

**OPTIONAL PURCHASING SPECIFICATIONS:
DELIVERY OF SCHOOL-BASED HEALTH CENTER (SBHC) SERVICES
THROUGH MEDICAID OR SCHIP MANAGED CARE**

A TECHNICAL ASSISTANCE DOCUMENT

(January 2002)

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This document, Optional Purchasing Specifications: Delivery of School-Based Health Center (SBHC) Services Through Medicaid or SCHIP Managed Care, was prepared by The George Washington University Center for Health Services Research and Policy (CHSRP) in consultation with officials from the Health Resources and Services Administration (HRSA).

These sample purchasing specifications are optional, and do not necessarily reflect the views of HRSA or the Centers for Medicare and Medicaid Services (CMS, formerly Health Care Financing Administration, HCFA).

This technical assistance document should be viewed as a tool to assist interested state officials, at their option, in purchasing SBHC services from managed care organizations (MCOs) under risk contracts on behalf of children who are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). The document addresses many of the issues relating to the contract between the state Medicaid or SCHIP agency (Purchaser) and an MCO (Contractor) through which the state agency is buying services on a risk basis. While the document also addresses some of the issues relating to the subcontract between an MCO (Contractor) and a school-based health center, it is not designed to be used as a model for such subcontracts.¹ The document also does not address managed care arrangements involving

¹ For examples of a subcontract between an MCO and an SBHC, see *Agreement to Provide School-Based Health Center Services Between School-Based Health Center Contractor and Managed Care Organization* (March 6, 2001) template for use in Salud! program, SBHC/MCO Pilot Project, New Mexico Human Services Department, Medical Assistance Division; Epstein, Becker & Green, *Model Agreement*, in M. Honig, *School-Based Health Centers and Managed Care: Contracting Issues and Options* (July 2000), Center for Health Care Strategies, Inc., at Appendix B, www.chcs.org.

primary care case management (PCCM) providers, which generally do not operate under risk contracts.²

A companion piece to these purchasing specifications, *School-Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues* (forthcoming), will be available on the CHSRP website, www.gwhealthpolicy.org. This analysis reviews in some detail many of the operational issues raised by SBHC participation in managed care that cannot be fully discussed in this document. These issues include SBHC information systems capacity, SBHC clinical resources, and SBHC administrative capabilities.

SBHCs and Managed Care

There is no standard, national definition of the term "school-based health center" (SBHC). Morone and his colleagues offer the following description of the estimated 1300 centers serving 1.1 million children in 45 states and the District of Columbia: "Today's SBHCs are a far cry from yesterday's school nurse. The health centers are designed to deliver comprehensive primary, preventive, and acute care. Most are staffed by nurse practitioners, nurses, mental health care providers, and aides. Many include part-time physicians on a regular schedule; some are training sites for medical students. SBHCs often have lab facilities for routine blood tests, and some even offer dental care. Most important, providers in the SBHCs are experts in adolescent and child health care." Morone, J., et al., "Back to School: A Health Care Strategy for Youth," *Health Affairs* (January/February 2001), p. 125.

Medicaid programs in 43 of the 45 states with SBHCs allow SBHCs to bill for services provided to children. The aggregate revenues for all SBHCs totaled \$47.7 million, and of that amount, 19% came from Medicaid in the amount of almost \$9 million dollars. However, this percentage varies from state to state and from SBHC to SBHC (Morone, J., et al., "Exhibit 2: Aggregate National Funding Sources for School-based Health Centers, 1999" in "Back to School: A Health Care Strategy for Youth," *Health Affairs* (January/February 2001), p. 130).

The most recent survey by the National Academy for State Health Policy (NASHP) regarding trends in use of managed care by state Medicaid agencies found that participation by school-based clinics in risk programs as owners, sponsors, or subcontractors is increasing. In 2000, of the 42 states with risk programs, 19 reported participation by school-based clinics. Four of the 42 states reported requiring Medicaid managed care risk contractors to subcontract with school-based clinics, while 22 reported encouraging managed care plans to subcontract

² For a discussion of PCCM contracting, see Sara Rosenbaum, et al., *Negotiating the New Health System: Findings from a Nationwide Study of Medicaid Primary Care Case Management Contracts* (May 2001), forthcoming on www.gwhealthpolicy.org.

with school-based clinics. Two of the 29 states with primary care case management (PCCM) programs reported that school-based clinics may serve as PCCM providers.³

A recent report sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that "in many [SBHCs], mental health care is the most frequent service sought by students."⁴ Medicaid coverage of behavioral health services for children and adolescents is broad. Some state Medicaid programs purchase these services on a fee-for-service basis, others through managed care arrangements, which can be quite complex. These purchasing specifications do not address many of the issues relating to the purchase of behavioral health services. CHSRP has developed a separate set of purchasing specifications for children with behavioral health needs in Medicaid managed care. See Children with Behavioral Health Needs Purchasing Specifications, www.gwhealthpolicy.org.

Most SBHCs are sponsored not by schools or school districts, but by hospitals, local health departments, and community health centers. According to the most recent survey of SBHCs conducted by the National Assembly on School-Based Health Care, 31 percent of SBHCs are sponsored by hospitals, 23 percent by local health departments, and 19 percent by community health centers. Only 10 percent of SBHCs are sponsored by the school or school district in which they operate.⁵ It should be noted that these purchasing specifications make no assumption as to the type of sponsor of an SBHC. Instead, these purchasing specifications assume only that an SBHC has the ability, either directly or through a sponsor, to contract with an MCO or to obtain a provider number from a state Medicaid agency for reimbursement purposes. Whether the contract or provider number is executed through a sponsor (and if so, the nature of the sponsor's relationship with the SBHC, the MCO, and the state Medicaid agency) will reflect the circumstances particular to each SBHC.

Many schools do not sponsor SBHCs and do not have affiliations with them. However, it is common for schools to deliver specialized health and educational services to children and adolescents under Individualized Education Plans (IEPs). In many instances, these services are paid for by state Medicaid programs.⁶ These SBHC purchasing specifications do not address Medicaid payments for IEP services furnished by schools or the related matter of "administrative

³ Neva Kaye, *Medicaid Managed Care: A Guide for States*, 5th Edition (May 2001), National Academy for State Health Policy, Tables 51, 52, and 54, pp. 93-97.

⁴ Gail Robinson, et al., *School-Based Mental Health Services Under Medicaid Managed Care* (2000), DHHS Pub. No. [SMA] 003456, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), www.mentalhealth.org.

⁵ National Assembly on School-Based Health Care, *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999* (June 2000), Figure 7 (ordering information at www.nasbhc.org).

⁶ For a discussion of Medicaid coverage of IDEA services in a school setting, see CMS, *Medicaid and School Health: A Technical Assistance Guide* (August 1997), <http://www.hcfa.gov/medicaid/scbintro.htm>

claiming." ⁷ For a brief summary of these issues in the context of purchasing agreements, see the *Children with Special Health Care Needs Purchasing Specifications* (August 2000), pp. 35-36, www.gwhealthpolicy.org. For language used by state Medicaid agencies in contracts with MCOs to purchase these specialized services, see Table 4.1 of CHSRP's *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, 4th Edition, www.gwhealthpolicy.org.

There are three institutional perspectives on the relationship between SBHCs and Medicaid managed care: that of the SBHC, that of the MCO, and that of the State Medicaid agency. As discussed below, different approaches are available to structure the payment and service delivery relationship among state purchasers, MCOs, and SBHCs. Each of these approaches presents advantages and disadvantages for each of the parties. For a review of the three perspectives and case studies of Medicaid managed care and SBHCs in Connecticut and Colorado, see *Reimbursement in School-Based Health Centers: A Dialogue with National and State Partners* (April 23, 2001), proceedings of a conference sponsored by HRSA and CMS, <http://www.hrsa.gov/financeMC/>.

States that rely on managed care plans to furnish covered services to Medicaid or SCHIP beneficiaries who are of school age may wish to consider the advantages of coordinating the MCOs with which they contract and the SBHCs operating in the service areas of these MCOs. As discussed below, this coordination can take a number of different forms. Common to each of these approaches, however, is the policy goal of improving access to preventive and primary care services by children and adolescents through the schools. From the standpoint of the state purchaser, encouraging or requiring coordination of MCOs with SBHCs has the advantage of sustaining a Medicaid revenue stream for SBHCs that function as "safety net" providers in their communities. From the standpoint of MCOs contracting with state Medicaid programs, increased coordination with SBHCs offers the potential for increasing the number of sites at which enrollees can access the MCO's provider network and receive the services for which the MCO's performance with respect to provision of immunization, management of asthma, or other dimensions is being measured by the state purchaser under the Health Plan Employer Data and Information Set (HEDIS) or other reporting systems.

For additional information on the use of Medicaid and SCHIP programs to further the delivery of health promotion and health care services to youth in schools, see:

- HRSA, *Opportunities to Use Medicaid in Support of School-Based Health Centers* (forthcoming), www.hrsa.gov/medicaidprimer;

⁷ See CMS, *Draft Medicaid School-Based Administrative Claiming Guide* (February 2000) <http://www.hcfa.gov/medicaid/schools/machmpg.htm>, and CMS, Letter to State Medicaid Directors (May 21, 1999), www.hcfa.gov/medicaid/smd52199.

- American Academy of Pediatrics, *Policy Statement: School-Based Health Services and Other Integrated School Health Services* (January 2001), www.aap.org/policy/re0030.html;
- Center for Adolescent Health and the Law website, www.adolescenthealthlaw.org;
- Center for Health and Health Care in Schools (CHHCS) website, www.healthinschools.org/home.asp; and
- National Assembly on School-Based Health Care, *Partners in Access: School-Based Health Centers and Medicaid, Policies and Practices* (October 2001), <http://www.nasbhc.org/APP/Partners%20in%20Access%20Medicaid%20report.pdf>.

Process for Developing this Technical Assistance Document

Since 1995, CHSRP has conducted an intensive examination of contracts between state Medicaid agencies and MCOs. This analytic work has produced three editions of a comprehensive study of contract provisions. The most recent version is CHSRP's *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 4th Edition* (2001), www.gwhealthpolicy.org. The study breaks down the contracts into a series of analytic tables. SBHC services are addressed in Tables 2.1 (benefits), 3.1 (provider network), and 4.1 (relationships with other public agencies).

Negotiating the New Health System is part of a broader analytic studies and technical assistance project on managed care contracts financed by numerous funders, including HRSA, the David and Lucile Packard Foundation, the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Original funding for this project was supported by Pew Charitable Trusts and the Annie E. Casey Foundation. The development of purchasing specifications for managed care products constitutes one component under this project. The process for developing these SBHC purchasing specifications began with guidance from a working group made up of representatives from HRSA, the National Assembly on School-Based Health Care, and the GW Center for Health and Health Care in Schools. The draft specifications were reviewed by the working group and through a series of vetting meetings involving state Medicaid and public health officials, SBHC administrators, MCO representatives, and experts on the delivery of school-based health center services. The specifications are available at www.gwhealthpolicy.org.

