Philanthropy Days, where nonprofit leaders, government officials, community leaders and business representatives along with the funders to discuss solutions. In sum, it has been found in previous studies and validated in this case study that SBHCs will never completely cover their operational costs and be able to provide services to the uninsured without non-patient revenue through grants and donations.[xxi] These three sites have developed their capacity to effectively apply for grant funding to fill in the gaps.

Summary and Recommendations

There is not a "one size fits all" solution to increasing SBHC revenue, but the sites in these case studies are committed to providing services, regardless of clients' ability to pay. All incorporate practices to reduce expenses, increase billable patient revenue and/or limit the delivery of non-billable services. There are many reasons that charges for services rendered are not billable to third parties. First, there are many students without health insurance. Even with insurance, some services are not a benefit such as health education. In addition, "confidential services" to which minors may consent by law, cannot be billed if the insurer mails an explanation of benefits, provides other documentation to the insured (usually a parent), or makes claim payments available to the insured online. Finally, even when services are billable, charges are sometimes applied to a deductible and/or copayment, making the charges the patient's responsibility. Often these amounts are more than families can afford. Several suggestions emerged for improving SBHCs' ability to increase patient revenue and to cover the costs of these unbillable or uncollectible services.

Carefully Consider the Role of the Medical Sponsor: The SBHCs in this case study have partnered with the licensed medical provider that makes the most sense for their communities. Three of the sites are partnered with an FQHC. The benefit of this arrangement is that FQHCs receive an all-inclusive amount per visit based upon their cost of doing business and supplemental funding from the federal government through Section 330 of the Public Health Service Act. However, in exchange for this generous funding, FQHCs must adhere to many federal regulations. The other three sites have found important benefits from their sponsors. When choosing a medical sponsor, SBHCs should take into account tangible financial and operational benefits, as well other factors such as reputation, history of working with the school district, linkages to community resources and support for and understanding of the SBHC model.

Reduce the Number of Uninsured Clients through Enrollment Outreach Efforts: Multiple strategies help to increase public and private insurance enrollment, and the sites have made great strides particularly in Medicaid enrollment. However, ongoing efforts are essential, particularly with the potential for increased opportunities for coverage expansion through the Accountable Care Act. Although the revenue

generated is fairly small at this point, the sites put efforts into becoming credentialed to bill private insurance companies.

Improve Billing Strategies: SBHCs are transforming from a model where they did not bill nor follow any formal business plan, to one in which they need well-supported administrative activities to ensure their sustainability. EHRs are essential tools not only for clinical practice management, but also for billing purposes. The sites stress the importance of devoting administrative resources to monitoring the quality and consistency of coding and reimbursements. SBHCs need to educate not only the community (parents, families and students) about the rationale behind and importance of billing for services, but they also need to train their providers in this and in proper coding techniques. For clients who are not insured, charging modest fees on a sliding scale can at least partially offset the amount of services that are not billable.

Secure Long-Term Flexible Non-Patient Revenue: Grant, in-kind and other donation revenue has long supported SBHC services, and will likely need to continue to do so to some degree. SBHCs need access to funds that are non-restricted in order to pay for unbillable services. In addition to the unbillable services described above, SBHCs are expected to be available to the school for a variety of activities that are not billable such as classroom presentations, faculty education, creating a positive and healthy school climate and assisting in managing crises in the school. All of these activities are essential to the model to some degree, and grant funding is required to support them. SBHCs hope that private and public funders will make a long-term commitment to funding SBHCs in Colorado.

Advocate for State and Federal Funding and Policies for SBHCs: In early 2013, the Colorado General Assembly approved a budget for 2013-14 that includes $5.3 million for a SBHC grant program. The intent of this funding is for the "establishment, expansion and ongoing operations of SBHCs in Colorado." Advocacy efforts can continue to educate about the value of public investments such as this in SBHCs. Finally, the actual implications of the Affordable Care Act for SBHCs are still to be determined, but the resources SBHCs have devoted to improving billing systems and insurance enrollment processes, as well as reporting on client services and outcomes will ensure that they are "at the table" with the upcoming changes.

Improved data collection and billing systems can help improve SBHC sustainability by increasing patient revenue to offset the cost of non-billable services, and help to finance services for the uninsured. The improved financial and client data collection systems can also help establish SBHCs as qualified players in the new health care landscape. In the end, it is imperative that SBHCs use a multi-strategy approach toward securing enough revenue to provide services to all in their target population.

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501 South Cherry Street, Suite 1100
Denver, Colorado 80246-1325
TEL: 303.953.3600 ◦ FREE: 877.225.0839

www.ColoradoHealth.org