How Medicaid and CHIP Can Support Student Success through Schools

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Seventh in a series of briefs on the future of children's health care

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Courtesy of Allison Shelley/The Verbatim Agency for American Education: Images of Teachers and Students in Action

Key Findings

1. Educators are increasingly focused on the role that physical and mental well-being play in academic success. Healthy children are more likely to attend school regularly, read on grade level, and graduate from high school on time. Student mental health support is a growing priority, particularly with concerns about school climate and safety.

2. Medicaid and the Children's Health Insurance Program (CHIP), which cover 37 percent of school-age children, are crucial to keeping kids healthy and can help pay for school-based health services. Recent legislative and regulatory changes have opened the door for greater collaboration among schools and community-based healthcare providers. But obstacles remain in handling both the logistics and costs of expanding school-based health care.

3. Schools are among the most efficient systems to reach children and families. They can identify children without health coverage and, in some cases, enroll them. They can also influence how often children receive preventive health services by setting robust standards for student health forms and supporting families in meeting those requirements. In some cases, schools can also provide some of the required screenings.

Summary

Recognizing that a healthy student is a better student, education and health officials have begun working closely in the past few years to integrate their efforts. Recent changes to federal education law, new grant programs and revised Medicaid rules have opened the door for further collaboration and better results for students. This work has become increasingly important amid a growing awareness of the role illness plays in school absenteeism and the urgent need for mental health services. Medicaid and CHIP play a key role in such partnerships, since these programs provide health coverage for 37 percent of school-age children and pay for many of the health services delivered to eligible children at school.

This paper examines how Medicaid can help schools better serve children and families and how schools can help students get the health care they need. It offers four recommendations to state and school district officials seeking closer linkages between health and education:

1. Ensure every eligible student has health coverage.
2. Help schools support and prioritize the comprehensive health needs of students as a pivotal factor in their ability to learn.
3. Increase access to school-based or school-linked preventive health care.
4. Help schools serve as resource "hubs" for families and caregivers especially in underserved or remote areas.

Introduction and Background

Over the past several decades, policymakers have dedicated considerable time, energy and resources to improving academic outcomes for our most vulnerable children. Everything from teachers' pay to instructional materials to the length of the school day has been subject to reform. Only recently have educators turned their attention to a vital consideration: student health. A student's physical health and mental well-being can have a direct impact on whether he or she is ready to learn and succeed in school. The Centers for Disease Control and Prevention (CDC) calls integrating health and education initiatives "an untapped tool for raising academic achievement and improving learning."[1] An updated version of federal education law broadens its scope beyond a strictly academic focus by emphasizing the health and safety of students.[2] The health community has also taken note: The American Academy of Pediatrics (AAP) recently issued guidance to its members on ways they can work with students and schools to reduce absenteeism.[3] Providing health coverage for nearly 40 percent of school-age children in the U.S.,[4] Medicaid and CHIP play a vital role in keeping students healthy and on track for success.

Physical and mental health provide a critical foundation for academic, social and life success for all.

Students who are in poor health, are engaging in risky behaviors, or are not receiving needed medical treatment are less likely to succeed in school. Research shows they miss more school days, are less able to focus in class when they are at school and less likely to achieve academically.[5] Children suffer from a variety of health-related ailments that can affect their academic success, "including uncorrected vision problems, unaddressed hearing loss, uncontrolled asthma, dental pain, persistent hunger, certain untreated mental and behavioral health problems and the effects of lead exposure."[6] As they age into adolescence, they face additional health risks that negatively affect school success, including substance use and unplanned pregnancies.[7] While teens are generally healthy, three out of four engage in at least one risky or unhealthy behavior.[8] And for children of all ages, the prevalence and impact of these untreated or unmanaged health conditions are greater among children of color and students who are economically disadvantaged. Students in families with lower incomes are also more likely to be negatively affected by the social determinants of health, with concerns like hunger, unstable housing, unsafe neighborhoods and exposure to environmental hazards.[9]

As they age, children are less likely to receive regular preventive care, regardless of the type of coverage they have. AAP recommends a series of annual "well-child" visits for school-age children so that a child's development and overall health can be assessed and monitored.[10] And while nearly 90 percent of children age 5 and younger have had at least one preventive care visit in the past year, the share declines as children age, with less than 80 percent of children 6 and older receiving a well-child check-up.[11] School-age children are also less likely to be insured than younger children, possibly because school-age children have fewer suggested or required interactions with the health care system.[12]

