CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE

Putting Health Care Where Kids Are

School-Based Health Centers
Maximizing Third-Party Reimbursement

School-based health centers (SBHCs) have grown across California, from a handful in the late 1980s to 293 in 2022. Despite this growth, sustainable funding remains a challenge. SBHCs currently obtain a patchwork of funding from: local, state, and federal sources; in-kind support from schools and lead agencies; private donations; and insurance payments.

SBHCs run by community clinics, hospitals, and other licensed health care providers can bill and be reimbursed by public and private health insurance programs for many of the services they provide. This can help support and expand SBHC operations, ensuring that scarce education funding need not be used to underwrite most costs.

In California, many SBHCs rely on "third-party reimbursement," meaning a health insurance plan or other program or entity that pays for services, rather than the person directly receiving the services. The primary source(s) of third-party reimbursement depend heavily on the type of health care provider/ lead agency and service providers involved.

Overview of Reimbursement Programs and Options

Reimbursement options depend on the services provided, lead agency, and student eligibility. The table below outlines, in general, which types of lead agencies can participate in which kinds of third-party reimbursement.

Program	Community Health Centers	Hospitals	Public Health Departments	School Districts	Mental Health CBOs
Medi-Cal Managed Care	√	√	Rarely		
Minor Consent Medi-Cal	√	√	Depends		√
Medi-Cal Specialty Mental Health Services	√ In some cases	√ In some cases		√ In some cases	√
Denti-Cal	√	√			

Program	Community Health Centers	Hospitals	Public Health Departments	School Districts	Mental Health CBOs
LEA Medi-Cal Billing Option (LEA BOP)				√	
School-Based Medi-Cal Administrative Activities			[1]	√ LEA MAA	
Presumptive Eligibility Medi-Cal for Pregnant Women (PE4PW)	√	√	√		
Family PACT	√	√	√		
Child Health and Disability Prevention Program (CHDP)	√ Comprehensive Care Providers	√ Comprehensive Care Providers	√ Depends on health department	√ Health Assessment Only Providers	
Private Insurance	√	√	Rarely		Rarely

Medi-Cal

Medi-Cal is the bread and butter for many SBHCs - the primary source of health insurance coverage and therefore reimbursement for SBHC services. Medi-Cal is California's Medicaid health insurance program. Using a combination of federal and state funding, it covers a variety of medical services for children and adults with limited income and resources. **About half of children in California are covered by Medi-Cal.**

[1] Local Governmental Agencies (LGAs) also have access to Medi-Cal Administrative Activities (MAA) that could hypothetically be used in an SBHC setting, but CSHA is not aware of any California SBHCs leveraging LGA MAA reimbursement.

There are many different Medi-Cal aid codes depending on the individual's eligibility and program. Most low-income children and youth qualify for "full-scope" Medi-Cal with a comprehensive benefits package that includes physical health, mental health, dental and vision services.

The California Department of Health Care Services (DHCS) administers the Medi-Cal program, and determines program eligibility, benefits, provider payment and beneficiary cost-sharing levels. DHCS works closely with the federal Centers for Medicare and Medicaid Services (CMS), which provides regulatory oversight, and each of California's 58 counties also plays a key role in implementing the Medi-Cal program. Counties are responsible for conducting eligibility determination, enrollment and recertification within specified eligibility rules.

There are several ways to apply for Medi-Cal including by phone, in person at a local county social services office, at hospitals and clinics where county eligibility workers are located, and/or with assistance from Certified Application Assistants (CAAs) working in community organizations. Some of the Medi-Cal programs described below have simplified, expedited and/or presumptive eligibility processes that are well suited for SBHC settings.

Medi-Cal providers must be licensed and accredited according to the specific laws and regulations that apply to their service type. Application criteria include having an established place of business and proof of liability insurance coverage and professional liability insurance coverage. Providers must complete an application packet specific to their provider type. Provider application packages are available at http://files.medi-cal.ca.gov/pubsdoco/prov_enroll.asp.

The following are the types of Medi-Cal coverage most frequently utilized by California SBHCs.