Organization and Structure of this Technical Assistance Document

Most, if not all, SBHCs are required to treat all children attending the schools in which they deliver services, regardless of the child's insurance status or the family's ability to pay. In the case of children enrolled in Medicaid MCOs, the SBHC must generally treat the child, regardless of whether the SBHC participates in the MCO's provider network or is eligible to receive reimbursement from the MCO on an out-of-network basis. If the SBHC is not paid for services furnished to the enrolled child, either by the MCO or by the state Medicaid agency, the

SBHC must rely on other funds to finance the costs of these services. The purpose of these specifications is to enable state purchasers to facilitate the payment of SBHCs for covered services furnished to Medicaid-eligible children enrolled in MCOs.

These specifications set forth three basic approaches to the payment of SBHCs for services furnished to children enrolled in Medicaid or SCHIP managed care (there is no approach under which the SBHC would not be paid). As discussed above, each of these approaches is optional:

Approach (A). *The SBHC does not participate in the provider network of the Medicaid or SCHIP MCO(s) in which children served by the SBHC are enrolled. The state purchaser does not seek to require contracting MCOs to subcontract with SBHCs or to make payments to out-of-network SBHCs for services rendered to the MCOs' enrollees. The purchaser therefore pays the out-of-network SBHC directly on a fee-for-service basis for the services it delivers to children enrolled in an MCO. An example of this approach, which some refer to as a "carve out" or "exclusion," is found in Illinois, where the state has established a separate Medicaid provider category ("Provider 56") for SBHCs; those SBHCs enrolling as Medicaid providers may bill the state Medicaid agency directly on a fee-for-service basis for covered services furnished to children and adolescents enrolled in Medicaid MCOs.*

Approach (B). *As in Approach (A), the SBHC does not participate in the provider network of the Medicaid or SCHIP MCO(s) in which children served by the SBHC are enrolled. Unlike Approach (A), however, the purchaser does not want to pay the SBHC directly for services provided to the MCO's enrollees. Instead, the purchaser mandates that the MCO make payment to an out-of-network SBHC for the services it provides to children enrolled in the MCO. An example of this approach is Michigan, where the state Title V agency designates qualified providers as SBHCs, and the state Medicaid agency requires contracting MCOs to pay the designated SBHCs for services furnished to enrolled children and adolescents on a fee-for-service basis without the need for prior approval from the MCO or its primary care providers.*

Approach (C). *The purchaser requires that an MCO subcontract with any SBHC that serves children enrolled in the MCO if the SBHC wishes to participate in the MCO's provider network (and is willing to comply with network requirements). Because the SBHC is not a party to the contract between the MCO and the purchaser, the contract cannot compel the SBHC to participate in an MCO's provider network. This approach is being implemented with four SBHCs on a pilot basis in New Mexico with funding from the Center for Health Care Strategies, Inc., www.chcs.org. Within this approach are three options regarding the terms of an SBHC's participation in the MCO's provider network. First, the SBHC can be a participating provider that coordinates with, but does*

not assume the responsibilities of, a primary care provider (PCP). Second, the SBHC can participate exclusively as a PCP for those enrolled children who choose the SBHC as their PCP. Finally, the SBHC can function both as a PCP for those enrolled children who choose it as their PCP and as a participating provider for other enrolled children.

Note that none of these approaches precludes a voluntary contracting arrangement between an MCO and a SBHC. Approaches (A) and (B) both assume that the SBHC has elected not to participate in the MCO's network or that the MCO has elected not to designate the SBHC as a network provider. Approach (C) assumes that a contracting arrangement between an MCO and a SBHC cannot be achieved on a voluntary basis and that the state purchaser, for its own public policy reasons, wants such an arrangement in place. Approach (C) would not be needed in cases where SBHCs and MCOs enter into such arrangements voluntarily. However, purchasers, MCOs, and SBHCs may find the illustrative language in §§102C - 104C useful as a checklist to inform the negotiations of such voluntary arrangements.

Approaches (A)-(C) represent three of the four Medicaid policy options to ensure that SBHCs are paid for the services they provide to Medicaid MCO enrollees that are identified by HRSA in Opportunities to Use Medicaid in Support of School-Based Health Centers (forthcoming, www.hrsa.gov/medicaidprimer). The fourth option is the use of incentives by state purchasers: "Incentives to MCOs to encourage the coordination with SBHCs include: enhanced capitation rates, enhanced scoring in competitive bidding, and increased Medicaid enrollment. For example, Medicaid often has an automatic enrollment method for persons who do not choose a specific plan during the open enrollment period. MCOs that include SBHCs [in their provider networks] might receive greater numbers of enrollees...." As described in Exhibit 2, the West Virginia Medicaid managed care contract for 1999-2000 authorizes the state Medicaid agency to increase a contracting MCO's capitation rate by up to 2 percent if the MCO subcontracts with a "publicly supported provider," a category that includes SBHCs.

These purchasing specifications do not advocate the adoption of any one specific approach. Each approach has advantages and disadvantages. Also, because state Medicaid agency policies with respect to managed care vary widely, an approach that is appropriate to one state may not be workable in another. For example, in a state with a high percentage of its Medicaid beneficiaries enrolled in MCOs, and with multiple MCOs enrolling beneficiaries in an area served by numerous SBHCs, Approach (A) may be less burdensome administratively for the purchaser, the MCOs, and the SBHCs, because neither the MCOs nor the SBHCs operating in the same service area would have to negotiate multiple contracts. In contrast, in a state with a high percentage of its Medicaid beneficiaries enrolled in just a few MCOs and a few SBHCs, one of the other approaches may have more advantages.

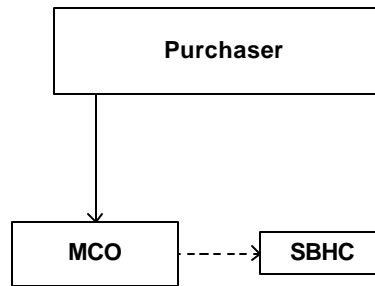
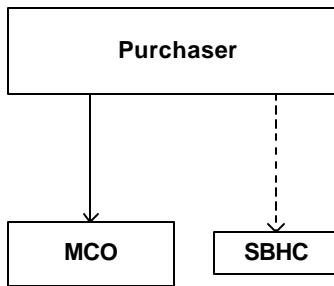
The diagram on the next page summarizes each of these approaches. In the figures below, a solid line denotes a contractual payment arrangement, while a dotted line represents a

non-contractual fee-for-service payment arrangement. The contractual payment arrangement between the purchaser and the MCO is by definition a risk-based, capitated arrangement. The contractual arrangement between the MCO and the SBHC in Approach (C) may be fee-for-service or capitated or a combination of both.

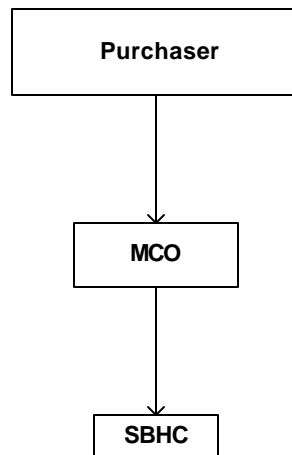
SBHC Out of MCO Network

**Purchaser Pays SBHC
(Approach A)**

**MCO Pays SBHC
(Approach B)**



**SBHC in MCO Network
(Approach C)**



This technical assistance document contains illustrative language specific to each of these approaches. Language relating to Approach (A) appears in §101A; language relating to Approach (B) in §101B; and language relating to Approach (C) in §101C. In order to minimize duplication, many terms that are common to all three approaches, such as "Contractor," "Purchaser," and "enrolled child," are defined in the Appendix (§101App.).

As noted above, these purchasing specifications may be used by state Medicaid or SCHIP agencies.⁸ There are, however, some provisions in these purchasing specifications that would have relevance only to Medicaid risk contracts because of federal statutory requirements specific to Medicaid. These provisions are §101B(d)(2)/§101C(d) (relating MCO payments to subcontracting SBHCs that are also federally-qualified health centers (FQHCs)) and §101B(e)(3) (relating to "prompt pay" requirements for "clean" claims). There are no corresponding policies in federal SCHIP law, and a state SCHIP purchaser would not have to address these policies in its purchasing agreements, although it could choose to do so.

How to Use this Technical Assistance Document

This technical assistance document is designed for the negotiation and drafting of Medicaid and SCHIP managed care purchasing agreements as they relate to school-based health center services. State managed care contracts cover a broad range of issues;⁹ this document focuses exclusively on those issues relating to the delivery of, and reimbursement for, services by SBHCs. CHSRP technical assistance documents addressing other purchasing issues, such as access to services and cultural competence, are listed in Table 1.

In order to be of most value to all potential users -- interested state purchasers, SBHCs, MCOs, and Medicaid or SCHIP beneficiaries -- this document contains several different approaches to contracting arrangements among purchasers, MCOs, and SBHCs. Users need refer only to the language reflecting the approach of their choice. Within each approach, individual provisions can be extracted and incorporated into other purchasing documents as the negotiations or purchaser's policy preferences indicate.

⁸ Note that 42 C.F.R. §457.402(x)(1)-(3) expressly authorizes federal SCHIP matching funds for state payments for "part or all of the cost of health benefits coverage provided to targeted low-income children for...(x) any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is: (1) prescribed by, or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law; (2) performed under the general supervision or at the direction of a physician; or (3) furnished by a health care facility that is operated by a state or local government or is licensed under state law and operating within the scope of the license."

⁹ See CHSRP's *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, 4th Edition (2001), www.gwhealthpolicy.org.

To achieve this portability, the following drafting format is used:

- *Each Part is divided into sections, identified by “§.”*
- *Each section, in turn, is divided into one or more subsections: “(a),” “(b),” etc.*
- *A subsection may be divided into one or more paragraphs: “(1),” “(2),” etc.*
- *A paragraph may be divided into one or more subparagraphs: “(A),” “(B),” etc.*
- *A subparagraph may be divided into one or more clauses: “(i),” “(ii),” etc.*

Every state purchaser has its own drafting format. The particular format used in these sample specifications is NOT intended as a substitute for each state’s own form. Instead, it is intended simply to divide each suggested provision into the smallest practicable policy elements. This division and subdivision format is designed to enable a user to identify quickly the policy choices contained in each provision and to identify which, if any, of the elements the user wishes to adopt. This format also serves as a detailed checklist for those users who wish to compare portions of their current purchasing documents with the relevant portions of these sample specifications.

The Balanced Budget Act of 1997, P.L. 105-33 (BBA), made a number of changes in the managed care provisions of the federal Medicaid statute. When CMS implements these changes through final regulations published in the Federal Register, these purchasing specifications will be revised accordingly. However, these purchasing specifications are consistent with the provisions of the BBA and with CMS's letters to state Medicaid directors and CMS's revised Preprint Renewal Submittal for a section 1915(b) Waiver (September 23, 1999), www.hcfa.gov/medicaid. These specifications are not, and should not be viewed as, an official interpretation of the BBA or of CMS's regulations or policy guidances.