Children Under 18 Who Received a Well-Child Visit in Past Year, by Age, 2017
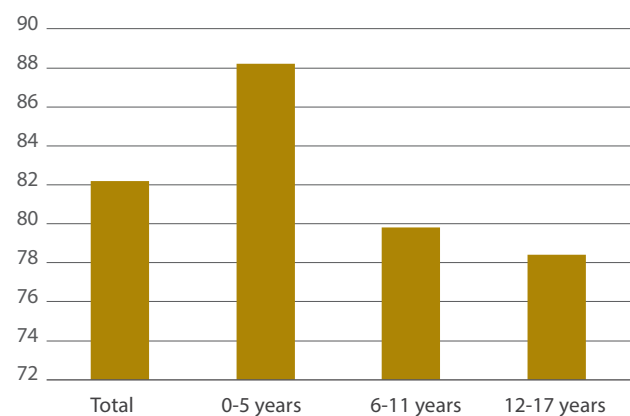
Source: National Survey of Children's Health, 2017

The Role of Medicaid and CHIP

Research is clear that having health coverage improves a child's access to needed services.[13] Medicaid and CHIP help families access health care and are currently serving approximately 40 percent of all U.S. children and 37 percent of school-age children.[14] In addition to coverage for basic health check-ups and treatment for illnesses and injuries, the federal Medicaid law requires that states provide a comprehensive set of pediatric benefits for eligible children under age 21, with an explicit prevention focus. Called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), Medicaid's child-centered benefit package requires states to screen, diagnose and provide access to medically necessary treatment for identified health needs. In many communities, schools play a key role in informing families about health coverage options, conducting preventive screenings to identify health issues early and, in some cases, providing treatment.

Schools that provide health screenings and medically necessary services to Medicaid-eligible children—either through school employees or health care partners—can receive Medicaid payments to cover a portion of their costs. Medicaid pays an estimated $4 billion to $5 billion in school-based health services annually (out of the program's approximately $650 billion annual spending at the state and federal levels).[15] Much of that money goes to pay for services prescribed for students with disabilities as identified under federal law. Depending on the state or district, this can include support for the school health workforce: school nurses, school psychologists, occupational and speech therapists, social workers and counselors.[16] In some states, Medicaid dollars can also be used for direct services provided to all Medicaid-eligible students on the school site, including immunizations, mental health therapy and management of chronic diseases such as asthma, allergies and diabetes.[17] Medicaid can also support health screenings for eligible students— vision, dental and hearing tests—as well as linking those students to treatment.[18] In addition to payment for direct health services, schools can also receive payment for administrative costs for time spent conducting outreach and care coordination.[19] It's important to remember that nearly two thirds of Medicaid-eligible children are enrolled in managed care organizations (MCOs), which often act

as the middleman between health care providers and the state Medicaid agency. These often complex arrangements are negotiated under contracts, which give states a lever to direct MCOs or provide incentives for them to expand access to school-based health services.[20]

The Role of Schools

Like the old adage about robbing banks because "that's where the money is," schools are a good place to deliver health care because they are, indeed, "where the kids are." Approximately 90 percent of U.S. children attend a public school.[21] And many children do receive health care services at school especially under the federal law that requires schools to provide various medical services and other supports to children with disabilities that impact their ability to learn.

Because of the trusted role that schools play in communities and because children interface with school on a more regular basis than almost any other institution, schools are among the most efficient systems for reaching school-age children and their families. This idea is not new. The school health community has been promoting this concept since the 1980s using several different approaches, including the Coordinated School Health model. The education and health sectors came together to update that model, and in 2014 the Whole School, Whole Community, Whole Child framework was launched by the CDC in partnership with ASCD, a professional development organization for educators. This framework emphasizes 10 elements of a healthy school environment, including health services, nutrition and wellness, mental health and social services, and the school's social-emotional climate. While the type and level of health education and services offered in schools varies by state and by district, this framework provides a common vocabulary and a model for integrating health and education outcomes, as well as communications tools for reaching parents and communities.

Schools are among the most efficient systems for reaching school–age children and their families.

Challenges and Opportunities

The recognition of the vital connection between health and education presents a number of opportunities and challenges for using Medicaid to provide health services in the school setting.

The updated federal education law governing K-12 education provides an opportunity to broaden and deepen collaboration between the health and the education sectors to support student success.