Medi-Cal Managed Care

Most children who qualify for comprehensive, "full scope" Medi-Cal coverage through their families are enrolled in managed care plans. As of December 2021, children under age 19 qualify for Medi-Cal if the family's household income is less than 266% of the Federal Poverty Level (FPL) - about $61,260 for a family of three and $86,371 for a family of five.[2]

Managed care plans differ by county and include commercial plans like Anthem Blue Cross as well as "Local Initiatives'' such as LA Care or the Partnership HealthPlan of California. Some counties operate a single health system for their Medi- Cal population while others offer multiple managed care plans. A list of Medi-Cal managed care plans by county can be found at https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

Medi-Cal managed care plans contract for health care services through established providers and networks of care. SBHCs that want to join this network must enter contracts with the health plan(s) in their county and this includes credentialing individual medical and mental health clinicians.

[2] For more information about FPL see https://www.coveredca.com/pdfs/FPL-chart.pdf.

Primary Care: All Medi-Cal managed care beneficiaries select or are assigned to a Primary Care Provider (PCP) which can be a private physician or physician group, community health center, county health clinic, Kaiser Permanente, or other arrangement. Primary care providers are generally paid a capitated monthly amount per member per month. Although some SBHCs act as official managed care PCPs, many are not able to provide the continuity during the week or the year required to fulfill this role, even if they are the primary place that young people receive medical care. FQHCs typically act as Medi-Cal managed care PCPs for hundreds or thousands of Medi-Cal members.

Even if an SBHC is not the PCP for a given student, they may be eligible for reimbursement. They can provide episodic primary care and be reimbursed through the CHDP program (see below), fee-for-service Medi-Cal, or by the health plan directly through contractual agreement. And although it is more complicated with respect to referrals and billing, SBHCs run by FQHCs can receive their full Medi-Cal PPS reimbursement rate when they provide care to Medi-Cal beneficiaries that are assigned to other clinics or providers. (See letter from DHCS)

Note: If Kaiser Permanente is the managed care plan the student is enrolled in, providers should not expect any direct reimbursement from the plan.

Mental Health: Medi-Cal managed care plans are responsible for contracting with a network of mental health providers that can provide evaluation, testing, and outpatient non-specialty mental health services. Some of these health plans contract with an intermediary mental health plan such as Beacon Health Options to credential providers and adjudicate/pay claims. Appropriately trained and licensed mental health providers working in an SBHC may be eligible to join these networks *even if the medical providers are not part of the primary care network*.

As with primary care services, SBHCs can be reimbursed for care provided by covered providers *even if the patient is assigned to another PCP.*

More information is available in CSHA's Behavioral Health Sustainability Guide: http://www.schoolhealthcenters.org/wp-content/uploads/2021/08/CSHA-IBH-Sustainability-Guide-2021.pdf.

Minor Consent Medi-Cal

In California, individuals under 21 years old may apply for a special confidential program called Minor Consent Medi-Cal without parent or guardian consent or knowledge. The program covers family planning, sexual assault, pregnancy-related services, outpatient mental health and substance abuse services.

Minors of any age can qualify for pregnancy and pregnancy-related services, family planning services and sexual assault services. Minors ages 12 to 20 can qualify for these services as well as STD treatment, drug and alcohol abuse treatment and counseling, and outpatient mental health treatment and counseling.

To qualify for these services a minor must be unmarried and considered living in the home of a parent or guardian; foster youth and other minors under the care of public agencies are not eligible. The program allows the minor to qualify based on only the minor's income and property and NOT that of the parent or guardian; thus, most adolescents qualify. (Proof of income may be required for any income the minor has.) Clients must be California residents but do not need to be citizens, have proof of documentation or provide a Social Security number. They can be eligible even if they have full scope Medi-Cal or private insurance if other criteria are met.

Minor Consent Medi-Cal Mental Health Services

Minors are only eligible for outpatient mental health treatment and counseling through the program if a mental health professional: [1] attests that the minor is mature enough to participate intelligently in the mental health treatment or counseling AND that the minor is either: (a) In danger of causing serious physical or mental harm to themselves or others without mental health treatment or counseling; OR (b) An alleged victim of incest or child abuse. This is documented in a written statement from the mental health professional which states that the child needs mental health treatment or counseling, the estimated length of time treatment will be needed, and that the minor meets these criteria shown above.

Minor Consent Medi-Cal recipients do not have full-scope Medi-Cal benefits and instead have access to a narrow scope of services with the specific scope dependent on the aid code assigned.

