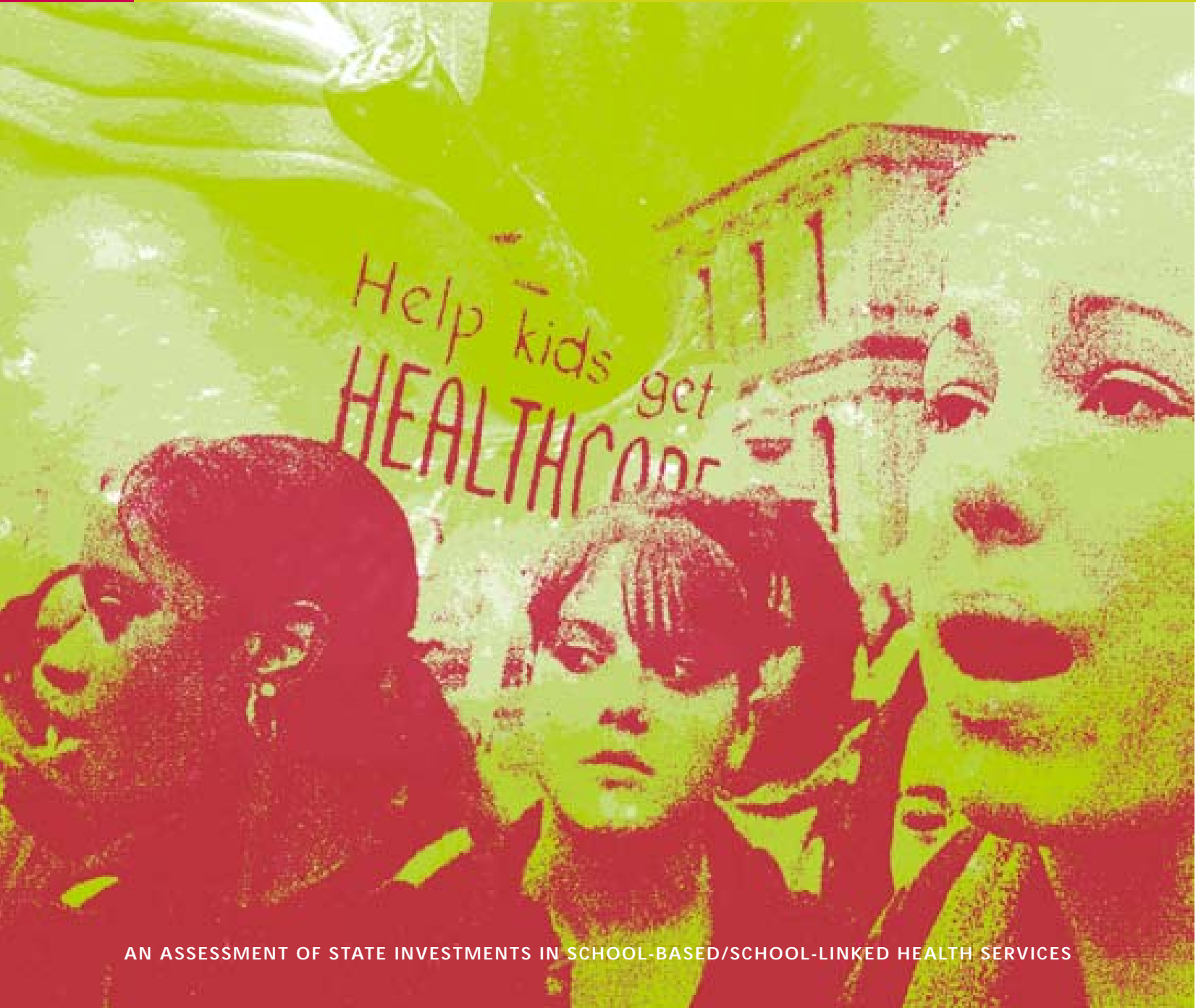




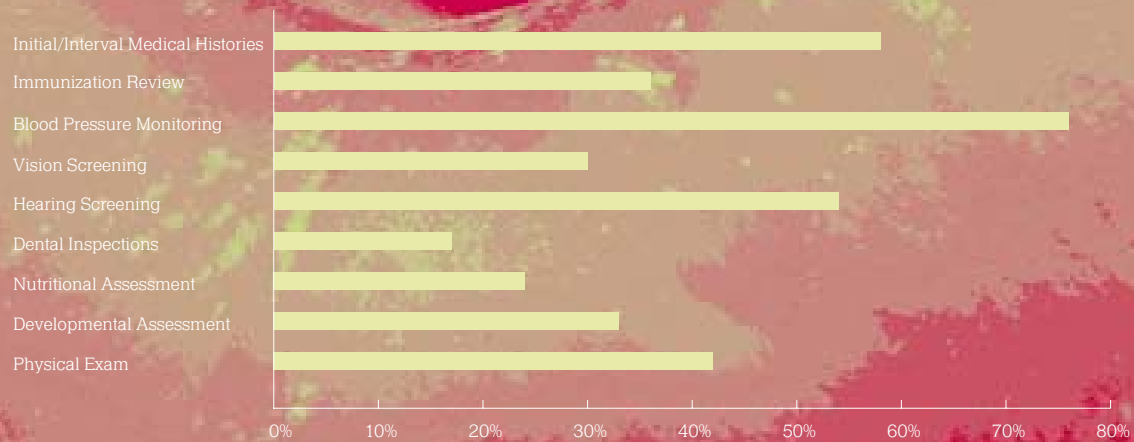
# Healthy Youth

  
BUDGET  
WATCH  
SPRING 2003



AN ASSESSMENT OF STATE INVESTMENTS IN SCHOOL-BASED/SCHOOL-LINKED HEALTH SERVICES

## Michigan Youth and Young Adults in Medicaid Managed Care Receiving Required EPSDT Services, Ages 13-21



Source: MCMCH EPSDT: A Snapshot of Michigan.

