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Coordinating Adolescent Health Centers and Managed Care:

State Experiences and Lessons Learned

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CHAPTER I

Introduction and Overview

By mid-1994, roughly 24 percent of all Medicaid recipients were enrolled in some type of managed health care system. This figure represents a dramatic increase from 1983 when just three percent of Medicaid recipients were served in managed care arrangements. In the past two years alone, Medicaid enrollment in managed care has increased by 60 percent (Health Care Financing Administration, 1995).

Almost every state has contributed to this growth. Today, all but eight states have implemented some form of Medicaid managed care and fully 21 states have submitted Section 1115 waivers to conduct statewide Medicaid research and demonstration programs, all of which involve mandating Medicaid recipients' enrollment in managed care. Increasing numbers of states embrace managed care in the hope that several positive goals will be achieved: that access to care will improve as all Medicaid children and their families are linked to a primary care "medical home," that quality of care will improve as service delivery becomes better integrated, and that health care cost inflation will slow as managed care providers are faced with incentives to operate more efficiently.

However, the advent of managed care, particularly for Medicaid recipients, has brought new concerns for adolescent health care. Traditionally low users of medical services (OTA, 1991), adolescents often prefer to use services provided by school-based clinics and other centers that meet their particular needs, including confidentiality, short waits for appointments, and convenient locations and hours of operation (GAO, 1994; Fox and Wicks, 1994). School-based clinics are proliferating, with more than 600 clinics in 42 states, nearly two-thirds of which are located in middle or high schools (Schlitt et al., 1994). The combination of this trend with the

rise of Medicaid managed care raises a number of issues for the delivery and financing of care to adolescents. For example:

- Traditionally, communities have supported school-based clinics in part because they offer services to all students in their schools. If managed care plans in which students are enrolled require that services be provided by the plan, not by the clinic, clinics may be asked to consider withholding services from certain groups of students.

- School-based clinics often appeal to adolescents because they provide services outside of the mainstream medical care system used by their parents. Not only are the clinic providers attuned to adolescents' particular needs, but the services they provide are confidential and their records are kept apart from the medical records to which their parents may have access. Managed care plans, however, often require that an entire family enroll in its plan. Therefore, in some states, records of all services provided to adolescents may be available to parents, and teens might be discouraged from using certain types of sensitive services such as family planning, substance abuse treatment, or mental health counseling.

- Capitation rates paid to Medicaid managed care plans are usually based on the historical utilization rates of enrollees in various demographic groups. If adolescents have traditionally under-used services, the capitation rates paid to managed care plans to cover their care may be relatively low, and plans may be unwilling to go to great lengths to encourage teens to use services or to offer reimbursement to other providers of adolescent health care. Moreover, if school-based clinics have not traditionally billed Medicaid, the cost of their services will be excluded from the base on which capitation payments to plans are calculated.

- If school-based clinics then provide services to Medicaid-enrolled students without reimbursement, they will in effect subsidize the managed care plans that are already being paid to provide these services.

These concerns will become increasingly pressing as the expansion of Medicaid eligibility mandated by OBRA-89 increases to include children in their adolescent years.[1] Therefore, to address these issues, many states and localities are beginning to explore mechanisms for coordinating services and negotiating contracts between managed care organizations and

[1] OBRA-89 requires that states extend Medicaid eligibility to all children born after September 30, 1983 in families with incomes under 100 percent of the Federal poverty level. This provision will result in all children up to the age of nineteen living below poverty having Medicaid coverage by the year 2001. At present, all children under age 13 who live below poverty are eligible for Medicaid under OBRA-89.

school-based health centers. While these mechanisms are promising, such efforts have raised a new set of issues. Policymakers, managed care administrators and school-based health center managers have struggled to balance often conflicting goals and objectives—between the need for coordination of services and adolescents' desire for confidentiality, and between plans' need to manage utilization and centers' efforts to encourage teens to take advantage of their services. In addition, issues of reimbursement, prior approval, and continuity of care must be addressed.

A. Adolescent Health Services and Medicaid Managed Care in Michigan

The State of Michigan has long been a leader in the development of managed care systems under Medicaid, having begun enrollment of Medicaid eligibles in Health Maintenance Organizations (HMOs) in 1972. Nearly 750,000 Medicaid eligibles in the state are now enrolled in HMOs. In 1982, Michigan first implemented its Primary Care Physician Sponsor Program, a primary care case management model that currently enrolls approximately 450,000 Medicaid recipients. An additional 28,000 eligibles are enrolled in partially-capitated clinic plans. As of July 1995, a total of 87 percent of Michigan's Medicaid population (excluding long-term care recipients) were enrolled in managed care programs.

Michigan has also been active in the development of specialized adolescent health centers. The state Department of Public Health (DPH) currently funds 22 Teen Health Centers (THCs), 15 of which are located in schools, along with seven additional school-linked Teen Health Centers. An additional seven adolescent health programs provide screening, case finding, referral, and health education but not primary care. Throughout the development of Medicaid managed care in Michigan, adolescent health services have always been included in the responsibility of managed care plans, with the exception of family planning, immunizations, and testing and treatment for sexually transmitted diseases (STDs), which may always be provided to enrollees in managed care by other providers outside the managed care organization and for which these providers will continue to be reimbursed by Medicaid on a fee-for-service basis. Therefore, in early 1993, DPH officials initiated discussions with the Department of Social Services (DSS), the state Medicaid agency, regarding THCs' participation in Medicaid managed care. As a result of these discussions, DSS and DPH have made significant headway in negotiating

workable arrangements between THCs and the PSP portion of the Medicaid managed care initiative. For example, DSS revised its requirements for the PSP model to allow THCs to participate as PSP providers even if they cannot meet DSS's normal requirement that a physician be available on-site 20 hours per week. These alternative provisions allow THCs to qualify as PSP providers if a physician remains the provider of record but care is provided by a mid-level practitioner under the physician's supervision. Alternatively, a nurse practitioner and a physician may enter into a collaborative agreement to provide care and the nurse practitioner would be the sponsor provider of record. Under these new regulations, however, only a handful of THCs have actually pursued enrollment as PSP providers.

However, arrangements have not yet been made between THCs and the capitated plans under the Medicaid managed care program. As discussed above, this is a more complex undertaking, as it involves the development of arrangements between plans and clinics so that clinics may be paid out of the capitated rates the plans receive from DSS. Not only may plans be unwilling to share their capitation payments, they may feel that the services provided by THCs are ones that their providers are fully qualified and prepared to provide; plans may therefore not see the value in contracting with an outside provider for these services.

B. Technical Assistance and Organization of Report

With these concerns in mind, officials of the Michigan Department of Public Health submitted a request for technical assistance to Health Systems Research, Inc. (HSR) in the fall of 1994. Under two contracts with the federal Maternal and Child Health Bureau, HSR is providing assistance to all states' maternal and child health agencies in developing comprehensive systems of services for children and their families. Michigan requested assistance in developing effective models for two vulnerable populations under Medicaid managed care: adolescent and children with special health care needs.

