

Part II - Financing and Policy Considerations

The research reported on here was not intended to prove the effectiveness of school-based services. There is an underlying assumption that school-based services promote positive health outcomes in school age children and youth. This research is focused on administrative, financing, and policy issues in order to better understand and explore different management structures that might be utilized to encourage investment in school-based health services. It is intended to describe current practices, explore financing opportunities, and suggest new policy directions. There is no attempt made to define what an ideal system of school-based health services might look like, to define best practice, or to delineate what a school-based health services system should cost. The reality is that what works in one school district may be somewhat different than in another. Local demographics, health delivery systems, and local relationships provide the context that, to some extent, defines not only best practice but what is reasonably possible.

Part I of the study produced five qualitative case studies based on interviews with key informants in each of five county school districts within West Virginia. These case studies were reviewed by the key informants interviewed to confirm the accuracy of the content. Part II of this research builds on the information obtained through the five case studies and focuses more specifically on the administrative, management, and financing issues related to the delivery of health-related services in schools. Income and expense data were collected in order to identify available resources to support direct health services and the level of investments made.

Selected models of school health services outside West Virginia were scanned as were the financing strategies that support these models. Issues related to management and financing of school health services by school districts in at least ten other states were reviewed with particular attention paid to models in Baton Rouge, La., Austin Texas, and Denver Co. Medicaid reimbursement strategies in New Mexico, Florida, and Michigan were also examined in some detail.

A glossary of acronyms, programs, and funding streams is included in Appendix D to assist the reader who may unfamiliar with the state and federal programs discussed in Part II of this report.

Related Work and Findings

The research presented here builds on previous research and analysis summarized in the following reports:

- (1) *School-based Health Center Practice Improvement Project-Phase I Report*
- (2) *Re-visioning School-based Health*

Some of the findings from these two previous studies that have particular relevance to the current research reported on here include:

From the School-based Practice Improvement Project:ⁱ

- < Management information systems utilized by sponsoring organizations (of school-based health centers) are not integrated with the Clinical fusion data collection system. This results in duplicative data entry and increases the possibility of inaccurate billing and financial reporting.
- < Difficulties in billing for behavioral health services (by SBHCs) make the provision of behavioral health services and receipt of appropriate reimbursement a challenge.
- < There were significant differences in the revenue per encounter and costs per encounter (across SBHCs).
- < There were significant differences in the extent of outside funding through grants and other sources.
- < SBHCs working relationship with county education systems varied based on the degree and type of support from school administrators and cooperation of other (school) personnel.

From Re-visioning School-based Health:ⁱⁱ

- < Four policy questions are being raised:
 - Are school-based clinics being well run?
 - How can the state establish funding equity between school-based health centers?
 - Are school-based services effective?
 - What indicators will demonstrate the success of school-based services?
- < By its very nature school health is inter-disciplinary and involves the health, education, and social service sectors at a minimum.
- < The best package of services for adolescents and children will be provided by an inter-disciplinary team.
- < We must identify ways to share our best practices and lessons learned through the common language of data and policy development, yet allow for community-based flexibility in adapting those findings.

Overview of Management Structures and Applicable Financing Streams

Introduction:

Each of the five West Virginia school districts included in the case studies manages health-related services differently and, to some degree, each of them accesses a different mix of financing to support those services. Additionally, a brief scan of school-based health services models in other states identifies a diverse array of approaches to supporting health-related services in schools.

Commonalities across West Virginia school districts and those in other states reviewed include:

- School districts provide some level of nursing services to students,
- School districts provide health-related services to special education students to the degree necessary to meet their individualized educational needs, and
- School districts access financing to support some portion of the health-related services provided to Medicaid eligible students with an IEP through the state-federal cost sharing

provisions of the Medicaid program utilizing state appropriated education funding streams to meet matching requirements for the state share.

In order to provide for some basis of analysis and classification of the different approaches to providing health-related services in schools, the researcher has defined four basic models or archetypes that define distinct approaches to the management and financing of health-related services in schools. American architectural giant Louis Sullivan knew “form never follows function”. Sullivan adopted this phrase as an aesthetic credo, the single "rule that shall permit of no exception".ⁱⁱⁱ We do not design concert halls like gymnasiums – concerts are not basketball games. This principle is no less relevant to the design of the structure (form) we use to carry out health-related services in schools. If the objective is to efficiently deliver health-related functions to children and youth in schools, it is advisable to design a form (or structure) that allows access to broad-based funding and investment in health services.

Design matters – it is the management structure used by a particular school district to deliver health-related services that generally defines access to financial support. Each of the models outlined below can be supported by a number of funding streams; however, the structure (model) in place determines what types of financing may be available to support health-related services in schools.

Four Basic Models Defined:

Based on the five in depth case studies of West Virginia school districts and a much less intensive scan of numerous other school districts outside the state, four structural models or archetypes for building a school-based health services system emerge. These four general models are designated:

- Local Education Agency Model
- Multi-Agency Model
- Lead Agency Model, and
- Comprehensive-Integrated Model

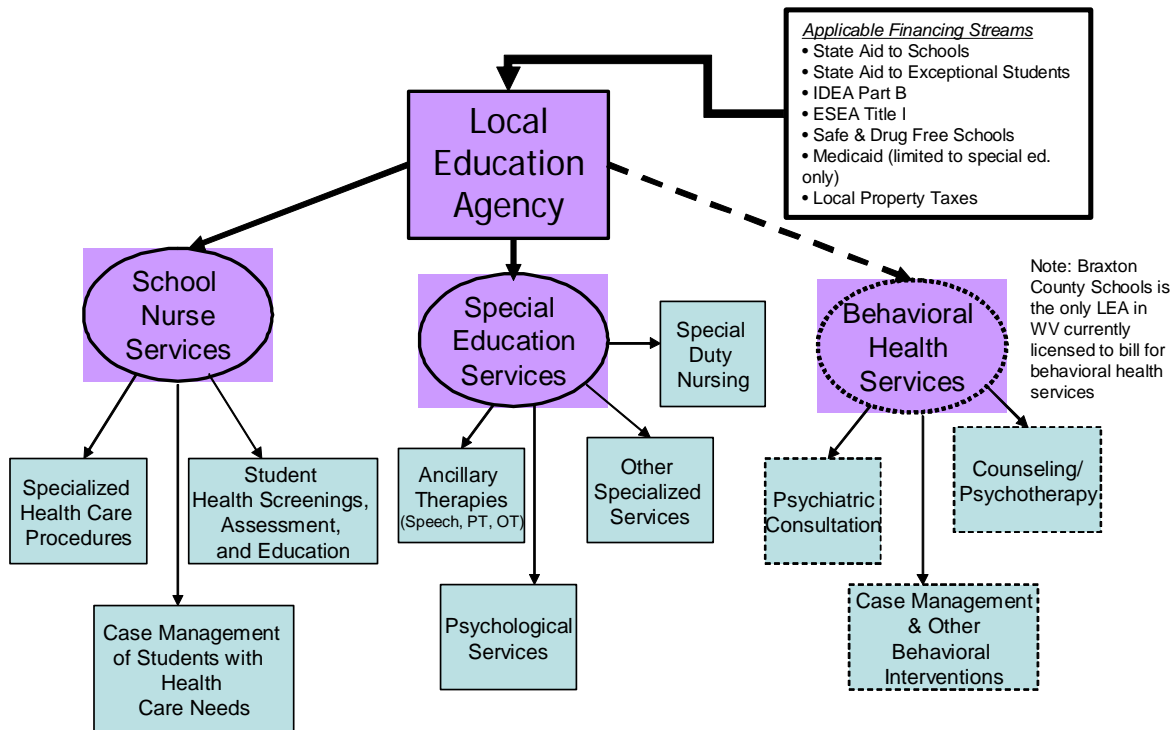
Each of these models may have multiple variations but each of the four archetypes is fundamentally distinct from each of the others in the management of school-based services, the funding streams accessed to support the services, and the scope of health care providers delivering services. Each model is discussed below in some detail in order to provide a context for policy and financing discussions in West Virginia.

Model 1 - Local Education Agency Model

This model is one that limits the scope of health-related services in schools to those services that are provided directly by the school district (County Board of Education). All school districts provide nursing services through one or more school nurses, health-related services to special education students, and some level (relatively small) of services though specific contracts with health care providers. These contracted services generally focus on specialty areas such as physical and occupational therapy and are provided only to the extent necessary to address the needs of the special education population as determined by an individualized education plan (IEP). All services provided under this model are administered by the local education agency. The LEA controls the

provision of all health-related services delivered in schools and the LEA is responsible for the necessary record keeping and documentation of those services. About half of the school districts in West Virginia operate under this model although each county school system may be structured somewhat differently related to internal organization, lines of authority for health-related services, and specific personnel responsible for service delivery and oversight.

Local Education Agency Model



School districts operating under this model may work informally with outside healthcare professionals to provide health screenings but there is no formal agreement or exchange of funds. A prime example of this type of informal arrangement is the “Cardiac Kids” project provided by West Virginia University Health Sciences Center that provides cardiac screening services to fifth grade students in some schools. Two of the school districts examined through the case studies are *Local Education Agency* models – Braxton and Clay. One of these (Braxton County) has applied for and received designation as a licensed behavioral health program allowing that school district to provide behavioral health services directly through its behavioral health license. No other school district (local board of education) in the state has pursued such designation. For more explanation of this arrangement see the Braxton County case study.

With the notable exception of the Braxton County LEA, school districts operating under the *Local Education Agency Model* generally limit health-related services to services provided by school nurses and necessary services to special education students. Financing is limited to traditional

education funding streams and Medicaid reimbursement through the School-Based Medicaid Services program (Special Education only) available to county boards of education.