Michigan's  
**Children**  
A Child Advocacy Organization

Authors: Patricia L. Sorenson, MSW, JD  
Richard Lower, MA

# Healthy Youth: An Assessment of State Investments in School-Based and School-Linked Health Services

**Adolescence is a time of dramatic physical, emotional and intellectual growth and change. It is during adolescence that young people increasingly make decisions that may affect their future opportunities and their health. Teenagers are faced with many difficult choices about tobacco use, alcohol, diet, sexual behavior, and drugs.**

It has been estimated that one of every four young people between the ages of 10 and 17 engages in high-risk behaviors, including excessive use of illegal substances, early unprotected sex, delinquency and dropping out of, or falling behind in school. Another 25 percent are at moderate risk because of school absences, minor delinquency, occasional use of cigarettes and alcohol, and early sexual activity.<sup>1</sup> Further, many young people are suffering from emotional or psychological conditions that threaten their well-being during this critical developmental period.

Unfortunately, adolescents are also less likely to seek and receive basic preventive health care, and the problem of access to preventive care is even more serious for certain groups of children. For example, Michigan youth in low-income families are more than twice as likely to have health conditions that limit their activities (20 percent compared to 9 percent of youth in higher income families), but are five times more likely to be uninsured.

Even for children who are insured, access to preventive care is not uniform. In Michigan, only 66 percent of adolescents report that they saw a doctor or health care provider for a preventive check-up or physical exam when they were not sick or injured during the past 12 months<sup>2</sup>. Of adolescents and young adults insured by Medicaid in Michigan—the primary public health care program for low-income children—58 percent had not had a physical examination in the last year, 83 percent had not had a dental screening, 70 percent had not been given a vision screening, and 64 percent had not had an immunization review.

## What Are Common Health Risks During Adolescence?

- Nearly half of Michigan high school students report using alcohol, with one-quarter engaging in binge drinking. Alcohol use among adolescents is significantly associated with a range of health-compromising behaviors and earlier onset of alcohol use and higher levels of use have also been associated with poorer academic functioning and higher rates of school dropout.<sup>3</sup>
- One quarter of all Michigan high school students smoke cigarettes.
- More than 25% of students report experiencing depression; one in 10 claims to have attempted suicide; and each year approximately 140 young people in Michigan take their own lives.<sup>4</sup>
- Nearly one third of high school students has engaged in recent sexual intercourse, including 17 percent of 9th graders.
- Although the rate of teen births is declining, nearly 5,000 babies are born to teenage girls every year in Michigan, and the national teen birth rate continues to be the highest in the developed world.

## Michigan Students and Physical Health

Youth Responses Grades 9-12, 2001

Youth who...	male	female
■ are overweight .....	14%	8%
■ described themselves as slightly or very overweight .....	25%	37%
■ were trying to lose weight .....	30%	62%
■ ate fruit one or more of the past seven days .....	83%	87%
■ ate other vegetables one or more of the past seven days .....	81%	84%
■ ate five or more servings of fruits and vegetables per day of the past seven days .....	22%	19%
■ drank three or more glasses of milk per day of the past seven days .....	27%	14%
■ exercised or participated in vigorous physical activities for at least 20 minutes on three or more of the past seven days .....	72%	57%
■ had ever been taught about HIV/AIDS in school .....	89%	89%
■ saw a doctor or health care provider for a check-up or physical exam when they were not sick or injured during the past year .....	66%	67%

Source: Youth Risk Behavior Survey, Center for Disease Control, U.S. Dept. of Health & Human Services

## Can Risky Behaviors by Teens Be Prevented?

There is ample evidence that access to health and mental health services can help prevent risky behaviors by teenagers, and improve their health and productivity in school and in the community.

- A well planned, sequential health education program reduced by 37 percent the proportion of seventh-grade students who started smoking.<sup>5</sup>
- The prevalence of obesity decreased among girls in grades 6 to 8 who participated in a school-based intervention program.<sup>6</sup>
- In one study where mental health services were available on-site, students were substantially more likely to see a counselor in the previous year—regardless of their health insurance coverage.<sup>7</sup>
- In a study of the STAR program—a school-based drug prevention program—participants were found to have significantly less drug use than the control group both at the end of high school and at age 23. Even though the program dealt only with drug use, program participants also exhibited fewer unintended pregnancies, dropped out of school less, and were more likely to be employed at age 23 than the control group.<sup>8</sup>

## What Are The Barriers To Prevention?

**There are a number of identified barriers to adequate health and mental health services for adolescents, including:**

- Many teenagers remain uninsured. Adolescents are less likely to have health insurance than other age groups. For low-income families, the cost of private insurance can be prohibitive, and many employers who hire low-wage workers provide either no health insurance coverage, or inadequate coverage that doesn't cover dependents or preventive services. Particularly lacking is adequate commercial coverage for mental and behavioral health services.
- Many children and teenagers that are eligible for publicly subsidized health insurance are not enrolled. The Urban Institute found that there are nearly 225,000 uninsured children in Michigan, or close to 8 percent of all children. Of those, 161,500 (over 70 percent) are uninsured even though they are eligible for Medicaid or other publicly-subsidized health care coverage. More aggressive outreach at the state and local levels is required to reduce the number of "needlessly uninsured" children.
- Many adolescents are uncomfortable seeking care through traditional health care providers.
- Many publicly-insured children and adolescents have trouble accessing preventive health care.



There is a range of reasons for this lack of access, including inadequate provider participation in Medicaid; inadequate procedures for ensuring services, including missed opportunities by health care providers to provide required services; insufficient training for providers on required Medicaid services for children and adolescents; and practical problems such as transportation and language barriers.

- Health care providers may not have extensive experience dealing with the broad range of prevention issues of importance to adolescents. Even when adolescents are connected to health providers, traditional providers may have limited impact on behavior-related problems because they are less likely to have frequent contact with their patients and are less likely to practice alongside professionals trained to focus on mental health and health education issues of an adolescent population.

### Michigan Youth Risk Behavior Status

Behavior	2001
Current cigarette use .....	25.7
Current alcohol use .....	46.2
Binge drinking .....	29.3
Carried a weapon .....	12.5
Current marijuana use .....	24.3
Experienced depression .....	27.3
Attempted suicide .....	10.2
Sexual intercourse:	
<i>past three months</i> .....	29.9
<i>9th grade</i> .....	17.4
<i>12th grade</i> .....	47.5

# What Is The State Doing to Ensure That Michigan Students Have Access to the Health-Related Information and Services They Need?

## Most public schools are responding in limited, but consistent, ways to the health needs of students.

Because of the high level of contact school employees have with students, schools have always assumed responsibility for a range of health-related services. School personnel administer medications, provide first aid for illness and injury, participate in vision and hearing screenings, and provide counseling services to children with emotional or social problems.