In January of 1995, Michigan was selected to receive technical assistance. To address the first half of the technical assistance request—the challenge of integrating adolescent health services with prepaid managed care systems—state officials asked HSR to gather and compile information from other states regarding models for coordination between adolescent health centers and managed care organizations, in the hope that this information would provide Michigan with insights into how to design its own arrangements.

This report presents the results of that effort. In June and July 1995, HSR staff contacted Medicaid and MCH officials in 13 states to discuss their progress in facilitating coordination between adolescent health centers (particularly school-based health centers) and managed care programs, particularly those sponsored by Medicaid. The 13 states interviewed, selected for their experience with both managed care and school-based health services, were: Arizona, California, Connecticut, Maryland, Massachusetts, Minnesota, New Mexico, Oregon, Rhode Island, Tennessee, Vermont, Washington, and Wisconsin. Table 1 presents the states interviewed, the type of Medicaid managed care waiver program being implemented in each, and the number of school-based health centers currently in operation in middle and high schools in the state. With officials of each state, HSR staff explored the Medicaid managed care arrangements being planned or implemented, the extent of coordination with school-based health centers in these managed care programs, and the role of state agencies in facilitating this cooperation.

The remainder of this report is organized into four sections. Section II discusses specific policy issues involved in the design of Medicaid managed care programs and their implications for adolescents' access to services. Section III describes the 13 study states' policies regarding coordination between Medicaid managed care plans and school-based health centers and the implementation of contracts between school-based clinics and managed care plans, and Section IV discusses the types of efforts that state agencies undertook to encourage the development of these contracts. The report concludes with a summary of the lessons learned in the 13 states interviewed regarding successful coordination between school-based health centers and managed care organizations.

CHAPTER II

Policy and Design Issues in Medicaid Managed Care

As shown in Table 1, the states interviewed are using different strategies in setting up their Medicaid managed care systems. Within each of these state systems, a number of more detailed policy and design decisions are being implemented, each of which may affect adolescents' access to services. This section discusses the Medicaid managed care systems in place or in development in the 13 states interviewed and examines those policy and design issues that are of particular importance for adolescent health care.

As discussed above, 21 states have applied for Section 1115(a) Research and Demonstration waivers to enroll large portions of their Medicaid populations in managed care and to expand Medicaid eligibility to uninsured families below a certain income standard. Other states are approaching managed care more cautiously, using the authority of Section 1915(b) to enact "freedom of choice" waivers to enroll only certain categories of Medicaid eligibles in managed care plans. Table 2 identifies the Medicaid populations that are covered by managed care in each of the 13 states studied by HSR, along with the approximate proportions of both the entire Medicaid population and the population Medicaid-eligible children and adolescents that are or will be enrolled in managed care under each state's plan. In addition, the table shows the percentage of the state's population enrolled in private HMOs at the end of 1993.

Table 1. Managed Care and School-Based Health Centers in Study States		
State	*Medicaid Managed Care Waiver Authority*	*School-Based Health Centers Serving Adolescents**
Arizona	Section 1115(a) research and demonstration waiver	40
California	Section 1915(b) freedom of choice waiver	21
Connecticut	Section 1915(b) freedom of choice waiver	30
Maryland	Section 1915(b) freedom of choice waiver	19
Massachusetts	Section 1915(b) freedom of choice waiver	28
Minnesota	Section 1115(a) research and demonstration waiver	17
New Mexico	Section 1915(b) freedom of choice waiver	28
Oregon	Section 1115(a) research and demonstration waiver	19
Rhode Island	Section 1115(a) research and demonstration waiver	3
Tennessee	Section 1115(a) research and demonstration waiver	6
Vermont	Section 1115(a) research and demonstration waiver	0
Washington	Section 1915(b) freedom of choice waiver	8
Wisconsin	Section 1915(b) freedom of choice waiver	2
*Number of clinics in middle or high schools. Source: Health Systems Research, Inc. and Schlitt et al., 1994		

As Table 2 demonstrates, states are approaching the enrollment of Medicaid eligibles in managed care differently. At a minimum, all states enroll AFDC and related groups, including most pregnant women and children, in managed care. Others also include additional eligibility groups, such as SSI-eligible children and aged, blind, and disabled adults. Because all states studied enroll AFDC and related populations in managed care, they also, by definition, enroll most Medicaid-eligible children and adolescents. Even in states where managed care is relatively uncommon, low-income children and adolescents are among the first to be enrolled in these new systems of care. The percentage of the total state population enrolled in private HMOs varies among the states studied from a low of 11 percent in Vermont to more than a third in Massachusetts and California; however, the proportion of Medicaid-eligible children in managed care is close to 100 percent in all 13 states.

Table 2.
Medicaid and Private Managed Care Enrollment in Study States

State	*Populations enrolled in Medicaid managed care*	*Approx. % of Medicaid eligibles enrolled in managed care*		*% of state residents enrolled in HMOs (as of 12/31/93)***
		*Total**	*Adolescents*	
Arizona	All	100%	100%	32.9%
California	AFDC and related groups in specific counties	53% (expected)	Unsure	35.0
Connecticut	AFDC and related groups	73% (expected)	98% (expected)	24.5
Maryland	Categorically needy (excluding aged)	73%	99% (all but foster children)	32.0
Massachusetts	AFDC, SSI under age 65, disabled	61%	100%	34.1
Minnesota	AFDC and others under 65 in eight pilot counties	33%	99% (in pilot counties)	30.1
New Mexico	All but institutionalized and dual eligibles	90% (expected)	100% (expected)	15.7
Oregon	All except some elderly and disabled	71%	100%	31.5
Rhode Island	AFDC and related groups (not SSI or foster care)	61%	Unsure	25.9
Tennessee	All	100%	100%	5.7
Vermont	All except TEFRA	99% (expected)	99% (expected)	11.1
Washington	AFDC and related groups	61%	99%	15.2
Wisconsin	AFDC and related groups in five counties	50%	All but SSI in five counties	23.1

Health Systems Research, 1995
*HSR analysis of data in National Institute for Health Care Management, 1995 and state information.
** Source: National Institute for Health Care Management, 1995

Beyond differing eligibility and enrollment policies, state Medicaid managed care programs also implement different policies regarding the choices of plans and providers offered to managed care enrollees and the exclusion of certain services from Medicaid managed care initiatives.

Each of these policies can affect the accessibility of services provided by school-based clinics and other adolescent health centers. The following discussion reviews these policies in the states interviewed and discusses the implications of these policies for adolescents' access to services.

A. Types of Plans Available

While some states enroll all of their Medicaid managed care eligibles in capitated plans, others provide enrollees with a choice between capitated HMO-model plans and a primary care case management (PCCM) option. Under the first option, HMOs are paid a capitated rate to provide all care for their enrollees. In the second option, a primary care provider is usually paid a nominal monthly fee to act as a "gatekeeper" and provide case management and referrals to specialty services within a network of providers. In most states, this provider is not at risk for the cost of these referral services, however, and may bill Medicaid on a fee-for-service basis for all health care services he or she provides directly. Eight of the states HSR interviewed offered or planned to offer only capitated managed care plans to Medicaid eligibles; five offer a choice of a PCCM or a capitated plan. In Tennessee, one PCCM plan is currently available to Medicaid eligibles (Blue Cross Blue Shield's Preferred Provider Option plan) as an alternative to capitated plans, but that option is being phased out. Connecticut does not offer a PCCM option, but does offer a partially capitated plan, in which primary care providers are at risk for all but inpatient services; this option will be phased out after three years.