Financing streams available to support this model are generally limited to a relatively small number of state and federal education-related funding streams that include:

- < State aid to schools
- < Local property taxes
- < State aid to exceptional students
- < Elementary and Secondary Education Act (ESEA-Title I)
- < Individuals with Disabilities Education Act (IDEA – Parts B and H)
- < Medicaid (through the School-Based Services Medicaid Program)

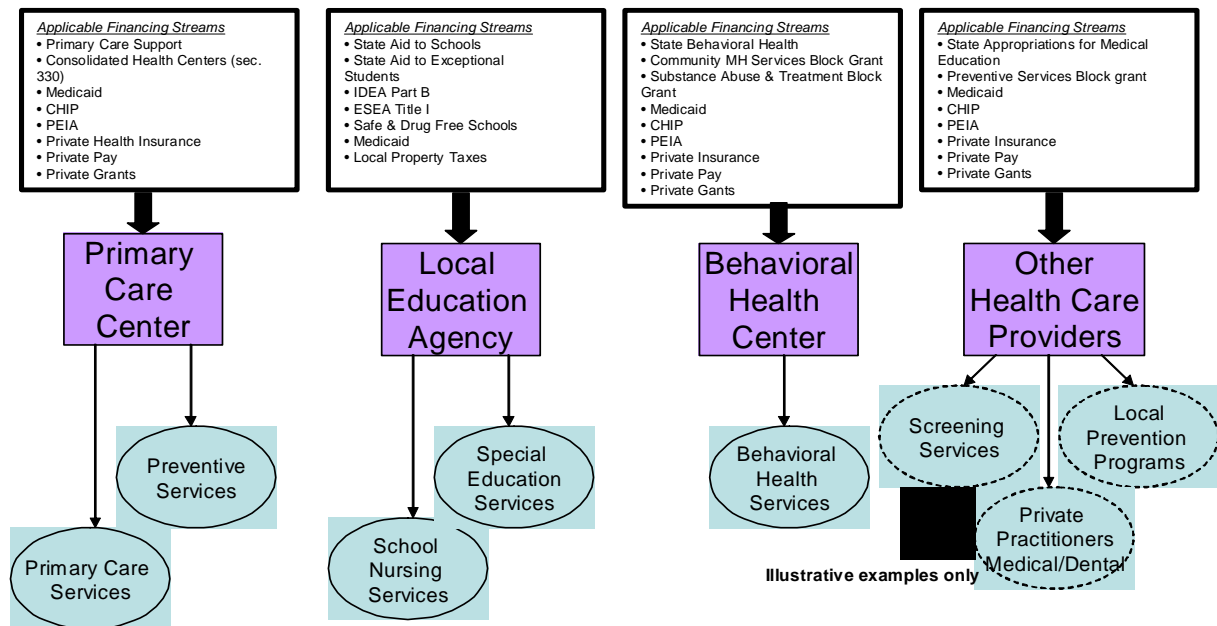
Model 2 - Multi-Agency Model

The *Multi-Agency Model* is one that allows for multiple independent agencies to operate and deliver health-related services within one or more of the public schools located in the school district. About half of the school districts in West Virginia deliver health-related services to students through some form of a multi-agency model. This includes twenty-two counties where other local healthcare agencies operate at least one school-based health center (SBHC) in at least one of the schools located in the county. These school-based health centers are generally satellite clinics or outreach locations operated by a local community health center (Rural Health Center or Federally Qualified Health Center). There are also additional counties where a local behavioral health agency provides mental health services in one or more schools. There are at least 15 such counties. It is estimated that a total of 27 county school districts in the state (half of all school districts) utilize some type of multi-agency model to deliver health-related services.

This model allows independent agencies to operate in school settings as outreach or satellite service locations. Under this model, each agency maintains responsibility for supervision and oversight of staff deployed to the school site, quality assurance, case records, billing, and general management and administration of the services provided by that agency. The local school district continues to provide health-related services in the schools as well, and essentially operates as one of the multiple health providers within the school. The degree to which personnel employed by the independent agencies exchange information about students receiving services is subject to federal law (most notably the Health Insurance Portability and Accountability Act or HIPAA and FERPA (Family Educational Rights and Privacy Act), and state and local agency policies governing the sharing of information. These confidentiality issues may present barriers to sharing information across the multiple agencies that may be providing services to any given student. Given these confidentiality concerns and differing internal procedures of each agency, this model does not necessarily provide for improved interdisciplinary service planning nor does it provide any assurance that the services provided to any given student are well coordinated.

The multi-agency model does provide for increased access to services by the students enrolled in schools where the services are available; however, services available at any particular school depend on whether or not the independent providers are out-stationed at that school.

Multi-Agency Model



Financing possibilities are also increased as compared to the *Local Education Model* since other community providers (community health centers, behavioral health centers, local hospitals, etc.) have access to funding streams that are not available to the LEA. These more traditional health care providers have billing systems and procedures in place that allow for a full range of third party reimbursement and also have broader access to reimbursement through public health insurance programs such as Medicaid and the Children’s Health Insurance Program that local school districts in West Virginia do not have.

Three of the case studies focused on county school systems operating under some form of the *Multi-Agency Model* (Cabell, Clay, and Barbour). For more detail on the agencies involved and the individual variations on the multi-agency theme in these counties the reader is referred to the case studies.

When healthcare agencies are invited into the schools to deliver services additional investment in student health from more traditional healthcare funding streams can be used to supplement the funding available to the LEA. In addition to the educationally based funding available under the

LEA model, the multi-agency model may be able to access the following additional sources of financial support:

- < Primary Care support
- < Consolidated Health Centers (sec. 330)
- < State behavioral health appropriation
- < State appropriations for medical education
- < Community Mental Health Services Block Grant
- < Substance Abuse and Treatment Block Grant
- < Maternal, Child, and Family Health Block Grant
- < Preventive Services Block Grant
- < Medicaid
- < Children's Health Insurance Program
- < Private Health Insurance - 3rd party payers

Model 3 - Lead Agency Model:

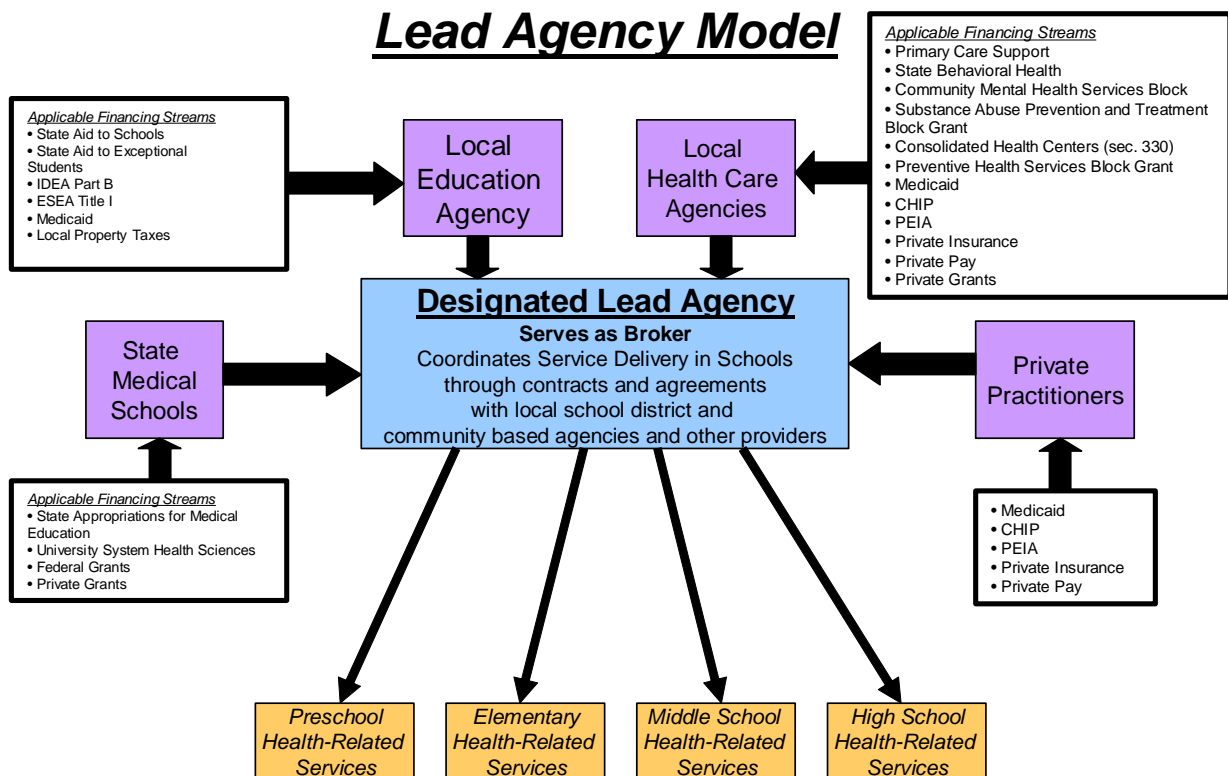
This model is one whereby the local education agency or a local consortium of providers that includes the LEA designates a single agency to manage and coordinate health-related services in schools. A variation of this model would allow for the LEA to establish a quasi-independent healthcare office or division within the school system that was licensed as a health care provider and serves as the lead entity. Each participating partner enters into an agreement with the designated "lead agency" that defines how that partner will contribute to a coordinated health-related service system provided to students in designated schools. Any number of existing agencies (or a local hospital) might serve in the lead agency role. The most likely candidates for the role are community health centers (RHC or FQHC), Public Health Departments, or Hospitals since the scope of services delivered by these provider types is generally broad and they have access to multiple funding streams. The *Lead Agency Model* could be established to serve a multi-county region.

Some degree of funding stream integration can be achieved through the *Lead Agency Model* utilizing "assignment of payment" agreements between the lead agency and other community providers. The lead agency essentially serves as a broker between the LEA, community health care providers, and local schools. At a minimum, the lead agency assures that health-related services to students are well coordinated and managed in order to avoid any duplication of services or unnecessary service provision and that the services comply with all applicable standards. Other functions of the lead agency might focus on case records management, quality assurance, and the development of integrated health service plans. This model allows for interdisciplinary cross-agency assessment and services planning and the exchange of information (on a need to know basis) among providers serving the same students since the participating health care providers are bound together through formal agreements and/or contractual relationships.

The designated lead agency is in a position to form "health care teams" at each school utilizing personnel employed by the LEA and drawing on practitioners employed by the other participating providers. Funds may or may not be transferred from the LEA and other health care agencies to the lead agency through contractual relationships.