Applications for Minor Consent Medi-Cal must be processed by eligibility workers working for County Social Service Agencies. Many SBHCs have relationships with these workers to help complete applications or expedite the process. Since the COVID pandemic, most counties have accepted applications and returned eligibility information via phone or email; this flexibility is expected to become permanent. In general, Minor Consent Medi-Cal eligibility is issued on a month-to-month basis with applications for ongoing coverage submitted monthly. Currently no coverage is being terminated during the COVID pandemic and the state is considering permanent changes to the coverage period (e.g., to 6 or 12 months).

For more information SBHCs should contact their local Social Services Agency or see if their local clinic consortium is able to help.

Medi-Cal Specialty Mental Health Services

In California, specialty mental health services are "carved out" of the broader Medi-Cal program, meaning that specialty mental health services for children and adults are provided through county mental health plans instead of through managed care health plans with the rest of the Medi-Cal benefits. Often county specialty mental health services for children may be referred to as "EPSDT services" but EPSDT (which stands for "Early and Periodic Screening, Diagnosis and Treatment") refers to the comprehensive health services available to children and youth enrolled in Medi-Cal, not just specialty mental health services.

"Specialty mental health services" include:

- rehabilitative mental health services (including mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services);
- psychiatric inpatient hospital services;
- targeted case management;
- psychiatric and psychologist services;
- EPSDT supplemental specialty mental health services; and
- psychiatric nursing facility services.

Medi-Cal children and youth are eligible for all medically necessary specialty mental health services if either of the following criteria are met:

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma[3]
   OR
2. The beneficiary meets both of the following requirements:
   a. The beneficiary has a significant impairment or a reasonable probability of significant deterioration or of not progressing developmentally AND
   b. The condition is a diagnosed or suspected mental health disorder or a result of significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

When a Medi-Cal beneficiary age 21 or younger meets medical necessity and these access criteria, the county mental health plan is responsible for providing, or arranging for the provision of, specialty mental health services. These services can be provided directly by county employed staff or counties may contract with community-based organizations.

[3] Per DHCS guidance, "experience of trauma" is evidenced by a high-risk score using an approved trauma-screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.

County mental health plans vary significantly in how they deliver specialty mental health services. The options available for schools and SBHCs to work with their counties to deliver specialty mental health services depends, in large part, on the county's overall system of care, priorities, and how school-based strategies align.

- School-based health centers or community providers - Many counties contract for the delivery of specialty mental health services through community providers. These providers can be community mental and behavioral health agencies, individual practitioners, healthcare providers like federally qualified health centers, and/or school-based health centers.
- School District providers – In some cases, the school district or county office of education can contract directly with the county mental health plan to become a contracted provider of specialty mental health services. However this arrangement is not common as provider qualifications and billing requirements can be significant barriers.
- County providers – In counties where the majority of specialty mental health services are provided "in house," i.e. by county-employed mental health professionals, schools can develop arrangements with the county to have permanent or periodic county-employed clinicians provide assessment and treatment services on the school campus.

Denti-Cal

An increasing number of SBHCs offer some dental prevention or treatment services onsite. Dental services are often a significant area of need in low-income communities.

All children covered by full-scope Medi-Cal (i.e., those with family incomes less than 266% of federal poverty) also have coverage for dental services. Covered benefits are comprehensive and include cleaning, exams, x-rays, sealants, fluoride varnish and restorative treatments such as fillings.

Most pediatric dental providers are already enrolled in the Denti-Cal program; if not, they can enroll through the Dental Services Division of the Department of Health Care Services: https://www.dental.dhcs.ca.gov/Dental_Providers/Medi-Cal_Dental/Provider_Enrollment_Outreach/. In Sacramento and Los Angeles Counties, some of these benefits are administered by Managed Dental Care Organizations.

For SBHCs operated by Community Health Centers and FQHCs, there is no enrollment in the Denti-Cal program. Instead, these services can be delivered and claimed using the same all-inclusive PPS rate that is used for eligible medical and behavioral health services. CHCs can also elect to include Registered Dental Hygienists in their Scope of Services by submitting a Change in Scope Request. For details see CPCA's toolkit: Increasing Access to Oral Health a Technical Assistance Guide for California Health Centers.

