



Developing a Business Plan for Sustaining School Mental Health Services: Three Success Stories

Donna Behrens, Julia Graham Lear, Olga Acosta Price

THE GEORGE
WASHINGTON
UNIVERSITY
WASHINGTON, DC



The Center for
Health and Health
Care in Schools
healthinschools.org

Introduction

Imagine an America where children arrive at their school desks, ready to learn and succeed. They have coping skills to address their everyday worries, concerns and stressors, as well as the more difficult challenges life may present. They have social skills to establish positive relationships with their peers, teachers and parents. They make healthy choices that allow them to focus on their education and prepare for future success. And if a problem arises, they have access to early intervention and treatment. Now, imagine having sustainable funding to make all of this a reality.

We may still be several steps away from making this vision a reality; but education and health professionals are increasingly aware of the research demonstrating that behavioral and emotional health contributes to effective learning and academic achievement. And in an increasing number of communities, students have access at school for help with mental health problems through mental health assessments, crisis intervention, early intervention and treatment.

Currently, however, barriers, particularly financing issues, restrict the expansion of existing programs and limit the growth of new ones that offer mental health and treatment services to students in a school setting. To shed light on successful models for sustaining school mental health services, the Center for Health and Health Care in Schools at George Washington University looked at three school mental health programs – in Pennsylvania, Washington, DC and Minnesota – that have crafted financial policies and processes that support their work. Their strategies include putting systems in place for billing Medicaid and other third-party payers and supplementing these patient-care revenues with public and private grant dollars and in-kind contributions. In short, they have developed and executed business plans that ensure long-term availability of services.

The hope is that by highlighting these three programs and sharing their business plans, we will shed light on some best practices that should be considered in searching for strategies to sustain school mental health services.

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A Definition of School Mental Health

For purposes of this paper, “school mental health services” refer to mental health promotion and treatment services offered to students in a school setting. Currently school mental health services are most commonly organized using one of two models: (1) the school district directly employs mental health personnel such as school social workers, psychologists and guidance counselors, or (2) the school district partners with community agencies, organizations and independent mental health professionals to bring care into the school setting.¹

Typically community mental health or social service agencies come into the school building and provide their services in coordination with the school and school-employed staff. The services provided by either school-employed or community-based providers include individual and family counseling and case management. Ideally services offer a continuum of care that includes mental health assessments, behavior management consultation, crisis intervention, early intervention and prevention, individual, group and family counseling, referral and case management. The three school mental health programs described in this paper are examples of school-based care that is provided by community mental health agencies that are professionally independent of the schools.

Three Case Studies

Many school mental health programs are funded primarily through government or foundation grants.¹ However, whether funding comes from public or private sources, depending on grant funds is a shaky strategy in today's unstable economy. In addition, reliance on time-limited funds such as grants can make school administrators wary of allowing such services into their schools, because ultimately, school administrators must answer to parents and school staff if services disappear when their funding runs out.

Thus solid and secure programs begin with a plan for what services will be provided and how those services can be sustained.

In order to grow and expand mental health services in schools, the challenge of securing long term, sustainable funding must be addressed and a clear plan developed for how these services will be sustained. The three case studies that follow are valuable because the leaders of these programs are developing strategies and putting systems in place for securing sustainable funding.

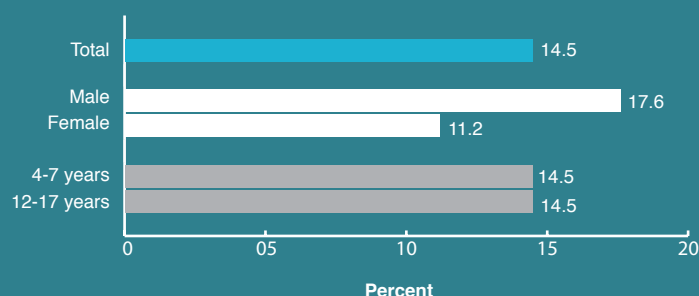
The following three paths for developing and sustaining school mental health services reflect the truth that, in public policy, there is rarely a "one size fits all" approach that will work. The rules for who is covered, what is covered, and what services are reimbursed are different in every state and with each insurance carrier. This variety makes the task of pursuing third party reimbursement daunting. Some school mental health programs make the case that the end (the amount collected from third party and patient reimbursements) does not justify the means (investment of time and funding to develop and manage the billing infrastructure). As suggested by the following case studies, we would argue that this viewpoint is unnecessarily pessimistic, and as the case studies demonstrate, a higher level of sustainability can be achieved when serious efforts are made to embrace an approach that includes maximizing third-party reimbursements.