The LEA may choose to contract with the designated lead agency to manage health-related services delivered in schools including school nursing services and services provided to special education students. This model would allow the lead agency to generate income from third party payers and grants to cover some of the costs of services provided in schools either directly or through “assignment of payment agreements” with other health care providers. A lead agency with multiple licensures (e. g. an FQHC with dual licensure as a behavioral health center) may be able to directly access an even broader range of state and federal funding streams as well as discretionary grants and private foundation funding.

There are no *Lead Agency Models* in West Virginia that serve to coordinate the full range of health-related services in schools.



The Cabell County model would fall within the previously described *Multi-Agency Model* archetype; however, there are some elements of the lead agency model operating within the two high schools (Cabell Midland and Huntington High). In these two schools, a local FQHC (Valley Health Systems) essentially serves as a lead agency for preventive and primary care services by having agreements in place with both the Cabell County Board of Education and Marshall University that allows the FQHC to seek reimbursement for physician services provided by faculty of Marshall University Medical School, and Family Nurse Practitioners employed by the county board of education (see case study).

The researcher is not aware of any school districts in other states that fully coordinate all health-related services in schools through a lead agency model; however, the Austin Independent School District (Austin, TX.) has an arrangement in place that provides for a limited lead agency service delivery model. The Children’s Hospital of Austin (Seton Healthcare Network) and the school district has established a public/private collaboration whereby the hospital serves as a lead agency in providing coordinated healthcare services at each school through a “health team” made up of RNs (registered nurses) and School Health Assistants. This team is managed by the hospital under an agreement with the school district and each team is responsible for school nursing services. The school-based team assures that students have an appropriate medical home and provide a wide range of health-related services in each school.^{iv}

Another example of a limited lead agency model is the Denver School-based Health Centers (Denver, Co.). These centers make up the School Health Division of Denver Health and Hospitals and serve as the lead agency coordinating health services in thirteen Denver schools. Community partners include the local education agency (Denver Public Schools), the Mental Health Corporation of Denver, The Children’s Hospital, Arapahoe House Inc., and St. Anthony’s Hospital. Denver Health also provides services to Head Start and some private preschool programs.

Denver Health serves as the lead agency to assure that health services are coordinated and a health team is established in each of the schools served. Funding is provided by the Denver Public Schools and the other local agencies involved in the consortium. Additional funds are provided through discretionary grants from the state Bureau for Primary Health Care and the Department of Public Health. Third party payers including Medicaid and CHIP are billed as applicable.^v

The “Lead Agency Model” allows access to a full range of education and health funding streams discussed under the two previous models. Although this model in and of itself does not necessarily open additional sources of public funding, it may be conducive to accessing administrative funds under Medicaid or negotiation of a capitated payment rate for school-based services. The primary advantage of the *Lead Agency Model* over the *Multi-Agency Model* is a more coordinated approach to the delivery of school-based services to students that has the potential to reduce duplication of effort.

The Illinois Coalition of School Health Centers has engaged in a process to identify functions that might be shared among the agencies involved or consolidated within one “lead agency” or management entity. They refer to this as “administrative cost-sharing” (not to be confused with state-federal cost sharing through matching requirements). The functions identified by the Illinois group that might be consolidated include:

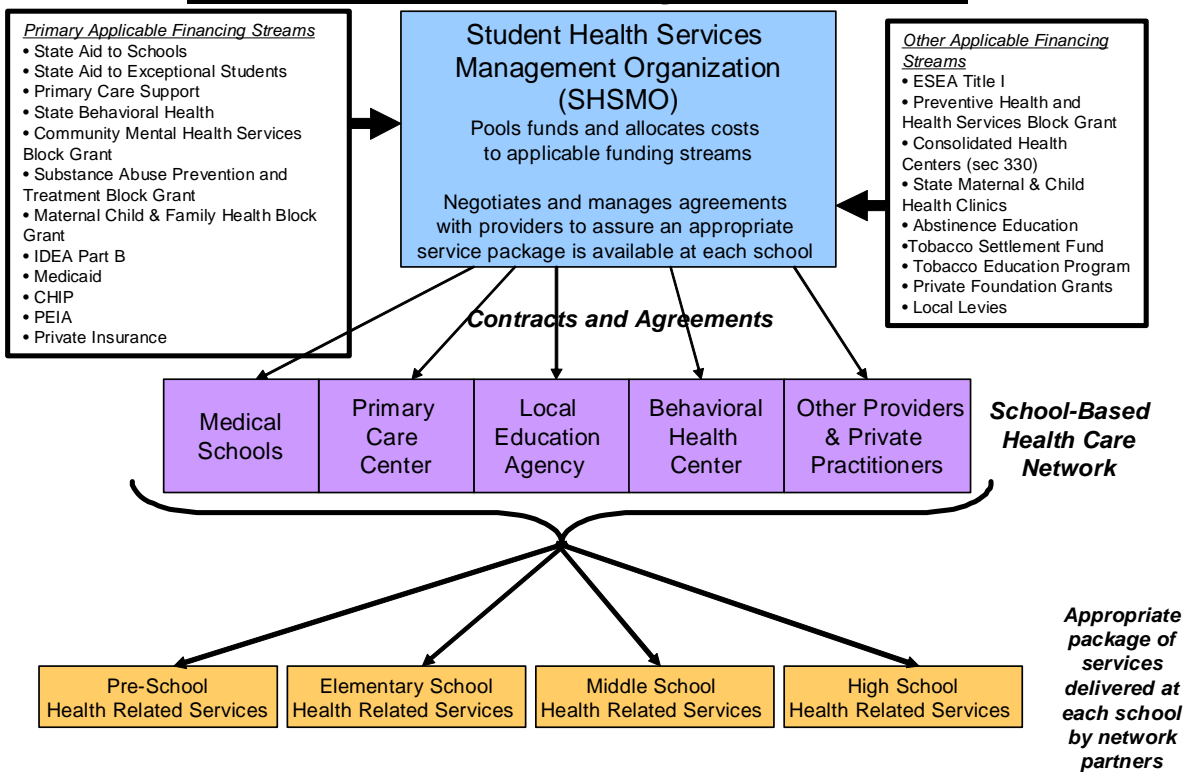
- < Practice management including scheduling, electronic encounter forms and billing,
- < Negotiation with private insurance and managed care entities,
- < Data collection and reporting,
- < Quality improvement,
- < Electronic medical records,
- < Bulk purchasing including supplies, lab testing and medications,
- < Human resources including supervision, background checks, and hiring, and
- < Grant writing.

The Illinois group has produced a feasibility study^{vi} that can assist WV providers in moving toward model 3 or model 4 structures as outlined in this report.

Model 4 - Comprehensive-Integrated Model:

A comprehensive model that integrates all health-related services in schools can theoretically be achieved by re-directing education and health funding streams that support these services to some type of management organization that has the ability to enter into contracts for appropriate packages of health-related services that meet the needs of students in each school setting. The major differences in this model and the “lead agency” model are in the flow of the multiple funding streams. Under a comprehensive-integrated model, all funding streams supporting school-based health services would flow to a management organization and then to providers based on purchase of service agreements. This model incorporates the coordinating advantages of a lead agency model with a streamlined financing system whereby numerous education and health-related financing streams are accessed by the coordinating entity and costs are allocated to the most appropriate source of funds.

Comprehensive Integrated Model



This model would attempt to eliminate (or at least streamline) the multiple and duplicative administrative, billing, and service reporting structures inherent in the multi-agency model while preserving access to a broad range of health-related services in school settings. A *Student Health Services Management Organization (SHSMO)* is established under this model that braids multiple

funding streams in a way that maximizes service delivery and minimizes administrative costs. The SHSMO would carry out management and coordination functions to assure that each enrolled student had access to health-related services appropriate to their needs as assessed by a multi-disciplinary team and prescribed in a coordinated health services plan.

Each school would have an on-site *Health Services Program* and access to appropriate health care services provided by a consortium of providers participating in the SHSMO network. A common, integrated and computerized billing and service reporting system would be utilized by all participating providers and costs would be allocated by the SHSMO to the multiple education and health-related funding streams based on the eligibility and enrollment of students receiving services.

Such a model would require significant changes in the flow of state and federal funds in order to redirect a portion of these funds to local or regional *Student Health Services Management Organizations*. It would also require some change in state law and State Department of Education rules. Integrated networks of local agencies and private practitioners would have to be established in a way that includes primary care, dental care, behavioral health, ancillary therapies, school nursing, psychological assessment and other health-related fields.

Examples of this type of comprehensive and integrated model do not currently exist in a way that is specific to the provision of health-related services in schools; however, health care networks and managed care organizations are similar in function. These more traditional healthcare delivery systems can be used as models to build a school-based services network.

Access to federal and state funding streams is increased under this model provided that the SHSMO is defined broadly and is recognized by state agencies and 3rd party payers. The SHSMO could negotiate agreements with existing managed care organizations or directly with state agencies to access all relevant funding sources. Capitated rates might be established based on the particular demographics and eligibility characteristics of the students in a particular school. An additional advantage may be the innovation inherent in this model in that demonstration grants might be secured from federal discretionary sources (such as the Healthy Schools/Healthy Communities grant program through HRSA), the Centers for Disease Control and Prevention, or from private foundations to assist in development and field testing of innovative approaches.

Although the *Comprehensive-Integrated Model* is, in theory, the most efficient; much of the functionality inherent in this model can be achieved through a well crafted *Lead Agency Model*. The necessary changes in state law and agency rules required to redirect funding and responsibility to a School Health Services Management Organization would be difficult to achieve in a short timeframe. It may be advisable, therefore, to develop a lead agency approach as a step toward the more fully integrated school-based health services network described here.

See Appendix C for a brief summary of the four models discussed above.

***Demographic and Socio-Economic Characteristics
County School Districts Included in the Case Studies***

The characteristics of the school age population in a given county make a difference when considering how best to manage and finance health services. For example, school districts with high numbers of Medicaid eligible students will benefit from financing strategies that maximize Medicaid revenues or a high number of students with chronic health conditions may indicate a greater need for school nursing services or partnerships with primary care agencies. In order to provide a portrait of the demographic and socio-economic characteristics of the school age population a set of key indicators was selected from available data. These indicators are presented in Table 5 for each of the counties included in the case studies and for the state as a whole.