B. Choices of Plans or Providers

Another area in which states differ is the degree of flexibility they give to families in choosing plans and primary care providers. In most states studied by HSR, families who chose the capitated plan were required to enroll all Medicaid-eligible family members in the same plan; within the plan, however, family members may choose different primary care providers. Exceptions to this were found in California, Minnesota and Massachusetts, where family members may choose different plans even if all enroll in capitated arrangements.

In those states that maintain a PCCM option, families who choose to enroll in the PCCM program may select different primary care providers for each family member. In Tennessee's Blue Cross Blue Shield plan, however, families are encouraged to enroll all family members with one primary care provider. As mentioned above, this option is being phased out of the TennCare system in 1996.

C. Service Exemptions

Federal law requires that enrollees in certain Medicaid managed care programs (those not operating under Section 1115 research and demonstration waivers) be given "open access" to family planning services; that is, they must be able to receive family planning services from providers outside of their managed care plans, who must then be reimbursed by Medicaid on a fee-for-service basis.[1] In three states (California, Massachusetts, and Washington) certain additional services are exempt, or "carved out," from managed care requirements as well. In these states, school-based clinics (and, in some cases, other providers as well) may provide these services to all Medicaid-eligible children and adolescents and bill Medicaid directly. The carve-out policies in these states are described below.

- California maintains a set of "minor consent services" that are fully state-funded. For these services, minors may consent to care and qualify for Medi-Cal (the state's Medicaid program) separately from their parents (that is, their parents' income is not considered in the Medi-Cal application). Therefore, nearly all adolescents qualify for these services independently. Some of these services—outpatient alcohol and drug treatment, outpatient mental health, and family planning—are carved out of the Medi-Cal managed care system. In addition, health services provided by local school districts for children pursuant to Individualized Education Plans or Individualized Family Service Plans including assessments, physical therapy, speech pathology and audiology, counseling, and nursing services, may be billed directly to Medi-Cal.

- Massachusetts exempts family planning, mental health services, and HIV testing from both of its managed care program options.

- In Washington State, during the first year of its managed care program, health department-run clinics (including those located in schools) were allowed to

[1] For a full discussion of the implications of this policy see Rosenbaum et al., 1994.

provide and bill Medicaid directly for reproductive health services, immunizations, and screening for tuberculosis and STDs. This provision has been authorized only through 1996 and may be phased out.

D. Implications of Design Decisions

Each of the policy options described above may affect both adolescents' access to services and school-based clinics' prospects for coordinating with the managed care system. First, the availability of a PCCM option may make it more likely that school-based clinics will be able to receive continued Medicaid reimbursement in the new system and that adolescent health services will remain accessible. Because primary care case managers are not at financial risk for care, they may be more willing to authorize school-based clinics to provide services to children whose care they manage. In addition, clinics could qualify to become primary care providers themselves in these systems. In capitated systems in which plans are at risk for the cost of services, HMOs may control utilization more tightly than primary care case managers and thus be less willing to reimburse school clinics out of their own capitation for services provided to their enrollees. Plans may therefore ask that clinics refer their enrollees to the plan for services rather than providing them in the clinic. If students are given the impression that access to school clinic services is limited for those enrolled in HMOs, they may become less willing to seek services at all.

Flexibility in the choice of plans or providers could be important for adolescents if certain providers who are particularly skilled or experienced in treating adolescent health concerns are included in the plans' networks. For instance, if a school-based clinic is included in one capitated plan's provider network but a teen's family is enrolled in another plan, the teen's access to the school-based clinic may be limited. Since the choice of a managed care plan is generally made by a parent, not by the teen, a plan may be chosen without regard for the degree of access to specialized adolescent health services the plan offers. Even in cases where family members may choose different plans or primary care providers (such as in PCCM plans), the fact that it is the parent, not the child, who actually chooses the primary care provider may limit the child's access to school-based health clinics or the clinics' prospects for Medicaid reimbursement.

Finally, carving out a package of adolescent health services for which school-based clinics may continue to bill Medicaid directly may provide short-term protection for school-based clinics and may help to assure adolescents' access to these services. However, these carve-out policies are not common and are unlikely to provide a viable long-term strategy for preservation of school-based clinics' services. Since the objective of managed care is to coordinate all care received by Medicaid recipients, carving out specific services undermines the ability of managed care plans to perform this function. In addition, it is unlikely that a carve-out policy will cover all (or even most) of the services provided by school-based clinics; arrangements with managed care plans will still be necessary for clinics to be reimbursed for the full range of services they provide. These arrangements are explored more fully in the next chapter.

CHAPTER III

Coordination with School-Based Health Centers

Many of the state and local officials interviewed for this study felt that, under any Medicaid managed care scenario, the most promising avenue to assuring access to appropriate services for adolescents enrolled in managed care is to include specialized adolescent health care providers, particularly school-based clinics, in their managed care systems. This is generally accomplished through contracts or other arrangements between the clinics and managed care plans. This chapter explores the types of arrangements in place or being developed in the 13 states interviewed and addresses some of the important policy and implementation issues that must be considered in the development of these arrangements.

Most of the states officials interviewed reported that some effort has been made in their states to coordinate school-based health center services with Medicaid managed care initiatives. Often, these arrangements were made in response to language included in the state's waiver application or in the contracts between the state Medicaid agency and the managed care plans that either mandate or encourage coordination with school-based clinics. In other cases, contracts between school clinics and managed care organizations have been developed on the local level in the absence of state-level mandates. This chapter first discusses state-level policies to require or encourage managed care plans to coordinate with school clinics, then goes on to examine the provisions of contracts between managed care plans and school-based clinics in capitated systems, PCCM models, and private managed care plans. Finally, we address the issue of confidentiality and discuss the administrative infrastructure necessary to implement these contracts.

A. Mandating or Encouraging Coordination

Several states reported that the waiver applications submitted to HCFA by the state Medicaid agency, or the contracts between the state Medicaid agency and managed care plans, contained language to require or encourage plans to coordinate or contract with school-based clinics. The types of provisions used by states in the study can be divided into four broad groups, as presented below.

- Required Contracts. States may, in their waiver applications or their contracts with managed care plans, require plans to develop contracts with school-based clinics in their service areas. These requirements may specify certain services for which school clinics must be paid by plans or may require that plans reimburse clinics for any Medicaid-covered services they provide to plan enrollees.

- Required Coordination. Rather than requiring plans to develop formal contracts and reimbursement arrangements with school-based clinics, states may provide a more flexible requirement in their managed care contracts. These may simply require that plans "coordinate" with school-based health centers, or may specify that plans must implement any of a range of options, from formal contracts to referral protocols or other coordination mechanisms.