During the spring of 2012, staff members at the Center for Health and Health Care in Schools interviewed representatives of the three community-based

programs described in this report. These programs have tackled the reimbursement challenge and are moving forward with a plan to sustain school mental health services. What they have done and what they have learned is summarized in the following three case studies.



Percentage of children aged 4–17 years whose parents talked to a health care provider or school staff about the child's emotional or behavioral difficulties in the past 12 months, by sex and age group: United States, 2005–2006



SOURCE: CDC/NCHS, National Health Interview Survey.

Simpson, G.A., Cohen, R.A., Pastor, P.N., & Reuben, C.A. (2008). *Use of mental health services in the past 12 months by children aged 4-17 years: United States, 2005-2006*. NCHS data brief, no 8. Hyattsville, MD: National Center for Health Statistics.

CASE STUDY

Family Service Association of Bucks County, Pennsylvania

PROGRAM DESCRIPTION

Beginning in 1953, the Family Service Association (FSA) of Bucks County has provided mental health and substance abuse services for adults and children in Bucks County, a community located in the southeastern corner of Pennsylvania. Today, the organization serves nearly 6,000 people of all ages in the county.²

In 1988, FSA began offering mental health services in schools. While this work was originally supported by private foundations, the county's Children and Youth Agency began to provide support to FSA shortly thereafter. Recently FSA has expanded its revenue base to include Medicaid reimbursements for school-delivered mental health care.

WHO IS SERVED

FSA has located its school services in nine elementary, two middle and one high school in Bucks County. In spring 2012, FSA had approximately 100 open cases for students in these schools. The agency works closely with each school to estimate the number of provider hours required to meet student needs. It should be noted that especially at the elementary and middle school levels, student enrollments may not be sufficient to warrant a full-time practitioner in each school.

The FSA school mental health program accepts all behavioral health referrals made by school staff. Privately insured students and those who are uninsured are referred to one of three FSA community-based mental health offices. The school mental health program provides on-site services to students who have a diagnosable mental health disorder and who are enrolled in Medicaid. The rationale behind the referral policy is that the school mental health offices are not equipped to set up sliding scale fees for the uninsured or to accept checks or money for sliding-fee-scale payments, deductibles and/or co-payments that are required by the private insurers.

SERVICES OFFERED

The FSA school mental health sites are staffed by master's-prepared clinicians who are licensed and have been approved as providers by Magellan Behavioral Health Care, the Medicaid managed mental health organization (MCO) in Bucks County. As part of the contract between FSA and Magellan,

the school-based providers are not required to be individually credentialed by the MCO but are accepted as part of the overall contract with FSA. The school mental health program employs four to five clinicians who are mostly part-time employees. The clinicians have summer months off and students and their families are followed in the three main FSA offices during the summer.³

Services offered through the FSA school mental health program include individual counseling and counseling for the families. If a student requires a psychiatric evaluation or a medication initiation or review, the student and family are referred to one of the three main FSA offices. Although the program managers indicate it would be ideal to offer these services at school, they believe it is neither economically or logistically practical.

The clinicians also provide some limited teacher consultation and attend meetings about students with whom they are working. FSA encourages the providers to attend these meetings but to be careful about how much time is spent this way. One FSA administrator pointed out,

“It is common to get invited to every meeting involving the child, but clinicians need to be judicious about which meetings they attend since the meetings are not a billable service. But when issues are on the table that affect students and their mental health, then they are there.”