All five of the school districts studied have relatively high rates of the school age population living in families below the federal poverty level. Since Medicaid eligibility for this age group (except for pre-K) is set at 100% of the FPL this is a good indicator of the potentially Medicaid eligible population in the schools. All five of the counties included in the case studies exceed the state average for school age children below the FPL.

***Table 5
Key Demographic Indicators^{vii}***

<i>Demographic Indicators</i>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Taylor</u>	<u>Statewide</u>
County population	15,476	14,950	94,801	10,424	16,202	1,815,354
School enrollment (preK-12)	2,599	2,457	12,249	2,111	2,417	279,457
% of county population enrolled in school	16.8%	16.4%	12.9%	20.3%	14.9%	15.4%
School age children below poverty level	704	654	3,050	636	582	62,223
% school enrollment below poverty level (Medicaid eligible)	27.1%	26.6%	24.9%	30.1%	24.1%	22.3%
Number of students receiving special education	486	453	2,279	406	478	54,368
% school enrollment receiving special education	18.7%	18.4%	18.6%	19.2%	19.8%	19.5%
Special education students receiving Medicaid services	377	399	1,047	284	219	26,686
% of total special education students receiving Medicaid services	77.6%	88.1%	45.9%	70.0%	45.8%	49.1%
Enrollment in schools with SBHC	736	0	3,480	1,614	0	25,954
% total school enrollment with access to SBHC	28.3%	0.0%	28.4%	76.5%	0.0%	9.3%

It is also interesting to note that the percentage of special education students receiving Medicaid services varies significantly across the five counties. Three of the counties bill for Medicaid services for seventy percent or more of their special education students (significantly exceeding the state average) while the other two provide Medicaid reimbursable services to only about 45% of the special education students (just slightly less than the state average).

In Clay County, a higher percentage of the overall population of the county (20.3%) falls within the school age range than in the other four counties or the state average. This may be an argument in favor of comprehensive school health services in that a higher percentage of county residents may

be reached in school-based settings. Significantly more of the student population in Clay County already has access to a School-Based Health Center than is the case in the other two counties where SBHCs operate (76.5% as opposed to 28%). SBHCs are only available in Cabell and Barbour counties at the high school level.

Analysis of Current Investments, Costs, and Financial Indicators

Revenue and Expense Estimates for the Five School Districts Studied:

In order to develop a fiscal picture of current school-based, health-related services provided by the five school districts studied, data was compiled related to revenues available and expenditures.

Revenues include state education funds available through the state aid to schools formula that support health-related school personnel, Medicaid revenues generated by the school district, revenue generated by other community agencies from services provided in schools (Medicaid, CHIP, & other 3rd party payments), and state or private grants supporting school-based health services. These investments in health-related services within each school district were calculated based on State Department of Education financial data and reports^{viii}, information contained in grant applications submitted to the State Bureau for Primary Care for SBHC supplementary funding^{ix}, and fiscal information received directly from local agencies^x. The researcher did not have access to local agency budgets or accounting documents at the agency level and no attempt was made to account for the in-kind value of health-related services that might supplement the health programs in schools such as the WVU cardiac screening project (*Cardiac Kids*) or nursing student rotations in a school setting. The researcher does however feel confident that the significant sources of cash investments are accounted for in the indicators listed. A more detailed summary of revenues identified for each of the five case study counties is provided in Appendix A. Expenses identified are listed in Appendix B.

For purposes of the analysis, state and local education funding supporting health-related personnel in schools is considered to be revenue available to the school district to support the provision of health services. The researcher is aware that the state aid to schools and local property tax revenues used to support health-related personnel in schools may be offset to some degree by the Medicaid revenues generated by local education agencies. Nevertheless, LEAs are required by state and federal law and Department of Education rules to provide these health-related services even if additional health care funding streams (such as Medicaid) are not available. Also, Medicaid payments received are based on costs of providing only specific services to a limited number of students (those students with an IEP); yet the school district must still provide for health-related services for the larger student population to the extent necessary to meet prescribed rules and standards. Given these responsibilities, state and local investments from education funding streams as well as additional revenue generated from billing of Medicaid services are considered to be revenues available to the LEA for health-related services.

Adjustments in Medicaid reimbursements for prior years (prior to July 2003) were paid to local school districts in FY04 and again in FY05. These payments totaled over \$32 million in FY04 and over \$9 million in FY05 statewide. The additional \$41 million in revenue (distributed to the 55

school districts over the two year period) is not considered in the analysis since the additional payments are not ongoing investments each year and are subject to audit and possible disallowance of some portion of these dollars.^{xi}

A summary of the major components of available revenue for each of the five school districts are presented in Table 1 (additional detail can be found in Appendix A).

Table 1
Summary of Available Revenues-County School Districts Included in Case Studies
FY05 Estimates

<u>Key Indicator</u>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Taylor</u>
State and local education funding (health-related personnel only)	\$359,560	\$670,024	\$2,225,673	\$206,583	\$361,154
Medicaid funding (LEA)	\$295,516	\$322,508	\$1,542,201	\$289,499	\$308,152
Collections from other 3 rd party payers & contract payments (other healthcare agencies)	\$16,559	\$0.00	\$205,180	\$102,748	\$0.00
Grants from state agencies	\$56,745	\$0.00	\$160,894	\$52,500	\$0.00
Total available revenue	\$728,380	\$992,532	\$4,133,948	\$651,330	\$669,306

Health-related expenditures made by the local school district include the costs of health-related personnel employed by the local school district; an estimate of indirect costs dedicated to oversight and support of the health-related services by the LEA, equipment, supplies, etc., and contracted healthcare services. Administrative costs and costs of any durable medical equipment and supplies specifically dedicated to healthcare services were not available to the researcher but were estimated at 10% of the direct health care personnel costs.

Table 2
Summary of Expenditures – County School Districts Included in Case Studies
FY05 Estimates

<u>Key Indicator</u>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Taylor</u>
Total health-related personnel costs incurred by LEA	\$359,560	\$670,024	\$2,225,673	\$206,583	\$361,154
Cost of health services purchased by LEA through contracts	\$108,502	\$33,500	\$308,811	\$50,000	\$110,600
Indirect costs of LEA (estimated at 10% of direct personnel costs)	\$35,956	\$67,002	\$222,567	\$20,658	\$36,115
Total expenses incurred by community health centers	\$80,547		\$188,040	\$190,533	
Total expenses incurred by behavioral health centers			\$187,056		
Total Costs	\$584,564	\$770,526	\$3,132,149	\$467,774	\$507,869

Expenditures by other providers operating within the three counties that operate under some form of a multi-agency model (Barbour, Cabell, and Clay) include the costs of direct care personnel, administrative support, and all other costs supporting the school-based operations. The researcher was able to identify specific categories of expense for these agencies that included administrative and other costs associated with the provision of services in the school settings.^{xii}

Some of the revenue and expense indicators are estimated and it is quite possible that not all revenues and expenses were captured for each of the five school districts. The purpose of the research presented here is to paint a reasonably accurate portrait of the fiscal environment within each school district as it applies to the provision of health-related services provided in school settings. A detailed analysis of the fiscal records of each agency that delivers health services in schools would be necessary in order to identify highly accurate dollar amounts; however, the researcher is reasonably confident that all significant cash revenues and expenditures have been captured.

Administrative and Financial Indicators

Information contained in the case study reports and financial information compiled for each county can be used to develop key indicators that define health-related administrative and financial functions within each of the county school districts. Both structural indicators (descriptors of administrative and management functions) and fiscal indicators (descriptors of health-related investments) are discussed below.

Administrative (Structural) Indicators:

A quantitative summary of key indicators of the management model utilized in each of the counties serving as case studies provides some degree of insight into the efficiency of the administration and management of health-related services. In general, higher numbers in the table below indicates less efficiency and more duplication of effort. All five of the school districts utilize some form of either the *Local Education Agency Model* or the *Multi-Agency Model* (as previously described). Three of the school districts use a limited multi-agency approach and the other two manage all health-related services through the local education agency.

Table 3
Management/Structural Indicators

<u>Structural Indicator</u>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Taylor</u>
Type of management model	Multi-Agency	LEA	Multi-Agency	Multi-Agency	LEA
Number of administrative entities providing services	2	1	3	2	1
Number of distinct billing systems utilized	2	2	3	2	1
Number of distinct service reporting systems	4	3	6	5	3
Number of distinct care plans developed	3	3	4	3	2

Healthcare providers operating in schools report service related information to multiple databases. In Cabell county where three distinct agencies provide services in schools, a total of six different service reporting systems^{xiii} are required while the fewest number of such systems is three (Taylor and Braxton). The number of billing systems utilized also increases with the number of agencies providing services since each type of provider must submit claims through distinct and separate systems in order to be paid.^{xiv} Even claims submitted to the same payer (Medicaid or 3rd party payers) must generally be submitted through separate systems.

Case records and plans of care are also developed within each distinct system. Even in the counties where all services are administered by the LEA (such as Braxton and Taylor), a school nurse may complete a healthcare plan for a special education student who also has an individualized education plan. The multiple plans increase as other provider types become involved since the “treatment plan” for behavioral health services and the plan of care prescribed by a primary care practitioner may be distinct from the plans developed by school personnel.

Although these inefficiencies are necessary and required if multiple provider types are to be paid for services, a considerable amount of practitioner time is involved in maintaining separate case records, reporting to multiple databases, and submitting claims for payment to different billing systems.

Financial Indicators:

Several key indicators were calculated that describe how health-related services are currently supported within the five school districts. These indicators are presented in Table 4.

These descriptors of the financing pattern in each of the five counties demonstrate how different each of the counties is in the way school-based health-related services are supported. Average investments per student (calculated as total identified expenditures on health-related services divided by total school enrollment) range from a high of \$313 in Braxton County to a low of \$210 in Taylor.

In four of the five counties, almost all of the health-related services in schools are supported by the local education agency; however, in Clay County, forty percent (40.7%) of the costs of providing health services in schools are supported by the SBHC (primary care agency). The increased access to SBHC services in Clay County at the elementary and middle school levels is most likely the primary reason the local school district does not incur a higher percentage of the overall costs. Eighty-five to ninety percent of all costs incurred directly by the five local school districts included in the case studies are related to providing health services to the special education population with the remaining ten to fifteen percent spent on school nurses that serve a broader population of students.