As part of its focus on the "whole child," the Every Student Succeeds Act of 2015 (ESSA) expanded the requirements for state accountability systems beyond test scores and graduation rates to include metrics of school quality and student success. Thirty-six states and the District of Columbia have selected chronic absenteeism as a metric with a strong connection to student health.[22] The law also consolidated several existing grants into a new flexible grant fund, known as the Student Support and Academic Enrichment program, which requires that a portion be spent on student safety and health-related initiatives and calls for stakeholders to conduct a needs assessment showing how they should spend their resources. It also provides dollars that can be used to train teachers to support students struggling with trauma, depression or behavioral issues.[23]

States are seeking to expand Medicaid payment for health services delivered at school.

Until recently, schools could bill Medicaid only for services prescribed for students with disabilities in education plans required under the federal Individuals with Disabilities Education Act (IDEA). But a 2005 ruling from U.S. Department of Health and Human Services and guidance that came in 2014 effectively lifted the so-called "free care rule," allowing schools to bill for services to all Medicaid-eligible students. In many states, legislative or state administrative rules stand in the way of implementing the change.[24] Some states are broadening the school health services that can be covered under Medicaid, including California, Louisiana, Massachusetts, North Carolina and Missouri.[25] But even with permission to seek payment, the process is often difficult for schools, given the challenges of medical billing, records requirements, and time required to document the medical necessity of these services.

Concerns about school climate, racial disparities in school discipline, and substance use have contributed to the growing awareness of the urgent need to provide more and better behavioral health services in schools.

An estimated 20 percent of young people experience a mental, emotional or behavioral disorder each year,[26] but less than one-third of them receive treatment.[27] While school gun violence is still relatively rare and its root causes are debated, the spotlight on student mental health has prompted renewed interest in identifying and supporting children and the role that schools should play.[28] What's more, the push to reduce racial disparities in school suspensions has reinforced the need for alternative approaches to reducing behavioral problems. Schools and health advocates are also recognizing the ill effects of childhood trauma on learning, and they are developing models to reduce the stress that students face.[29] The opioid epidemic and its impact on children and families also underscores the need to address mental health concerns and addiction in schools. Among adolescents, it is estimated that up to 10 percent suffer from substance use disorders.[30]

Despite progress, schools still have limited resources to support children's health.

Across the country, state and local funding for education has faced an unusually long downturn. Most states are still spending less on education than before the 2008 recession, with some having cut spending by 10 percent or more.[31] In many communities, local governments have also reduced spending on education, which has put further pressure on school district budgets.[32] And when faced with these cuts, local districts have reduced spending anywhere they can—including significant cuts to so-called "non-essential" personnel such as social workers, psychologists and school nurses.[33] While ESSA has provided more flexibility in using federal resources to support health services, less than 10 percent of overall spending on education in the United States comes from the federal government.[34] For now, Congress is not pursuing proposals to cut or cap federal Medicaid funding.[35] If such ideas re-emerge, that could mean less federal money flowing into state coffers for

health care; states may be forced to make a false choice between health or education spending cuts to make up the difference. Either option would have a negative impact on children.[36] Beyond the costs, the school and health communities often suffer from a disconnect, with little administrative coordination or even common vocabulary to deal with the problems they both recognize. The 2017 debates in Congress over cutting Medicaid funding to states and, by extension, schools brought the communities closer together. This report offers recommendations for educators, health providers and children's advocates seeking to build on that collaboration. While policy and practice vary from state to state, we include a series of examples showing how states and communities are deepening this work.

Recommendations for State and Local Leaders

☑ Recommendations Summary

1. Ensure every eligible student has health coverage.
   - Ask about student health and health coverage at school entry and periodically thereafter.
   - Streamline application and eligibility determination processes.
   - Promote collaboration between schools and health care organizations.
   - Support specialized outreach to older children and their families to help them stay enrolled.

2. Help schools support and prioritize the comprehensive health needs of students as a pivotal factor in their ability to learn.
   - Leverage ESSA opportunities to expand support for student health.
   - Use CHIP funding to pilot school/health sector partnerships.
   - Identify gaps and opportunities to improve student health and school-based services.

3. Increase access to school-based/school-linked preventive health care.
   - Promote the expansion of sustainable school-based health centers.
   - Remove legal and regulatory barriers so that schools can receive payment for allowable services provided to all Medicaid-eligible students.
   - Help schools navigate the intricacies of Medicaid payment.
   - Make better use of school-based health providers for care coordination.
   - Motivate managed care organizations to work with schools and school-based providers.

