AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-22)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

Whereas, School Based Health Centers (SBHCs) are facilities located within the kindergarten through twelfth grade school setting that provide an array of high-quality health care services to students [1,2]; and

Whereas, SBHCs were first established in the 1960's by the American Academy of Pediatrics to increase access to primary health care and preventative health services, especially for the most vulnerable underserved population of children[3]; and

Whereas, Services available are driven by community need, ranging from primary medical care to dental, vision, and behavioral health services, alongside wraparound programming such as substance abuse counseling and social case management, and about 40% of SBHCs employ physicians[1,2,4]; and

Whereas, The benefits of routine preventive care are well-established and are incredibly important for children from infancy to adolescence, providing 1) prevention of serious medical illnesses through vaccination and screening, 2) tracking growth and development, 3) raising medical-related concerns, and 4) creating a strong patient-centered medical home[5]; and

Whereas, The SBHC model provides students with increased access to health care resources and improved long- and short-term health care outcomes, including decreased emergency department visits and hospital utilizations [3,6,7]; and

Whereas, SBHCs act as a "safety net health care delivery model" for uninsured, underinsured children or those who lack accessible healthcare[8] ; and

Whereas, SBHCs can receive both grant funding by private organizations and the government, and reimbursement for services rendered by a third-payer payer, most commonly Medicaid and the Children's Health Insurance Program (CHIP); through private organizations;[9] or through direct funding programs established by federal, state and local governments[10]; and

Whereas, The federally qualified health center (FQHC) program funds community health centers that serve medically underserved populations, such as SBHCs, by providing cash grants, drug discounts, legal protections, medical staff and, most uniquely, per-visit reimbursement by Medicaid[11] ; and

Whereas, Funding SBHCs has been shown to be cost-effective by increasing access to preventive care and reducing utilization of expensive acute care services, leading to a net savings for Medicaid of $30 to $969 per visit[12]; and

Whereas, School-based health centers have grown substantially over the past two decades, primarily due to an increase in federally qualified health center (FQHC) sponsorship, with 2,584 SBHCs in the United States in 2017, more than double in number present in 1998, and since 2008, SBHC growth in urban areas has been greatly outpaced by growth in rural and suburban settings[13] ; and

Whereas, The majority of students without access to SBHCs attend schools in low-income communities eligible for Title I funding, and while increased FQHC sponsorship has greatly contributed to recent growth, 80% of FQHCs are not currently partnered with SBHCs[4]; and

Whereas, Many SBHCs rely on public funding,[9] although in 2014 only 89% of SBHCs billed Medicaid and 71% billed CHIP in 2014[4]; and

Whereas, Not all services rendered can be reimbursed under Medicaid at SBHCs, since among many requirements: 1) the child must be Medicaid-eligible, 2) the service must be among those covered by Medicaid and 3) the service must be provided by a Medicaid-participating provider - further, until 2014, reimbursement was not allowed for services given without charge to the beneficiary, except under rare exceptions[4,14,15] ; and

Whereas, Apart from seven state Medicaid agencies, SBHCs are not considered a provider type[16] making the reimbursement of services more difficult for SBHCs;

Whereas, The lack of differentiation on claims data means that Medicaid is unable to identify what services were rendered by an SBHC versus a different type of provider, making it difficult to track and attribute improvements in quality of care or outcomes to SBHCs, making it difficult for SBHCs to meet quality standards expected by the state[16]; and

Whereas, Multiple states have recently enacted policies that have facilitated or increased Medicaid reimbursement to SBHCs, with seven states (Delaware, Illinois, Louisiana, Maine, New Mexico, North Carolina, and West Virginia) naming SBHCs as a provider under Medicaid, four states (Louisiana, Maryland, Michigan, and New Mexico) mandating Medicaid reimbursement through a managed care organization, and eight states (Connecticut, Delaware, Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) waiving prior authorization[16]; and

Whereas, The AMA supports the study of SBHCs and recommends SBHC standards (H-60.991), supports adequately resourced SBHCs for healthcare delivery to children and adolescents (H-60.921), and supports physician service reimbursement and reimbursement for physician practices (H-240.966; H-385.990; H-385.942; 385.952); therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.921, "School-Based and School-Linked Health Centers," by addition and deletion to read as follows:

School-Based and School-Linked Health Centers, H-60.921

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.