Table 4
Financial Indicators

<u>Financial Indicator</u>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Tayl</u>
School District					
Average investment in health-related services per student	\$224.92	\$313.60	\$255.71	\$221.59	\$210.12
Percent health investment from outside agencies (non-LEA)	13.8%	0.0%	12.0%	40.7%	0.0%
Avg. cost to LEA for health-related services per special ed. student	\$981.90	\$1,628.11	\$1,162.37	\$640.57	\$1,013.09
Avg. Medicaid revenue per eligible special education student	\$783.86	\$808.29	\$1,472.97	\$1,019.36	\$1,407.09
SBHC – Primary Care Agency					
Percent total SBHC (Primary Care) revenue from grants	77.4%		39.0%	33.8%	
Percent total SBHC (Primary Care) revenue from Medicaid	11.5%		42.0%	39.4%	
Indirect cost rate (Primary Care SBHC)	28.60%		57.16%	24.20%	
Average Cost per encounter	\$97		\$68	\$101	
Average cost per enrolled user	\$196		\$121	\$284	
Behavioral Health Agency					
Percent total behavioral Health revenue from grants			42.9%		
Percent total behavioral health revenue from Medicaid			43.7%		
Indirect cost rate (Behavioral Health Services)			4.7%		
Average cost per encounter			\$91		

There is a great deal of variance in the average expenditure of each of the school districts on services to the special education population (from \$640 per student in Clay to \$1,628 in Braxton) and there is also considerable variation in Medicaid revenue generated per student ranging from \$784 per eligible student in Barbour to almost double that amount (\$1,472) in Cabell.

There are considerable differences in the funding mix that supports the SBHCs as well as how available funds are used. Three indicators related to the community health centers that operate SBHCs in three of the counties are included in Table 4. The percentage of total revenues that come from the state grant range from 77% in Barbour to about 34% in Clay with a corresponding difference in Medicaid revenue (Barbour generates only about 11% of its revenue from Medicaid while that source of funds accounts for around 40% in Clay and Cabell).

The average cost per encounter and cost per enrolled user was calculated for the primary care agencies (RHC or FQHC) operating school-based clinics in three of the counties. These indicators are also presented in Table 4.^{xv} The average cost per encounter in Cabell County is significantly lower than at the other two counties with SBHCs (Clay and Barbour). This lower cost per encounter is likely due to the lower costs incurred for professional personnel (two nurse practitioners and the physician are not paid by the community health center). If these personnel

costs were included, it is likely that the average cost per encounter would be about the same as at the other two SBHCs. The average cost per user at the SBHCs in Barbour and Cabell are about twice the cost per encounter indicating that the average number of encounters by each user is close to two. At the Clay County SBHCs users tend to have closer to three encounters on average.

An indicator is also provided that shows the ratio of non-direct costs to total costs at the SBHCs (primary care agency only). This is referred to as the indirect cost rate and reflects the percentage of total costs that are not attributable to direct health care personnel. The high indirect cost rate in Cabell County (more than double the rate in Clay or Barbour) is at least partially due to the previously mentioned arrangement in Cabell whereby key personnel in the SBHCs are not paid by the community health center. The community health center in Cabell is able to bill for services provided by these practitioners without incurring the expense of their salaries and fringe benefits; thus, the Cabell County SBHCs reflect a much higher percentage of their expenditures in areas of administration and other costs.

Four indicators are also provided that describe the funding mix that supports behavioral health services in Cabell County. Cabell is the only county included in the case studies where an independent local provider of behavioral health services provides behavioral health services in schools. Medicaid revenues provide for about 44% of the financing to support behavioral health practitioners in the school settings and a state grant provides an additional 43%. Most of the remaining funds are through a contract with the local school district. Indirect costs reported by the behavioral health agency are quite low at less than five percent. The average cost per encounter is \$91.00.

Financing Strategies and Policy Issues

General Considerations:

The categorical nature of state and federal funding and the separate and sometimes isolated local provider structures that have been built over time to deliver the categorically defined services supported by this funding, present significant barriers to collaborative and integrated approaches to service delivery. The policy challenges are often around issues related to cross-agency administration and management of seamless services.

- < How do multiple agencies and individual practitioners work together across categorically defined lines to improve student health status, promote healthy behaviors, and manage chronic conditions that impede our children's ability to reach their full potential?
- < How does government best direct available resources toward desired outcomes?
- < What changes in practice are needed?
- < What is the best way to build integrated management, billing and record keeping systems and eliminate duplicative administrative support functions?
- < Which funding streams can be redirected to support comprehensive school-based health services?

Policy questions such as these must be seriously considered if we are to provide a supportive environment where local school-based systems can grow.

Numerous categorical funding streams may be accessed to support health-related services in schools. The list of possibilities is long but, without question, Medicaid is the most important. Within the education sector of public funding, state aid to schools, state aid to exceptional children, and federal funds available through the Individuals with Disabilities Education Act (IDEA) are of primary importance. Many other federal and state programs, private grants, and 3rd party payers may also contribute to the financing of school-based health-related services. Across the nation, states have tapped their general fund (state dollars), the Maternal Child and Family Health Block Grant, Tobacco Settlement dollars, and dedicated taxes (primarily on tobacco products) to support school-based health centers.^{xvi} Often, it is these smaller state and federal funding streams or private foundation grant programs that provide the necessary catalyst to build a school-based program, but it is the much larger Medicaid and Education investments that must be looked to if we are to build and sustain comprehensive systems of care.

Statewide, West Virginia school districts drew down nearly \$31 million in Medicaid revenues during the 2004-05 school year and spent over \$45 million in state and local education funds to support health-related personnel employed by the local education agencies. Almost all of these services supported by these funds are provided to special education students. The Medicaid program provided reimbursement for other services provided in school settings by other provider groups as well. These include primary care services (through RHCs and FQHCs) and mental health services (through behavioral health centers). In addition to the Medicaid funds, the state Division of Primary Care provided \$965,000 in state grant funds to support local SBHCs and the Office of Behavioral Health Services provided a total of \$706,320 in federal block grant and state funds to support mental health services in schools.

Several key financing and policy issues are discussed in the following paragraphs. Most involve Medicaid since that is where the dollars are. Many of these issues are inter-related and, due to complexity of the details, require considering changes that encourage service integration and coordination across different categorically defined programs. The following discussion is intended to provide an overview of some of the more important policy considerations and financing possibilities.

Mental Health Services:

Only one of the five case studies (Cabell) addresses the provision of mental health services in schools. Nevertheless, the school-based mental health services in Cabell County are illustrative of many of the issues involved in providing these services in schools. Services are provided at the two High Schools and three Middle Schools by the regional community mental health center - Pretera Center. These services are financed almost entirely from Medicaid and grant funds provided by the state Office of Behavioral Health Services. The local school district (Cabell County Schools) supplements this funding with a contract which covers about 13% of the total costs. Medicaid revenues cover 44% of the costs and the state grant supports 43%. Not surprisingly, third party reimbursement from private health insurance is extremely low since most private health plans do not cover the counseling and case management services provided by the Pretera staff.

Current public policies related to mental health services for children and youth do not encourage the provision of school-based services. The reliance on Medicaid as the primary funding source over the past 20 years has resulted in neglect of the mental health needs of children who are not eligible for Medicaid services. Specific health-related funding streams (non-Medicaid) that are available to support mental health services are directed almost exclusively at severe, pervasive, and chronic problems.^{xvii}

Schools in West Virginia are seeing an ever increasing number of children in need of mental health services. The case studies confirmed the need for counseling, family therapy services, crisis intervention, and case management services at all grade levels. Key informants interviewed in all five counties mentioned behavioral and mental health issues with students as a major and growing concern. A national study conducted by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)^{xviii} and released in 2005 concluded that one-fifth of all students (nationally) receive some type of school-supported mental health services during the school year. The most common funding sources cited by the school districts to support mental health services were education funding streams including IDEA, state special education funds, and local funds. What is unknown is how much of the special education budgets in schools are used to address these issues.

West Virginia and other states across the nation provide Medicaid reimbursement to local LEAs through a school-based Medicaid program (special education only).^{xix} In West Virginia, this program allows reimbursement for limited mental health services (psychotherapy up to 10 sessions without prior approval) but the services must be provided by a licensed clinical psychologist or certified school psychologist. This excludes reimbursement to LEAs for mental health services provided by other qualified practitioners and severely limits access to mental health services for the special education population. In Braxton County the local education agency secured licensure as a behavioral health center in order to provide needed counseling and case management services to Medicaid eligible students (see Braxton case study).

Additional state investment in school-based mental health services will be necessary if effective systems of care are to be built that include the types of support needed by school age children. Various options are also available under the Medicaid program to expand support for school-based mental health services. The Pretera Center's experience thus far in Cabell County seems to indicate that about 45% (slightly less than half) of the costs of school-based mental health services can be covered by Medicaid provided that qualified practitioners employed by licensed behavioral health centers are out-stationed in the schools.

Additional financing options are possible that would utilize existing state appropriated dollars to match federal Medicaid funds for mental health services. Some Federally Qualified Health Centers operating school-based health centers in West Virginia have sought Medicaid reimbursement for a wider range of behavioral health services under provisions of federal law that require that FQHC's be reimbursed for "all ambulatory services" provided for in the Medicaid State Plan.^{xx} Another option worthy of consideration is the special Medicaid certified match program in Florida that expands mental health services by licensed social workers beyond the special education population to all students who are enrolled in the Medicaid program.^{xxi}

The School-Based Medicaid program specific to special education students is another vehicle to provide for a broader scope of mental health services. In New Mexico individual and group counseling services provided by all qualified practitioners (including licensed social workers, licensed professional counselors, marriage and family therapists, and psychiatric nurses) is paid by the Medicaid agency through its school-based services. This policy recognizes the range of qualified mental health practitioners and the realities of a rural state where licensed psychologists and psychiatrists are often not available.