In addition, a grant from the County Children and Youth Agency enables providers to offer case management services that are not billable and also supports them in conducting home visits and some outreach activities.

HOW THE PROGRAM IS FUNDED

The FSA school mental health program was originally financed through private foundation grants and monies from state grant programs. After experiencing a significant reduction in these funds, FSA decided to support its school services by developing a business plan that included a focus on third-party payments. As a first step, the plan called for licensing the school-based mental

health programs as outpatient mental health sites with the state of Pennsylvania and each school site also had to be licensed individually by the Magellan Behavioral Health, the behavioral health managed care organization (BH-MCO) in its area of the state. To meet the licensure requirements of the state, each school mental health program had to have designated space within each school that was specifically allocated for the delivery of services. Pennsylvania also requires licensed mental health clinics to have on-site psychiatric oversight.

However, one of the reasons for FSA's success was its ability to work with the state to secure a waiver of this requirement for the school mental health sites.

The agreement reached was that each site would be exempted from that requirement as long as the school site was in close geographic proximity to the main clinic site where psychiatric backup was available.

In Pennsylvania, the Medicaid program is a capitated managed care program with separate programs for physical health and behavioral health/substance abuse services. The behavioral health program is HealthChoices Behavioral Health (HC-BH).⁴ The Pennsylvania Medicaid office has oversight of HC-BH at the state level, but responsibility for organizing and managing mental health services locally is the responsibility of the 67 counties in Pennsylvania. There are different managed behavioral health organizations operating in various regions and counties of the state.

FSA had already developed the capacity to bill effectively for its services in its three main clinics. When FSA expanded its billing to include the school mental health program, it followed the same procedures established for the main sites. The clinicians use both paper records and a separate electronic database that handles billing and enrollment data. All electronic data are submitted to the central office. Verifying insurance information is done centrally on a monthly basis. Currently, FSA is transitioning to cloud-based electronic medical records and the school mental health clinic sites will become part of that system.

The billing codes that are reimbursable were established in the contract with Magellan Health Care. There is no pre-approval required, no limit on the number of visits a student is allowed and no need to have treatment plans submitted to Magellan prior

to service or as a condition for service continuation. Treatment plans must be completed and updated as part of the students' records. The school-based clinics conduct internal audits frequently.

Even with an established list of reimbursable services, FSA reports there are many services for which it would like to bill but cannot. For example, because there is no reimbursement for mental health visits that do not carry a diagnosis, no early intervention care is covered.

SUCCESSES

FSA believes that the biggest reason for success in its school mental health program is the support it has received from the Bucks County local government. It was the county that wanted this program and used its leveraging position to get Magellan and everyone else involved to work out the details. And it was everyone being at the table and wanting to make this work that has been the force behind the success.

CHALLENGES

FSA would like to expand its school mental health program into other schools, but this would require both Magellan and the county to approve an expansion. Even with the success of the current program, it requires a lot of effort to keep the program vital and growing. FSA reports the logistics of working in a school setting can be very challenging. FSA staff comment that any time you go to a new school, there is a huge learning curve. It is difficult for the school to understand how and when to make referrals to the clinic and accept the limits on what the school mental health program can and cannot do for students and families.

The other major challenge, according to FSA, is for the school clinics to engage parents in the mental health care of their children. The very reason why school mental health is so valuable is that the students can be seen during the school day, reducing barriers to care such as transportation and employment demands that may limit parents' ability to get their kids to needed services. However, parents remain critical to successful treatment and providers in the school mental health programs must "go the extra mile" to engage parents in the treatment process.

CASE STUDY

The Washburn Center for Children in Minneapolis, Minnesota

PROGRAM DESCRIPTION

The Washburn Center for Children in Minnesota is a community mental health center in the Twin Cities area.⁵ The agency serves children and adolescents with a wide variety of needs such as trauma, anxiety, depression and learning difficulties. The Center's goal is to improve access for underserved populations by reducing financial, cultural and transportation barriers to care. To increase families' access to mental health services for their children, the Washburn Center has offices in 18 schools in three school districts, primarily in elementary schools.