One final note: Children who are signed up for the temporary CHDP Gateway Program described below also have full dental coverage for the period of time they are enrolled. If there are concerns that the

family will not apply or qualify for permanent Medi-Cal benefits, this window of time can be very helpful in scheduling any needed dental prevention or care.

The California Advancing and Innovating Medi-Cal (CalAIM) went into effect on January 1, 2022 and includes additional dental benefits that are an extension of the Dental Transformation Initiative, a five-year pilot program to increase the use of preventive dental services and continuity of care for children.

CalAIM authorizes the Medi-Cal Dental Program to provide supplemental payments for select preventative services and continuity of care/establishing a dental home, as well as adds two new benefits; Caries Risk Assessment and Silver Diamine Fluoride for children and high-risk groups.

LEA Medi-Cal Billing Option (LEA BOP)

The LEA Medi-Cal Billing Option Program allows local education agencies (LEAs) to seek partial reimbursement for health and mental health assessments and services provided to Medi-Cal eligible students. Reimbursement rates vary but, generally, schools can receive up to 50% of the cost of services they provide to eligible students.

In 2014, the federal government reversed a longstanding policy that impeded the ability of school districts to be reimbursed for the school health services they provide to all Medi-Cal eligible students (called the "Free Care Rule"). Prior to this change, LEAs were limited to receiving reimbursement for health services to special education students only. In April 2020, the federal government approved a California state plan amendment allowing the state to implement the reimbursement for health services to all Medi-Cal eligible students, including general education students. To seek reimbursement through the LEA Medi-Cal Billing Option Program, LEAs must have an approved Provider Participation Agreement (PPA) with the Department of Health Care Services (DHCS).

More information about LEA BOP can be found on the Department of Health Care Services' website at https://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx.

School-Based Medi-Cal Administrative Activities

The School-Based Medi-Cal Administrative Activities program (SMAA) reimburses local education agencies (LEAs) for the federal share (50%) of certain activities such as outreach, enrollment and facilitating the Medi-Cal application process; and making referrals for enrolled students to Medi-Cal covered services.

To participate in the SMAA program, LEAs must contract with the Department of Health Care Services through their Local Educational Consortium (LEC) or Local Governmental Agency (LGA) (for example a participating county or city health department). SMAA also reimburses these entities for arranging non-emergency/non-medical transportation and program infrastructure like program planning, policy development, and SMAA claims coordination. Many school districts use this program only in relation to their LEA Billing Option Program and for administration related to special education services, but SMAA

can be used more universally to cover Medi-Cal outreach and enrollment among the student population as a whole.

More information about SMAA can be found on the DHCS website at https://www.dhcs.ca.gov/provgovpart/Pages/SMAA.aspx.

Presumptive Eligibility Medi-Cal for Pregnant Women (PE4PW)

The PE4PW program allows qualified providers to grant immediate, temporary Medi-Cal coverage to low-income, pregnant patients for prenatal care and prescription drugs for conditions related to pregnancy. The program also covers pregnancy termination.

The application process is straightforward and can be completed in a clinic setting with temporary eligibility beginning the same day. Patients can then formally apply for Medi-Cal at the County Department of Social Services or the clinic can extend the temporary Medi-Cal card for up to 2 months or more. Currently providers can utilize telephonic signatures for PE4PW applications, noting in the case file “COVID-19 protocol."

For information on the PE4PW program, please visit the state’s PE4PW Information Page.

Family PACT

The Family PACT program was implemented in 1997 under the California Department of Public Health, Office of Family Planning. Individuals who reside in California, are at risk of pregnancy or causing pregnancy, have a gross family income at or below 200% of the Federal Poverty Guideline, and have no other source of health care coverage for family planning services *or require confidentiality to receive family planning services* are eligible for the program. Because adolescents apply independently based on their own income, almost all qualify. No proof of documentation or social security number is required. Enrollment is completed at the point of service and takes only a few minutes with an immediate response from the program and eligibility good for one year.