- Encourage Coordination. A third and still less rigid approach is for states to include language in their contracts with managed care plans "encouraging" them to coordinate with school-based clinics.

- No Requirements. States may choose not to address this issue explicitly in their managed care waivers or contracts.

Table 3 below shows the number of state that have chosen each of these policy options. The discussion that follows explores each option further and presents the approach used by each of the 13 study states.

Table 3. State Policies Regarding Coordination Between School-Based Clinics and Managed Care Plans	
Option	*States Choosing Option*
Require Contracts or Reimbursement	**3**: CT, VT, WA
Require Coordination	**4**: CA, MA, MN, RI
Encourage Coordination	**2**: NM, OR
No Requirements	**4**: AZ, MD, TN, WI

1. Require Contracts

Two states included in HSR's study, Connecticut and Vermont, require managed care plans to contract with the school-based clinics in their service areas. The contracts between the Connecticut Department of Social Services (the state Medicaid agency) and plans participating in the Medicaid managed care program specify that the plans must contract with any school-based clinics in their catchment area; it does not specify which services must be covered by these contracts, however.

Vermont's 1115(a) research and demonstration waiver received final approval in July 1995, and contracts have not yet been written between the state Medicaid agency and managed care plans. In addition, although the state has received a grant from The Robert Wood Johnson Foundation to plan and implement several school-based clinics, no clinics are yet in operation. However, the RFP requires that "if a state-designated school-based health center exists or is being developed in the health plan's service area, plans for coordination of care and reimbursement of services provided in school-based health centers shall be established by the Office of Health Access through protocols developed in consultation with the plans, participating providers, the centers and other participating AHS departments."

Finally, the state of Washington has recently added a clause to its contracts with managed care plans that requires them to reimburse school-based clinics for services provided to their enrollees if those services are authorized by the students' primary care providers. Although this provision seems to require that plans contract with school-based clinics, it actually provides no

guarantee that clinics will receive reimbursement from plans, as the primary care providers are not obligated to authorize the clinics to provide services. Local officials consider this arrangement to be unworkable and are trying to negotiate with plans to define a minimum package of services for which clinics may be reimbursed by plans without prior approval (for example, three acute-care visits and one EPSDT exam per enrolled child per year). A few plans have been receptive to this proposal, but most have not shown any interest.

2. Require Coordination

Four states—California, Massachusetts, Minnesota, and Rhode Island—include language in their managed care contracts requiring some form of coordination between plans and school-based clinics. These states' policies are outlined below.

- California has several managed care programs in place under Medi-Cal. In the largest of these initiatives, the state is implementing a managed care program in 13 populous counties in which the state will contract with one commercial HMO in each county, and each county will also offer a "Local Initiative," a managed care network made up of public-sector providers. Both types of networks will be required to assure that their enrollees receive health screens under the Child Health and Disability Prevention (CHDP) program (the state's EPSDT program). In order to help to fulfill this requirement, the commercial HMOs involved in the pilot will be required to do one of the following:

  - Develop subcontracts with qualified school clinics for the provision of CHDP services;

  - Establish "cooperative agreements" with school clinics whereby the plans will provide staff or resources to support the provision of CHDP services in the schools;

  - Develop referral protocols between school clinics and the managed care plan for children in need of CHDP services; or

  - Implement "any innovative approach...to assure access to CHDP services and coordination with and support for" school-linked clinics.

  Information about how plans are responding to these requirements will become available when the contracts are awarded in October 1995.

- In Massachusetts, the contracts between HMOs and the state Medicaid agency require the plans to "develop linkages" with school-based clinics and to report to

the state regarding their progress in developing these linkages. In practice, some HMOs have contracted with school-based clinics in their service areas, while many other plans have responded to the requirement by developing forms for clinics to use to record and report services provided to the plan's enrollees or protocols for clinics to follow in requesting authorization to provide services.

- In Minnesota, the state's contracts with managed care plans require them to cover services that may be provided in schools, but give plans flexibility in carrying out this requirement: they may contract with school-based providers, place their own providers on-site in the schools, or cover the cost of transportation between the schools and their provider sites.

- Rhode Island's contracts with managed care plans do not require the plans to establish reimbursement arrangements with school-based clinics, but do include language requiring the clinics to coordinate with plans. Thus, the responsibility for implementing this coordination resides with the clinics, not the plans, and plans are not required to reimburse clinics for services.

These policies provide plans with broad flexibility in designing their arrangements with school-based providers. Since Medicaid managed care systems are still quite new, and since managed care plans in many states are approaching coordination with school-based clinics cautiously, it is too early to report whether or not this type of contract language is effective in stimulating reimbursement arrangements between plans and school clinics. As will be described further below, Minnesota has been a leader in the development of contracts between plans and school-based clinics; however, few examples of coordination have yet emerged in California, Massachusetts, or Rhode Island.

3. Encourage Coordination

One state, Oregon, reported that its contracts between Medicaid and managed care plans encouraged plans to coordinate with school clinics. Similarly, New Mexico officials expect that their contracts will encourage, but not require, plans to contract with school clinics. (Since some rural areas have few potential primary care providers, state officials feel that such a requirement may not be necessary.) Although this approach will not necessarily spur plans to seek out contracts or other arrangements with managed care plans, it may provide support for clinics if they seek reimbursement from plans independently.

Officials in several states felt that requiring plans to contract with school-based clinics was neither feasible nor politically astute; mandates of any sort are not well received in many areas of the country and could undermine states' attempt to encourage competition among plans for Medicaid clients. Rather, contract language was often preferred that encouraged this coordination or, as in Minnesota, required a certain outcome (the provision of services in schools) with flexibility as to how it would be achieved.

4. No Requirement

Three states—Arizona, Maryland, and Tennessee—reported that their managed care contracts and waivers contained no requirements regarding coordination between plans and school-based clinics. In addition, Wisconsin has not yet developed its policies in this area. Wisconsin's approach is being developed through a fifty-member Work Group including managed care plans, schools, and public health agencies. This Work Group has used an open, statewide process that has received over 200 suggestions on how to achieve coordination between plans and school-based clinics. Final policies, however, have not yet been approved.

B. Contracting Options in Capitated Systems

As discussed in the preceding section, many states included in HSR's study require or encourage managed care plans to contract with school-based clinics. However, even in those states that do not mandate such coordination, arrangements between school-based clinics and Medicaid managed care plans are being formulated at either the state or the local level. Of the 13 states interviewed, a total of 11—all but New Mexico and Wisconsin—reported that arrangements were in place or were being planned to involve school-based clinics in Medicaid managed care systems. The mechanisms through which school-based clinics participate in Medicaid managed care initiatives vary widely among the states; they also differ between capitated managed care systems and primary care case management programs. This section presents the results of HSR's interviews with states regarding their arrangements for the inclusion of school-based clinics in capitated systems; the following sections discuss the participation of school clinics in PCCM plans and commercial managed care organizations, and

then go on to discuss confidentiality provisions and the administrative mechanisms necessary for implementing these arrangements.