A survey of Michigan Public Schools<sup>9</sup> found that nearly all schools administer first aid (93%) and medication (91%) to their students. In addition, 3 of every 4 public schools participate in vision and hearing screenings, and make referrals to community resources. Approximately one-third of the schools provided mental health services, case management for children with chronic health problems, health counseling, substance abuse referral and treatment, and home visits to discuss student health problems with their families.

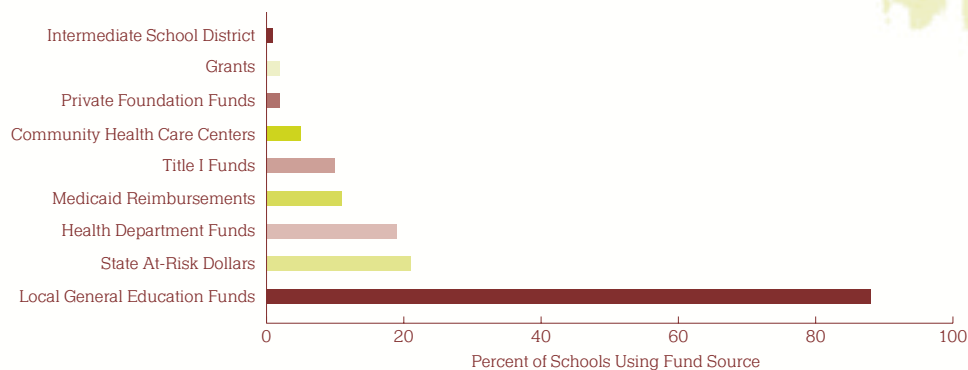
The majority of these school health services are delivered by school staff, including secretaries, principals and teachers. Approximately one-third of the schools report that school social workers or

other mental health professionals are providing services to students. Approximately one quarter of the public schools relied on a school nurse employed by the school district. Districts were less likely to contract with local health care providers and nurses for services.

Most public schools (88%) report that they use local general education funds for school health services. Approximately one in five use State School Aid funds from the “At Risk” program. These funds are provided to school districts for a wide range of supplemental activities for children at risk of educational failure, including social work services. Other significant sources of funding for basic school health services are funds from the state or local health departments, Medicaid reimbursements, and federal Title I funds.

In the Governor’s FY 2004 budget, School Aid funds for at-risk students are maintained at fiscal year 2003 levels. The Governor recommends \$314.4 million for the School At-Risk program. The Governor also recommends that the allowable uses of At-Risk School Aid funds be expanded to include before-and after-school programs.

## Funding Sources for School Health Services (1998)



Source: Michigan School Health Services Report, Michigan Department of Education

## Most Michigan schools have a basic health education curriculum.

Over 90 percent of Michigan public schools provide health education to their students, based on the Michigan Model for Comprehensive Health Education (the Michigan Model).<sup>10</sup> The Michigan Model was established in 1985, and is a cooperative effort between state agencies, including the Michigan Departments of Community Health and Education, the Michigan Family Independence Agency, the Michigan State Police, and the Office of Highway Safety Planning. The curriculum is currently implemented in over 90% of Michigan's public schools in grades kindergarten through twelve and in more than 200 private and charter schools accounting for nearly one million students. The Michigan Model connects health messages to other parts of the student's lessons, including language arts, social studies, science, math and art.

### *Basic tenets of the Michigan Model:*

- Families are their children's most important health teachers;
- Health teaching and being well are positively related to greater personal and academic success;
- Illegal drug use is wrong and harmful;
- Violence can be stopped through teaching conflict management; and
- Good health comes from making wise choices early in life.

### *The Michigan Model is designed to teach:*

- Self discipline and cooperation;
- Respect for others and for oneself;
- Respect for property and the environment;
- Respect for laws and school rules;
- Compassion and helpfulness; and
- Kindness and non-violent resolution of conflicts.

Governor Granholm's proposed fiscal year 2004 budget recommends eliminating \$3.2 million in funding for the School Health Curriculum. There had previously been funding in both the Department of Education and Michigan Department of Community Health (MDCH) budgets. Still unclear is the fate of approximately \$100,000 in the MDCH budget for the school health curriculum. The funds are used for training and technical assistance to school districts through a network of 26 regional coordinating sites, typically located in intermediate school districts.

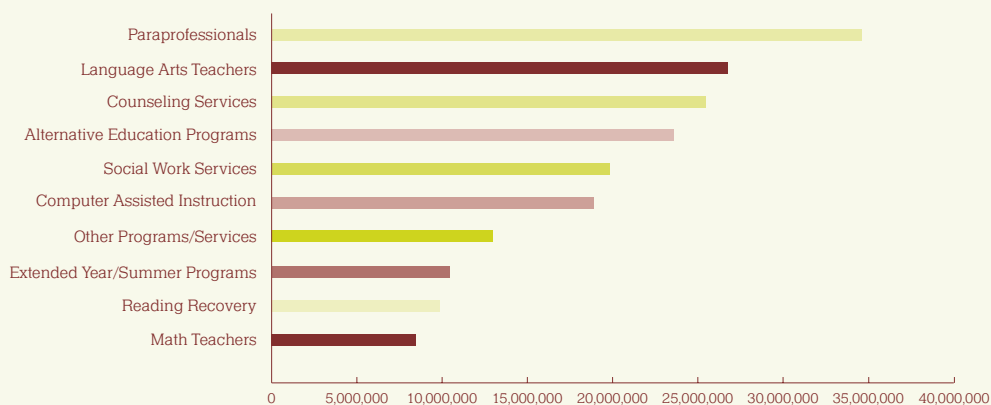
## Local health departments provide basic health services through the schools.