The following services are reimbursable under the Family PACT program:

- Various birth control methods, including long-acting reversible contraceptives, emergency contraception, and sterilization
- Family planning counseling and education
- Sexually transmitted infection (STI) testing & treatment
- HIV testing
- Cervical cancer screening
- Limited fertility services

Although the program includes coverage for STI prevention, diagnosis and treatment, the primary diagnosis must be related to family planning or pregnancy prevention. **Family PACT does NOT cover prenatal care or abortion services for pregnant clients.**

All Family PACT reimbursement is on a fee-for-service basis and rates are generally lower than most FQHCs' PPS Medi-Cal rates. At the same time, Family PACT reimburses providers for some services that other payers do not, including family planning education and counseling provided by a Registered Nurse or non-licensed health care provider.[4] Because these types of encounters add complementary value to adolescent clinical services, SBHCs often utilize unlicensed health educators to provide more ample counseling sessions before and after clinical visits. Another covered benefit that some SBHCs utilize is an orientation to sexual and reproductive health services which can be provided in a group setting.

Immediate on-site enrollment is one key advantage of the Family PACT program. The enrollee must fill out a Client Eligibility Certification form, which includes his/her name, date of birth, self-declared income, demographic info, and phone number. The enrollee then receives a green plastic HAP (Health Access Program) card from the provider, which is good for one year. Enrollment forms are available online at: http://www.familypact.org/en/Providers/

To become a Family PACT provider, entities must:

- be a Medi-Cal provider in good standing
- attend a provider orientation and update session
- follow program policies, standards and administrative procedures
- directly or by referral provide a scope of Comprehensive Family Planning services consistent with Family PACT standards

For more information about benefits package, procedures, forms, or to apply to become a provider, please refer to https://familypact.org/.

Child Health and Disability Prevention (CHDP)

CHDP is a health promotion and disease prevention program through which eligible children and youth receive preventive health assessments and can be referred for diagnosis and treatment. The CHDP program is operated at the local level by city and county health departments[5] who are responsible for provider enrollment, quality assurance and case management as needed, although most of these roles have now been transferred to Medi-Cal managed care plans as more and more low-income children have become eligible for Medi-Cal.

[4] Although these positions must be supervised by a licensed physician, nurse practitioner or physician assistant, the supervisor need not be onsite when education and counseling is provided.
[5] Only 3 cities in California have their own health departments: Berkeley, Long Beach and Pasadena.

CHDP covers all low-income children/youth under age 19 with family incomes up to 200 percent of the federal income guidelines and without preventive health care coverage, regardless of immigration status. Through a process called CHDP Gateway, eligible children whose parent or guardian complete a simple application are immediately and temporarily enrolled into full scope, no-cost temporary Medi-Cal for the month of their CHDP health assessment and the following month. Most of these children will then be offered enrollment into full-scope Medi-Cal coverage.

The CHDP program provides comprehensive health assessments, physical exams, laboratory testing, health screening, immunizations, health education and referrals for the early detection and prevention of disease and disabilities. These health assessments include health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, and health education/anticipatory guidance. Health assessments must follow the following periodicity schedule:
https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx

Eligible CHDP providers include Pediatricians, Family Practitioners, and Internists (for youth 14 years of age and older) or Independent Certified Family or Pediatric Nurse Practitioners, and clinics/agencies employing the preceding types of professionals, including Outpatient Clinic, Rural Health Clinic, Community Health Clinic, Indian Health Clinic, and Schools. Some providers are comprehensive care providers with 24 hour year-round coverage for follow-up care and management, while others are considered health assessment only providers.

To participate in the program, SBHCs must possess an active Medi-Cal provider number; enroll in the local CHDP program; meet licensure requirements; and employ clinicians that meet the conditions of participation. Health care providers complete a separate application for each location. Approval includes an on-site facility inspection and medical record review by the local CHDP office. The facility review is conducted to ensure site access and safety conditions are met (e.g., appropriate emergency medical equipment and supplies; laboratory compliance; and proper immunization storage.) This last component is often combined with a site visit from the Vaccines for Children program.[6] The provider will then be assigned a provider number to use when billing the CHDP program. The CHDP provider application form, DHS 4490, and instructions can be found at:
http://www.dhcs.ca.gov/formsandpubs/forms/Forms/ChildMedSvcForms/dhcs4490.pdf

Billing and reimbursement depend on the type of provider entity, age of child, complexity of visit and whether the patient is new or established.

CHDP Gateway Program

In 2003 California created the "CHDP Gateway," an automated pre-enrollment process for uninsured children to gain access to Medi-Cal through periodic well-child exams and vaccinations.