4. Help schools serve as resource "hubs" for families and caregivers in underserved or remote areas.
   - Create more "community schools" that provide health supports to both students and their families.
   - Expand the use of telehealth in schools.

Recommendation 1:
Ensure every eligible student is enrolled in health coverage.

Despite the gains made in expanding insurance coverage over the past decade, there are still approximately 3.9 million uninsured children under age 19 across the nation.[37] Even more alarming is the fact that this figure, which had been steadily decreasing, rose for the first time in a decade by about 276,000 between 2016 and 2017.[38] An analysis of 2016 data indicates that more than half of uninsured children are eligible for Medicaid/CHIP, but are not enrolled.[39] And among these eligible children, the rate of enrollment in the program for school-age students, particularly teenagers, is lower than for younger children.[40] The most basic way that schools can help improve the health of students is to help ensure that all children and families have health coverage.

> *The most basic way that schools can help improve the health of students is to help ensure that all children and families have health coverage.*

☑ Ask about student health status and health coverage at school entry and periodically thereafter.

At the state level, policymakers can develop or enhance policies to require more frequent health assessments as part of school registration, and they can require that schools ask families about student health coverage or screenings. In 2017, Illinois updated its school health requirements to ensure entry forms indicate whether a child has received age-appropriate, developmental and social-emotional screenings before entering child care or preschool, kindergarten or first grade. This documentation provides a concrete and early linkage between health care providers and schools.[41] Many states require health assessments and forms at kindergarten entry and never again. According to a recent study, only half of states require parents to provide a doctor's certification of student health status at initial enrollment, and only six required proof of at least one additional health examination between school entry and eighth grade.[42] Some states

however require more. The District of Columbia requires health exams every year, and New York updated its policy in 2018 to require examinations every other year through high school. These policies serve to re-enforce the AAP's recommendation that students have a well-child visit with a variety of screenings at least once a year, under their Bright Futures schedule.[43]

> The state of North Carolina used federal grant funds to develop a school-based intervention that involved training school staff, including school nurses, on how to use the state's Kindergarten Health Assessment to help families determine or renew their eligibility for Medicaid. This intervention, which focused on the state's highest poverty counties, yielded a 12.2 percent increase in the number of families enrolled in health insurance.
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> Source: Jenkins, J.M. "Healthy and Ready to Learn: Effects of a School-Based Public Health Insurance Outreach Program for Kindergarten-Aged Children," Journal of School Health, January 2018 88(1):44-53.

The school health form is an important lever that can help improve student health and school achievement. State leaders could further strengthen these forms to include questions about whether a child has health coverage, as has been done in some states. Requiring more frequent health assessments as part of annual school registration requirements and using that opportunity to ask families about their health coverage would provide another opportunity for schools to help families enroll and stay on top of renewing their eligibility for public insurance. These policies can contribute to ongoing student health and, by extension, academic success. Schools should also provide parents with the support they need to fill out these forms and, if possible, connect them with agencies or nonprofits that can help them apply for health coverage. The Children's Defense Fund and AASA, The Superintendents Association, have developed a toolkit that spells out the best ways for schools to connect children and families to health coverage.[44]

> Concerned that older students were not receiving preventive health care, The Illinois legislature voted in 2018 to require 9th graders to provide proof of a dental visit. Previously law required dental exams for children in kindergarten, 2nd and 6th grades.
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> Source: Illinois General Assembly

☑ Streamline application and eligibility determination processes.

States can also help schools by promoting coordination across the various programs that provide support to low-income families. For example, states can streamline the application process for families so that a single filing can determine eligibility (or renew eligibility) for multiple programs, including child care benefits (for children through age 12), free and reduced-price meal programs for students, and Medicaid. "Express lane eligibility," a state option for children, allows Medicaid programs to use data and eligibility findings from other public need-based social programs—such as Head Start, the National School Lunch Program, or Supplemental Nutrition Assistance Program (SNAP)—to streamline and simplify Medicaid eligibility determinations and enrollment. Coordination with these programs, many of which serve a high percentage of uninsured children,[45] would help improve coverage of low-income children and eliminate duplicative applications by the family. Despite the reported benefits, including cost savings and reduced administrative burden, only 13 states offered express lane eligibility in 2017.[46]

☑ Promote collaboration between schools and community institutions.