Michigan has 30 single county health departments, 14 district health departments covering multiple counties, and one city health department in Detroit. Michigan's Public Health Code<sup>11</sup> requires the state to identify priority health problems and a list of basic health services to be made available to residents through local health departments. Included in the list is immunizations, communicable and sexually transmitted disease control and prenatal care. The Health Code also requires the Michigan Department of Community Health to establish a plan for school health services in cooperation with the Department of Education.<sup>12</sup>

One major involvement of local public health departments in the schools is the hearing and vision screening program. Vision screenings are performed on pre-school age children, as well as those in grades 1, 3, 5, 7, 9, and 11. Hearing screenings are provide at least once between the ages of 3 and 5 years, and every other year between the ages of five and twelve years. In fiscal year 2001, local health departments screened 571,535 children for vision, and 716,448 for hearing.<sup>13</sup>

## At-Risk Pupil Support: Top Ten Uses by Michigan School Districts

(FY2001-02)



Source: Michigan Department of Education, Field Services Division

**Federal and state laws require school districts to provide certain health and mental health services to children eligible for special education services, including children with physical and emotional disabilities.**

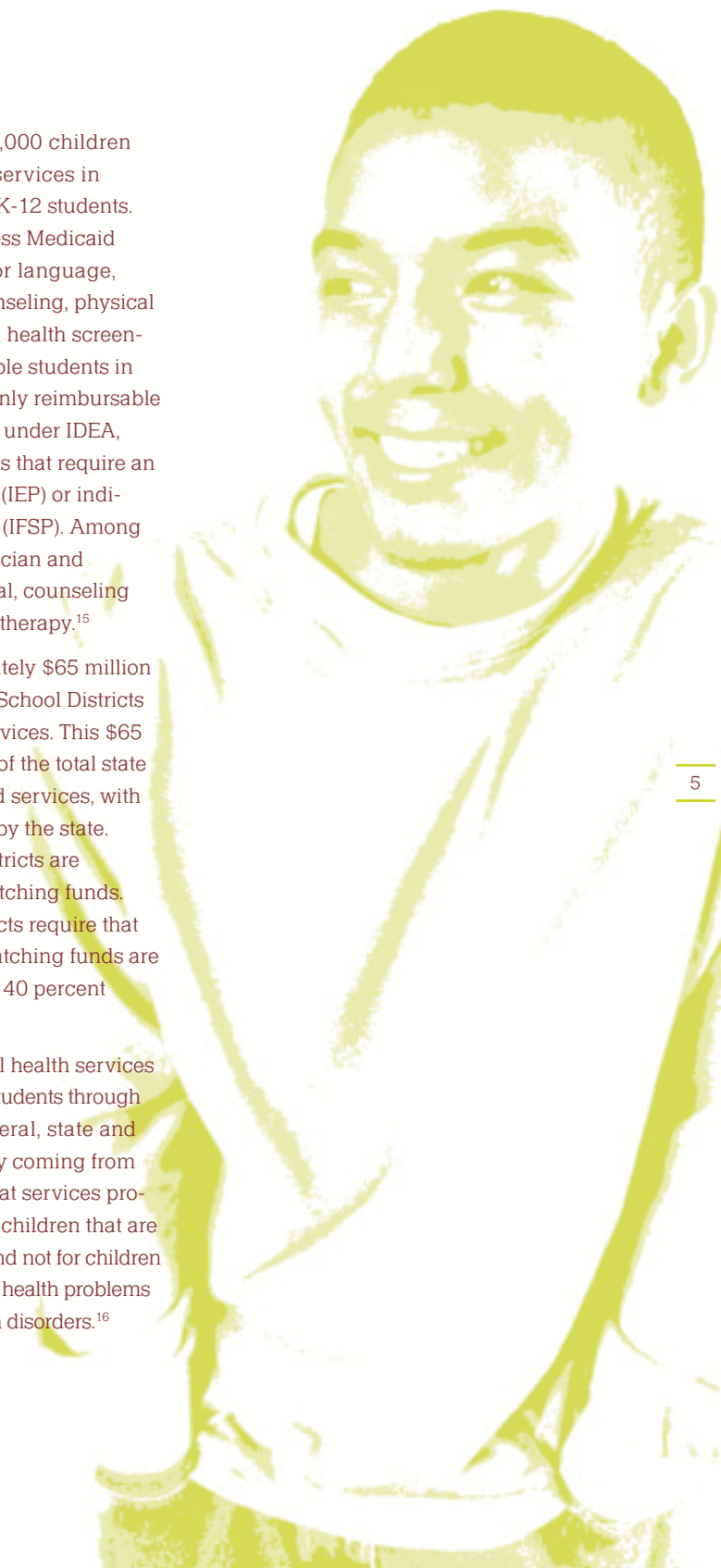
Federal and state laws require school districts to provide special health and educational services to students suffering from physical or psychiatric disabilities, emotional problems, behavioral problems, and learning disabilities. Federal law mandates that every child will receive a free and appropriate education in the least restrictive environment. Three Federal laws apply to children with special needs:

- The Individuals with Disabilities Education Act (IDEA). IDEA governs all special education services for children in the United States. Under IDEA, in order for a child to be eligible for special education services, they must be in one of the following categories: serious emotional disturbance, learning disabilities, mental retardation, traumatic brain injury, autism, vision and hearing impairments, physical disabilities, and other health impairments.
- Section 504 of the Rehabilitation Act of 1973. Section 504 is a civil rights statute that requires that schools not discriminate against children with disabilities and provide them with reasonable accommodations.
- The Americans with Disabilities Act of 1990 (ADA). The ADA (1990) requires all educational institutions, other than those operated by religious organizations, to meet the needs of children with psychiatric problems. The ADA prohibits the denial of educational services, programs or activities to students with disabilities and prohibits discrimination against all such students.<sup>14</sup>

There are approximately 230,000 children receiving special education services in Michigan, or 14 percent of all K-12 students. Michigan school districts access Medicaid funding for health services for language, speech, hearing, nursing, counseling, physical and occupational therapy, and health screening services to Medicaid-eligible students in school settings. Services are only reimbursable if provided to children eligible under IDEA, and those enrolled in programs that require an individualized education plan (IEP) or individualized family service plan (IFSP). Among the covered services are physician and nursing services, psychological, counseling and social work, and physical therapy.<sup>15</sup>

In fiscal year 2003, approximately \$65 million was provided to Intermediate School Districts for Medicaid school-based services. This \$65 million represents 60 percent of the total state appropriation for school-based services, with the remainder being retained by the state. Local Intermediate School Districts are reimbursed with Medicaid matching funds. Agreements with school districts require that 60 percent of the Medicaid matching funds are distributed to the schools, and 40 percent retained by the state.