WHO IS SERVED

Services are available to any student enrolled in the school who might be experiencing mental health symptoms or difficulties and whose parent has consented to their child's care.⁶ The service is available to students regardless of family income level or insurance status. Social workers, teachers, school administrators or parents who note problem behaviors or mental health symptoms refer the student to the school social worker. The social worker then facilitates a request for Washburn Center services. All agency procedures and policies related to parental consent, patient information protections, privacy, mandated reporting and other aspects of therapeutic practice are followed. When a referral is made, the therapist contacts the parent or guardian to schedule an initial conversation. Based on a diagnostic assessment, the clinician determines what therapeutic services are appropriate and whether referrals for additional services, such as case management or psychiatry, are needed. Of the children served who qualify for a DSM diagnosis, roughly two-thirds are receiving mental health services for the first time. Thus, it appears that many of the children receiving help through the school mental health center would otherwise be falling through the cracks.

SERVICES PROVIDED

The school mental health program focuses on providing an integrated continuum of care, including therapeutic assessment, consultation and care coordination services. Services include individual, group and family therapy, as well as diagnostic assessment. Additionally, the program offers consultation and training for parents, teachers, social workers and other school staff members.

The school mental health therapists are all independently licensed mental health professionals

and work full time in their assigned schools. Therapists work with teachers and pupil support personnel to address the social, emotional or behavioral issues impacting students' academic and social success. The school mental health offices are open year round and are considered satellite clinics of the Washburn Center for Children.

HOW THE PROGRAM IS FUNDED

The Washburn Center for Children uses a braided funding strategy that weaves together third-party reimbursement from health care plans, contributions from local school districts, county funding for uninsured clients and state grant funds. Key informants at the state, county and local level believe this blend of financial commitments is essential for making the school mental health program work and ensuring its sustainability. Program representatives report that these arrangements have assured access for all children, regardless of their ability to pay.

The Minnesota State Medicaid program is a combination of fee-for-service and managed care. Behavioral health is carved into the Medicaid program. The Medicaid managed care program, known as the Pre-Paid Medical Assistance Plan, has four participating entities: Medica, Health Partners, Blue Cross Blue Shield and UCare. These plans are all non-profit organizations and serve both the Medicaid population as well as those who are commercially insured. The health plans work together to make the mental health services in the commercial product as similar as possible to the Medicaid product.

Because the Washburn Center has a long history of providing mental health services to children in the community, it had existing contracts and personal relationships with the managed care organizations and was able to add the school mental health satellite centers to its existing provider arrangements. The Washburn Center has found that the plans have been glad to have the school mental health satellite clinics in place because these arrangements have increased client access and shown improved outcomes for the children served. The plans reimburse for care provided to both Medicaid and commercially insured students seen at school.

About 10 percent of the total school population that Washburn serves is uninsured, although that percentage is much higher in some individual schools.

To cover the cost of serving the uninsured, there are two sources of funds: state and county dollars. The state funds go directly to the mental health providers. Part of the agreement between state Medicaid and the provider agencies is that the providers must bill for all services that they can and that are covered by insurance, and that the state grant funds will cover the cost of the uninsured and non-billable services only. Local support comes through Hennepin County Human Services and the Public Health Department, and these funds are granted through “not to exceed” contracts to many of the agencies, including Washburn, that are providing school mental health services to uninsured students for medically necessary clinical services. The cap on these contracts varies by agency depending on the number of uninsured students they serve in a school year.

The critical element in the Washburn financial plan is the contractual relationship between the Washburn Center and the therapists in the school mental health program. The Washburn contract explicitly states that each therapist will provide an average of 15 billable sessions per week during a 46-week year. To accommodate the fewer clinic hours during the summer months, most therapists average about 17 billable sessions weekly during the school year and 10 during the summer months. In addition, each therapist is expected to provide up to nine hours per week of non-billable services, including time for care coordination and teacher consultation. On average, clinicians spend two-thirds of their time providing billable services and one-third of their time on non-billable activities.