From a policy point of view, some form of integrated service delivery that includes a full range of mental health services would seem to be most desirable. It is obviously inefficient and potentially confusing to students and families when three or more agencies are providing mental health services in school settings under different sets of rules. Some form of the management models discussed earlier (the Lead Agency Model or the Comprehensive –Integrated Model) that has mental health services as a primary component would be most desirable.

Further information is needed about mental health services in schools in order to determine the level of need, current resources supporting these services, specific changes in Medicaid policy that might be necessary, and other funding sources that could be tapped.

Partnerships with Community Health Centers (RHCs & FQHCs):

In a rural state such as West Virginia much of the state is designated as a medically underserved area providing opportunities for Rural Health Centers and Federally Qualified Health Centers to establish partnerships with virtually all local education agencies and other health care providers serving rural communities. Establishment of school-based health centers (SBHCs) as satellite clinics of existing community health centers has been a strategy employed in recent years in many school districts. School-based satellite clinics increase access to primary and preventive health care for school age children; however, the scope of services available in schools, billing practices, hours of operation, and local procedures for accessing services varies greatly across the state. Some examples exist where school nurses and special education personnel work closely with these satellite clinics; however this is the exception and not the rule. Generally a school-based health center in West Virginia serves to increase services available to students in their schools but does not function as a comprehensive and coordinated health services system. A Kellogg Foundation report on SBHC sustainability found several areas that need to be addressed including accountability standards, evaluation of outcomes, documentation of the role of SBHCs in the context of the larger healthcare system, and developing a national strategy for financing.^{xxii}

Nevertheless, there are obvious advantages inherent in the LEA-FQHC partnership including:

- < Cost based reimbursement available to FQHCs
- < Access to 3rd party reimbursement not available to the LEA
- < Enhanced access to new federal healthcare initiatives, and
- < Access to drug pricing programs at below market rates.^{xxiii}

An additional advantage to FQHC involvement is the provision in federal law that requires that FQHC's be reimbursed by the Medicaid agency for all ambulatory services provided for in the State

Medicaid Plan.^{xxiv} If an RHC or FQHC designated health center was, in fact, able to provide and be reimbursed for “all ambulatory services”, such agencies would be able to serve as “lead agencies” in providing for comprehensive school-based services. Even if the FQHC did not deliver a comprehensive array of services directly through the SBHC, the SBHC could serve to coordinate billing and records keeping functions for all providers delivering health-related services in the schools through “assignment of payment” agreements and contracts among the different providers. This type of arrangement has been put in place at the SBHCs in Cabell County to limited extent.

Coordination between Title V and Title XIX of the Social Security Act:

Federal law and regulation requires that the state Title V agency (Maternal, Child, and Family Health) have a “memorandum of agreement” in place with the Title XIX agency (Medicaid) to assure a coordinated approach in providing health services to women and children. The provisions for close cooperation between Medicaid and MCFH are advantageous to the development of school-based services since they can be used to eliminate what might otherwise be cumbersome administrative requirements that school-based providers determine the third party coverage of students served and bill each student or the student’s insurer for any services billed to the Medicaid agency. There are two exceptions to this “free care” rule. The first is if the service is provided to a special education student under an Individual Education Plan (IEP) or an Individual Family Services Plan (IFSP). Thus, the local education agency is under no obligation to verify if special education students have 3rd party coverage or to bill for services in order to draw down Medicaid reimbursement. The second recognized exception is when the covered services are provided by Title V (MCFH). It may be possible to develop agreements between community providers of school-based services and the Title V agency in ways that would permit the billing of services to Medicaid (for Medicaid enrolled students) without having to bill 3rd party payers or the student’s family when services are provided to non-Medicaid enrolled students. Another policy consideration that should be explored is investment of some Title V funds in the support of SBHCs. If Title V funds some portion of the SBHC services and includes such in the memorandum of agreement with the state Medicaid agency, the Medicaid “free care” rule may not apply.

The Florida Medicaid agency has made provisions for Medicaid funds to be used to support school-based services provided to Medicaid-enrolled children and youth who are not designated as special education students through their agreement with the Title V agency. A certified match of existing state funds is used making available additional federal dollars for school-based services. The Florida Medicaid agency cites several advantages to the Title V affiliation including:

- < Elimination of free care billing requirements,
- < Streamlined verification of Medicaid eligibility,
- < Expanded coverage, and
- < Provision of a “carve out” for students enrolled in managed care plans.^{xxv}

The Florida program runs through county health departments; however there is no reason it could not be administered by other local agencies under agreements with the Title V and Medicaid agencies.

A third possibility that might be considered is a partnership between Maternal, Child, and Family Health and the Office of Behavioral Health Services to jointly support mental health services in schools. Since very little if any 3rd party reimbursement is available for mental health services

provided in schools, such a partnership would remove requirements that these services be billed to all potential payers and open possibilities for a capitated payment from Medicaid to cover a defined package of mental health services provided to students who are enrolled Medicaid beneficiaries.

Waivers to Promote Comprehensive School-Based Health Services:

A Medicaid waiver could be pursued to promote comprehensive health services in “high need” schools (or all schools for that matter) and streamline administrative procedures for accessing Medicaid payments. Something similar to what was proposed in a concept paper by Martin Gerry, Assistant Secretary for Planning and Evaluation at HHS might be pursued. In 1992, Mr. Gerry proposed that schools with a high percentage of Medicaid eligible children be declared a “universal health services area” through a Medicaid waiver process and that such schools be encouraged to provide students with a comprehensive package of preventive and primary care services that would partially be funded by Medicaid through a capitated payment. All children in the school attendance area would be eligible for the designated services that might include EPSDT screening, health promotion and prevention services, and basic primary care regardless of whether or not they were enrolled in the Medicaid program. The Medicaid program would provide a per student payment to a designated lead agency or management structure and other health care providers such as FQHCs or Behavioral Health Centers would be encouraged to participate. These 15 year old basic ideas still have merit. Even though the environment has changed considerably with State CHIP and increased managed care, categorical provider groups within the Medicaid program continue to shape how services are provided to school age children. A Medicaid demonstration waiver focused on improved coordination of school-based health services and establishment of universal service areas may be a way to move toward a more integrated approach.

Approaches to Promote Outreach, Education, and Prevention:

A basic package of outreach and health education services could be developed and financed through multiple funding streams including Medicaid. State funds from the Bureau for Public Health or the State Department of Education could be certified as the required match for Medicaid federal financial participation to support outreach and education services through school-based programs. Outreach and enrollment activities are legitimate administrative activities under the Medicaid program to assure that all eligible children are enrolled. The state of Michigan has designed a Medicaid funded approach to providing outreach and education services through school-based centers using state dollars already appropriated to state agencies responsible for health and education services as the required state matching funds. The Michigan program provides a capitated payment for each student and funds are distributed by a fiscal agent who receives the dollars from the state Medicaid agency. An approach similar to the Michigan program could be developed in order to increase access to EPSDT and other preventive services and assure that eligible children were enrolled in Medicaid and state CHIP.

Conclusions

Numerous categorical funding streams may be accessed to support health-related services in schools. Without question, Medicaid is vital. Within the education sector of public funding, state aid to schools, state aid to exceptional children, and federal funds available through the Individuals with Disabilities Education Act (IDEA) are of primary importance. Other federal and state programs, private grants, and 3rd party payers also contribute to the financing of school-based health-related services. But it is the much larger Medicaid and Education investments that must be looked to if we are to build and sustain comprehensive systems of care.

Health services for special education students through education sector funds

State and federal education policy requires the provision of health services to the special education population. The vast majority of the education sector funding supports services to this population. In West Virginia, special education students make up 19% of the total public school population.

- Each of the 5 school districts (LEAs) included in the case studies accessed four major funding streams to support health-related services – Medicaid, state aid to schools, state aid to exceptional children, and IDEA. The relative portion of funds from each funding source varied considerably from one school district to another. 85% to 90% of all costs incurred directly by the 5 school districts studied were related to providing health services to the special education population with the remaining 10% to 15% spent on school nurses that serve a broader population of students.
- Statewide, West Virginia school districts drew down nearly \$31 million in Medicaid revenues during the 2004-05 school year. During that same period, the school districts spent over \$45 million in state and local education funds to support salaries and fringe benefits of health-related personnel employed by the local school systems. (Statewide expenses for additional personnel who provide health services for the school system on a contractual basis are unknown; however, for the 5 counties studied, this figure ranged from \$33,500 to \$308,811.) Almost all of these services supported by the \$45 million spent for health related personnel employed by the school systems are provided to special education students who have individualized educational plans (IEPs).¹

Health services available to the general student population

The school system is charged with providing health services during the school day to all students with specialized health care needs, including daily chronic disease maintenance ordered by the

¹ Education policy requires the provision of the following health-related services to special education students, where needed: speech therapy, physical therapy, occupational therapy, psychological services, private duty nursing and audiology. Other billable services include initial/triennial planning, annual treatment planning, care coordination, personal care services and specialized transportation vehicles and aides for the special education population.

student's medical home to allow optimal educational achievement. Examples of such needs are gastrostomy tube feedings, medication, sterile suctioning, sterile catheterization and seizure management.

Health services provided in schools by traditional health care providers

In some school systems, traditional health care funding streams including Medicaid and CHIP also provided reimbursement for health services through providers, other than the school system, who are supported by funding streams totally separate from the schools' services described above. These include primary care services from qualified medical providers through Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) as well as mental health services through behavioral health centers.

- In 2004-05 the state Division of Primary Care invested \$965,000 in state grant funds to support the provision of primary and preventive care through local school-based health centers (satellites of community health centers) and the Office of Behavioral Health Services used a total of \$706,320 in federal block grant and state funds to support mental health services in schools

Average per-pupil investment

Using data from the five school districts studied, the annual investment from both education sector and non-education sector funding sources for health-related services averaged \$245 per student.

Considering only funds available to the school systems, West Virginia's total per-pupil educational expenditure in 2004-05, based on the total enrollment statewide, was \$8,030.14.² The estimated cost per pupil statewide for health related personnel employed or contracted by local school districts is estimated to be \$190 which represents only 2.37% of total per pupil education sector expenditures dedicated to health related services.

Variation in health service models

There is no such thing as a standard model for delivering school-based health services in WV – considerable variations in local management, participating agencies, and use of available funds exist across different school districts.