Other CHSRP Purchasing Specifications

CHSRP has also developed a number of purchasing specifications which are listed in Table 1 below. The dated specifications are posted on CHSRP's website, www.gwhealthpolicy.org. All other listed specifications are under development.

**Table 1. Purchasing Specifications
Under Development or Available from CHSRP**

Population-Based Specifications

Adults with Behavioral Health Needs (December 2001)
 Child Welfare (December 2001)
Children with Behavioral Health Needs (October 2000)
Children with Special Health Care Needs (August 2000)
 Pediatric Services (Medicaid) (November 1999)
 Pediatric Services (SCHIP)
 Individuals Who Are Homeless (June 2000)

Service-Related Specifications

Child Development Services (August 2000)
 Immunizations (May 1998)
 Pediatric Dental Care (March 2000)
Pharmaceuticals and Pharmaceutical Services (December 2001)
 Prevention of Lead Poisoning (November 1998)
 Reproductive Health (May 2000)
School-based Health Center Services (January 2002)
 Smoking Cessation

Public Health Conditions Specifications

 Asthma
 Diabetes (July 2000)
 Epilepsy
 HIV/AIDS (August 1999)
 Sexually Transmitted Diseases (November 1999)
 Tuberculosis (August 1999)

Specifications for Programmatic Issues

Access to Services (July 2000)
 Cultural Competence (Updated, November 2001)
 Data and Information
Memoranda of Understanding between MCOs and Public Health Agencies

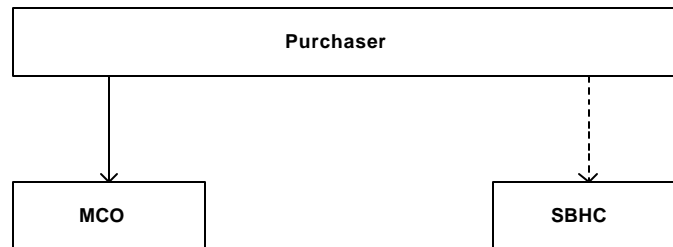
Integrated Specifications

User's Guide Relating to Behavioral Health (December 2001)
 User's Guide Relating to Pediatrics
 User's Guide Relating to Public Health Conditions and Services

Approach (A): Purchaser Pays Out-of-Network SBHC Directly

SBHC Out of MCO Network

Purchaser Pays SBHC



Commentary: The following illustrative language assumes that the state purchaser does not wish to require contracting MCOs either (1) to subcontract with SBHCs or (2) to pay out-of-network SBHCs for covered items and services furnished to enrolled children. Instead, the SBHCs do not participate in the MCO provider networks, and the purchaser makes payments directly to the SBHCs on a fee-for-service basis for the covered services they provide to MCO enrollees who are Medicaid or SCHIP beneficiaries. This approach avoids the need for state purchasers, MCOs, and SBHCs to invest the staff and financial resources in developing the systems and administrative capacity to integrate operation.

As a general rule, federal Medicaid and federal SCHIP matching funds are not allowable for more than one state payment for the furnishing of a covered service to an eligible individual at a single encounter between a beneficiary and a provider.

If a Medicaid-eligible child is enrolled in an MCO that is receiving a capitation payment from the state Medicaid agency, and if the capitation payment is in part for the furnishing of primary care services to the enrolled child, then the potential for duplication exists if the child receives primary care services through an SBHC that is not affiliated with the MCO. According to CMS staff, duplication of payment is not an issue if the state

Medicaid agency has not included payments to SBHCs in the fee-for-service equivalent calculation required by the upper payment limit specified in 42 C.F.R. §447.361.¹⁰ State purchasers and MCOs are advised to consult with CMS Regional Offices on this matter.

Because the SBHC is not a party to the contract between purchaser and the MCO, there is no reference in the following language to the amount or timing of payment to the SBHC by the purchaser, or to the billing and coding formats that the SBHC must use in filing claims with purchaser. The SBHC, and the practitioners who staff it, are not required to meet the MCO's credentialing or other provider participation requirements. The SBHC and its practitioners are, however, required to meet the standards that apply to providers participating in the state's Medicaid or SCHIP program on a fee-for-service basis. To ensure that the MCO is aware of the services furnished to its enrollees by SBHCs, the purchaser would be required to make available to the MCO information regarding the fee-for-service claims it has processed from SBHCs resulting from encounters with the MCO's enrollees. The MCO would be prohibited from disclosing the provision of confidential services by the SBHC.

§101A. Offset for Items and Services Furnished by an SBHC

(a) **Offset** — The amount otherwise payable to Contractor in a payment month under [drafter insert reference to payment provisions in purchasing agreement] shall be reduced by the amount Purchaser paid to a school-based health center (SBHC) (as defined in **§101App(j)**) for the furnishing of an item or service enumerated in subsection (b) to an enrolled child in the [] month prior to the payment month.

(b) Items and Services Subject to Payment

(1) **Items and Services that are not Confidential** — The items and services enumerated in this paragraph are: [drafter insert categories of items and services not described in paragraph (2) for which Contractor is responsible under the purchasing agreement and for which the SBHC is authorized to bill the State's Medicaid or SCHIP program on a fee-for-service basis].¹¹

¹⁰ Comments received during NASHP vetting meeting held on November 5, 2001.

¹¹ A national survey found that 80 percent of SBHCs reported providing the following types of services on site: anticipatory guidance, comprehensive health assessment, treatment of acute illness, vision and hearing screenings, immunizations, asthma treatment, nutrition counseling, sports physicals, prescriptions for medications, laboratory tests, administration of medications, treatment of chronic illness, and pregnancy testing. National Assembly on School-Based Health Care, *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999* (June 2000), Figures 12 and 14 (ordering information at www.nasbhc.org). Not all of these service categories would necessarily be covered under risk contracts between state Medicaid agencies and MCOs.

(2) **Confidential Health Services** — The items and services enumerated in this paragraph are: *[drafter insert categories of items and services treated as confidential health services under state law for which Contractor is responsible under the purchasing agreement and for which the SBHC is authorized to bill the State's Medicaid or SCHIP program on a fee-for-service basis]*.¹²

(c) **Purchaser Duty to Notify** — Purchaser shall make available to Contractor, within [] days of an offset under subsection (a):

(1) the dates of, and enrolled children involved in, the encounters to which the offset is attributable; and

(2) the amounts paid by Contractor with respect to encounters under paragraph (1).

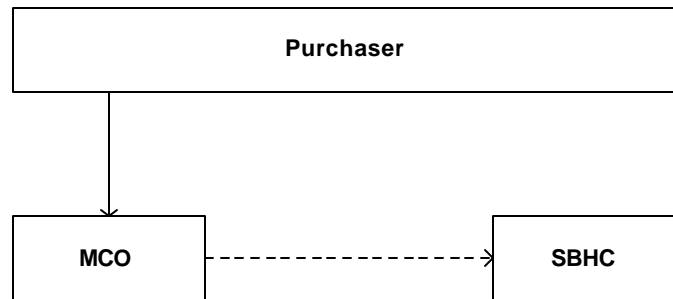
(d) **Duty to Withhold Notification by Purchaser of Encounter Involving Confidential Health Services** — In the case of encounters of which Contractor is notified under subsection (c)(1) relating to an item or service covered under subsection (b)(2) (relating to confidential services), Contractor shall not mail or otherwise transmit a bill, an explanation of benefits (EOB), or other notification of the furnishing of the item or service to the family or caregiver (as defined in §101App(d)) of the child.

¹² For a survey of state laws regarding "confidential services" for minors (e.g., contraceptive services, prenatal care and delivery, STDs testing and treatment, drug or alcohol abuse counseling and treatment, and outpatient mental health services) see Heather Boonstrah and Elizabeth Nash, *Minors and the Right to Consent to Health Care: The Guttmacher Report on Public Policy 2000*, 3(4): 4-8, http://www.agi-usa.org/pubs/ib_minors/minors_table.html.

Approach (B): Purchaser Requires MCO to Pay Out-of-Network SBHC

SBHC Out of MCO Network

MCO Pays SBHC



Commentary: As in the case of Approach (A), the following illustrative language assumes that the state purchaser does not wish to require contracting MCOs to subcontract with SBHCs, and that SBHCs do not participate in the MCO provider networks. Unlike Approach (A), however, this language assumes that the purchaser does not want to make payments directly to SBHCs on a fee-for-service basis for the covered services they provide to MCO enrollees who are program beneficiaries. Instead, this language assumes that the purchaser wishes to require a contracting MCO to make payment to SBHCs that do not participate in the MCO's network for specified services delivered to Medicaid-eligible children enrolled in the MCO. The language draws upon Maryland regulations, Code of Maryland Regulations (COMAR) 10.09.68, that reflect this policy, which is also known as "self-referred" SBHC services. Of course, not every state will choose to implement this approach; some may be concerned about the implications of this approach for closed MCO provider networks.

Note that this approach does not raise the duplication of payment issues potentially posed by Approach (A). That is because the state purchaser must make only one set of payments for which it claims federal matching funds -- the capitation payments to the

MCO on behalf of enrolled program beneficiaries. The state purchaser simply requires that the MCO make payments directly to SBHCs from the federally-matched capitation payments it receives. The state purchaser does not itself make payments to the SBHCs for which it might wish to claim federal matching funds.

Note also that, as in the case of Approach (A), the out-of-network SBHC is not a party to the contract between the state purchaser and an MCO. Thus, the purchaser cannot use the contract with the MCO to impose requirements upon the SBHC (e.g., notifying the MCO of an encounter with the MCO's enrollee within two business days or submitting invoices to the MCO within 60 days of the encounter). However, if the state purchaser or other state agency has licensure or other regulatory jurisdiction over the SBHC, this authority could serve as the basis for the imposition of such requirements directly upon out-of-network SBHCs.

The following language can be used in conjunction with the illustrative language in Approach (C) below requiring an MCO to subcontract with an SBHC that serves its enrollees. Because the SBHC is not a party to the contract between the state purchaser and the MCO, its participation in the MCO's network cannot be compelled. To address both contingencies, interested purchasers may wish to use the illustrative language from this approach addressing non-participating SBHCs as well as language from Approach (C) relating to participating SBHCs.