The budget for the school mental health program is based on an average cost of \$90,000 for a full-time therapist. The therapist generates about \$60,000 from third-party reimbursements (including Medicaid, commercial insurance and county contract reimbursement for the uninsured). The remaining \$30,000 is covered by state grants, foundation support and school district funds. The schools are also providing space for the program as an in-kind contribution to the program.

BILLING CAPACITY

Washburn has invested in an electronic health record and outcomes systems. Each therapist is required to submit billing data and visit reports within 48 hours of service provision. In return, the therapist receives reports twice monthly that track their billable and non-billable hours. Monthly reports by program and by individual therapist also summarize outcome measures and completion of treatment plans and diagnostic assessments. This system allows for timely

feedback, tracking and quality assurance. Washburn also offers an incentive plan and a revenue-generating compensation plan. An incentive plan is available for therapists who meet productivity goals. For providers not meeting minimum productivity standards, there is a revenue-generating compensation plan based on a per-session compensation model. This combination has worked well in maintaining budgeted productivity and giving the therapist the needed data and feedback to make necessary adjustments.

SUCCESSSES

Critical to the success of the Washburn Center for Children’s school mental health program has been the support of a county-wide organization, the Hennepin County School Mental Health Administrators Group, which includes key representatives from all sectors with a stake in school mental health. This group has focused on sustaining and growing the school mental health program in Hennepin County. The group meets regularly to exchange information, problem-solve, and assess implementation successes and barriers. There are 14 school districts in the county of which Minneapolis is the largest. All but one of the school districts has school mental health programs.

Another key element in the success of this program has been a jointly funded position (by Hennepin County Human Services, the Public Health Department and the Minneapolis Public School District) for a school mental health coordinator. This person focuses on implementation of school mental health programs in the Minneapolis Public School District as well as ongoing evaluation and research related to these programs. The school mental health coordinator, in collaboration with other partners, developed the data collection tools used to monitor, evaluate, and conduct research on school mental health services in Minneapolis and Hennepin County. At the county level, the coordinator provides technical assistance to individual programs and to Hennepin County on school mental health initiatives, their contracts, and the student and program outcomes.

CHALLENGES

Despite its ability to bill both private and public insurers, the program remains dependent on grant money to fund care for uninsured students and to help support non-clinical services. The level of support from current funding sources (public and private insurers and school districts) will need to increase if the program is to decrease its dependency on grant money and move the school mental health program toward greater self-sufficiency.

CASE STUDY

The District of Columbia School Mental Health Program

PROGRAM DESCRIPTION

The school mental health program in Washington DC has been in existence since the 2000-2001 school year. By 2011, the school mental health program was located in 53 schools (40 DC public schools and 13 public charter schools), totaling 25 percent of all school buildings. The DC school mental health program, developed and managed by the DC Department of Mental Health (DMH), recruits and places licensed clinicians in these schools. Service availability ranges from a half-time to a full-time clinician, five days a week during the academic year.

WHO IS SERVED

The school mental health program serves any student who presents with a mental health issue or need. The program does not turn any student away regardless of insurance status or presence or absence of a diagnosable disorder. For those students enrolled in special education, clinicians provide mental health services that address problems that are *not* included as part of an Individualized Education Plan.

SERVICES OFFERED

Services include mental health promotion and early intervention and treatment services, including diagnostic assessment as well as individual and group counseling. Additionally the clinicians are integrated into the school itself and work with school staff to improve overall school climate. The clinicians conduct workshops for school staff in universal mental health promotion strategies, consult with teachers, and offer workshops on topics requested by teachers and school administration.

HOW THE PROGRAM IS FUNDED

The DC School Mental Health Program was originally launched with funds from the city's DMH. The program continues to receive departmental funds, garnering almost \$5 million dollars of local support annually. The DC school mental health program recognized the need to diversify its funds, decrease the dependency on one funding source, and free up public grant dollars to expand the program to serve more schools. It began billing third party payers for school mental health services in March 2009. The DC School Mental Health program bills all insurance carriers for all students and for all billable services.