- Four structural models of administering and financing school health services emerged from a review of conditions and practices in West Virginia and other states: a Local Education Agency Model, a Multi-agency Model, a Lead Agency Model and a Comprehensive Integrated model. In general, the first 2 models exist in West Virginia. Policies and strategies for delivering health services in schools in West Virginia must be reformed to move towards a Comprehensive Integrated Model. A comprehensive, integrated system could advance our children's health and educational outcomes dramatically while preventing duplication in services and ensuring each child has a medical home.

² WV Department of Education: 2006 Source Book

Lack of coordinated comprehensive health service delivery

Clearly, the investment of public funds in health-related services provided in school settings is significant. However, current investments are inequitable and insufficient to build a comprehensive and coordinated school-based health services system that serves all students with unmet health needs and enables every child to have a medical home.

- Many school districts in WV (about half) have no level of primary care or behavioral health services available in the schools and in those districts that do, these services are available only in a small number of schools through a satellite of a community health center or a local behavioral health agency.
- Nineteen WV counties have only one school nurse. Nursing services in most school districts are not adequate to provide for the day-to-day health care needs of the student population
- Mental health services are not available to students in many schools and these services are insufficient to meet student needs in schools where some level of service is available. Policies related to Medicaid reimbursement for mental health services and the lack of state investment in children's mental health limits access to supportive services for students and families, frustrates school officials, and places children at risk for ongoing and worsening problems.
- Current financing policies and strategies to promote school-based health services are generally uncoordinated and result in duplicative administrative activity. Multiple billing, service reporting, and record keeping processes take time away from the provision of direct services needed by students.
- Well intentioned efforts by many state agencies to support school-based, health-related services are carried out in an environment that lacks clear policy directives, well defined standards, definitions of best practice, and a shared vision for what coordinated, comprehensive school-based services should be.
- Cross-system discussions related to building electronic records systems and integrated billing systems are lacking. In the absence of such planning for integrated systems, it is likely that any technological advances in electronic medical records, billing systems, and evaluation/service reporting will be overshadowed by continuing administrative inefficiency.
- Much of the current health-related activity carried out in schools is provided by school personnel in the general framework of an education mission. Most local school districts lack the administrative capacity and health oriented infrastructure necessary to provide a broad range of health services to all students while ensuring quality outcomes and evidence-based practice.
- An outcome driven school-based health services system would most likely not look like the models that are currently available. The health services component in schools has evolved and grown in the context of local conditions and as opportunities have become available to

local providers. This is not unlike most other publicly supported service systems; nevertheless, new structures need to be built if we are to establish coordinated comprehensive school-based health programs that reach all students in all schools. Considering the investments in school health-related services, more needs to be done at the federal, state and community levels to reverse WV's poor child health outcomes. Reforming current policies and practices is needed so West Virginia children are healthy for the mastery of learning content standards and objectives to become productive and educated citizens and employees in the 21st century.

Recommendations

- The current “system” of financing and administering health services in school should be reformed. While recognizing the ideal of moving toward changes in policy and practices that would encourage a *Comprehensive-Integrated Model* for management of school-based health services over the longer term, WV should begin by moving to the *Lead Agency Model*.
 - Expand school health services through a comprehensive, coordinated model with one lead administering agency at sites where cooperative relationships have been demonstrated, local providers are willing to enter into necessary agreements with a lead entity, and school district and other health care providers are committed to a healthy schools climate and improved health outcomes in students.
 - Secure commitments of appropriate state-level agencies to support a hold harmless policy of reform and expansion in order to assure local providers that they will not lose money by adapting to a new delivery system.
 - Continue to study the sites to determine what works well, barriers to implementation, and factors that contribute to necessary cooperation.
 - Compare and contrast comprehensive coordinated sites with school districts utilizing a Multi-Agency Model to identify cost savings and improved coordination of services.

- Define a comprehensive, coordinated system of school-based health services that is outcomes driven and designed to meet the needs of the school age population at the preschool, elementary, middle and high school levels.
 - Open a dialogue with the state Medicaid agency related to policy and financing options to better support school-based, health-related services including options for a more comprehensive school-based Medicaid program and reimbursement of needed services for the Medicaid eligible school age population not designated as special education
 - Examine results of current year-round school-based health centers nationally and statewide to determine feasibility of providing year-round services in school settings elsewhere.
 - Examine current status of standards for school-based health centers to determine if quality standards need to be developed in a way that better defines and standardizes differing levels of school-based health services delivery and design

- Review the current status of behavioral health services in West Virginia schools to determine current expenditures, sources of funding, providers delivering mental health services in schools, scope of services offered, and level of need.
 - Work with newly established *Comprehensive Behavioral Health Study Commission* to establish a school-based mental health services task team as a vehicle to conduct necessary research and develop sound policy.
 - Review mental health utilization data for the school age population.
 - Use school-based mental health services assessment data to develop policy and financing recommendations.
 - Identify behavioral health standards of care.

- Provide training to local education agencies and health providers on models of school-based health services, Medicaid reimbursement options, and utilization of other education and health funding streams to support health-related services in schools.
 - Develop workshops and training sessions from material contained in this report for presentation at forums, conferences, and in-service training venues.
 - Tie this study to other initiatives including the School Health Partnership report, “Healthy Kids – Healthy Schools”

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Appendix A
Identified Revenues

<u>Local School Districts</u>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Taylor</u>	<u>Total State</u>
Medicaid Revenue FY05 (special ed)	\$295,516	\$322,508	\$1,542,201	\$289,499	\$308,152	\$30,803,857
Other Medicaid Revenue (Behavioral health)		40,000				
State Aid funding for health-related personnel	\$263,684	\$490,680	\$1,640,626	\$153,799	\$263,040	\$33,229,497
State Aid funding for health-related fringe benefits	\$95,876	\$179,344	\$585,047	\$52,784	\$98,114	\$11,952,650
Sub-total personnel	\$359,560	\$670,024	\$2,225,673	\$206,583	\$361,154	\$45,182,147
 <u>Total Cash Revenues</u>	 <u>\$655,076</u>	 <u>\$992,532</u>	 <u>\$3,767,874</u>	 <u>\$496,082</u>	 <u>\$669,306</u>	 <u>\$75,986,004</u>
 <u>Community health centers</u>						
Medicaid Revenue FY04	\$8,466		\$79,890	\$61,133		
CHIP Revenue	\$0		\$4,850			
Private Insurance	\$7,358		\$29,338	\$39,007		
Private Pay	\$735		\$2,033	\$2,608		
Federal Grant funds for health-related services						
State grant funds for health-related services	\$56,745		\$49,320	\$52,500		
Private grant funds (Cabell-Huntington Hospital)			\$25,000			
<u>Total Cash Revenues</u>	<u>\$73,304</u>		<u>\$190,431</u>	<u>\$155,248</u>		
 <u>Behavioral Health Centers</u>						
Medicaid Revenue			\$88,301			
Insurance			\$768			
Grant from BHHF (federal CMHS Block Grant)			\$86,574			
Contracts			\$26,314			
<u>Total Cash Revenues</u>			<u>\$201,957</u>			
 <u>Total Available Revenue</u>	 <u>\$728,380</u>	 <u>\$992,532</u>	 <u>\$4,160,262</u>	 <u>\$651,330</u>	 <u>\$669,306</u>	

Appendix B
Identified Expenditures

<i>Local School Districts</i>	<u>Barbour</u>	<u>Braxton</u>	<u>Cabell</u>	<u>Clay</u>	<u>Taylor</u>	<u>Statewide</u>
School Nurses (salaries)	\$74,490	\$91,646	\$300,040	\$47,692	\$65,590	\$6,938,774
Psychological Services	\$83,324	\$130,185	\$357,906	\$31,474	\$0	\$4,932,954
Other Healthcare Services	\$105,870	\$268,849	\$982,680	\$74,633	\$197,450	\$21,357,769
Total health-related personnel (salaries)	\$263,684	\$490,680	\$1,640,626	\$153,799	\$263,040	\$33,229,497
Fringe Benefits	\$95,876	\$179,344	\$585,047	\$52,784	\$98,114	\$11,952,650
Sub-Total Health-related Personnel (Salary & Fringe)	\$359,560	\$670,024	\$2,225,673	\$206,583	\$361,154	\$45,182,147
Indirect costs (estimated at 10% of direct personnel costs)	\$35,956	\$67,002	\$222,567	\$20,658	\$36,115	\$4,518,215
Contracted Healthcare Services	\$108,502	\$33,500	\$308,811	\$50,000	\$110,600	Unknown
<u>Total expenditures</u>	<u>\$504,017</u>	<u>\$770,526</u>	<u>\$2,757,052</u>	<u>\$277,241</u>	<u>\$507,869</u>	<u>\$49,700,362</u>
<i>Community health centers</i>						
Health-related Personnel (Personnel & Fringe)	\$57,512		\$64,551	\$144,422		
Contracted Healthcare Services	\$0		\$16,000	\$0		
Sub-Total Direct Health-related Personnel	\$57,512		\$80,551	\$144,422		
Administrative Support (Personnel & Fringe)	\$7,502		\$52,814	\$31,513		
Other (rent, utilities, supplies, equipment, travel, etc.)	\$15,533		\$54,675	\$14,598		
Sub-Total Admin & Other	\$23,035		\$107,489	\$46,111		
<u>Total expenditures</u>	<u>\$80,547</u>		<u>\$188,040</u>	<u>\$190,533</u>		
<i>Behavioral Health Centers</i>						
Health-related Personnel (Personnel & Fringe)			\$146,945			
Administrative Support			\$31,412			
Indirect Costs (all other costs)			\$8,700			
<u>Total expenditures</u>			<u>\$187,057</u>			
<u>Total Expenditures</u>	<u>\$584,564</u>	<u>\$770,526</u>	<u>\$3,132,149</u>	<u>\$467,774</u>	<u>\$507,869</u>	

Appendix C
Summary of Primary Characteristics of the Management Structures Discussed

The table below summarizes some of the significant differences in the four models discussed in this paper as they might apply to West Virginia school districts.