[6] The Vaccines for Children (VFC) Program helps provide free vaccines to health providers who serve low-income children and youth. A child is eligible for the VFC Program if they are younger than 19 years of age and is uninsured, underinsured, Medi-Cal eligible, American Indian or Alaska Native.

The same eligibility applies as shown above; children already enrolled in full scope Medi-Cal are not eligible for the Gateway. The application process is simple, does not require income verification, and can be completed online by SBHC staff with no County worker involved. SBHCs can use the CHDP Gateway program to enroll students into temporary full-scope Medi-Cal effective that day through the next calendar month. Then a joint Medi-Cal/Covered California application is sent to the family home and a parent/guardian can continue the child's Medi-Cal coverage by completing it.

For more information or to become a CHDP provider, contact your local CHDP program office: http://www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx

Please note that California plans to eliminate the CHDP program by July 1, 2023 in order to simplify and streamline the delivery of services to children and youth under age 21, in alignment with the goals of the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Presumptive eligibility services will continue under a new Children's Presumptive Eligibility program which will expand to include all applicable Medi-Cal providers, thereby permitting more providers to make presumptive eligibility determinations and expanding access to Medi-Cal services for more children/youth. More information can be found on the DHCS website.

Private Insurance

Most medical providers can bill and be reimbursed by some private health insurers. The majority of private payers are managed care organizations that require providers to enter contracts, including credentialing individual clinicians, in order to be considered "in network."

For most SBHCs, there will be a low volume of students with any one health insurance plan - with the exception of Kaiser Permanente. Many California students and families have commercial (not Medi-Cal) Kaiser coverage; however, Kaiser is a "closed HMO" and therefore generally will not reimburse outside providers for services rendered to their members.

In short, SBHCs should not expect private insurance to entail a sizable portion of their overall revenue; however, a well-resourced lead organization with a strong billing and contracting department may yield some additional reimbursement.

Good Practices to Maximize Third-Party Reimbursement

Many SBHCs, especially those run by community health centers, have established good strategies and systems to maximize third-party reimbursement. Below are some recommendations based on this experience.

SCREENING FOR COVERAGE

Many SBHCs collect student registration and parent/guardian consent at key times each school year, most notably at school enrollment events. This can be combined with requesting proof of immunizations, physical and/or dental visit as required by school districts. When collecting information from families, SBHCs should request the students' health insurance information, including member number and expiration date, although families are not accustomed to providing this information to schools. Having the information in advance greatly facilitates insurance claims when the student is seen for a reimbursable visit.

Some SBHCs are enrolled in portals or other systems that check Medi-Cal coverage online through their lead agency, managed care organization, clinic consortium or other entity. Some may have arrangements with the county social services department to allow easy eligibility screening. Most Electronic Health Records (EHRs) are paired with Electronic Practice Management Systems (EPMs) that verify Medi-Cal eligibility in real time assuming the patient's social security or BIC number is already in the system. Unfortunately there are very few ways to screen for Medi-Cal coverage using just patient demographics like name and date of birth, and many students do not carry their health insurance cards or even know what kind of coverage they have, so systems like these can be extremely valuable.

> One SBHC partners with its County Social Services Agency to share access to CalWIN, a statewide real-time automated system that allows staff to search for Medi-Cal information with basic patient information.

END-TO-END REVENUE CYCLE MANAGEMENT

Claiming third-party reimbursement requires adequate systems and staff time commitment. Unless an SBHC has revenue cycle support from an experienced individual or billing department, it will be difficult to maximize third-party reimbursement.

Most health care billing is now conducted electronically, with a few exceptions, and EPM systems are commonly linked to EHRs to support a streamlined process.

An effective revenue cycle includes the initial screening for coverage; provider coding appropriately for services provided within this coverage; someone with expertise reviewing this claim before submission; submitting the initial claim for services rendered; and mechanisms to track and reconcile payments, correct and re-submit claims, and manage payer denials in a timely manner. The Center for Medicare & Medicaid Services (CMS) estimates that 30% of medical claims are denied or ignored on first submission. Common reasons for denials include eligibility errors, diagnosis codes not covered, procedures not covered, gender mismatch, and providers not credentialed with insurance plans.