The states with arrangements for including school-based clinics in capitated Medicaid managed care systems can be divided into two broad groups: those that include school-based clinics in specific managed care networks, either independently or through a parent agency, and those in which clinics contract independently with one or more managed care plans. Table 4 presents the states that have chosen each of these mechanisms, and the discussion that follows describes each state's approach in more detail.

Table 4.
Contracting Options in Capitated Systems

Option	*States Choosing Option*
SBCs as Network Providers	**4**: CA, OR, VT, WA
SBCs Contract Independently with Plans	**6**: AZ, CT, MA, MN, RI, TN

1. SBCs as Network Providers

Under this option, school-based clinics may join with other providers (often, but not always, other public-sector providers) to form a managed care plan. Clinics could then either serve as primary care providers within the plan and receive a capitation rate for serving students who choose the clinic as their primary care provider, or could be paid on a fee-for-service basis by the plan for serving the plan's enrollees regardless of their primary care provider. Separate arrangements would still need to be made if the clinic is to be paid for serving students enrolled in other plans.

Arrangements like this are in place or are being planned in four states: California, Oregon, Vermont, and Washington. These four states' arrangements are described below.

- California. Under the pilot managed care program currently being implemented, school-based clinics may be included in the Local Initiative networks being created in each of the pilot counties. These networks are required to include all "providers of last resort" (such as county hospitals) and are encouraged to

contract with all traditional public-sector providers, such as Community Health Centers, as well. As these networks will not be fully implemented until December 1995, it is as yet unclear how many Local Initiative networks will include school-based clinics.

- Oregon. The ten school-based clinics in Multnomah County are run by the county health department. A consortium of public-sector providers, including several federally-funded Community Health Centers, the Oregon Health Sciences University in Portland, and the local health department's clinics, make up the provider network of CareOregon, one of several managed care plans available to Medicaid enrollees in the county. If a student enrolls in CareOregon and chooses the school clinic as his or her primary care provider, the clinic is paid a capitated rate to cover the child's care; if the clinic is not the primary care provider but the student is enrolled in CareOregon, the clinic may bill the plan on a fee-for-service basis. The clinics are beginning to negotiate with other plans for fee-for-service reimbursement for services provided to their enrollees, but at present the clinics simply provide services to these students without reimbursement.

- Vermont. As mentioned above, no school-based clinics have yet been established in Vermont, although one will be in operation in October 1995. However, plans are being made for the inclusion of the clinics, when they are implemented, in managed care plans. Since most Medicaid services in Vermont are currently provided by private-sector providers, state officials assume that managed care networks will be made up primarily of private physicians and hospitals and that these networks will include school-based clinics as well. It is expected that the clinics will not serve as primary care providers for students who choose them and will coordinate their services with the students' primary care providers of students.

- Washington. All of the State of Washington's school-based clinics are located in Seattle/King County, and each is operated by a local agency such as a Community Health Center or a hospital. Through their sponsoring agencies, all of the clinics are in at least one of the eight managed care networks available in the county. If a student chooses the clinic's nurse practitioner as his or her primary care provider, the clinic will be paid by its parent agency (it is unclear to local officials on what basis the clinic is paid). Otherwise, the clinics are not paid by managed care plans at all. The clinics are beginning to negotiate with the plans to receive fee-for-service reimbursement for services they provide to students who are enrolled with other primary care providers or with other plans.

Under the arrangements described above, school-based clinics often serve as students' primary care providers. In these cases, states may need to alter their requirements for primary care providers (such as full-time, full-year access or physician coverage rules) in order to allow these

clinics to qualify. However, no such changes were required in Oregon or Washington to allow school-based clinics to function as primary care providers, as the clinics were included in networks that met these requirements through their other providers. (In the case of Washington, the clinics' parent agencies met the requirements.) In Vermont, the relevant rules have not yet been written, and in California, it is not yet clear whether or how school-based clinics might be included in managed care networks.

Although the enrollment of school-based clinics as primary care providers presents clinics with the advantage of a guaranteed source of income (in the form of capitated payments on behalf of those Medicaid eligibles who choose the clinics as their primary care providers), this can be a perilous arrangement for clinics. First, as mentioned above, it is the parents who usually choose the family's primary provider, and they may be unlikely to consider a school-based clinic as an appropriate source of comprehensive care for their children. Second, since an entire family must usually choose the same capitated plan, the availability of school-clinic services is unlikely to be the family's main reason for choosing a managed care plan, so many families may not even have the option of choosing the clinic as their child's primary provider. Washington State officials confirm that it is rare that a child is actually enrolled with the clinics for primary care. Second, as is also evident from the Washington State example, qualifying as a primary care provider should not replace the negotiation of payment arrangements when the clinic serves children who are enrolled with other primary care providers or other plans.

2. SBCs Contract Independently with Plans

If school-based clinics are not explicitly included in managed care networks, they may still be paid for the services they provide to managed care enrollees through contracts negotiated directly with managed care plans. This is happening to some extent in six states: Arizona, Connecticut, Massachusetts, Minnesota, Rhode Island, and Tennessee. Under these arrangements, school-based clinics are not likely to serve as primary care providers; rather, they more often serve as occasional, reimbursable providers of services for adolescents. The arrangements in place in these states are described below.

- Arizona. Only one of the state's 40 school-based clinics is an "authorized provider" under the Arizona Health Care and Cost Containment System (AHCCCS), the state's managed care Medicaid system that has been in place since 1982. As a qualified primary care provider, this clinic subcontracts with three Medicaid managed care plans in the area as well as two commercial plans. If a child is enrolled in one of these plans, he or she may choose the clinic as a primary care provider and the clinic will be paid a capitated rate. In this case, as the clinic is located in a rural area, it is not uncommon for the family to choose the clinic as a primary care provider both because the clinic serves all family members and because there are few other providers in the area. State officials hope that more school-based and school-linked clinics will be able to qualify as AHCCCS providers under a tobacco-tax funded grant that will help clinics to expand their capacity to become full-time, full-year providers as required by AHCCCS.

- Connecticut. As discussed above, managed care plans participating in Medicaid are required to contract with school-based clinics in their catchment areas. These contracts are quite new and in some cases are still being negotiated, so it is not yet clear whether school-based clinics will serve as primary care providers. In many cases the clinics will not act as primary care providers; rather, all students in the managed care plans will be able to use the clinics regardless of which primary care provider they or their parents choose. In some cases, however, the clinics may serve as primary care providers with their parent organizations as back-up providers. The services for which school clinics will be paid appear to vary among plans but, in general, clinics are refusing to sign contracts that offer reimbursement for only a single service such as physical exams or immunizations. Clinics are also accepting a variety of payment mechanisms, with some being paid on a fee-for-service basis and others receiving a portion of the plans' capitation rate in the form of a sub-capitation. Finally, several plans initially attempted to require pre-authorization for all services provided at the school-based health centers, but the centers have resisted signing contracts with strict pre-authorization requirements. Since plans are required to contract with school-based clinics, the clinics appear to have substantial leverage in the negotiation of these arrangements.