Nationwide, health and mental health services provided to special education students through IDEA are funded through federal, state and local sources, with the majority coming from state budgets. Of concern is that services provided under IDEA are only for children that are eligible for special education, and not for children with certain less serious mental health problems or those at risk for mental health disorders.<sup>16</sup>



## School districts receive funding for substance abuse and violence prevention.

The federal Safe and Drug-Free Schools and Communities Act supports programs to prevent violence in and around schools, as well as to prevent substance abuse by youth. The program has two major components. The state grant component is a formula grant program, with at least 80 percent of the funding provided to the state to distribute to school districts through a formula. Up to 20 percent of a state's money may be given to the Governor's office for distribution as special grants and contracts to school districts or community groups for services to youth with special needs, such as dropouts, or homeless or pregnant students. In addition to the state grants, there is a federally administered program that provides discretionary funding for demonstration projects and special initiatives.

In Michigan, the Safe and Drug-Free Schools program is administered by the Michigan Department of Community Health (MDCH). In addition to allocating a set amount of the

federal funds to school districts, the MDCH awards the Governor's discretionary funding through an annual competitive process. In fiscal year 2003, school districts received a total of \$16.4 million in funding for a wide range of drug and violence prevention activities. Eighty percent of those funds are provided to schools through a formula, while 20 percent (\$3.3 million) is provided to school districts and community agencies through the Governor's discretionary fund through a competitive grant process. Federal funds to Michigan for the Safe and Drug-Free Schools program peaked in FY1998 at \$20.7 million.

In addition, Michigan uses federal funds from the Centers for Disease Control for rape and sexual assault prevention education grants. These federal preventive block grant funds are used for grants to community-based organizations that work with the schools on rape and violence prevention activities. Services are provided to youth between the ages of 12 and 18, and include student and public education, peer counseling, and training of community professionals.

## Very few schools in Michigan have adolescent health centers.

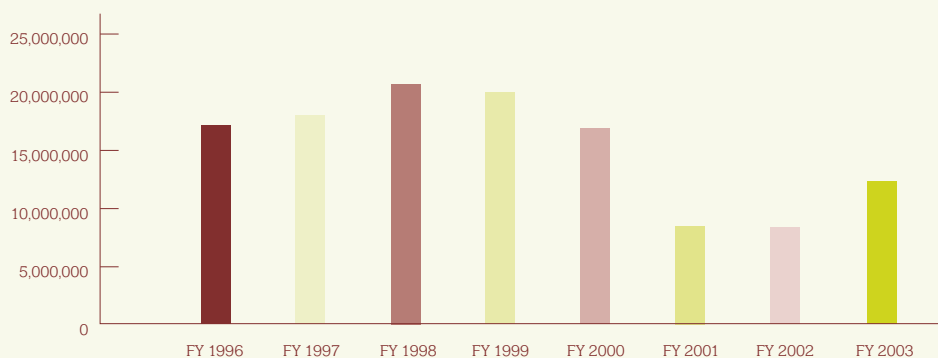
Adolescent health centers in Michigan provide comprehensive services, including asthma care, the dispensing of medications, general medical check-ups, sports physicals, mental health and substance abuse referrals, health promotion/disease prevention education, dental screenings, and immunizations. The ability to provide comprehensive services in a location that is convenient, easily accessible, non-threatening and tailored to young people has been a special strength of adolescent health centers.

There are 743 public schools in Michigan, and 47 adolescent health centers. Of these, 28 receive public funds through the Michigan Department of Education—in conjunction with the Michigan Department of Community Health. Specifically, school-based health centers are located in or on school property while school-linked health centers are mainly located off school property. All centers are supervised by a licensed physician, while services can be given by a certified nurse practitioner, licensed physician or a licensed physician's assistant working under the supervision of a physician.

Public funds are used to support two types of adolescent health centers in Michigan:

- **Clinical Adolescent Health Centers:** There are currently 19 state-funded clinical centers that serve approximately 20,000 Michigan youth, providing nearly 55,000 health care visits and 76,000 services. Clinical centers provide primary health care, as well as mental health and prevention services.
- **Non-Clinical Adolescent Health Centers:** There are currently 9 state-funded non-clinical programs providing approximately 20,000 direct services to Michigan adolescents, as well as health education to nearly 70,000 youth. Non-clinical programs are designed to provide health education, peer counseling, screening services and referrals for primary or specialty care.

## Funding Trends for Grants to Michigan Safe and Drug-Free Schools and Communities Program (FY 1996-2003)



Source: Michigan Department of Community Health, Office of Drug Control Policy,

# What Are Adolescent Health Centers? Why Are They Needed?

Adolescent health centers are designed to overcome barriers that hinder adolescents from getting needed comprehensive health care and services, including primary medical services, assessment and referral, health education and mental health counseling.

Some clinics also provide prenatal care, recreational activities, employment and training services, teen parenting programs and high school completion classes. Adolescent health centers generally serve students with and without health insurance and the fact that services are available for all students in the participating school districts has helped to broaden community support for the centers.

Public schools are a logical place to provide health and mental health care and referrals for adolescents because of their convenient location and because students often feel more comfortable seeking health care and advice in the more familiar setting of a adolescent health center<sup>17</sup>. Adolescent health centers have been able to more effectively address the concerns of many youth about confidentiality, as well as obstacles such as transportation, inconvenient appointment times, costs, and uncomfortable feelings about discussing personal problems.

Twenty years ago, there were few adolescent health centers. There are now approximately 1,500 centers across the country, with nearly two of every three located in urban communities. Approximately 36 percent of the centers are connected to high schools, 37 percent to elementary schools, and 18 percent to middle schools.<sup>18</sup> Most adolescent health centers are administered by community-based organizations such as hospitals, local health departments and non-profit organizations, in collaboration with the schools.<sup>19</sup>

Adolescent health centers in Michigan are primarily located in medically under-served communities, and assist low-income children and families. While nearly half of the services provided by the centers are general medical services, more than 20 percent are health promotion, and 6 percent mental health services.<sup>20</sup>

## ***Studies have shown that adolescent health centers improve students' health and school performance.<sup>21</sup>***

- A Texas study found that schools with health centers experienced a 32 percent decrease in absences, a 31 percent decrease in course failures, and a 95 percent decrease in disciplinary referrals.
- A study by Henry Ford Health System in Detroit found improvements in MEAP scores and improved attendance rates in schools with school-based health centers.
- A Detroit middle school with a school-based health center experienced a 70 percent decrease in violent activities following violence prevention activities.
- A Detroit middle school that promoted pregnancy prevention through its school-based health center had a 62 percent decrease in the pregnancy rate after the first year.