Although billing and capturing third-party reimbursement is complex, it is one of the most important factors in developing a sustainable SBHC. Fortunately, most community health providers have billing systems in place and can use these systems to support their SBHCs in securing reimbursement. CSHA recommends:

- Dedicated staff from the SBHC responsible for understanding and keeping current on billing practices that are relevant to their SBHCs (e.g., changes to the Family PACT program benefit package for high school SBHCs).
- Established protocols for staff that provide guidance on how to maximize third-party reimbursement, including how to identify and prioritize among the payer options.
- Printed billing matrix or "cheat sheets" to help providers code correctly. These should include a breakdown of services that are reimbursed by each payer, the diagnosis and treatment codes to use for each payer, and how frequently diagnosis and treatment codes can be used per patient.
- Regular provider meetings to review billing codes and share tips for improved coding. These meetings should also include a review of billing claim denials so providers and support staff learn from missed opportunities.
- IT support for EHR configuration and training. SBHCs often need special EHR templates for confidential services under the minor's consent, as well as additional screening for social determinants of health.

THE SBHC DOES NOT HAVE TO BE THE PCP

It is a commonly held myth that if a Medi-Cal managed care member is assigned to a different Primary Care Provider (PCP), the SBHC or its lead agency cannot see the patient or be reimbursed for their care.

In fact, there are several exceptions to that rule, especially for SBHCs operated by FQHCs. For one, Medi-Cal managed care members have the freedom to receive family planning services from any provider, and this provider must be reimbursed by the health plan even if they are "out of network."[7]

In addition, for FQHCs, the California Department of Health Care Services has confirmed that out of network visits are reimbursable at an FQHC's PPS rate. In order to obtain their PPS rate, an SBHC must:

[7] "Out of network" refers to cases where a health care provider renders services to a patient whose assigned primary care provider is not that provider.

a) Be sponsored by an FQHC.
b) Document that they reminded the patient be seen by an "in network" provider or redirect the patient back to their PCP to receive services, or ask that the patient request that the health plan change their PCP to the SBHC.

The billing staff of the SBHC or SBHC sponsor agency must:

a) Submit a claim for payment to the patient's health plan for the "out of network" services. In most cases, the SBHC will receive a denial for these services.
b) Maintain proof of the denial or payment from the health plan, which is subject to review during the billing reconciliation process.
c) Submit a Code 18, 19, or 20 for these visits.

However, if the SBHC is going to continue providing ongoing primary care to the student, it is worth trying to have the family change the official PCP. This will establish an ongoing capitation stream and also enable any outside referrals for specialty care the patient needs.

ONGOING ACTIVE OUTREACH

Of course, an SBHC cannot maximize reimbursement if it's not filling clinician schedules. Even with lower overall productivity expectations than other settings, SBHCs should be able to generate 8-15 visits per primary care clinician per day and 7-12 for behavioral health providers. But filling these schedules takes ongoing efforts to ensure that students, school staff and families are aware of the services available, especially given regular turnover in students and staff. Some good outreach strategies include:

- SBHCs can include information in school registration material and packets, whether hard copies or electronic. This information should be shared with centralized enrollment or district offices so they can direct new families toward the centers as appropriate.
- Whenever possible, parent/guardian consent and registration forms should be made available to families. They can be sent with registration packets, made available at school wide events, and posted on school/district websites. Many SBHCs are now using digital consent forms that can be linked to school announcements and emails to families, thus sharing the links and/or QR codes widely.
- Staff should attend school staff meetings to ensure all school staff and administrators understand where the SBHC is and how it works.
- SBHC staff can attend PTSA, School Site Council and other relevant meetings.
- SBHC staff should participate actively on Coordination of Service Teams or other events where student needs are identified and referrals discussed, always following appropriate HIPAA protections. See www.schoolhealthcenters.org/hipaaferpa for more information.
- Peer-to-peer outreach is essential! This can be achieved through training peer health educators, a youth advisory board, or students in Health Academies or gaining Independent Work Experience. Students can be assisted in designing and posting accurate information on social media that promotes good health and utilization of the SBHC.

- Outreach can also be included in loudspeaker announcements and student newspapers. Utilizing QR codes and digital links to promote services can allow for students to request an appointment confidentially.
- SBHCs should offer tours of the health center, especially for new students and staff. School staff champions can encourage or reward students for visiting the SBHC to learn about what it provides.