- Massachusetts. As discussed above, all HMOs participating in Medicaid in Massachusetts are required to develop linkages with school-based clinics. The first plan to actually contract with school clinics for services under this requirement was an HMO developed by a Community Health Center; the plan is allocating funds from its administrative budget to pay clinics on a fee-for-service basis for services provided to the plan's enrollees. After the plan has developed some familiarity with utilization rates in the clinic, it hopes to set a capitation rate for the school-based clinic. Since this model was developed, several other plans have begun to develop contracts with school-based clinics in their areas, some specifying that the plan will only be reimbursed for a limited range of services provided to the plan's enrollees.

- Minnesota. All of the school-based clinics in Minneapolis and St. Paul have contracts with some or all of the managed care plans serving Medicaid enrollees in the Twin Cities. Under these contracts, students need not choose the school-based clinics as their primary care providers; rather, the clinics provide primary, preventive and acute care to any student enrolled in any of the plans and bill the plans on a fee-for-service basis. The clinics receive payment for any services covered under the Medicaid benefit package. Clinic administrators hope to develop a capitation rate for school-based clinics once utilization rates under these contracts have been established.

- Rhode Island. One of the state's three school-based clinics has contracts with two of the five managed care plans participating in the state's Medicaid managed care initiative, and two additional plans have indicated that they are willing to negotiate with the clinic. Under these contracts, the clinic does not serve as a primary care provider; therefore, the student does not have to choose the clinic to receive services. The clinic is paid on a fee-for-service basis by the plans for services provided to enrolled students.

- Tennessee. For the most part, school-based clinics which are not linked to local health departments do not bill TennCare. However, three clinics, all satellites of local health departments, have contracts through their parent agencies to serve all TennCare enrollees in their areas. Under these contracts, students who choose the local health department as their primary care provider can receive family planning, immunizations, and testing and treatment for sexually transmitted diseases from the school clinic, which is then paid by the managed care plan. If the student has another primary care provider, the school clinic is expected to find out who the primary provider is and set up an appointment for the student with that agency. Often, however, the clinics will simply provide the services and absorb their cost.

In two additional states, California and Maryland, school-based clinics have made arrangements to receive reimbursement from managed care plans, but not through formal contracts. In California, as mentioned earlier, plans will be required to coordinate with school-based clinics for the provision of CHDP services. In addition, all managed care plans will be required to reimburse school-based clinics for family planning and STD testing and treatment provided to the plans' enrollees, regardless of the contracts or other arrangements in place between the clinic and the managed care plan. In Maryland, the ten school-based clinics run by the Baltimore City Health Department have an "agreement" with one of the four Medicaid HMOs in the state that allows the clinics to receive authorization from the plan to perform EPSDT screens and provide immediate acute-care services for their enrollees; with authorization to

perform a particular service for a particular enrollee at a particular time, the clinics are then able to bill the plan. Unfortunately, since this authorization can be difficult to receive, the clinics often provide services and absorb their cost. The health department is currently attempting to negotiate similar agreements with other plans but has not yet been successful.

During HSR's interviews, states rarely reported that school-based clinics refuse to provide services to students enrolled in managed care plans with which they do not have contracts or other reimbursement arrangements. In nearly all cases, state and local officials reported that clinics provide services and absorb their cost, as they do not want to communicate to students that access to care at the clinic is limited. Moreover, officials felt that school districts might cease to support clinics if their services were not available to all students in the school. Therefore, although clinics' arrangements with plans sometimes require that the clinics receive authorization from the plans before providing services or refer students to the plan for services, clinics often do not comply with these requirements.

C. Coordination with PCCM Programs

Five of the states interviewed—Maryland, Massachusetts, New Mexico, Oregon, and Tennessee—offer or plan to offer a PCCM option to their Medicaid managed care enrollees. In New Mexico, the managed care plan is still in its developmental stage, so no arrangements with school-based clinics have yet been planned or implemented. In Oregon, the PCCM option is available only in regions where capitated plans are not available; in these areas, school-based clinics have not begun to participate in Medicaid managed care. Arrangements for school-based clinics' participation in PCCM programs in the remaining three states are described below.

- The Maryland Access to Care (MAC) program allows school-based clinics to participate as primary care case managers. To do so, they are required to have 24-hour call access and to offer services year-round. Ten of Baltimore's 17 school-based clinics are run by the Baltimore City Health Department, which maintains a 24-hour call line. In addition, all health department-run school-based clinics are open at least two days a week during the summer, so the individual clinics did not have to make any special arrangements to serve as full-time, full-year primary care providers.

If students have another primary care provider, the clinics are technically expected to receive permission from that provider to provide services. However, a provision of the Medicaid regulations allows local health departments to bill Medicaid directly for all services provided to Medicaid eligibles not enrolled in an HMO; therefore, since Baltimore's clinics are run by the local health department, they may simply provide services and bill Medicaid directly. (The only exception to this rule is that health departments may only be reimbursed for EPSDT screens if they are the child's primary care provider of record.) If a student has actually seen his or her primary care provider, the clinics will notify that provider of any services provided at the clinic and may refer the student to the primary care provider for follow-up, but students often do not have a history with their primary care providers.

- In Massachusetts, school clinics are run by community agencies such as Community Health Centers and hospitals. The clinics may serve as primary care case managers through their parent agencies; the enrollee (or parent) chooses the parent agency as the primary care provider and the clinic bills Medicaid under the parent agency's provider number. Because the parent agencies meet the state's criteria for primary care providers, no regulations had to be altered to allow the clinics to participate.

  If a student has a primary care case manager outside of the community agencies, clinics must call the provider to receive authorization to provide services and bill Medicaid. One primary care practice, however, has given the school clinics in its area blanket authorization to provide and bill for urgent care. Others have provided clinics with a list of their enrollees and instructions for requesting authorization. Often, however, the clinics simply provide the services and request authorization afterwards, as they do not want to give students the impression that access to care at the school clinics is restricted.

- Tennessee. As mentioned above, the TennCare program includes a PCCM option through Blue Cross/Blue Shield (BCBS); however, this option will be phased out in 1996 and BCBS will begin to accept capitated payments. School-based clinics who are authorized BCBS providers are permitted to provide services to BCBS enrollees without permission from the student's primary care provider; they are then reimbursed by BCBS.

D. Coordination with Commercial HMOs

Few states reported that school-based clinics were developing contracts with private managed care organizations. In several states, clinics had not traditionally billed third-party payers at all and had only recently begun billing Medicaid; in others, officials reported that clinics sent bills

to private third-party indemnity insurers when possible but not to HMOs. (In Oregon, local officials reported that the clinics were able to bill private insurers, including managed care plans, but since these plans would not agree to withhold information about sensitive services provided to students from their parents, the clinics have declined to bill in the interest of maintaining client confidentiality.) In Minnesota, where both school-based clinics and HMOs are particularly well established, school-based clinics in Ramsey County have had a contract to be reimbursed on a fee-for-service basis by one private HMO since 1991 (Zimmerman and Rief, 1995), and those in Hennepin County bill commercial plans under an informal arrangement when students can show their insurance cards. In Massachusetts, state officials expressed the hope that any contracts developed between school-based clinics and managed care plans participating in Medicaid would apply to plans' commercial enrollees as well. Similarly, Connecticut officials hope that the relationships established between clinics and plans under the Medicaid managed care initiative will serve as models for coordination with the private HMOs; strategies for encouraging private HMOs to contract with school-based clinics will be developed and implemented as part of the state's Robert Wood Johnson Foundation "Making The Grade" grant project.