## What Makes An Adolescent Health Center Successful?

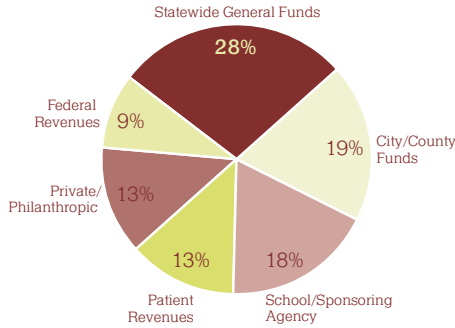
Adolescent health centers are successful because they:

- are located where young people are, providing health care when they want it, where they need it;
- screen to prevent and treat diseases and other health threats;
- provide health promotion to keep students drug-free and physically fit;
- are a safe place for teens to talk about troubling issues;
- reduce parental work absences;
- strengthen the connection between school and family;
- link families to a variety of needed services;
- help to keep students in school and work with school staff to remove physical and emotional barriers to learning;
- provide counseling and support to students experiencing family and community stress;
- identify students at risk for violence and substance abuse and intervene early to promote a safe and healthy environment;
- help to reduce the need for special education services;
- help to keep children out of hospitals and emergency rooms; and
- detect illness early to help reduce the need for expensive treatment later.

# How Are Adolescent Health Centers Funded?

## Funding Sources for Adolescent Health Centers

(United States 2002)



Source: Smith, V.K. Opportunities to Use Medicaid Support of School-Based Health Centers, Lansing, MI

Adolescent health centers, like most community-based health programs, have needed to piece together funding from multiple sources to sustain themselves. In Michigan, less than half of the adolescent health centers receive state funding; the remainder are funded through local hospitals, foundations, local governments and other sources. Nationally, the largest component of adolescent health centers funding has been state general funds (28% of total funding). Other important sources of funding include county and city funds (19%), and school or sponsoring agency support (18%), private and philanthropic funds (13%), and federal funds (9%). Patient revenue accounts for 13 percent of total funding, with most coming from the federal Medicaid program.<sup>22</sup>

Adolescent health centers have in the past relied on state funding in part because of their unique mission. The centers have served all students in a school setting—whether or not they are insured. For uninsured students, this is a primary source of health care. For children with insurance, it has been difficult to obtain information about the source and scope of insurance, in part because many students often do not know if they are covered or the scope of their insurance.<sup>23</sup>

## Adolescent Health Services

Michigan began funding adolescent health centers in 1987. The original appropriation for adolescent health centers was \$1.25 million, growing to only \$3.7 million in the current fiscal year 2003. This state funding, which was administered by the Michigan Department of Community Health provided base funding for the adolescent health centers. Many of the centers and programs used this state funding to leverage other federal, local and private dollars. The average adolescent health center in Michigan runs on a budget of approximately \$250,000 annually, with \$100,000 from the State through Adolescent Health Services.

In November of 2001, Governor John Engler issued an Executive Order that eliminated state funding for the adolescent health centers. With relatively little planning time to find alternative funding to sustain

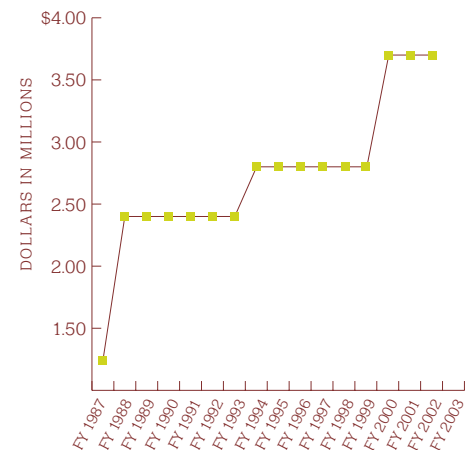
their operations many of the centers began planning to close their doors. State legislators responded to strong community support, including a rally in Lansing attended by students and parents, and moved to restore funding for the centers.

Facing a shortage of state general fund revenues, the Michigan legislature elected to restore funding for adolescent health centers by shifting the program to the K-12 School Aid budget. The funds were distributed to existing health centers by the department in collaboration with the Department of Community Health. The allocation for adolescent health centers for fiscal year 2003 is \$3,743,000, with grants awarded through a competitive process approved jointly by the Department of Education and the Department of Community Health. For fiscal year 2004, Governor Jennifer Granholm has recommended continuation funding for adolescent health centers.

State funds are a limited, but essential component, of the operating budgets of adolescent health centers. State funding has been used to establish a core staff and to attract a range of financial and other support from sponsoring organizations, foundations, local governments and other funders.<sup>24</sup>

## State Funding for Adolescent Health Centers

(1987 to 2003)



Source: Michigan Dept. of Community Health; Michigan Dept. of Education.

## Medicaid

Because many adolescent health centers are located in urban and low income communities, many of the children they serve are eligible for Medicaid. Consequently, Medicaid is a potential source of funding for school health services, and the pursuit of Medicaid and Medicaid managed care reimbursements has been a focus of the financing strategy for adolescent health centers.

The Medicaid program provides health care coverage for low-income families and individuals, including families with children, pregnant women, and persons under the age of 21. The Medicaid program, which is funded with federal funds, and state matching funds, is now the single largest source of financing of health care for school-age children and adolescents.<sup>25</sup> As of June 2002, 683,544 children and adolescents (nearly one in every four Michigan children) were covered by Medicaid.

To claim Medicaid reimbursements, the service provided by an adolescent health center must be covered by the state's Medicaid program. Medicaid benefits vary from state to state, but all states are required to provide basic health screenings and prevention services under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program. Included in EPSDT are basic physicals, immunizations, hearing and vision screening, dental care and behavioral health services, as well as any medically necessary service identified through an EPSDT screening, even if the service is not otherwise a covered benefit in the state. For example, even if the state does not provide for dental services, dental diagnosis and treatment can be required under EPSDT for children and adolescents. Consequently, the EPSDT requirement for comprehensive coverage can include many of the types of services provided in adolescent health centers. Further, Medicaid can be tapped for services not usually covered by health insurers such as case management and transportation.<sup>26</sup>



The majority of children enrolled in Medicaid in Michigan are required to enroll in a managed care plan. The movement to managed care can make it more complicated for adolescent health centers to be reimbursed by Medicaid for services. Managed care providers (Health Management Organizations, or HMOs) receive a capitated payment for children and youth insured by Medicaid that includes all preventive, primary and speciality care. The managed care provider (not the Medicaid office) reimburses providers for care. Consequently, adolescent health centers, or their sponsoring organizations, must be enrolled in the HMO's network, or have special contracts for services.<sup>27</sup>

As of June 2002, 43 of the 45 states that have adolescent health centers allow the centers to bill Medicaid for student health care.<sup>28</sup> Since December 1, 1997, Michigan has required managed care plans, including HMOs, clinic plans, and qualified health plans (QHPs) serving Medicaid beneficiaries to reimburse adolescent health centers for services provided to Medicaid clients—even if there is no prior authorization by the managed care plan or contract between the adolescent health centers and the plans. Despite that strong policy, very few adolescent health centers are maximizing Medicaid as a source of funding.