Health care systems and community-based organizations can also play a role in supporting schools in their efforts to ensure families and students are enrolled in and using their health insurance. Organizations and physician groups that have expertise in the ins and outs of eligibility and enrollment processes can collaborate with schools to connect with families at school events and other opportunities. These organizations can also partner with schools to develop materials and other resources. The CDC recommends that health care organizations and other community-based providers be engaged in school health teams—sometimes referred to as school health councils, school wellness committees, or school health advisory councils—to provide advice on aspects of the school health program, including helping to identify student problems and concerns, set priorities, and design solutions.[47]

> Several Ohio state agencies have developed a toolkit for building partnerships among schools, healthcare providers and community-based organizations. The toolkit includes advice on assembling a community coalition, conducting needs assessments, creating data-sharing agreements, and raising the money needed for such collaborations.
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> Source: School-Based Health Care Support Toolkit, http://education.ohio.gov/Administrators/School-Based-Health-Care-Support-Toolkit.

> HOPES Community Action Partnership, Inc. (HOPES CAP) in New Jersey partners with local schools, public agencies, and corporations to host a number of Back-to-School events and Parents' Nights to engage parents in school readiness and connect families to health coverage. In 2017 HOPES CAP assisted 1,392 children and adults with enrollment; 60 percent of these cases were made possible through its partnerships.
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> Source: Insure Kids Now, https://www.insurekidsnow.gov/newsletter/2018/07/18/index.html.

☑ Support specialized outreach to older children and their families to help them stay enrolled.

Data shows that eligible elementary-age children are less likely than younger children to be enrolled in Medicaid/CHIP, and eligible teens are even less likely.[48] Parents of older children, more often than those of younger children, report that they are unaware that their child is eligible, or remains eligible, for public insurance.[49] Outreach programs tailored to families with adolescents or the students themselves could help address this disparity. In Michigan, a health plan worked with schools to connect with families who qualify for free and reduced-price meals. In Oregon, school-based health clinics asked students whether they had coverage and helped eligible students apply or referred them to someone who could assist them. Some communities used back-to-school night and parent-teacher conferences to reach out to parents of teens.[50]

School health teams can play an important role by assessing, tracking, and monitoring trends in health coverage among their student populations. Using a data-driven approach to identify gaps can help these teams and their community-based partners effectively plan targeted outreach to enroll and retain teens and their families in Medicaid or CHIP. These teams must be careful to navigate complex federal laws on student privacy for both education and health providers.[51]

> Nemours Children's Health System is partnering with schools in four states to implement an innovative new health literacy curriculum geared towards high school students. The curriculum is focused on teaching teens how to navigate the insurance and health care system with the goal of helping them be more informed and empowered consumers.
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> Source: Nemours Children's Health System, https://www.nemours.org/about/mediaroom/press/dv/nemours-launches-new-national-health-literacy-curriculum.html#.WyhBlTGM560.email.

☑ Recommendation 2: Help schools support and prioritize the comprehensive health needs of students as a pivotal factor in their ability to learn

Schools, community partners, and state agencies can support student and family health by maximizing the new opportunities presented in federal education law; collecting and sharing information on school-based and school-linked health services to identify gaps and opportunities; and making use of federal funding opportunities to test health sector partnerships that focus on low-income students.

☑ Leverage ESSA opportunities to expand support for student health

The federal education law's recognition of the importance of supporting the whole child and the flexibility it gives states in measuring success and funding programs present opportunities for supporting student health. These include the chronic absenteeism indicator that many states have chosen to measure, a new pool of grant money for health and wellness activities, and the requirement for a school needs assessment to help guide and set priorities for use of key federal funding. States and school districts should:

- Document the role that illness plays in chronic absenteeism to reinforce the need for health screenings, treatment and expanded resources based in schools.

- Use the needs assessment required under ESSA, as well as the law's Student Support and Academic Enrichment grants, to improve delivery of health services for students.

- Tap professional development dollars to train teachers and staff about trauma-informed care, adverse childhood experiences and other factors influencing behavioral health.

> With California receiving more than $44 million in federal Student Support and Academic Enrichment dollars, the state legislature voted to designate the money for two priorities: visual and performing arts education or expanding access to physical and mental health care.
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> Source: California Department of Education guidance, https://www.cde.ca.gov/pd/ps/ssaecgp2018.asp.