The majority of students seen in the DC school mental health program are either enrolled in Medicaid or are Medicaid-eligible. The DC Medicaid mental health program is a managed care "hybrid" with some mental health services for certain populations carved out of Medicaid managed care; for other populations, their mental health services are carved in. Services for children on Medicaid who have severe mental illness are carved out of the managed care organizations and administered by the Department of Mental Health under the Medicaid Rehabilitation Option. This represents about 5 percent of the children seen for publicly supported mental health services; the remaining 95 percent are considered to have mild to moderate mental health conditions and are cared for through managed care organizations and carved into the Medicaid managed care system. Two behavioral managed care organizations serve the DC Medicaid population: United Behavioral Health and Chartered (managed by Beacon).

DC's Medicaid managed care organizations (MCOs) receive an automatic capitated amount for each covered person. School mental health services are seen as having the potential to increase student access to care and expand the level of services delivered. The MCOs see this as a beneficial increase in the services they can offer to children and youth in DC.

About 52 percent of children in DC were publicly insured through Medicaid/CHIP in 2010.⁷ With a high percentage of students enrolled in or eligible for Medicaid, the DC School Mental Health Program pursued recognition by the Medicaid managed mental health organizations as mental health providers. Perhaps because DMH is part of the DC government, there was a willingness on the part of the managed care organizations to contract with DMH and cover school mental health services. Even with the willingness, it has been a challenge to secure reimbursement for all services delivered in the school setting.

Through discussions and negotiations, DMH and the managed care organizations reached an agreement on a package of services that can be billed by the DMH school-based providers, although it does not include prevention and early intervention services.

DMH and the MCOs have begun negotiations to add new codes to the list of covered services. These codes would allow for reimbursement of services that target the at-risk student population to prevent them from developing more severe mental health or substance abuse conditions (99401 series; evaluation and management code).

For privately insured students, their payers are billed for services. Although the reimbursement rates are low, DMH receives payment for qualified services by most commercial insurers, with the exception of Kaiser Permanente, an insurer that does not allow for out-of-network care. For those commercial insurers that require collection of co-payment or where there is a deductible, DMH is developing a system to invoice the families directly. DMH also created a sliding-scale fee structure for their uninsured population.

While billing third-party payers will bring in new and needed revenues, at this point these payments are insufficient to finance the entire program. DMH continues to receive support for school mental health services through a line item in the DC budget.

BILLING CAPACITY

DMH is responsible for all aspects of the school mental health program including billing and collections. After getting agreement from Medicaid managed care organizations for a reimbursement arrangement, DMH has created the necessary internal billing infrastructure. This included ensuring all clinical staff met the credentialing requirements of the managed care organizations and establishing intake systems to collect and verify insurance information on students. For uninsured students who seek services, mechanisms had to be established to enroll eligible students in Medicaid. The licensed clinicians had to be credentialed with the managed care organizations, eligible service codes identified, and reimbursement rates established.

Currently, DMH has a dedicated staff person responsible for all the intake and insurance authorizations for the school based mental health program. There is an expectation that school mental health clinicians will have a minimum of 10 hours per week of billable services and carry a caseload of 10 to 20 cases.

SUCCESSSES

The MCOs have been happy to partner with the school mental health program. The program increases the number of Medicaid children served and that has gone a long way in providing good press and reassuring elected officials.

Mental health services are being reimbursed and these new revenues can cover some program costs, thereby decreasing reliance on local tax dollars. While the reimbursement numbers are still smaller than anticipated, DC DMH has made much progress. The third-party reimbursements collected in the past school year were three times higher than the previous year.

CHALLENGES

It takes time, skill, and persistence to secure reimbursement for services provided in schools and, to date, the reimbursement levels remain low, despite persistence and hard work. It is acknowledged that third-party payments will not cover the total cost of the program. There is also concern about the renegotiation of the contracts with the MCOs in the coming year. With current budget deficits, school mental health program managers and supporters worry about potential limitations on services and/or reductions in reimbursement rates required by the managed care organizations.