3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 04/08/22

References:

1. U.S. Health Resources & Services Administration. School-Based Health Centers. https://www.hrsa.gov/our-stories/school-health-centers/index.html. 2017.
2. Komro KA, Tobler AL, Delisle AL, O'Mara RJ, Wagenaar AC. Beyond the clinic: improving child health through evidence-based community development. BMC Pediatr. 2013;13:172. Published 2013 Oct 21. doi:10.1186/1471-2431-13-172
3. Arenson M, Hudson P, Lee N, Lai B. The Evidence on School-Based Health Centers: A Review. Glob Pediatr Health. 2019;6:2333794X1982874. doi:10.1177/2333794x19828745
4. Love HE, Schlitt J, Soleimanpour S, Panchal N, Behr C. Twenty Years Of School-Based Health Care Growth And Expansion. Health Aff (Millwood). 2019;38(5):755-764. doi:10.1377/hlthaff.2018.05472
5. Bright Futures & American Academy of Pediatrics. AAP Schedule of Well-Child Care Visits, Periodicity Schedule. 2018.
6. Falkner F. Prevention in childhood of health problems in adult life. Geneva: World Health Organization; 1980. Available for download at https://apps.who.int/iris/bitstream/handle/10665/39219/9241560649_eng.pdf?sequence=1&isAllowed=y
7. Bixenstine P, Conway P, Jain SH. Fighting chronic disease starts with better pediatric care. Harvard Business Review. 2017.
8. Knopf JA, Finnie RK, Peng Y, et al. School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review. Am J Prev Med. 2016;51(1):114-126. doi:10.1016/j.amepre.2016.01.009
9. Kanaan SB. Making the grade: State and local partnerships to establish school-based health centers [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2007. Available for download from: https://www.rwjf.org/en/library/research/2007/02/making-the-grade.html
10. Heller E. Improving Access to Care with School-Based Health Centers. National Conference of State Legislatures. 2017;25(18).
11. Health Resources and Services Administration: Health Center Program. What is a Health Center? 2018.
12. Ran T et al. Economic evaluation of school-based health centers: A community guide systematic review. Am J Prev Med. 2016;51(1):129-138. doi:10.1016/j.amepre.2016.01.017
13. Love, H., Soleimanpour, S., Panchal, N., Schlitt, J., Behr, C., Even, M. (2018). 2016-17 National School-Based Health Care Census Report. School-Based Health Alliance. Washington, D.C.
14. Department of Health and Human Services. Re: Medicaid Payment for Services Provided without Charge (Free Care). 2014. Letter. Accessible at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf
15. Accountability Office. Subject: School-Based Health Centers: Available Information on Federal Funding. 2010. Letter. Accessible at https://www.gao.gov/assets/100/97141.pdf
16. School-Based Health Alliance. Medicaid Policies that Work for SBHCs. Accessible at https://www.sbh4all.org/advocacy/medicaid-policies-that-work-for-sbhcs/.

RELEVANT AMA POLICY

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a

physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.
CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

School-Based and School-Linked Health Centers H-60.921
Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.
CSAPH Rep. 1, A-15

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966
(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.
(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.
(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.
(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.
Sub Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation: I-98; Reaffirmation: A-02; Reaffirmation: I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19

Payment for Physicians' Services H-385.990
Our AMA:
(1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.
(2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.
(3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.
(4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.
CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: CMS Rep. 01, A-20

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942
The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.
Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952
Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.
Res. 118, I-95; Reaffirmation: A-00; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19