☑ Use CHIP funding flexibilities to pilot school/health sector partnerships

States may devote a portion of their CHIP administrative funds to develop health services initiatives (HSIs). These flexible, limited funds allow states to adopt initiatives to improve the health of children eligible for CHIP and/or Medicaid, but may serve children regardless of income.[52] States may only use up to 10 percent of their annual allotment for administrative costs; HSIs must fall into this 10 percent.[53] Twenty-two states have received federal approval for about 50 projects that typically involve preventive services and interventions for children.[54] Eight states—Florida, Idaho, Massachusetts, Missouri, Nevada, New Jersey, New York, and West Virginia—use HSIs to support various school-based health services programs.[55]

HSIs provide a unique opportunity to test partnerships between the health care sector and schools that could address such issues as infusing trauma-informed care practices into schools, developing a school-based asthma awareness program, or starting a program to help children from families impacted by opioid addiction. With fewer than half the states running HSIs, there is significant untapped potential to address pressing and emerging health concerns among children.[56] States can use funds allotted for administrative activities, as long as they don't exceed the 10 percent cap on administration.[57]

> Recognizing ESSA's emphasis on using evidence-based practices, the Connecticut State Department of Education has created a series of guides highlighting interventions backed up by research and evidence.
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> Source: Connecticut State Department of Education https://portal.ct.gov/SDE/Connecticut-State-Department-of-Education-Evidence-Based-Practice-Guides.

> In 2017, Delaware launched a school-based health services initiative (HSI) that helped increase access to vision services and eyeglasses for uninsured and underinsured children. Massachusetts' HSI addresses youth violence via an afterschool program that seeks to address adverse childhood experiences.
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> Sources: National Academy for State Health Policy, https://nashp.org/health-service-initiatives-give-states-unique-tools-to-improve-the-health-of-low-income-children/; Centers for Medicaid and Medicare Services, https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf

☑ Identify gaps and opportunities to improve student health and school-based services.

The ESSA-required needs assessment provides an opportunity for schools not only to document the unmet health needs among their students, but also to catalog efforts to improve physical and mental health that are already underway. Hundreds of thousands of students receive some type of school-based health service each year, particularly students with disabilities whose support is often funded with Medicaid dollars. A 2017 survey of 1,000 school superintendents found that two thirds use Medicaid dollars to pay salaries for health professionals, and 45 percent pay for expanding services; 39 percent use the dollars to facilitate outreach and coordination with other providers.[58] Yet many state and local education policymakers knew little about this vital source of revenue until it was threatened by Congressional action in 2017. Likewise, school nurses and counselors are helping to identify students with needs and helping them access care, either at school clinics or through community referrals.

Better information on the ways that school health care providers help children succeed in school would be useful for state and local policymakers and the general public to understand as they assess the opportunities for improvement. That information could include data on the type and number of services provided, the extent to which there are gaps in these services (e.g. rural vs. urban and suburban; lack of mental health providers) and how schools pay for these services. States that rely on Medicaid managed care organizations to provide children's health care should develop incentives for these organizations to support school-based services. Otherwise, school-based clinics and health providers are essentially subsidizing the MCOs that state Medicaid agencies already pay to coordinate and provide care.

Pediatricians have emerged as an ally in this work, particularly efforts to reduce chronic absenteeism. Acknowledging that illness remains the No. 1 reason that students miss school, AAP released guidance in January 2019 detailing how school absenteeism correlates with academic difficulty, including weaker social skills in kindergarten, poorer reading scores in third grade and lower graduation rates in high school. The report also documented the connection to poorer health as adults.[59] AAP outlines several steps doctors should take, including talking to children and families about the importance of attendance in regular checkups and helping them navigate when a child should stay home with an acute illness.

The American Federation of Teachers launched a survey of school districts to assess how they use Medicaid to pay for health services provided on school sites. The goal is to create a series of snapshots from diverse settings and to build on them to create a national agenda that the teachers' union will use to support innovation, learning and advocacy on Medicaid and the school-health connection. AFT has also developed a glossary of terms to help educators and healthcare providers communication more effectively.

Source: "Digging Deep: Medicaid in School Districts, Building data snapshots to improve school health services," https://healthyschoolscampaign.org/wp-content/uploads/2017/12/Strategies-for-Data-Collection-AFT.pdf.

Recommendation 3:
Increase access to school-based/school-linked preventive care.

In many communities, schools are among the most convenient and trusted institutions, so it makes good sense to provide children's health care in the school setting. Strategies include promoting the growth of school-based health centers, helping schools navigate the Medicaid payment process, ensuring that schools can be reimbursed for allowable services provided to all Medicaid-eligible students, and leveraging school-based health care for improved care coordination. In the majority of states where Medicaid children are enrolled in managed care, managed care organizations (MCOs) will be critical players in the success of these initiatives.