SPECIAL CLINICS

Children and adolescents require a number of health services in order to enroll in school and participate in various school activities. These represent an opportunity for SBHCs to support students and introduce their services, especially those without adequate health coverage or without a strong health home. SBHCs can partner with their schools to promote services such as the following:

- **Sports physicals:** All students, including those with a regular PCP, may benefit from receiving a comprehensive sports physical at their SBHC. It is convenient, student-centered, and thorough, and the results can be shared with the outside provider if there is a signed records release. (A reminder that if a student has private coverage such as Kaiser, you should not expect to be reimbursed.)

- **New students and newcomers:** It is often helpful to host special clinic days just for students registering at the school for the first time. During visits on these clinic days, SBHCs can enroll eligible children into the CHDP Gateway program, provide the required services (well-child physicals, immunizations, dental screenings, etc.), and schedule any required follow-up appointments.

- **School-wide screening:** Many SBHCs are offering population health services by screening an entire grade or school for things like dental caries, STIs, mental health, trauma and social determinants of health. Each of these efforts is evidence-based and offers the opportunity to identify young people in need of the services offered by the SBHC and therefore build its reimbursement base.

One Oakland SBHC holds an annual two-day event targeting every 9th grade student in the school. SBHC staff coordinate with 9th grade teachers to visit their classrooms to conduct a 30-minute presentation. Staff describe the services offered at the SBHC and ask all students to complete pre-registration paperwork, including minor consent and Family PACT enrollment forms. Students complete and return all pre-registration paperwork during this classroom visit. After the classroom visits, SBHC staff use administrative time to process all

student registration paperwork, entering new patient registration information in their practice management system, activating FPACT, and screening for student insurance eligibility. This process requires about 20 minutes per student. The SBHC then follows up with all of the students two weeks after registration. All these students are offered a brief visit with the medical provider which is a good opportunity to screen for sexual health and safety, and offer preventive health guidance. The health center can also bill for these visits.

ENGAGING NON-LICENSED PROVIDERS

SBHCs are an ideal setting to incorporate health care provider types that are skilled at screening, prevention, counseling and connecting with young people. In some cases, services provided by these staff can be reimbursed by payers. For example:

- Family PACT reimburses providers for family planning education and counseling provided by nurses or trained health educators
- Medi-Cal visits can include education and coaching provided by a variety of coaches and navigators. Hopefully through policy change, there will eventually be certification for youth peer providers as well.
- Under Medi-Cal, the total services of the care team can be included as part of a clinic visit. So even if a community health worker, behavioral health navigator or medical assistant provides much of the counseling and education, assuming a licensed clinician such as physician or nurse practitioner/physician assistant is meaningfully engaged in the visit, the visit can be claimed through their provider license, increasing the time and complexity of the coded visit.
- Medi-Cal rules have begun to include a broader range of behavioral health providers. For example, Medi-Cal specialty mental health services allow registered mental health interns to provide eligible visits, and Community Health Centers such as FQHCs are now able to bill for ASW visits immediately and for MFT visits as long as they submit a Change in Scope of Services Request (CSOSR). Further broadening of the behavioral health workforce is likely through the Children and Youth Behavioral Health Initiative now underway in California. For more information, see our BH Sustainability Guide.
- The LEA Medi-Cal Billing Option Program and School-Based Medi-Cal Administrative Activities allow services to be delivered by a wide range of clinical and non-clinical personnel.
- Denti-Cal covers visits by Registered Dental Hygienists and CHCs/FQHCs can bill for their visits if they submit a CSOSR.

About the California School-Based Health Alliance

The California School-Based Health Alliance (CSHA) is the statewide nonprofit organization helping to put more sustainable health care services in schools to improve the health and academic success of children and youth while reducing health and education disparities.

CSHA:

- **H**elps schools and communities start SBHCs
- **E**nsures high-quality SBHCs through education and training
- **A**dvocates for public policies to support SBHCs
- **R**aises the visibility of SBHCs so they are valued by the public
- **S**upports youth engagement and healthy youth development

Learn more about our work and find additional resources for school-based health on our website: https://www.schoolhealthcenters.org.

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