<i>Archetype</i>	<i>Management</i>	<i>Funding</i>	<i>Scope of Providers</i>
Local Education Agency Model	All health-related services are administered by LEA	Limited to education funding streams and School-Based Services Medicaid Program	Limited to school employees or staff under contract to school district
Multi-Agency Model	Different health-related services administered by multiple independent agencies operating within schools	Healthcare and education funding streams are accessed by each individual agency in a manner consistent with that provider's licensure	School employees and other healthcare providers employed by multiple independent agencies deliver services in the school environment
Lead Agency Model	Health-related services are managed by a designated "lead" agency selected by the school district	Healthcare and education funding streams accessed through agreements between lead agency, local LEA, and other providers	School employees and other health care providers work as a team through agreements with lead agency
Comprehensive-Integrated Model	All health-related services administered and managed by a designated management organization	Healthcare and education funding streams provided to management organization and contracts negotiated with network partners	Wide range of health-related providers participate in school-based healthcare network and deliver coordinated healthcare through school-based service centers

Appendix D
Brief Glossary
Selected Terms, Programs, and Funding Streams

Capitated Rate - A payment structure whereby a provider or provider network is paid a negotiated amount per person enrolled and served rather than a “fee for service” for each individual service provided. This type of rate structure is common in managed care environments or in situations where a group of identified persons (such as the public school student population) is provided a defined package of services by a single provider or management organization.

Certified Match – State appropriated funds not specifically designated in the state budget as Medicaid funding that is set aside and used by the administering agency to match federal Medicaid funds (pay the state share of health care costs to Medicaid eligible persons).

CHIP - Children’s Health Insurance Program (sometimes known as State Children’s Health Insurance Program) - This is a public Health Insurance program for children and it is authorized by the federal government under Title XXI of the Social Security Act. CHIP provides states with federal matching funds to support health care for children who are not covered by Medicaid or other health insurance programs.

ESEA - Elementary and Secondary Education Act -The federal law that addresses public education and provides for federal financial support of public education programs.

FPL - Federal Poverty Level -The federally defined level of annual household income that defines poverty. The FPL is based on family size and periodically adjusted for inflation. The FPL is used as a factor in determining eligibility for some federal programs.

FQHC - Federally Qualified Health Center - A healthcare clinic (sometimes referred to as a primary care clinic or community health center) that is located in a rural, medically underserved area that has met certain federally defined requirements and is granted certain competitive advantages to encourage health care delivery in underserved areas.

Health-related Services - Health-related services as used in the report includes services that are made available to students in school settings. Such services include preventive health services, primary care services, mental health services, dental services, nursing services, psychological assessment, diagnostic services, and ancillary therapies (speech, physical and occupational therapies).

Provider or Health Care Provider - Any community-based agency or individual who delivers health-related services.

IDEA - Individuals with Disabilities Education Act. The federal law that addresses services to special education students and provides for federal financial support for special education services in public schools.

IEP - Individual Education Plan. A plan of services developed for each identified special education student that defines what special services are to be provided to that student.

IFSP - Individualized Family Services Plan. A plan of services developed for each preschool child identified by public schools requiring special education services.

Medicaid - The federal program that provides health insurance to low income children, some adults, and other defined groups based on need. Costs are shared between the federal and state governments.

SBHC - School-based Health Center. A clinic providing preventive and primary care health services in a school or on a school campus.

SHSMO - Student Health Services Management Organization. The term used in the discussion of the Comprehensive-Integrated Model for the coordination and management of school-based health services through a provider network.

Title XIX - Title XIX of the federal Social Security Act. Title XIX defines and authorizes the Medicaid program and the Medicaid program is sometimes referred to as Title XIX.

Title V - Title V of the federal Social Security Act. Title V defines and authorizes the Maternal, Child, and Family Health Block Grant. The MCH or MCFH program is sometimes referred to as Title V.

Local Funding Streams:

- **Local Property Taxes** – Local funds available to County Boards of Education to support public schools

State Funding Streams (state dollars):

- **State Aid to Schools** – The primary source of state support to public schools.
- **State Aid to Exceptional Students** – Allocation of state dollars to support services in public schools for special education students.
- **Medicaid matching funds** – State appropriated dollars used as the required state share of expenditures through the state's Medicaid program.
- **Primary Care Support** – State appropriation to support community health centers (rural health centers and federally qualified health centers).
- **State Behavioral Health** – State appropriation to support mental health services.
- **University System Health Sciences** – State appropriations to support medical schools.

Federal Funding Streams (federal dollars):

- **Elementary and Secondary Education Act (ESEA)** – Federal funding for public education.
- **ESEA-Title I** – A portion of ESEA funding dedicated to schools with a high percentage of low income students.
- **Individuals with Disabilities Education Act (IDEA-Part B)** – Federal funding to support special education services in public schools and services to preschool children (3 to 5) with special needs.
- **Medicaid** – Federal portion of funds used to provide health care to low income children and other special populations.
- **Children's Health Insurance Program** – Federal portion of funds used to provide health care to children who do not qualify for Medicaid or other health insurance programs
- **Community Mental Health Services Block Grant** – Federal block grant funds provided to the state for the support of mental health services.
- **Substance Abuse Prevention and Treatment Block Grant** – Federal block grant funds provided to the state for the prevention and treatment of substance abuse.
- **Maternal Child and Family Block Grant** – Federal block grant to the state for support health services for pregnant women and children.
- **Preventive Health Services Block Grant** – Federal block grant to the state for support of preventive health services.
- **Safe & Drug Free Schools** – Federal funding available to school districts to support substance abuse prevention programs and strategies to reduce the use of alcohol, tobacco, and drugs by students.

Other potential funding sources to support school-based health services:

- **Tobacco Settlement Funds** – Funds awarded to the state by tobacco companies as a result of lawsuits.
- **PEIA** – Public Employees Insurance Agency that provides health insurance to state and some local government employees.
- **Private Insurance** – Any number of private health insurance plans providing health insurance through employer based health plans or directly to individuals and families.
- **Private Pay** – Out of pocket payments made by individuals for health care expenses.
- **Private Grants** – Grants from Private Foundations of Charitable Organizations to local agencies for the support of health-related services in schools.
- **Discretionary Grants** – Grant programs offered by state or federal government agencies that are made to local agencies or organizations on a competitive basis.
- **Dedicated Tax** – A tax imposed by state or local government to raise revenue for a specific purpose. Tax revenues generated are then used only for that specific and defined purpose.

End Notes:

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- ⁱ Chandler, Brett, West Virginia School-based Practice Improvement Project - Phase I Report, January 2005
- ⁱⁱ Taylor, Henry, *Re-Visioning School-Based Health*, April 2005.
- ⁱⁱⁱ Wikipedia on-line encyclopedia, http://en.wikipedia.org/wiki/Form_follows_function
- ^{iv} [Http://www.childrenshospital.com/getinvolved/advocacy/schoolhealthpage.asp](http://www.childrenshospital.com/getinvolved/advocacy/schoolhealthpage.asp)
- ^v Denver School-based Health Centers, 2002-2003 Annual Report.
- ^{vi} *Striking a Balance – Administrative Cost Sharing in School Health Centers*, The Illinois Coalition of School Health Centers, 2005.
- ^{vii} Data from US Census Bureau, State Department of Education reports, and Clinical fusion reports.
- ^{viii} Average Contracted Salary PE-all positions, Report OSF2, March 2005 & Status Report to the West Virginia Board of Education on the School-based Medicaid Services Program, September 2005.
- ^{ix} SBHC Grant Application for Funding Renewal, Fiscal Year 2006.
- ^x Information was received directly from Valley Health Systems related to revenues and expenses for providing primary care services at SBHCs in two Cabell County high schools and from Pretera Center related to revenues and expenses for providing behavioral health services in high schools and middle schools in Cabell County.
- ^{xi} Status Report to the West Virginia Board of Education on the School-based Medicaid Services Program, September 2005.
- ^{xii} Revenue and expense data was taken from the FY06 applications for SBHC grant funds from the Division of Primary Care Services and directly from information provided by the providers.
- ^{xiii} Distinct reporting or documentation systems include: (1) Medicaid/Special Ed. program service record, (2) WVEIS reporting system, (3) School Nurse Activity Report, (4) Clinical fusion Data report, (5) Community health center service activity reporting, and (6) Behavioral Health service reporting.
- ^{xiv} Distinct billing systems include: (1) Medicaid school-based services program, (2) Primary Care (FQHC) billing system, (3) Behavioral Health billing system.
- ^{xv} Data on the number of encounters and users for community health centers was taken from the FY06 SBHC Grant Application for Funding Renewal and does not include non-billable nursing services. Encounter data for behavioral health providers in Cabell County was provided by Pretera Center and includes encounters in all Cabell County schools (not just schools with SBHCs). The encounter and user data does not necessarily correspond to data collected through the Clinical Fusion reporting system managed by the WV School-Based Health TA Center at Marshall University.
- ^{xvi} 2002 State Survey of School-based Health Center Initiatives conducted by the Center for Health and Health care in Schools, <http://www.healthinschools.org/sbhcs/survey02.htm>
- ^{xvii} *Financing Mental Health for Children and Adolescents*, Center for Mental Health in Schools, 2000.
- ^{xviii} *School Mental Health Services in the United States, 2002–2003 (SMA05-4068)*
<http://www.mentalhealth.samhsa.gov/publications/allpubs/sma05-4068/>
- ^{xix} WV Code 18-2-5b
- ^{xx} 42 USC1396d(a)(2) and 42USC1395x(aa)(1)
- ^{xxi} Florida Medicaid Summary of services - <http://www.fdhc.state.fl.us/Medicaid/sos.pdf>
- ^{xxii} W. K. Kellogg Foundation, Discussion Paper for the Foundation’s Invitational Forum on School-Based Health Care Reimbursement and Sustainability, 1998.
- ^{xxiii} Swider, S. et. al., *Options for Sustaining School-Based Health Centers*, Journal of School Health; April 2004, Vol 74, Issue 4.
- ^{xxiv} 42USC1396d(a)(2) and 42USC1395x(aa)(1)
- ^{xxv} Handbook for County Health Department Certified Match Program –
<http://ahca.myflorida.com/Medicaid/childhealthservices/countyhealthdept/index.shtml>

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