E. Confidentiality

In all of the systems described in the preceding sections, a balance must be struck between adolescents' need for confidentiality and plans' and providers' need to coordinate and manage the services that adolescents use. In addition, when school-based clinics contract with managed care plans and are paid on a fee-for-service basis, some information must necessarily be exchanged so that the clinics can be paid by the plans. However, part of the appeal of school-based clinics to adolescents is their distinctness from systems of care that serve their parents and the assurance that the services they receive there will be kept confidential. Care must therefore be taken not to compromise these strengths in the pursuit of reimbursement mechanisms under Medicaid managed care.

The issue of the exchange of confidential medical information between school-based health centers and managed care plans is legally complex, and the implications of contracts between

clinics and plans for the confidentiality of services are not fully understood. Under federal law, services provided under the Maternal and Child Health Block Grant must remain confidential unless their disclosure is required by other applicable laws (English and Tereszkiewicz, 1988). If a clinic is reimbursed for services by a managed care plan, however, this protection may be lost if the clinic must provide medical information to the plan in order to be reimbursed. As is discussed below, state law in many states further protects records of "sensitive services" provided to adolescents from disclosure without the patient's consent; however, records of services that are not included in this designation may be available to parents if they are shared with the plan in which a student is enrolled.

In six states (Maryland, Massachusetts, Oregon, Rhode Island, Tennessee, and Washington), some medical record information is shared between clinics and plans. However, in each of these states, some provision is made to protect records of sensitive services (often including family planning, mental health and substance abuse services, pregnancy-related services, and/or STD testing and treatment) from access by parents. These provisions include the suppression of notification forms, often called Explanations of Benefits (EOBs), that are generally sent to an enrollee's family after services are provided in a capitated plan. Sensitive services may also be excluded from the medical record kept by the managed care plan, or may be included in the medical record but not released to parents without the adolescent's permission.

In two of the 13 states interviewed—Minnesota and Arizona—medical information is not routinely shared between managed care plans and school-based health centers. In Minnesota, plans have agreed to keep billing information separate from medical records; therefore, although plans receive bills for services provided at school-based clinics, no information about clinic services is in the medical record unless a referral to specialty care is required. In Arizona, the one clinic that is an AHCCCS provider is paid on a capitated basis, so it does not submit bills or other information to the plan.

Finally, in the remaining five states (California, Connecticut, New Mexico, Wisconsin and Vermont), plans for coordination between school-based clinics and managed care plans are in their infancy, and confidentiality provisions have not yet been developed.

F. Administrative Arrangements

A final issue to be considered in the development of arrangements between school clinics and managed care plan is the administrative infrastructure necessary to make the arrangement work. Not only must a clinic have the ability to generate bills for services, a mechanism must be in place to determine the Medicaid enrollment status of clients and to identify their plans or primary care providers. Several such arrangements exist, such as those described below:

- In Tennessee, a central TennCare enrollment database is shared with the local health department (and thus with its clinics) so clinic staff can look up each student's information.

- In Massachusetts, students' insurance status and managed care plan are reported on the clinic enrollment form their parents fill out at the start of each school year; however, families' eligibility status often fluctuates and students may change plans. Therefore, all school clinics have access, through their parent agencies, to the state's Recipient Eligibility Verification system, which provides information on a client's current Medicaid eligibility and choice of plan based on the client's Medicaid number. If the Medicaid number is not available, clinic staff may receive eligibility and plan enrollment information by phone based on the client's name.

If a mechanism is not in place to provide school-based clinics with students' enrollment information, clinics will have to depend on their clients to know their plan or their provider and possibly even to carry a Medicaid card. Since adolescents cannot necessarily be relied on to have this information, an alternative arrangement, such as a shared enrollment database, is preferable.

CHAPTER IV

State Efforts to Facilitate Coordination

In many states, adolescent health coordinators within state MCH agencies or other state officials have been actively engaged in facilitating the development of arrangements between school health centers and managed care plans. These efforts have taken two major forms: technical assistance and the facilitation of meetings or working groups, and data collection and evaluation. States' efforts in these two areas are described below.

A. Technical Assistance and Facilitation

Officials in several states reported that they have tried to encourage coordination between school-based health centers and managed care plans by facilitating meetings and providing direct assistance to clinics in the process of negotiating contracts with managed care plans. In 11 of the 13 states interviewed by HSR, the state MCH agency has taken an active role in facilitating these arrangements. (Washington State reported that these arrangements were seen as a local issue and the state health department chose not to be closely involved, and Maryland reported little state-level involvement.) Often, state involvement has included the development and staffing of work groups or task forces that bring together representatives of clinics, managed care plans, and professional associations. Some examples of these efforts are presented below.

- In Connecticut, the MCH agency established a statewide advisory council that included universities, professional associations, and community groups; together with the Steering Committee for the state's Robert Wood Johnson Foundation "Making The Grade" grant project, this council worked hard to persuade Medicaid to include language in managed care contracts requiring contracts with clinics. Further, the council worked with an attorney and other experts in the managed care field to educate school-based clinic administrators about managed care plans' language, priorities, and needs. Sample contract language was developed to assist the clinics in the contracting process.

- In Massachusetts, the Department of Public Health has facilitated meetings between school-based clinics and managed care plans, and has held technical assistance workshops around the state for clinics on topics such as confidentiality, EPSDT standards, and Medicaid approval requirements.

- In Oregon, the state medical society and AAP chapter passed resolutions supporting school-based clinics; the medical director of Blue Cross/Blue Shield in the state was prominent in these organizations. The presence of such an

effective champion was described as crucial to the positive reception of clinics by managed care plans.

B. Data Collection and Evaluation

Another way that state officials can support the development of arrangements between school-based clinics and managed care organizations is in the collection and analysis of data that demonstrate that school clinics provide effective and cost-effective services to the Medicaid-eligible adolescent population. However, outcome and cost-effectiveness data are rarely available. Instead, states that have effective mechanisms for data collection have been somewhat more likely to focus on the provision of utilization data to demonstrate that school clinics provide needed services to adolescents enrolled in Medicaid or in Medicaid managed care plans.

Few states reported that they had succeeded in assembling data to demonstrate the value of school-based clinic services to managed care plans. Two states (Rhode Island and Massachusetts) explained that, at the time that arrangements with managed care plans were being negotiated, data systems were not available to collect data on school clinic utilization. Of those states that do have the capacity to collect data, two (Connecticut and Tennessee) were able to present data to support clinics in their negotiations with plans by demonstrating the types of services that school clinics, or the local health departments that run school clinics, were already providing to Medicaid-eligible children. The types of information gathered included:

- The number of Medicaid-enrolled children served by school clinics (or by local health departments who administer clinics);
- The number of clinic users who may be eligible for Medicaid but were not enrolled;
- Rates of utilization of school clinic services; and
- In Tennessee, increased immunization rates among children who use local health departments (who run the school clinics).