The illustrative language is organized as follows

:

§101B. Payment to Out-of-Network School-Based Health Centers

(a) In General

- (1) Right of Enrolled Child to Self-Referral to Out-of-Network SBHC*
- (2) Duty to Make Payment to Out-of-Network SBHC*
- (3) Duty to Inform Out-of-Network SBHCs*
- (4) Duty to Withhold Notification on Furnishing of Confidential Health Services by Out-of-Network SBHCs*
- (5) Duty to Require Primary Care Providers (PCPs) to Coordinate Information with Out-of-Network SBHCs*
- (6) Nondelegation*

(b) Items and Services Subject to Payment

- (1) Items and Services that are not Confidential*
- (2) Confidential Health Services*

(c) Documentation

- (1) Required Elements*
- (2) Timeliness of Required Documentation*

(d) Rate of Payment

- (1) *SBHC that is not an FQHC*
- (2) *SBHC that is an FQHC*
- (e) *Timeliness of Payment*
 - (1) *Clean Claims*
 - (2) *Claims for Which Initial Documentation is Incomplete*
 - (3) *Minimum Timeframe*

§101B. Payment to Out-of-Network School-Based Health Centers

(a) In General

(1) Right of Enrolled Child to Self-Referral to Out-of-Network SBHC — Contractor agrees that an enrolled child is entitled to receive items and services enumerated under subsection (b) from a school-based health center (SBHC) (as defined in §101A(j)) serving the school that the child attends, whether or not the SBHC:

(A) participates in Contractor's provider network; or

(B) has obtained approval for payment (in advance or otherwise) for the items or services furnished to an enrolled child from Contractor or the child's primary care provider participating in Contractor's network.

(2) Duty to Make Payment to Out-of-Network SBHC — Contractor shall make payment to an SBHC described in paragraph (1) for items and services enumerated in subsection (b) furnished to an enrolled child by the SBHC in accordance with the following requirements:

(A) upon receipt of the documentation described in subsection (c)(1) within the time frame set forth in subsection (c)(2);

(B) at a rate of payment specified in subsection (d); and

(C) within the time frame specified in subsection (e).

(3) Duty to Inform Out-of-Network SBHC — Contractor shall make available to an SBHC described in paragraph (1), promptly upon request, the following information:

(A) the name and contact information for the individual who is authorized to represent Contractor in matters relating to the furnishing of items and services by SBHCs to enrolled children;

(B) the name and contact information for the individual who is authorized by Contractor to receive the documentation described in subsection (c) from SBHCs;

(C) the name and contact information for the individual who is authorized by Contractor to make payment to SBHCs under paragraph (2);

(D) the items and services enumerated under subsection (b) for which payment must be made to an SBHC without approval under paragraph (1)(B); and

(E) the guidelines, protocols, or procedures (including any confidentiality requirements under State law) an SBHC must follow in order to transmit the documentation required under subsection (c)(1) and to receive the payments described in paragraph (2).

(4) Duty to Withhold Notification on Furnishing of Confidential Health Services by Out-of-Network SBHCs — In the case of a request for payment submitted by an SBHC for an item or service described in subsection (b)(2) (relating to confidential services) furnished to an enrolled child, Contractor shall not mail or otherwise transmit a bill, an explanation of benefits (EOB), or other notification of the furnishing of the item or service to the family or caregiver (as defined in §101App(d)) of the child.

(5) Duty to Require Primary Care Providers (PCPs) to Coordinate Information with Out-of-Network SBHCs — Contractor shall require, through its written subcontracts with primary care providers (as defined in §101App(e)) participating in Contractor's provider network, that a primary care provider respond within [] to a request from a practitioner from whom an enrolled child is seeking treatment through an SBHC that does not participate in Contractor's provider network for medical information relating to the child that is necessary for the treatment of the child.

Commentary: In some instances, an MCO may not subcontract directly with hospitals, physicians, or other provider participating in its provider network. Instead, an MCO may be organized so that the legal entity that contracts with the state purchaser and receives capitation payments (e.g., "Contractor") subcontracts with other entities such as

Physician-Hospital Organizations (PHOs) or Integrated Delivery Systems (IDSs) that in turn subcontract with individual hospitals, physicians, and other practitioners. To simplify the administration of these payment duties, the following illustrative language would prohibit the legal entity that contracts with the state purchaser from delegating its duty of payment to an out-of-network SBHC to any intermediate PHOs or IDSs.

(6) **Nondelegation** — Contractor shall not delegate the performance of the duties enumerated in paragraphs (1) through (5).

(b) Items and Services Subject to Payment¹³

(1) **Items and Services that are not Confidential** — The items and services enumerated in this paragraph are: *[drafter insert categories of items and services not described in paragraph (2) for which Contractor must make payment to out-of-network SBHCs]*.¹⁴

(2) **Confidential Health Services** — The items and services enumerated in this paragraph are: *[drafter insert categories of items and services treated as confidential health services under state law]*.¹⁵

Commentary: The following illustrative language requires, among other things, that the SBHC document to the MCO that it (and its practitioners) meet the requirements under state law or regulation for issuance of a Medicaid provider number. It is not necessary that the SBHC (or its practitioners) actually hold a Medicaid provider number, since the SBHC will be reimbursed for services delivered to enrolled Medicaid beneficiaries by the MCO, not by the state Medicaid agency. The purpose of this documentation requirement

¹³ Maryland regulations specify that Medicaid MCOs reimburse SBHCs for the following "self-referred services: (1) Diagnosis, treatment, and uncomplicated follow-up (limited to one follow-up visit to the SBHC, of acute or urgent somatic illness, and related prescribing of medications); and (2) family planning services...." Code of Maryland Regulations (COMAR) 10.09.68.03. These regulations are incorporated into the purchasing agreement with MCOs used by the Maryland State Medicaid agency. See Table 4.1 in CHSRP's *Negotiating the New Health System*, 4th Edition (2001), www.gwhealthpolicy.org.

¹⁴ A national survey found that 80 percent of SBHCs reported providing the following types of services on site: anticipatory guidance, comprehensive health assessment, treatment of acute illness, vision and hearing screenings, immunizations, asthma treatment, nutrition counseling, sports physicals, prescriptions for medications, laboratory tests, administration of medications, treatment of chronic illness, and pregnancy testing. National Assembly on School-Based Health Care, *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999* (June 2000), Figures 12 and 14 (ordering information at www.nasbhc.org). Not all of these service categories would necessarily be covered under risk contracts between state Medicaid agencies and MCOs.

¹⁵ For a survey of state laws regarding "confidential services" for minors (e.g., contraceptive services, prenatal care and delivery, STDs testing and treatment, drug or alcohol abuse counseling and treatment, and outpatient mental health services), see Heather Boonstrah and Elizabeth Nash, *Minors and the Right to Consent to Health Care: The Guttmacher Report on Public Policy 2000*, 3(4): 4-8, http://www.agi-usa.org/pubs/ib_minors/minors_table.html.

is to ensure that the amounts paid by the MCO to the SBHC from the Medicaid capitation payments it receives from purchaser are paid only to providers that satisfy Medicaid program requirements.

The illustrative language would not require the SBHC, or the practitioners who staff it, to meet the MCO's credentialing or other provider participation requirements, because they do not participate in the MCO's network. Evidence of Medicaid provider status, or of meeting the qualifications for Medicaid provider status, should be sufficient to address any quality or program integrity concerns.

Note that in order to receive payment, the SBHC must document, among other things, that the practitioner who furnished services to an enrolled child has attempted (within a time frame specified by Purchaser) to notify the child's primary care provider of the encounter or, if the primary care provider is not known, the MCO. The purpose of this documentation requirement is to promote coordination of care among clinicians treating the child. The documentation is not for purposes of obtaining prior approval; under subsection (a)(1)(B), the SBHC would be exempt from any Contractor or gatekeeper approval requirements with respect to certain specified services. Note further that the SBHC would not be required to furnish evidence of the child's enrollment in Medicaid or SCHIP at the time of the encounter; low-income children treated by SBHCs are unlikely to carry their Medicaid or SCHIP cards (or other evidence of enrollment) with them to school.

(c) Documentation

(1) Required Elements — The documentation required to be submitted by an SBHC to Contractor as a condition of receipt of payment is:

- (A) (i) a Medicaid provider number for the SBHC or for each practitioner furnishing services to enrolled children through the SBHC; or
- (ii) evidence that the SBHC (and each practitioner furnishing services to enrolled children through the SBHC) is qualified to meet the requirements under [drafter insert reference to state law or regulation] for issuance of a Medicaid provider number;

(B) the claim, including the encounter data and billing information, as specified by Purchaser;¹⁶

(C) a written certification by the practitioner who furnished the item or service to the enrolled child through the SBHC that the practitioner attempted, within [] days of the encounter at which the item or services was furnished, to notify:

(i) the child's primary care provider participating in Contractor's provider network of the encounter between the child and the practitioner; or

(ii) if SBHC or practitioner does not know the identity of the child's primary care provider, Contractor of the encounter between the child and the practitioner; and

(D) *[drafter insert other desired documentation]*.

Commentary: The following language would provide for a cut-off date for the initial submission of claims and accompanying documentation by the SBHC. The purpose of this requirement is to enable state purchasers to impose a commercially reasonable limit on the amount of time out-of-network SBHCs have to submit to MCOs claims arising from the provision of services to enrolled children.

(2) **Timeliness of Required Documentation**

(A) **Time Frame** — Contractor shall notify in writing each SBHC serving children residing in Contractor's service area that, in order to receive payment from Contractor for a covered item or service under subsection (b) furnished to an enrolled child, an SBHC must submit the documentation required to be submitted under paragraph (1) within [] after the furnishing of the item or service by an SBHC to Contractor.

(B) **Construction** — This paragraph shall not be construed to invalidate a claim for services rendered that is submitted to Contractor within the time frame specified in subparagraph (A) but that is subject to requests by Contractor for additional documentation or is subsequently reviewed or disputed by Contractor.

¹⁶ For example, Maryland regulations specify that, in order to receive reimbursement for self-referred services, SBHCs must transmit to the MCO "encounter data and billing information using the CMS 1500 format." COMAR 10.09.68.03D.(1).

(d) Rate of Payment

Commentary: The following illustrative language draws a distinction between SBHCs that are Federally-Qualified Health Centers (FQHCs) and those that are not. This distinction applies for purposes of Medicaid, but a state purchaser may not wish to apply it to contracts under its separate SCHIP program. In the case of Medicaid contracts, the language implements the prospective payment system for FQHCs enacted in December 2000. In the context of managed care arrangements, federal law requires that state Medicaid agencies make supplemental payments to FQHCs that are subcontractors with MCOs to fill in the difference between the amount the FQHC receives from the MCO and the amount it is entitled to receive under the prospective payment system. The following illustrative language extends this payment principle to a situation in which the SBHC, while an FQHC, is not contracting with the MCO.

(1) SBHC that is not an FQHC — In the case of an SBHC (as defined in §101App(j)) that does not bill for services as a Federally-Qualified Health Center (FQHC) under §1905(l)(2)(B) of the Social Security Act, 42 U.S.C. §1396d(l)(2)(B), Contractor shall reimburse the SBHC for items and services described in subsection (b) furnished to an enrolled child:

(A) in an amount that is not less than the amount which Contractor would pay for the items and services if the items and services were furnished by a provider participating in Contractor's provider network;¹⁷ or

(B) if Contractor reimburses participating providers on a capitated per-member per-month basis, in an amount and on terms specified by Purchaser.