Lessons Learned

Every state and community is unique in how it organizes and pays for mental health services for children. A viable plan to sustain school mental health services should be tailored to reflect and build on this uniqueness. These three case studies, however, illustrate some common elements that contributed to their success. These include the following:

They left no money on the table

All three community-based programs are maximizing all possible sources of support for their school mental health services including public and private insurance, in-kind contributions from the school systems and grants from a variety of public and private entities to subsidize non-billable services.

They used clout as needed

All three programs had a source of “clout” (power and influence) that was either intrinsic to the program (as in the case of DC program which is part of the local government) or existed because of established connections to people and/or organizations with influence that helped bring insurance providers to the table to negotiate.

They adopted a “no margin, no mission” approach to sustaining their program

All three community-based programs were committed to serving all students in need of mental health care regardless of ability to pay. They also set clear productivity expectations for clinicians around maintaining a balance of billable versus non-billable services. This approach operationalizes the wisdom of the “no margin, no mission” mantra coined by Sister Irene Krause of the Daughters of Charity National Health Care System, a saying that acknowledges that a commitment to a strong fiscal foundation is essential to achieve their mission of serving all students with mental health needs.

They invested in billing infrastructure

All three community-based programs made an investment in the administrative infrastructure to support their billing capacity. They had a consistent way of collecting financial and insurance information on all students receiving services, verifying eligibility, entering and tracking encounter data, submitting claims and tracking reimbursement. They also had established sliding scale fee structures and a system to collect co-payments and deductibles.

They knew the 3 E’s essential to third party reimbursement

All three community-based programs knew the eligible services, eligible clients, and eligible providers of the commercial and public insurance providers that covered the students they served. With this essential information in mind, sponsors of the school mental health programs were well positioned to negotiate more effective third-party billing arrangements and rates.



Looking Forward

Schools and school mental health programs are on the frontlines of providing mental health services to students, both insured and uninsured. Therefore, school mental health programs must address how they are going to sustain their services—both billable and non-billable. In the near future, even with the best outcomes for health care reform and the most efficient billing systems in place, there will continue to be a need for funds to cover those without insurance and to pay for the non-billable services that are vital parts of school mental health programs.

One must also take into consideration the changes currently affecting school systems, which will invariably affect school mental health programs. While it is unclear where schools will be in ten years, it is all but certain that academic achievement, high-stakes testing and the charter school movement will persist, sustaining the pressure on schools to direct funds towards those goals. Thus, despite growing support for school mental health programs, program developers will need to look for additional revenues, outside the traditional school budget, to sustain school mental health.

If health care reform survives, patient care revenue may be the most promising building block for long-term school mental health support. Thus Medicaid and other third-party insurers will be a critical source for developing and sustaining a successful school mental health business plan.



Business Planning for Sustainable School-Based Mental Health Services

Developing a business plan to sustain a school mental health program forces a critical examination of the school community to be served (the market), gaps in services (gap analysis), how the program will address the gaps (what services will be offered by whom and where), a definition of program goals, and the sources (revenues) and use (expenses) of funds.

In the planning process, one key revenue source that must be considered is third-party reimbursement. A sustainability plan must factor in all possible services that would be covered by Medicaid or private insurers and how to ensure these potential reimbursements are captured. By paying closer attention to patient care revenues as part of a planning process, school mental health providers will increase the likelihood of continuous support for the program, thereby increasing the likelihood of sustaining services.

1

Identifying the right people who can make things happen.

In developing the business plan, it is important to identify and meet with representatives of the insurance carriers you hope to bill. This includes commercial insurance carriers who have clients in the community as well as representatives from the local or state Medicaid office. Working with insurers may be a new role for school mental health providers and working with school mental health programs may be new for the insurers, so establishing a trusting and effective partnership early in the game is important.

2

Getting the right pieces in place to bill.

Determine the 3 E's -- Eligible Services, Eligible Clients, Eligible Providers -- for each insurer. These fundamentals underpin the insurance-based, health care delivery model. There are eligible enrollees, who receive eligible services that are delivered by providers who are empanelled or are certified as eligible to be reimbursed for services by the plan.