Other states, including Massachusetts, New Mexico and California, are beginning to collect this type of information now. In Maryland, clinic utilization data have not been systematically collected, but a rich source of data does exist in Medicaid billing records; school clinics have continued to submit bills for all services provided to Medicaid-eligible children, even after the implementation of managed care. According to local health department staff, 60 percent of school clinics' Medicaid bills are rejected because the clients served are enrolled in HMOs. Therefore, the local health department could assemble data to show that their clinics are providing services that are covered under HMOs' capitation payments and thus could argue to receive reimbursement for their services from that capitation payment.

Few states have made a systematic effort to evaluate the effectiveness or cost-effectiveness of services provided in school-based clinics. In Oregon, a recent evaluation of three school-based health centers showed no improvement in health risk behaviors in two of the three clinics, but did show decreases in both substance use and sexual activity and improvements in reproductive health attitudes and behavior among students who used the third clinic. The investigators concluded that the benefits of school-based clinics to adolescents were not easily measurable and that attempts to attribute specific health outcomes to particular school-based interventions should be made with a clear understanding of the methodologic challenges involved (Stout and White 1995, forthcoming).

Although many clinic administrators and state officials would like to be able to show that the use of school-based clinics results in improved health outcomes or reduced health care costs for adolescents, these evaluations are quite complex; it is not easy to attribute improved health outcomes or reduced use of expensive services to the use of school-based clinics. Such a study would require the ability to link utilization records from school clinics to those of hospital emergency rooms as well as other primary care providers used by the same adolescents. Until more complete administrative coordination between school clinics and managed care networks is achieved, these data sets are unlikely to be available. Under the new contracts between school-based clinics and managed care organizations, however, the Minnesota Medicaid program is planning to begin a study of the outcomes of care provided in various settings.

CHAPTER V

Conclusions and Lessons Learned

In response to the challenges presented by the enrollment of adolescents in Medicaid managed care programs, many of the states interviewed by HSR for this study have begun to develop productive relationships between school-based clinics and managed care plans. These states were able to report on both the barriers they faced and the advice they would give to states as they worked to develop similar arrangements. A summary of the findings of HSR's study and the overall impressions of the state officials interviewed is presented below.

- In certain critical policy areas, the way in which a state designs its Medicaid managed care system may affect adolescents' access to school-based services. For example, making a PCCM option available to families may allow an adolescent to access these services more easily. Furthermore, allowing different family members to choose different primary care providers within capitated plans can also help to preserve adolescents' access to services. The exclusion of certain adolescent health services, such as family planning or STD testing and treatment, from managed care programs can also help to assure their availability through school-based clinics.

- Including language in either its waiver or its contracts with managed care plans that requires or encourages managed care plans to coordinate with school-based clinics can help a state to stimulate system integration. Nine of the 13 states studied by HSR have developed such language. The most common type of provision is that which requires plans to establish some form of coordination with school-based clinics, but does not prescribe any particular arrangement. Since relationships between plans and clinics are quite new and are still evolving, it is still too early to tell which types of contract or waiver language are most effective in ensuring that workable arrangements are developed.

- The development of reimbursement mechanisms for school-based health centers is often more complex in capitated managed care systems than in PCCM systems, as PCCM programs allow clinics to continue to bill Medicaid on a fee-for-service basis. However, it is possible for school-based clinics to coordinate with capitated plans either by becoming part of a single managed care network

or by negotiating independent subcontracts with a number of plans. Again, it is too soon to tell which is a more effective strategy; however, the inclusion of a school-based clinic in one network is not a complete solution, as the clinic will have to negotiate subcontracts with other plans as well in order to be reimbursed for serving their enrollees. Once a reimbursement system has been established, it may actually be simpler to implement such a system in an HMO environment than in a PCCM system; clinics may find it more straightforward to work with a single administrative entity than to coordinate with and submit bills to a number of separate primary care providers.

- The major barrier to effective coordination between school-based clinics and managed care plans reported by states was plans' lack of appreciation for the need to provide adolescent services in settings where teens feel comfortable. To address this barrier, officials from several states believed that extensive education efforts to raise plans' awareness of adolescent health issues were needed. States that have succeeded in establishing school-based clinics, such as Minnesota and Oregon, reported that plans already shared the clinics' mission of increasing adolescents' access to care and were relatively receptive to the negotiation of contracts. In contrast, states in which clinics are new, such as Washington, have found it more difficult to convince plans of their value.

- In several of the states included in this study, school-based clinics were operated by local health departments, community health centers, or hospitals. In these cases, coordination with managed care plans was often more successful, as these parent agencies were often included in managed care networks or were able to negotiate subcontracts with plans. In Tennessee, for example, only the clinics operated by local health departments are currently involved in TennCare.

- A history of billing Medicaid on a fee-for-service basis is crucial both to clinics' ability to demonstrate that they are important providers of services to Medicaid-eligible children and to their ability to convince plans that reimbursing clinics from their capitation payments is an equitable measure. In Minnesota, for example, the Medicaid agency did not require that plans pay for services in school clinics that had not previously billed Medicaid. In addition, if clinics are operated by community agencies, it is important that they retain their own Medicaid billing numbers; in Massachusetts, the clinics found that they could not show how many Medicaid enrollees used their services, as they had traditionally billed under their parent agencies' numbers.

- In addition to arguments based on equity, clinics can offer plans the ability to reach adolescents and to help them meet Medicaid's quality standards. If clinics can demonstrate that they can help plans increase the rates at which they provide EPSDT screens to enrolled adolescents, increase immunization rates, or meet standards for preventive services to adolescents, they will be able to offer a direct benefit to managed care plans.

- States' provisions for maintaining adolescents' confidentiality under contracts between school-based clinics and managed care plans generally focus on protecting records of "sensitive services" provided at the clinics. The larger issue of ownership of medical records and the reconciliation of federal and state laws protecting clients' confidentiality has not yet been resolved. The way in which this issue is addressed will have important implications for the future of adolescent health services in a managed care environment.

- Officials from nearly all states emphasized the key role that MCH officials can play in facilitating the development of workable arrangements between school-based health centers and managed care organizations. By beginning conversations with managed care organizations early and bringing all parties, including plans, clinics, and the Medicaid agency, together to discuss these issues, MCH programs can help to ensure that the unique needs of adolescents are considered during the development of Medicaid managed care systems. In addition, it was mentioned that the clinics be seen not as outside entities but as part of a comprehensive system of adolescent health care.

Finally, it is important to recognize that, in nearly all states studied, formal contracts between school-based clinics and managed care plans are new and evolving arrangements. No evaluations have yet been conducted to measure the success of these models, and, therefore, it is too early to report on what works. However, the development of various models of coordination in a variety of health care environments, when approached with an understanding of adolescents' particular needs, presents an opportunity both to further study the effects of various health care delivery and financing arrangements on teens' use of services and to create effective, comprehensive systems of care for adolescents.

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