(2) SBHC that is an FQHC — In the case of an SBHC that bills for services as a Federally-Qualified Health Center under §1905(l)(2)(B) of the Social Security Act, 42 U.S.C. §1396d(l)(2)(B):

(A) Contractor shall reimburse the SBHC for services described in subsection (b) furnished to an enrolled child in the same amounts and on the same terms (consistent with the timeliness requirement of subsection (e)) as Contractor would reimburse a provider participating in Contractor's

¹⁷ This illustrative language is derived from language in section 1903(m)(2)(A)(viii) of the Social Security Act, 42 U.S.C. §1396b(m)(2)(A)(viii). An alternative option would be to require Contractor to reimburse the out-of-network school-based health center at the same rate that the State's Medicaid program would pay the provider for the item or service on a fee-for-service basis.

provider network that is paid the average amount paid by Contractor for the same item or service; and

(B) Purchaser, consistent with §1902(aa)(5) of the Social Security Act, 42 U.S.C. §1396a(aa)(5), shall make a supplemental payment to the SBHC no less frequently than [*drafter insert accounting period no longer than every 4 months*] in an amount equal to:

(i) the amount (calculated on a per visit basis) the SBHC is entitled to receive for the services furnished during [*drafter insert accounting period*] under §1902(aa)(1) of the Social Security Act, 42 U.S.C. §1396a(aa)(1); minus

(ii) the payments made by Contractor to the SBHC under subparagraph (A) during the [*drafter insert accounting period*].

(e) Timeliness of Payment

Commentary: The following illustrative language sets forth standards for the timeliness of payment of claims received by an MCO from an out-of-network SBHC under this Approach (B). State purchasers may choose to use existing standards under state law or regulation, or they may wish to develop standards specific to this Approach.

(1) **Clean Claims** — In the case of a claim for which the documentation required under subsection (c) has been provided in full by the SBHC (as defined in **§101App(j)**) to Contractor, Contractor shall make payment to the SBHC within []¹⁸ days after receipt of the claim from the SBHC, unless:

(A) Contractor has made a determination, prior to [] days after receipt of the claim, that the claim should not be paid because the claim is not for an item or service covered under [*drafter insert reference to medical necessity and related coverage provisions in the purchasing agreement*]; and

(B) Contractor has given notice of the determination described in subparagraph (A) (and the reasons therefore) in writing to the SBHC within [] days of the determination.

¹⁸ Maryland regulations provide that "An MCO shall pay undisputed claims of the SBHC for services provided to its enrollees within 30 days of the MCO's receipt of the invoice." COMAR 10.06.68.03F. Interested purchasers may wish to provide for shorter response times in the case of electronic submissions than in the case of hard copy invoices.

(2) Claims for Which Initial Documentation is Incomplete — In the case of a claim for which the documentation required under subsection (c) has not been provided in full, Contractor shall:

(A) provide notice in writing to the SBHC within [] days of receipt of the documentation submitted by the SBHC specifying any additional information required under subsection (c) in order to make payment; and

(B) within [] days of receipt of the information described in subparagraph (A), make payment for the claim (or a portion thereof).

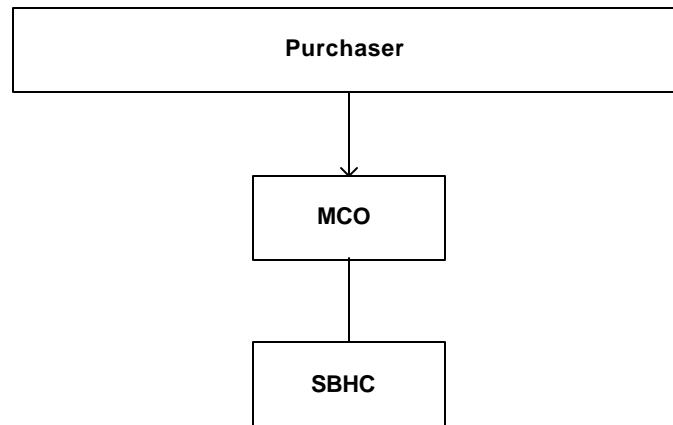
Commentary: The following illustrative language applies timeliness of payment standards to MCOs that are derived from the federal Medicaid statute. Under these standards, 99 percent of "clean" claims -- i.e., claims for which no further written information or substantiation is required in order for payment to be made -- must be paid within 90 days of receipt. A state purchaser may not wish to apply these standards to MCO contracts under its separate SCHIP program.

(3) Minimum Timeframe — Contractor shall ensure that the payments under paragraphs (1) and (2) shall in no event be less prompt than required under §1932(f) of the Social Security Act, 42 U.S.C. §1396u-2(f).¹⁹

¹⁹ Section 1932(f) requires that Medicaid risk contracts provide that the MCO make payment to health care providers for covered items and services furnished to enrollees "on a timely basis consistent with the claims payment procedures described in §1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule." Under §1902(a)(37)(A) of the Social Security Act, 42 U.S.C. §1396a(a)(37)(A), 90 percent of clean claims must be paid within 30 days of the date of receipt, and that 99 percent of clean claims are paid within 90 days of receipt.

Approach (C): Purchaser Requires MCO to Subcontract with SBHC

SBHC in MCO Network



Commentary: Currently, SBHCs in 22 states have subcontracts with MCOs to participate in the MCO's provider network.²⁰ In some cases, the SBHCs are network providers but not primary care providers (PCPs); in other cases, the SBHCs function exclusively as PCPs; and in other instances, they are both PCPs and participating providers that are not PCPs, depending upon the child. For a discussion of the issues relating to SBHC participation in MCO networks as PCPs in the New York State context, see M. Honig, School-Based Health Centers and Managed Care: Contracting Issues and Options, (July 2000), Center for Health Care Strategies, Inc., www.chcs.org.

The following illustrative language would require an MCO to subcontract with an SBHC that provides services to Medicaid-eligible children enrolled in the MCO.²¹ This

²⁰ See press release of the 50-state survey of school-based health centers for 2000, Center for Health and Health Care in Schools, March 1, 2001, www.healthinschools.org/press/PR00002.asp.

²¹ The 1999 contract between the Rhode Island Medicaid agency and MCOs provides: "There are three school-based clinics in Rhode Island located in.... Contractor is required to include these three school-based clinics in its networks for delivery of Rite Care covered services available at the school-based clinic as of..." See Table 4.1 in CHSRP's *Negotiating the New Health System*, 4th Edition (2001), www.gwhealthpolicy.org

requirement would apply only in the case of SBHCs that choose to subcontract with the MCO and that meet certain qualifications. The language at §101C assumes that an SBHC would negotiate with an MCO and decide whether, based on the terms offered by the MCO, it is willing to participate in the MCO's provider network, and on what basis. If the SBHC determines that the MCO's offer is acceptable, it would then submit to the MCO a notice of intent to subcontract. The MCO would then have a specified time period within which to agree to the requested subcontract.

The illustrative language would require the MCO to offer the SBHC three different subcontracting arrangements. Under the first, the SBHC could participate in the MCO's provider network as other than a PCP (§102C). Under the second, the SBHC could participate in the MCO's provider network exclusively as a PCP (§103C). Under the third arrangement, the SBHC could participate (1) as a PCP in the case of those enrolled children whose families select the SBHC as their child's PCP and (2) as a participating provider that is not a PCP in the case of those enrolled children whose PCP is another provider in the MCO's network (§104C).

The purpose of this approach is to enable each SBHC to enter into a subcontracting arrangement with a particular MCO that is suitable to that SBHC's particular market circumstances. For example, consider an SBHC with several Medicaid MCOs operating in its service area. Assume MCO #1 has contracted with hospitals other than the hospital with which the SBHC is affiliated. Because the SBHC would not be able to admit patients to any of MCO #1's contracting hospitals, it could not participate as PCP in the MCO's provider network under §103C, but it could participate as other than a PCP under §102C. Assume further that MCO #2 has contracted with the hospital with which the SBHC is affiliated. In this case, the SBHC would be able to participate either as a PCP under §103C, or as both a PCP and non-PCP provider under §104C. Thus, the SBHC could enter into a non-PCP arrangement under §102C with MCO #1 and a PCP arrangement under §103C with MCO #2.

An alternative option is for purchaser to specify in its purchasing agreement with the MCO that the MCO offer one particular subcontracting arrangement to a qualified SBHC. This approach would reduce the ability of an SBHC to negotiate workable subcontracting arrangements with each MCO operating in its service area.

As noted above, an SBHC is not a party to the contract between the state purchaser and the MCO, so that its participation in the MCO's network cannot be compelled through the contract. Thus, even though a state purchaser may require an MCO to subcontract with an SBHC as per the illustrative language below, not all SBHCs in the MCO's service area may be willing to subcontract with the MCO. To address a situation in which an

SBHC chooses not to enter into a subcontract with the MCO, interested purchasers may wish to use the illustrative language from Approaches (A) or (B) above.

The illustrative language is organized as follows:

§101C. Requirement to Subcontract with SBHC

(a) Duty to Subcontract with SBHC

(b) Notification of Intent to Subcontract

(c) Qualifications Required of SBHCs to Subcontract

(d) Purchaser Duty to Make Supplemental Payment

§102C. Subcontract with SBHC not Serving as a Primary Care Provider

§103C. Subcontract with SBHC Serving as a Primary Care Provider

§104C. Subcontract with SBHC Serving as a Participating Provider and as a Primary Care Provider

§101C. Requirement to Subcontract with SBHC

(a) Duty to Subcontract with SBHC

(1) In General — No later than [] after receipt of the notification described under subsection (b) from a school-based health center (SBHC) (as defined in **§101App(j)**) that meets the qualifications required under subsection (c), Contractor shall enter into a subcontract with the SBHC that meets the requirements described in one of the following participation arrangements:

(A) **§102C** (relating to participation in Contractor's provider network as other than a primary care provider);

(B) **§103C** (relating to participation in Contractor's provider network only as a primary care provider); or

(C) **§104C** (relating to participation in Contractor's provider network both as a primary care provider and as a provider that is not a primary care provider).

Commentary: Not all MCOs subcontract directly with the physicians, clinics, and other providers that participate in their provider networks. Instead, some MCOs contract with other entities, such as Physician-Hospital Organizations (PHOs), that in turn subcontract with individual providers. The following illustrative language would allow an MCO to delegate its duty to subcontract with an SBHC to an intermediary such as a PHO, but

only if each delegation is approved in advance by the purchaser and only if the contracting MCO retains ultimate responsibility for the duty to subcontract with SBHCs.

(2) **Delegation of Duty**²² — Contractor may delegate the duty described in paragraph (1) only if the following requirements are met:

(A) **Subcontract** — The delegation of any duty from Contractor to subcontractor is effective only to the extent that the delegation is set forth, and only for the term specified, in a written subcontract approved by Purchaser in advance of any delegation.

(B) **Contractor's Ultimate Responsibility** — Notwithstanding any delegation of a duty of Contractor under subparagraph (A), Contractor shall maintain ultimate responsibility for adhering to, and otherwise fully complying with, the duties under this section and all other requirements, terms, and conditions of [*drafter insert name of purchasing document*].