Promote the expansion of sustainable school-based health centers.

School-based health care is a commonsense idea that has been gaining traction over the past two decades as a tool for addressing health equity and improving student outcomes. There are currently about 2,300 schools offering school-based health clinics (SBHCs) across 49 states and the District of Columbia.[60] The number of clinics has doubled since 1997; however, that figure represents less than 5 percent of schools with high concentrations of poverty.[61]

School-based clinics have been shown to improve a number of health and education-related outcomes, including more regular receipt of immunizations and other preventive healthcare, and decreased emergency room visits. The clinics have also been linked to improvements in grades, grade-to-grade promotion, and high school graduation rates.[62] Another significant benefit for schools and student learning is that children can receive care without missing school.

School-based health centers can be staffed by school district employees, but for a variety of reasons the majority contract with a medical partner—a local hospital, community health clinic, community mental health center or a rural health clinic that sets up a facility at the school. Since MCOs control what providers their clients can visit, clinics must often negotiate contracts with these organizations. While Medicaid and/or private insurance payments help to offset operating costs, additional funding is needed to cover start-up costs and expenses that can't be reimbursed. Seven states—Delaware, Illinois, Louisiana, Maine, New Mexico, North

Carolina, and West Virginia—designate school-based clinics as a specific provider type under Medicaid. Four—Louisiana, Maryland, Michigan, and New Mexico—allow Medicaid reimbursement from managed care for student visits to SBHCs, even when the center is not in the MCO's provider network.[63] Eighteen states provide some type of state funding for SBHCs,[64] but many clinics must rely on private grants or other local support. Some districts have successfully partnered with Federally Qualified Health Centers (FQHCs) to run all or part of their school-based programs.[65] FQHCs qualify for a higher Medicaid payment rate and other payment policies that help make their services more cost-effective and sustainable over the long-term.

> Federally Qualified Health Centers (FQHCs), also called community health centers, receive funds from the U.S. Department of Health and Human Services to provide health care services in underserved areas. FQHCs must provide care on a sliding fee scale based on ability to pay and operate under a governing board that includes patients. Because of the community benefit they provide, these centers receive special assistance and guarantees from the federal government, including a higher Medicaid reimbursement rate. FQHCs may serve the general public or special populations like migrants, homeless people or public housing residents.
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> Source: Department of Health and Human Services, Health Resources and Services Administration website, Accessed at https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html.

Remove legal and policy barriers so that schools can receive payment for allowable services provided to all Medicaid-eligible students.

In many states, school districts are not permitted to bill Medicaid for some covered services because their state has not updated its policies subsequent to the federal government's 2014 official annulment of the "free care rule." [66] Prior to this policy change, schools were sometimes allowed to bill Medicaid for services specifically prescribed for students with disabilities, who are authorized for services included in individualized education plans under the provisions of IDEA.

According to the National Health Law Program, more than half of states may need to amend their state Medicaid plans, pass legislation or approve other policy changes so that districts

can bill for health screenings, assessments, and treatments that are generally provided to all students at no cost and for which no other payment sources were pursued.[67] At least seven states—Florida, Louisiana, Massachusetts, Missouri, New Hampshire, North Carolina and South Carolina—have made changes that allow schools to better access Medicaid funding for all eligible students. Some have sought changes to their state Medicaid plans to add providers or specific services that can be covered, while others have used legislation or simply expanded what's possible under their existing plans. California, Georgia and Michigan are awaiting federal approval on state plan amendments.[68] States should analyze their policies and billing procedures to determine what changes are needed in administrative guidance, state legislation or both.

Starting in 2016, a group of education stakeholders and advocates in Missouri came together to address barriers to improving student health. The group identified mental health services as one of the greatest unmet needs in the state, one that was a significant contributor to high school suspension rates. The group worked with the state health and education agencies, mental health providers and others to identify the root causes of the challenge in providing mental health services to students. As a result of the group's work, the state announced a policy change in July 2018 that would allow approved Medicaid providers (including schools) to bill Medicaid for mental health services provided in the school setting to all Medicaid-eligible students, something not previously permitted under state rules. The policy is still in the early stages of implementation, but it provides an example of how the education and health care sectors can collaborate to overcome obstacles.