## What Barriers Exist to Full Medicaid Reimbursement?

A number of barriers exist to full Medicaid reimbursement, including:

- Medicaid may not cover many of the mental health, health education, and prevention services that were being provided by adolescent health centers because they are not covered services or because billing codes do not reflect certain prevention services.
- The growth of managed care complicated financing as adolescent health centers must now contend with an array of managed care plans to ensure that services provided by their centers will be covered, and many lack the clout or necessary relationships to negotiate effectively with managed care providers.
- Adolescent health centers generally have small staffs, and lack the experience, administrative capacity and technology to pursue aggressively third-party payments.

An effort is underway through the School/Community Health Alliance of Michigan—with start-up philanthropic funds—to establish a billing service that could serve all adolescent health centers in Michigan and set up systems to facilitate Medicaid and other third-party reimbursements.

## **MIChild—the State’s Children’s Health Insurance Program**

MIChild is a health insurance program for low-income children who are not eligible for Medicaid. MIChild is Michigan’s implementation of the federal State’s Children’s Health Insurance Program (SCHIP) which was created by Congress in 1997 to expand health care coverage among children. MIChild covers children ages 18 and under with family incomes up to 200 percent of poverty. The MIChild program is modeled on private insurance, with the majority of the children served by Blue Cross/Blue Shield of Michigan. Mental health and substance abuse services are provided by local Community Mental Health Services Plans (CMHSPs) and Substance Abuse Coordinating Agencies.

In Michigan, a single application form is used for MIChild and Medicaid, and children who apply for MIChild that are eligible for Medicaid are referred to the Michigan Family Independence Agency. As a result of this coordinated outreach, the MIChild program has increased the number of children insured by Medicaid as well. Since May of 1998, 67,044 children have received health insurance through the MIChild program, and another 162,537 have been transferred to the Medicaid program.<sup>29</sup>

Adolescent health centers are technically able to receive reimbursement for services to MIChild-eligible children, however many of the same problems face the centers in accessing those funds as in Medicaid, including difficulties with billing for prevention and health promotion services. Governor Granholm’s fiscal year 2004 budget recommends that children enrolled in MIChild be moved into the Medicaid system and Medicaid Health Management Organizations (HMOs). This change was recommended because of expected increases in Blue Cross/Blue Shield of Michigan premiums, and is expected to save

the state \$2.2 million, and avoid expected rate increases totaling \$8 million. This shift, if it occurs, would require adolescent health centers to work with managed care providers rather than Blue Cross/Blue Shield of Michigan to bill for services for children eligible for MIChild. Further, there are concerns with access to health services, as some families in the Medicaid program report having trouble finding a provider because the state does not reimburse doctors enough to cover their costs.

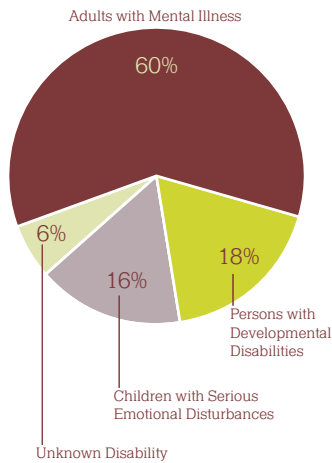
## **Community Mental Health Services Programs**

In many adolescent health centers, mental health is the most frequently provided service. Most centers offer a range of mental health and counseling services, including crisis intervention, case management, comprehensive evaluation and treatment, substance abuse, assessment and treatment of learning problems, and group counseling for peer support, behavior modification, substance use prevention and treatment and gang intervention.

It is estimated that 7.5 million children and adolescents in this country (12%) suffer from mental health problems, including anxiety, depression, eating disorders, conduct disorders or substance abuse.<sup>30</sup> On average, no more than 25 percent of those needing care get the help they need, and of those who do get care, 70 to 80 percent receive that care in a school setting—often from school counselors rather than mental health professionals.<sup>31</sup>

Problems in accessing mental health services are particularly acute for children of color. Children in minority populations are less likely to have access to mental health services, and the care they receive is often of poorer quality. Hispanic youth are the least likely to access speciality mental health care, even though they and African-American children have some of the highest rates of need.<sup>32</sup>

## Persons Served by Community Mental Health (Michigan, FY 2001)



**Source:** Michigan Dept. of Community Health, FY 2003 Executive Recommendation to House Appropriations Subcommittee

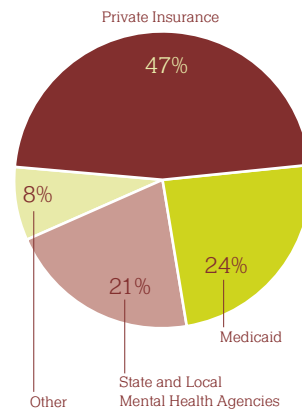
Michigan spends over \$2.2 billion annually for mental health and substance abuse services, as well as services to persons with developmental disabilities—largely with Medicaid and state funds. Services are provided through 49 community mental health services programs. In fiscal year 2001, 180,031 persons were served, down from fiscal year 1999 when 205,559 received services. Of these 29,356 (16.3%) were children with serious emotional illnesses.