(b) **Notification of Intent to Subcontract** — The notification described in this subsection is a written statement submitted to Contractor by an SBHC (as defined in **§101App(j)**) that meets the qualifications required under subsection (c) that the SBHC agrees to enter into a subcontract described in [*drafter insert subcontract type selected under subsection (a)*].

Commentary: The following illustrative language sets forth qualifications that an interested purchaser could require an SBHC meet before the purchaser requires the MCO to subcontract with the SBHC. The language assumes that under state law, the SBHC is licensed and participates in Medicaid as an entity. In some states, however, SBHCs are not licensed; instead, the physicians and other practitioners who deliver services through the SBHC are licensed and bill the Medicaid program for services rendered. In such states, drafters would have to reframe the illustrative language accordingly. Of course, each of the requirements enumerated below in paragraphs (1) through (4), and within paragraph (4), is optional.

(c) **Qualifications Required of SBHCs to Subcontract** — The qualifications required of an SBHC (as defined in **§101App(j)**) in order to enter into a subcontract with Contractor described in [*drafter insert subcontract type selected under subsection (a)*] are that the SBHC:

(1) furnishes primary health care services to children or adolescents who reside in Contractor's service area;

²² For comparable delegation provisions in the Medicare+Choice context, see 42 C.F.R. §422.502(i).

(2) holds a current license from [*drafter insert reference to applicable state licensing authority*];

(3) holds a Medicaid provider number or, in the judgment of [*drafter insert reference to state Medicaid agency*], meets the requirements under [*drafter insert reference to state law or regulation*] for issuance of a Medicaid provider number; and

(4) meets the requirements that Contractor applies to providers participating in Contractor's provider network with respect to:

- (A) credentialing of practitioners;
- (B) maintenance of patient records;
- (C) reporting of encounter data;
- (D) referrals of enrolled children to specialists;
- (E) prescribing of covered outpatient drugs;
- (F) malpractice liability coverage; and
- (G) [*drafter insert additional requirements*].

(d) Purchaser Duty to Make Supplemental Payment — In the case of an SBHC that bills for services as a Federally-Qualified Health Center (FQHC) under §1905(1)(2)(B) of the Social Security Act, 42 U.S.C. §1396d(1)(2)(B) and that enters into a subcontract under [*drafter insert subcontract type selected under subsection (a)*], Purchaser, as required by §1902(aa)(5) of the Social Security Act, 42 U.S.C. §1396a(aa)(5), shall make a supplemental payment to the SBHC no less frequently than [*drafter insert accounting period no longer than every 4 months*] in an amount equal to the amount (if any) by which:

- (1) the amount (calculated on a per visit basis) the SBHC is entitled to receive for the services furnished during [*drafter insert accounting period*] under §1902(aa)(1) of the Social Security Act, 42 U.S.C. §1396a(aa)(1) exceeds
- (2) the payments made by Contractor to the SBHC under the subcontract described in [*drafter insert reference §102(C)(i), §103(C), or §104(C)(i), depending upon purchaser's policy preference*].

§102C. Subcontract with SBHC not Serving as a Primary Care Provider

Commentary: Under §101C(a), the Contractor would have a duty to subcontract with an SBHC that has submitted a notice of intent to subcontract and is qualified – i.e., meets the requirements specified in §101C(c). The following illustrative language represents the first of three options available to the SBHC for structuring the terms of its subcontractual relationship with the MCO. Under this option, the SBHC would participate in the MCO’s provider network but would not be required to assume the responsibilities of a primary care provider (PCP) within that network, such as making covered services available 24 hours per day, 7 days per week. The suggested language is intended to clarify the terms of participation in an MCO’s network and to enable the MCO and an SBHC to identify and resolve issues regarding the coordination of covered services to enrolled children between the SBHC and the primary care providers participating in the MCO’s network.

The illustrative language does not cover all of the issues that would need to be addressed in a subcontract between an MCO and SBHC, such as remedies in the event of breach, resolution of disputes, etc. For examples of contract language on these additional issues, see Exhibit 1 at the end of this document.

The illustrative language is organized as follows:

§102C. Subcontract with SBHC not Serving as a Primary Care Provider

- (a) Purpose*
- (b) Parties*
- (c) Term*
- (d) Items and Services Subject to Payment*
- (e) Contractor’s Operating Policies and Procedures*
- (f) Utilization Management Requirements*
- (g) Coordination with Primary Care Providers*
- (h) Submission of Claims*
- (i) Reimbursement to Subcontractor*
- (j) Record Keeping*
- (k) Quality of Care Studies*
- (l) Other Requirements*

§102C. Subcontract with SBHC not Serving as a Primary Care Provider — A subcontract described in this subsection shall meet the following requirements:

(a) **Purpose** — The subcontract shall have as its purpose the coordination of, and designation of responsibility for, the furnishing of items and services covered under [drafter

insert reference to coverage provisions in purchasing document] to an enrolled child by Contractor and by an SBHC (as defined in §101App(j)).

(b) **Parties**²³ — The parties to the subcontract described in this section shall be Contractor and an SBHC (“Subcontractor”) that:

(1) meets the qualifications required under §101C(c); and

(2) has submitted the notice of intent to subcontract under §101C(b).

(c) **Term** — The subcontract shall be effective beginning on the first day of the [] month following the month in which Contractor agrees under §101C(a) to subcontract with the Subcontractor and shall be in effect for a period of [*drafter insert period consistent with the term of the purchasing agreement between the state Medicaid agency and the MCO*].

(d) **Items and Services Subject to Payment**²⁴ — The subcontract shall apply with respect to the following items and services furnished by Subcontractor to an enrolled child who has not selected Subcontractor as the child's primary care provider (as defined under §101App(e)):

(1) **Items and Services that Are not Confidential** — The items and services enumerated in this paragraph are: [*drafter insert list of items and services that are covered under the purchasing agreement between Purchaser and Contractor and that SBHCs (or the practitioners staffing SBHCs) are licensed under state law to furnish*].²⁵

²³ Note that the purchasing agreement between the state Purchaser and Contractor designates enrolled children as intended third-party beneficiaries to the agreement, which under state law would entitle them to enforce the terms of the agreement against both Purchaser and Contractor. Purchasers may wish to consider extending this right of enforcement in subcontracts between Contractor and participating providers, including SBHCs. For an example of such language, see Section 13.7 of North Carolina's Medicaid Managed Care Risk Contract (Effective March 1, 2000): "Medicaid Members are the intended third party beneficiaries of contracts between the Division and the Plan and any subcontractors or provider agreements entered into by the Plan..." (p. 24).

²⁴ Maryland regulations specify that Medicaid MCOs reimburse SBHCs for the following "self-referred services: (1) Diagnosis, treatment, and uncomplicated follow-up (limited to one follow-up visit to the SBHC, of acute or urgent somatic illness, and related prescribing of medications); and (2) family planning services...." Code of Maryland Regulations (COMAR) 10.09.68.03. These regulations are incorporated into the purchasing agreement with MCOs used by the Maryland State Medicaid agency. See Table 4.1 in CHSRP's *Negotiating the New Health System*, 4th Edition (2001), www.gwhealthpolicy.org.

²⁵ A national survey found that 80 percent of SBHCs reported providing the following types of services on site: anticipatory guidance, comprehensive health assessment, treatment of acute illness, vision and hearing screenings, immunizations, asthma treatment, nutrition counseling, sports physicals, prescriptions for medications, laboratory tests, administration of medications, treatment of chronic illness, and pregnancy testing. National Assembly on School-Based Health Care, *Creating Access to Care for Children and Youth: School-Based Health Center Census*

(2) **Confidential Health Services** — The items and services enumerated in this paragraph are: *[drafter insert categories of items and services treated as confidential health services under state law]*.²⁶

(e) Contractor's Operating Policies and Procedures

(1) **Duty to Inform Subcontractor** — Within [] days of the effective date of the subcontract, the subcontract shall require Contractor to provide to Subcontractor:

(A) Contractor's policies and procedures manual and any memoranda, guidances, and other materials, whether in written or electronic format, relating to the requirements described in subsections (f)-(l);

(B) Contractor's memoranda, guidances, protocols, and other materials, whether in written or electronic format, needed by Subcontractor to perform its duties under the subcontract; and

(C) the name and telephone number of the individual who is authorized by Contractor to furnish to Subcontractor upon request information regarding the name and phone number of the primary care provider of an enrolled child for purposes of coordination under subsection (g).

(2) **Duty to Withhold Notification on Furnishing of Confidential Health Services by Subcontractor** — In the case of a request for payment submitted by Subcontractor for an item or service covered under subsection (d)(2) (relating to confidential services) furnished to an enrolled child, Contractor shall not mail or otherwise transmit a bill, an explanation of benefits (EOB), or other notification of the furnishing of the item or service to the family or caregiver (as defined in §101App(d)) of the child.

(f) Utilization Management Requirements

Commentary: The following illustrative language would require that Contractor specify in the subcontract with the SBHC any utilization management requirements or procedures to which the SBHC is subject, as well as the particular items or services

1998-1999 (June 2000), Figures 12 and 14 (ordering information at www.nasbhc.org). Not all of these service categories would necessarily be covered under risk contracts between state Medicaid agencies and MCOs.

²⁶ For a survey of state laws regarding "confidential services" for minors (e.g., contraceptive services, prenatal care and delivery, STDs testing and treatment, drug or alcohol abuse counseling and treatment, and outpatient mental health services, see Heather Boonstrah and Elizabeth Nash, *Minors and the Right to Consent to Health Care: The Guttmacher Report on Public Policy 2000*,3(4): 4-8, http://www.agi-usa.org/pubs/ib_minors/minors_table.html.

provided by the SBHC to which these requirements apply. The language would also prohibit the imposition upon SBHCs of utilization management requirements or procedures more restrictive than those imposed upon other participating providers that deliver primary care services.

(1) **Specification** — The subcontract shall specify:

(A) the patient visit limits or other utilization management procedures of Contractor to which Subcontractor is subject; and

(B) each item or service furnished by Subcontractor under the terms of this subcontract that is subject to prior authorization (as defined in §101App(g)), if any.

(2) **No More Restrictive** — The patient visit limits or other utilization management requirements or procedures of Contractor to which Subcontractor is subject under paragraph (1)(A), if any, shall be no more restrictive of Subcontractor's ability to obtain payment for primary health care services furnished to enrolled children than the limits, requirements, or procedures applicable to other providers participating in Contractor's network that furnish primary health care services to enrolled children.

Commentary: Note that final regulations implementing the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, require compliance by most health plans and health care providers by April 2003. The illustrative language below relating to confidentiality does not reflect the requirements of these regulations, which were issued in December 2000.

(g) **Coordination with Primary Care Providers** — The subcontract shall require that Subcontractor:

(1) within [] after a patient visit by an enrolled child,

(A) attempt to notify by telephone or facsimile the enrolled child's primary care provider participating in Contractor's provider network of the visit, the items or services furnished, and the recommendations of the treating practitioner;

(B) record the notification (or attempted notification) in the child's medical record; and

(C) make the enrolled child's medical record available to the child's primary care providers upon request by the provider, subject to:

(i) written consent of the child's parents (or, in the case of an adolescent, the adolescent), which consent may apply to more than one request; and

(ii) [*drafter insert reference to applicable state confidentiality laws and regulations*].