The providing organization must have credentialed staff, a defined list of services, established methods for billing and collections, an identified list of billing codes that align with those covered by insurers, and have a system in place for reconciling claims and following up on claims denied.

3

Managing the billing process.

Once an agreed-upon system for billing and reimbursement is established, getting a mechanism in place to resolve billing and reimbursement issues as they develop is essential.

Decisions will need to be made about how to handle commercial insurance when there is a required co-payment or deductible. Decisions also need to be made about how to handle cash payment for services.

School mental health providers historically have not pursued collection of co-payments from students or their families. However, the benefit of pursuing private third-party payments is worth giving thought to dealing with any requirements around the collection of co-payments.

4

Maintaining healthy working relationships.

There will be bumps in the road, but by developing a collaborative environment at the beginning of the relationship, and maintaining open lines of communication throughout the process, challenges can usually be resolved. Create processes and expectations for ongoing dialogue to address new issues as they arise and be prepared to think innovatively about approaches. Having advocates in the community for ensuring the sustainability of these important student-serving services will go a long way when risks or threats arise.

(Endnotes)

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About CHHCS

The Center for Health and Health Care in Schools (CHHCS), located within the George Washington University School of Public Health and Health Services, is a nonpartisan policy and resource center that builds on a 25-year history of testing strategies to strengthen school-connected health programs for children and adolescents. Center staff and consultants work with institutional leaders, state officials and clinical providers to maximize outcomes for children through more effective health practices, programs, and policies.

CHHCS maintains an extensive web site of 5,000 pages that combines information on key school health issues with guidance on organizational and financing challenges. High-quality school health programs are the most direct, efficient ways to assure that all children get the help they need to lead healthy and productive lives.

Donna Behrens, RN, MPH, BSN, associate director of the Center for Health and Health Care in Schools. Prior to joining CHHCS, Ms. Behrens was Executive Director of the Maryland Assembly on School-Based Health Care, an advocacy organization that supports increasing children's access to health care through expanded use of school based health centers. Previously she served as Director of Health Policy and Director of the School-Based Health Center Initiative in the Maryland Governor's Office for Children, Youth and Families. In these two positions she used her extensive background in nursing, children's health, mental health, policy and program development to develop stronger systems to prevent teen pregnancy, expand children's mental health services, reduce infant mortality, and increase access to school mental health programs. Ms. Behrens received Associate and Bachelor's degrees in nursing from Prince George's County Community College and Catholic University of America respectively and a Masters Degree in Public Health from The Johns Hopkins University Bloomberg School of Public Health.

Julia Graham Lear, PhD, is senior advisor and founder of the Center for Health and Health Care in Schools at the The George Washington University School of Public Health and Health Services and professor in the Department of Prevention and Community Health. For 25 years she has worked with the Robert Wood Johnson Foundation to develop school-based health programs and services as a means of promoting the well-being of children and adolescents. She teaches courses at the university and writes and speaks frequently on the organization of health care for children and adolescents. She graduated from Brown University and received her master's degree and doctorate from Tufts University.

Olga Acosta Price, PhD, is director of the Center for Health and Health Care in Schools and associate professor at the School of Public Health and Health Services, at the George Washington University. Her faculty appointment is in the Department of Prevention and Community Health. She comes to the Center with experience in managing school-based mental health programs in Washington, D.C. where she was Director of the School Mental Health Program at the D.C. Department of Mental Health, an award-winning community-based program. Dr. Acosta Price managed the development, implementation, and evaluation of this program in 30 public schools for over five years. Before coming to Washington, Dr. Acosta Price was associate director at the Center for School Mental Health Assistance and assistant professor at the University of Maryland School of Medicine in Baltimore. She has presented at local and national meetings on school-based mental health, program evaluation, and violence prevention and has written several articles and book chapters on these topics. Dr. Acosta Price graduated from Vassar College and received her master's degree and doctorate from the State University of New York at Buffalo.