During the current fiscal year, state rates for Medicaid mental health services were reduced by 1.1 percent effective March 1, 2003. Funding for mental health services provided to non-Medicaid patients through community mental health services programs was reduced 2.5% effective February 1, 2003. Although the Governor's proposed fiscal year 2004 budget provides a small increase (1.6%) in rates, there is concern about ongoing under-funding of the mental health system. Further, there are barriers to addressing the needs of low-income children. Local Community Mental Health agencies receive a payment of less than \$4 per child

per month for children enrolled in the MICHild program, and actual expenditures for serving MICHild children are far in excess of the capitated payments received.<sup>33</sup>

In some areas of the state, there are creative examples of collaborative programs between local CMH agencies, the Family Independence Agency, the courts, and schools in providing children's mental health services. These programs range from school-based assessment teams, early intervention programs in elementary schools, to intensive intervention with wrap-around models. Barriers to broader collaboration range from school districts fearing mental health services will serve as a case finder for an already overburdened special education system, the allocation of space within schools, staff time out of a classroom, and the overall lack of funding within the community mental health system. As schools are the primary service provider for children with developmental disabilities and teachers are usually the first to identify mental health issues for children, they remain the logical place for accessing mental health services.

## Major Funding Streams for Services for Children with Mental Health Needs



**Source:** Mental Health Services for children: An Overview, 2002

## Temporary Assistance For Needy Families (TANF)

Some adolescent health centers, including Willow Plaza Services in Lansing, have used federal welfare funds under the Temporary Assistance for Needy Families (TANF) program for services to pregnant and parenting teens. TANF funds are received as a block grant to states, and give Michigan unprecedented freedom to shift funds from basic income assistance to other programs and services.

Michigan, like many states, has used the funds to provide prevention and family support services, some of which are school-linked or school-based. While some TANF funds are used by state agencies to contract directly with local programs, other funds are provided to communities with decisions made at the local level about how they are spent.

One Michigan program that is partially funded with TANF funds is the Strong Families/Safe Children program (core funding is provided under the federal Adoption and Safe Families Act). Michigan has appropriated \$16.8 million in fiscal year 2003 for the program, with the funding used to support systems reform at the local level by requiring local collaboratives to develop plans for family support and preservation. Among the services provided locally are school-based services targeted to high-risk youth, maternal and child health outreach services, and teen pregnancy prevention services.

The federal TANF program is currently being reauthorized at the national level, and there is concern among advocates that funding levels will not increase to match increases in costs, or could even be reduced in light of new federal priorities. Under this scenario, competition for capped TANF dollars will become even stiffer.

# Findings and Recommendations

## **Develop an inter-agency plan to expand adolescent health centers and services over the next decade.**

A 1986 task force on adolescent health recommended that the Michigan Department of Public Health work toward the establishment of 100 adolescent health centers across the state. Since that time there has been little expansion in the public resources dedicated to adolescent health centers. In addition, administration of the program has been shifted to the Michigan Department of Education. This shift, which was made in order to save funding for the adolescent health centers, could result in some disruption of support to the centers in a time when they are being increasingly required to draw down Medicaid funding.

An inter-agency approach is critical to ensure adequate funding and support for adolescent health centers. The plan should address a range of possible long-term funding sources for adolescent health centers, including state general funds, federal and state educational funding including federal Title I funding, Medicaid and MICHild, and the Maternal and Child Health Block Grant, and Safe and Drug Free Schools funds. One potential source of funding for an expansion of adolescent health centers and services is the 40 percent of Medicaid funds for adolescent health centers and services currently retained by the state.

## **Increase access to mental health services in the schools.**

Because the state is often the payor of last resort when children's mental health issues become so serious that they impair their ability to function, it is imperative that children's mental health needs be identified and treated early. Many children are receiving costly care and services in the state's mental health institutions, foster care and group homes, juvenile detention facilities and prisons because their mental health needs were not recognized or treated soon enough. Of the \$137 million dollars in federal funds devoted to children's mental health in 1998, only 3 percent were for early

identification and intervention. Of the remaining funds, the majority was spent on services for youth with serious mental health disorders—after they had entered systems such as special education or the juvenile justice system.<sup>34</sup>

Schools are in the best position to recognize unmet mental health needs of their students, and to ensure early access to mental health services. To accomplish this task, there must be adequate, trained staffing in the schools, as well as access to community-based services. This can only be achieved through collaboration between the schools, Community Mental Health and other involved local agencies. Community collaborations will be needed to pool funds, coordinate and streamline services, and develop "systems of care" that meet the needs of children and youth.<sup>35</sup>

## **Use adolescent health centers to increase enrollments in Medicaid, MICHild, and other public insurance programs.**

Adolescent health centers are advantageously positioned to provide needed services to children and adolescents, and they are ideally situated to assist in marketing, promotion, outreach and enrollment activities. During the current fiscal year, funding for outreach for MICHild was reduced, despite the fact that many Michigan children are uninsured—even though they are eligible for publicly-subsidized health insurance.

## **Maximize the ability of health centers to access Medicaid and MICHild funds.**

Adolescent health centers not only contribute to the health and educational success of students, but can also reduce overall Medicaid spending by preventing costly emergency and hospital emergency room use. It has been shown that access to adolescent health centers can significantly reduce inpatient, non-emergency care, the need for pharmaceutical interventions, and emergency department Medicaid expenses.<sup>36</sup> To ensure access to Medicaid funding, collaborations among the Michigan Department of Community Health, local public health departments and adolescent health centers is critical.

## **Priorities in increasing Medicaid reimbursements for adolescent health centers:**

- **Assist adolescent health centers in forming partnerships with managed care providers and commercial insurers.** Most adolescent health centers lack sufficient staff or expertise to handle billing and manage medical records. The state could play a role in training and funding billing services.
- **Develop Medicaid policies that facilitate billing for the range of services adolescent health centers provide.** Advocacy at the state and national level is needed to expand billable codes for prevention services provided in adolescent health centers, and to ensure that the EPSDT mandate cover all.

## **Maintain funding for school health education. Through the Michigan Model, Michigan has been a national leader in school health education.**

Funding for the Michigan Model assures the dissemination of a state-of-the-art health education curriculum, training and technical assistance to school districts through a network of 26 regional coordinating sites. At a cost of approximately \$3 per pupil per year, school health education addresses a range of risks facing youth, including mental health problems, bullying, character education, HIV prevention, tobacco and substance use, physical activity and health nutrition.



# Endnotes

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**Michigan's Children** is a non-profit, privately funded advocacy group which acts as a voice for children.

In collaboration with policy-makers, other organizations, and communities throughout the state, Michigan's Children endeavors to improve the quality of life for children and their families.

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