(h) **Submission of Claims** — The subcontract shall provide that, in order to receive payment for items and services described in subsection (d), Subcontractor shall, within [] of a visit by an enrolled child to Subcontractor, submit:

(1) the claim, including encounter data and billing information, as specified by Purchaser;²⁷

(2) a written certification by the SBHC that the SBHC has complied with the coordination requirement under subsection (g) with respect to the encounter; and

(3) [*drafter insert other desired documentation*].

(i) **Reimbursement to Subcontractor** — The subcontract shall require that Contractor reimburse Subcontractor for items and services covered under subsection (d) furnished to an enrolled child on a fee-for-service basis²⁸ in an amount that is not less than the amount which Contractor would pay for the items and services if the items and services were furnished by a provider participating in Contractor's provider network.²⁹

²⁷ For example, Maryland regulations specify that, in order to receive reimbursement for self-referred services, SBHCs must transmit to the MCO "encounter data and billing information using the CMS 1500 format." COMAR 10.09.68.03D.(1).

²⁸ An alternative option could be to provide for subcapitation of the Subcontractor by Contractor. There is some skepticism, however, that many SBHCs have the administrative or financial resources to enter into successful subcapitation arrangements. One SBHC director who has also had experience as an MCO finance executive writes, "I have seen the difficulty of making subcapitation work even with sophisticated primary care physicians in a mature managed care market...and I shudder to think of the 'rank and file' school-based health center nationally trying to comprehend and manage capitation. In a nutshell, an [SBHC] simply cannot afford to pay someone 12 months a year to manage that portion of the health care dollar for services we don't provide." Correspondence to GW CHSRP from Raymond J. Martin, Health Start, St. Paul, Minnesota, August 20, 2001.

²⁹ This illustrative language is derived from language in section 1903(m)(2)(A)(viii) of the Social Security Act, 42 U.S.C. §1396b(m)(2)(A)(viii). An alternative option would be to require Contractor to reimburse the out-of-network school-based health center at the same rate that the State's Medicaid program would pay the provider for the item or service on a fee-for-service basis.

(j) **Record Keeping** — The subcontract shall require that Subcontractor:

(1) comply with the requirements relating to the creation and maintenance of medical records of an enrolled child set forth in [*drafter insert reference to Contractor's policies and procedures manual or other relevant guidance to participating providers*]; and

(2) subject to 42 C.F.R. §§ 431.300 - 431.307 and [*drafter insert reference to applicable state confidentiality laws*], make available to Contractor's representatives, for inspection at the SBHC site, medical records relating to enrolled children to whom Subcontractor has furnished items and services described in subsection (d) to the extent required in order for Contractor to comply with [*drafter insert applicable provisions of purchasing agreement relating to HEDIS or other reporting requirements*].³⁰

(k) **Quality of Care Studies** — The subcontract shall require that Subcontractor, upon request of Contractor, assist in the conduct of any studies of quality of services furnished to enrolled children and in any clinical studies required of Contractor under [*drafter insert reference to quality measurement and improvement provisions in the purchasing agreement between Contractor and Purchaser*].³¹

(l) **Other Requirements** — [*drafter insert other requirements*].

³⁰ One such measure could be the accessibility of immunization services by SBHCs to enrolled children. This measure is one of the "Access/Availability of Care Measures" in HEDIS 2000. For more information on HEDIS, see the website of the National Committee on Quality Assurance, www.ncqa.org. Although MCOs participating in Medicaid are not required by CMS to report HEDIS measures, a number of state Medicaid MCO contracts specify the reporting of HEDIS measures. See Table 5.2 in CHSRP's *Negotiating the New Health System*, 4th Edition (2001), www.gwhealthpolicy.org.

³¹ For examples of illustrative language on quality of care and clinical studies, see CHSRP, **Part 8** of *Medicaid Pediatric Purchasing Specifications* (September 1999), www.gwhealthpolicy.org.

§103C. Subcontract with SBHC Serving as a Primary Care Provider

Commentary: Under §101C(a), the Contractor would have a duty to subcontract with a qualified SBHC that has submitted a notice of intent to subcontract. The following illustrative language represents the second of three options available to the SBHC for structuring the terms of its subcontractual relationship with the MCO. Under this option, the SBHC would participate in the MCO's provider network exclusively as a primary care provider (PCP). The SBHC would be reimbursed only for covered services it furnishes to children enrolled in the MCO who (or whose family on their behalf) have selected the SBHC as a primary care provider.

The illustrative language does not cover all of the issues that would need to be addressed in a subcontract between an MCO and a primary care provider, such as remedies in the event of breach, resolution of disputes, etc. For examples of contract language on these additional issues, see Exhibit 1 at the end of this document.

(a) **Standard Subcontract** — A subcontract described in this section is the standard subcontract entered into by Contractor with providers participating in Contractor's provider network as primary care providers.

(b) **Non-standard Subcontract Terms** — If the Contractor does not in the usual course of business use a standard subcontract described in subsection (a), a subcontract described in this section is a subcontract between Contractor and an SBHC that:

(1) addresses the requirements enumerated in §102C (other than §102C(g) (relating to coordination with primary care providers));

(2) contains only terms and conditions that are no less favorable in than the terms and conditions applicable to any provider participating in Contractor's provider network as a primary care provider; and

(3) does not require the SBHC to make arrangements for ensuring the availability of covered items or services to enrolled children on a 24-hour per day, 7-day per week basis that are more stringent than the arrangements that Contractor requires other primary care providers participating in Contractor's provider network to make.

§104C. Subcontract with SBHC Serving as Primary Care Provider and as Participating Provider

Commentary: Under §101C(a), the Contractor would have a duty to subcontract with a qualified SBHC that has submitted a notice of intent to subcontract. The following illustrative language represents the third of three options available to the SBHC for structuring the terms of its subcontractual relationship with the MCO. Under this option, the SBHC would participate in the MCO's provider network both as a primary care provider (PCP) and as a participating provider that does not have the responsibilities of a PCP. In the case of those children enrolled in the MCO who (or whose parents on their behalf) have selected the SBHC as their PCP, the SBHC would assume the responsibilities of a PCP and would bill the MCO for services rendered on the same basis as other PCPs. In the case of enrolled children who have not selected the SBHC as their PCP but who seek services at school from the SBHC, the SBHC would coordinate with the child's PCP and would bill the MCO for services rendered on the same basis as other participating providers. In short, this option combines the roles of the SBHC in each of the previous two options.

The illustrative language does not cover all of the issues that would need to be addressed in a subcontract between an MCO and SBHC, such as remedies in the event of breach, resolution of disputes, etc. For examples of contract language on these additional issues, see Exhibit 1 at the end of this document.

The language is organized as follows:

§104C. Subcontract with SBHC Serving as Participating Provider and as Primary Care Provider

- (a) Purpose*
- (b) Parties*
- (c) Term*
- (d) Contractor's Operating Policies and Procedures*
- (e) Items and Services Subject to Payment*
- (f) Contractor's Requirements for Primary Care Providers*
- (g) Contractor's Requirements for Participating Providers*
 - (1) Coordination with Primary Care Providers*
 - (2) Submission of Claims*
 - (3) Utilization Management Requirements*
 - (4) Reimbursement to Subcontractor*
- (h) Other Requirements*

(a) **Purpose** — The subcontract shall have as its purpose the designation of responsibility for the furnishing of items and services covered under [*drafter insert reference to coverage provisions in purchasing document*] to an enrolled child by Contractor and by an SBHC (as defined in §101App(j)) in the case of:

(1) an enrolled child who has selected the SBHC as the child's primary care provider (as defined under §101App(e)); and

(2) an enrolled child who has selected a provider other than the SBHC as the child's primary care provider (as defined under §101App(e)).

(b) **Parties**³² — The parties to the subcontract described in this section shall be Contractor and an SBHC (“Subcontractor”) that:

(1) meets the qualifications required under §101C(c); and

(2) has submitted the notice of intent to subcontract under §101C(b).

(c) **Term** — The subcontract shall be effective beginning on the first day of the [] month following the month in which Contractor agrees under §101C(a) to subcontract with Subcontractor and shall be in effect for a period of [*drafter insert period consistent with the term of the purchasing agreement between the state Medicaid agency and the MCO*].

(d) **Contractor's Operating Policies and Procedures**

(1) **Duty to Inform Subcontractor** — Within [] days of the effective date of the subcontract, the subcontract shall require Contractor to provide to Subcontractor:

(A) Contractor's policies and procedures manual and any memoranda, guidances, and other materials, whether in written or electronic format, relating to the requirements described in subsections (f) and (g);

³² Note that the purchasing agreement between the state Purchaser and Contractor designates enrolled children as intended third-party beneficiaries to the agreement, which under state law would entitle them to enforce the terms of the agreement against both Purchaser and Contractor. Purchasers may wish to consider extending this right of enforcement in subcontracts between Contractor and participating providers, including SBHCs. For an example of such language, see Section 13.7 of North Carolina's Medicaid Managed Care Risk Contract (Effective March 1, 2000): "Medicaid Members are the intended third party beneficiaries of contracts between the Division and the Plan and any subcontractors or provider agreements entered into by the Plan..." (p. 24).

(B) Contractor's memoranda, guidances, protocols, and other materials, whether in written or electronic format, needed by Subcontractor to perform its duties under the subcontract; and

(C) the name and telephone number of the individual who is authorized by Contractor to furnish to Subcontractor upon request information regarding the name and phone number of the primary care provider of an enrolled child for purposes of coordination under subsection (g)(1).

(2) Duty to Withhold Notification on Furnishing of Confidential Health Services by Subcontractor — In the case of a request for payment submitted by Subcontractor for an item or service covered under subsection (e)(2) (relating to confidential services) furnished to an enrolled child, Contractor shall not mail or otherwise transmit a bill, an explanation of benefits (EOB), or other notification of the furnishing of the item or service to the family or caregiver (as defined in §101App(d)) of the child.

(e) Items and Services Subject to Payment — The subcontract shall apply with respect to the following items and services furnished by Subcontractor to an enrolled child (whether or not the child has selected Subcontractor as the child's primary care provider (as defined under §101App(e))):

(1) Items and Services that Are not Confidential — The items and services enumerated in this paragraph are: *[drafter insert list of items and services that are covered under the purchasing agreement between Purchaser and Contractor and that SBHCs (or the practitioners staffing SBHCs) are licensed under state law to furnish]*.³³

(2) Confidential Health Services — The items and services enumerated in this paragraph are: *[drafter insert categories of items and services treated as confidential health services under state law]*.³⁴

³³ A national survey found that 80 percent of SBHCs reported providing the following types of services on site: anticipatory guidance, comprehensive health assessment, treatment of acute illness, vision and hearing screenings, immunizations, asthma treatment, nutrition counseling, sports physicals, prescriptions for medications, laboratory tests, administration of medications, treatment of chronic illness, and pregnancy testing. National Assembly on School-Based Health Care, *Creating Access to Care for Children and Youth: School-Based Health Center Census 1998-1999* (June 2000), Figures 12 and 14 (ordering information at www.nasbhc.org). Not all of these service categories would necessarily be covered under risk contracts between state Medicaid agencies and MCOs.

³⁴ For a survey of state laws regarding "confidential services" for minors (e.g., contraceptive services, prenatal care and delivery, STDs testing and treatment, drug or alcohol abuse counseling and treatment, and outpatient mental health services, see Heather Boonstrah and Elizabeth Nash, *Minors and the Right to Consent to Health Care: The Guttmacher Report on Public Policy 2000*,3(4): 4-8, http://www.agi-usa.org/pubs/ib_minors/minors_table.html.

(f) **Contractor's Requirements for Primary Care Providers** — The subcontract shall provide that in the case of an enrolled child with respect to whom Subcontractor serves as the child's primary care provider (as defined under §101App(e)), Subcontractor is subject to the same requirements, terms, and conditions as apply to any primary care provider participating in Contractor's provider network, except to the extent such requirements, terms, and conditions are inconsistent with the provisions of subsection (g).

(g) **Contractor's Requirements for Participating Providers** — The subcontract shall provide that in the case of an enrolled child with respect to whom Subcontractor does not serve as the child's primary care provider (as defined under §101App(e)), Subcontractor is subject to the same requirements, terms, and conditions as apply to any provider who participates in Contractor's provider network and who is not a primary care provider, except as provided in the paragraphs (1) through (4):

(1) **Coordination with Primary Care Providers for Enrolled Children for Whom Subcontractor Is not a Primary Care Provider**— The subcontract shall require that, within [] after the visit, Subcontractor shall:

(A) attempt to notify by telephone or facsimile the enrolled child's primary care provider participating in Contractor's provider network of the visit, the items or services furnished, and the recommendations of the treating practitioner;

(B) record the notification (or attempted notification) in the child's medical record; and

(C) make the enrolled child's medical record available to the child's primary care providers upon request by the provider, subject to:

(i) written consent of the child's parents or, in the case of an adolescent, the adolescent, which consent may apply to more than one request; and

(ii) [*drafter insert reference to applicable state confidentiality laws and regulations*].

(2) **Submission of Claims for Enrolled Children for Whom Subcontractor Is not a Primary Care Provider**— The subcontract shall provide that, in order to receive payment for items and services under in subsection (e) furnished to an enrolled child who has not selected Subcontractor as the child's primary care

provider (as defined under §101App(e)), Subcontractor shall, within [] of the furnishing of the item or service, submit:

(A) the claim, including the encounter data and billing information as specified by Purchaser;³⁵

(B) a written certification by the SBHC that the SBHC has complied with the coordination requirement under paragraph (1) with respect to the encounter; and

(C) [drafter insert other desired documentation].

Commentary: Section 104C further complicates the application of utilization management requirement because the subcontracting SBHC is both a primary care provider (PCP) and a participating provider. As a PCP, the SBHC may be responsible for acting as a "gatekeeper" with respect to children in its panel vis-à-vis other participating providers. Yet as a participating provider, the SBHC may be subject to gatekeeper or other utilization management requirements administered by other PCPs. The following illustrative language would require the Subcontract to specify what utilization management requirements or procedures, if any, apply to the SBHC in its role as a participating provider for those children who have not selected it as their PCP. The language assumes that, for administrative convenience, the MCO would not impose requirements or procedures upon the SBHC as a participating provider that are more restrictive than those the SBHC administers in its role as a PCP.

(3) Utilization Management Requirements for Enrolled Children for Whom Subcontractor Is not a Primary Care Provider — The subcontract shall specify the utilization management requirements (if any), including the patient visit limits (if any), applicable to items and services furnished by Subcontractor to an enrolled child who has not selected Subcontractor as the child's primary care provider (as defined under §101App(e)).

(4) Reimbursement to Subcontractor for Items and Services Furnished to Enrolled Children for Whom Subcontractor Is not a Primary Care Provider — The subcontract shall require that Contractor reimburse Subcontractor for items and services covered under subsection (e) furnished to an enrolled child who has not selected Subcontractor as the child's primary care provider (as defined under §101App(e)) on a fee-for-service basis in an amount that is not less

³⁵ For example, Maryland regulations specify that, in order to receive reimbursement for self-referred services, SBHCs must transmit to the MCO "encounter data and billing information using the CMS 1500 format." COMAR 10.09.68.03D.(1).

than the amount which Contractor would pay for the items and services if the items and services were furnished by a provider participating in Contractor's provider network.³⁶

(h) Other Requirements — [*drafter insert other requirements*].

³⁶ This illustrative language is derived from language in section 1903(m)(2)(A)(viii) of the Social Security Act, 42 U.S.C. §1396b(m)(2)(A)(viii). An alternative option would be to require Contractor to reimburse the out-of-network school-based health center at the same rate that the State's Medicaid program would pay the provider for the item or service on a fee-for-service basis.

Appendix

Commentary: The following illustrative language sets forth definitions of terms common to all three approaches set forth in this document.

§101App. Definitions

(a) Contractor – the managed care organization doing business as [*drafter insert name*] that has entered into an agreement with Purchaser under [*drafter insert name of purchasing document*].

(b) Covered items and services – items and services enumerated in [*drafter insert reference to benefit specifications in purchasing document*] that Contractor is required to furnish to an enrolled child under the coverage determination standards and procedures set forth in [*drafter insert reference to applicable provisions in purchasing document*].

(c) Enrolled child – a child under 21 (including an adolescent³⁷) for whom Contractor assumes financial responsibility for furnishing or arranging for the furnishing of items and services covered under [*drafter insert reference to purchasing document*].

(d) Family or caregiver – a biological or adoptive parent of a child; a grandparent or stepparent with whom the child resides; an individual or entity that is a foster parent or legal guardian; or other individual (including a relative) or agency with legal authority or responsibility to care for the child.

(e) Primary care provider – a physician or [*drafter other applicable health care practitioners*] participating in Contractor's provider network who assumes responsibility for the medical management of an enrolled child, including the furnishing of primary care services covered under [*drafter insert reference to purchasing document*] to the child.

(f) Primary health care services – comprehensive health assessment, anticipatory guidance, treatment of acute illness, vision and hearing screenings, and [*drafter insert other types of services SBHCs as defined in subsection (j) are expected to provide*].

(g) Prior authorization – a utilization management requirement under which an enrolled child (or the child's treating practitioner) must obtain authorization from Contractor for the furnishing of a covered item or service in advance of furnishing the item or service to the child in order to ensure payment to the treating practitioner.

³⁷ For a definition of adolescents, see §1401(a) of the *Medicaid Pediatric Purchasing Specifications*.

(h) Provider network – the set of providers that have entered into enforceable written agreements with Contractor which comply with the requirements of [*drafter insert name of purchasing document*] to furnish, or arrange for the furnishing of, covered items and services to enrolled children.

(i) Purchaser – [*drafter insert name of state purchasing agency*].

(j) School-based health center (SBHC)³⁸ – a school-based health center (SBHC) is a public or private non-profit entity operating under [*drafter insert reference to a state law or regulation*]³⁹ in or adjacent to a school that furnishes primary health care services (as defined in subsection (f)) to children (including adolescents) without regard to ability to pay.

³⁸ One model of SBHCs is those funded under Healthy Schools and Healthy Communities Program administered by BPHC, www.bphc.hrsa.gov/HSHC. Among the elements of this model are: (1) capacity to provide comprehensive primary, preventive and supplemental health care services; (2) on-site (or arrangements for) delivery of mental health and oral health services; and (3) appropriate hours of operation, access to after-hours care (24-hour coverage) and arrangements for referrals and emergency health services. (BPHC Policy Information Notice 2001-04).

³⁹ An alternative option in a state which licenses SBHCs would be to require the SBHC to meet the applicable licensure requirements.

Exhibit 1: Sample Managed Care Provider Subcontracts

Commentary: Approach C includes three different subcontracting arrangements (§§102C - 104C). The illustrative language for each of these subcontracts is incomplete; it does not address generic issues such as remedies in the event breach, resolution of disputes, etc. This Exhibit lists references to complete subcontracts between MCOs and providers to which drafters may wish to refer for additional language on the issues not addressed in this document.

American Academy of Pediatrics, *Model Managed Care Agreement* (1998).

American Health Lawyers Association, *Managed Care Contracting Handbook: A Guide for Payors and Providers*, 4th Edition (June 2001).

American Medical Association, *Model Managed Care Contract* 2nd Edition (2000), www.ama-assn.org/ama/upload/mm/38/mmcmsa.pdf.

Epstein, Becker & Green, PC, "Model Agreement," in *School-Based Health Centers and Managed Care: Contracting Issues and Options*, (July 2000), M. Honig, ed., Appendix B, Center for Health Care Strategies, Inc., www.chcs.org

New Mexico Human Services Department, Medical Assistance Division, SBHC/MCO Pilot Project, *Agreement to Provide School-Based Health Center Services Between School-Based Health Center Contractor and Managed Care Organization* (March 6, 2001), template for use in Salud! program.

Exhibit 2: Incentives for Subcontracting with SBHCs

Under Approach (C), a Purchaser would require that an MCO subcontract with any SBHC that serves children enrolled in the MCO. An alternative to requiring the MCO to subcontract would be to establish financial incentives for MCOs to subcontract with SBHCs.

This approach is discussed in HRSA's Opportunities to Use Medicaid in Support of School-Based Health Centers (forthcoming, www.hrsa.gov/medicaidprimer): "Incentives to MCOs to encourage the coordination with SBHCs include: enhanced capitation rates, enhanced scoring in competitive bidding, and increased Medicaid enrollment. For example, Medicaid often has an automatic enrollment method for persons who do not choose a specific plan during the open enrollment period. MCOs that include SBHCs [in their provider networks] might receive greater numbers of enrollees..."

The West Virginia Medicaid managed care contract for 1999-2000 provides as follows:

"4.5 Incentive-based Payments to Managed Care Plan.

The Department may offer additional incentive-based payments within the constraints of the Upper Payment Limit, as described in section 4.4. For the initial year of this contract term, the Department will award up to 2 percent in additional capitation to each managed care plan in each county in increments of one-half of one percent (0.5%) as an incentive to contract with certain types of publicly supported providers. The managed care plan will only receive financial incentives for contracting with publicly supported providers that serve those counties where the managed care plan has a Department Medicaid contract. The following types of providers are considered to be publicly supported for the purposes of the Mountain Care program:

- *Children with Special Health Care Needs (CSHCN) providers;*
- *Local Public Health Departments;*
- *Primary Care Centers (State-designated centers that are not FQHCs or RHCs);*
- *Federally designated Critical Access Hospitals; and*
- *School-based Health Centers."*

State of West Virginia Department of Health and Human Resources, Bureau of Medical Services, Purchase of Service Contract (State Fiscal Year 2000), p. 31.