Source: Provider Bulletin: Behavioral Health Services in a School Setting, Volume 40, Number 54, Missouri Department of Social Services, April 17, 2018. Accessed at https://dss.mo.gov/mhd/providers/pdf/bulletin40-54_2018apr17.pdf.

☑ **Help schools navigate the intricacies of Medicaid payment.**

Seeking payment from Medicaid is complicated, and the rules vary from state to state. Schools not only have to navigate student enrollment and reenrollment issues, but also the complex billing and payment policies for services provided and the administrative time it takes. If the students are enrolled in a Medicaid managed care organization, that adds another

layer of complexity. That's why some schools and school districts that could be receiving reimbursement from Medicaid, particularly smaller districts serving rural communities, never seek these dollars. Some are not aware that they are eligible; others believe it is too much of an administrative burden or are concerned about making costly mistakes. In a recent survey of superintendents, 37 percent of rural school districts said they did not attempt to bill Medicaid, despite having a sizeable population of Medicaid-eligible students, because of the costs of complying with the paperwork and administrative requirements. A quarter of the rural districts said they had actually lost money trying to comply with the requirements.[69]

School staff members generally do not have the knowledge and expertise to navigate specialized medical billing processes. Successful Medicaid billing requires funding to cover the administrative costs and involves a steep learning curve, as well as some financial risk for schools. It grows more complicated when billing Medicaid MCOs that cover many of the Medicaid-eligible children. Without some sort of arrangement, the schools are essentially doing for free what the state pays the MCOs to do: provide health care for eligible children. School districts need technical assistance and support from both the state education agency and the state Medicaid agency to overcome these barriers, as well dedicated staff to manage the billing process. Schools would be more likely to provide a more comprehensive array of health services if they could be assured of receiving payment for at least a portion of the costs.

In West Virginia, the Children's Health Collaborative Project created a primer laying out how state and local agencies can expand the use of Medicaid to pay for school-based health clinics and services.

Source: Medicaid Matters to West Virginia Schools, available at http://wvahc.org/wp-content/uploads/Medicaid-Matters-to-West-Virginia-Schools-Pt-1.pdf.

☑ Make better use of school-based health providers for care coordination.

Many school-aged children and adolescents—especially those who are from low-income families, ethnic minorities, or immigrants—receive health care from a disjointed set of providers who often don't communicate with one another. This can lead to costly, duplicative and suboptimal care. Coordination of care, which includes a variety of efforts to promote timely communication and information sharing among an individual's various health care providers, is integral to effective chronic disease management and may lead to fewer emergency department visits, decreased chronic absenteeism, improved student health, and overall cost savings.[70] And care coordination is a Medicaid-covered service that helps to address fragmented and incomplete care.

In many ways it makes sense for school-based health providers to serve as care coordinators for children with chronic health conditions—such as asthma, diabetes, attention deficit hyperactivity disorder, and hearing disorders—as they often rely on school nurses or other school-based providers to provide them with disease management support during the school day.[71] Since school-based health care is often more convenient and better meets the needs of students and families, states should determine how best to leverage a range of providers in schools to conduct care coordination.[72] States should also allow school-based health centers to receive Medicaid payment for care coordination performed in the school setting. That could include amending the state Medicaid plan to add care coordination in school settings as a covered service and expanding the types of providers recognized as qualified Medicaid providers—such as school nurses, school psychologists, social workers, and occupational therapists—who can serve as student care coordinators.[73]

For example, schools can receive Medicaid funding for administrative activities that support the provision of Medicaid-allowable services to children in schools and activities related to health coverage outreach and enrollment.[74] Maryland schools can receive federal matching funds for activities including care coordination and transportation to and from school on a day a child receives a Medicaid-covered service, and transportation to treatment services if the service is provided on a day that school is in session and the service is delivered at a setting other than the school.[75]

☑ Motivate managed care organizations to work with schools and school-based providers.

With managed care organizations (MCOs) controlling Medicaid spending and provider access for two-thirds of the children enrolled in the program, these entities can play an important role in expanding access to school-based care.[76] Typically, an MCO receives a payment for every person enrolled in the plan—rather than a "fee-for-service" payment for every individual service provided—in exchange for helping to manage their member's overall care and keep costs down. States can use contracts with MCOs to provide financial incentives and clear direction on how to coordinate with school-based clinics or providers. States should include directives in the text of the contract on what services children need and how they should be delivered, as well as required metrics to enable state regulators and the schools, themselves, to understand how well the efforts are working.[77] A handful of states, such as New York and Oregon, are in the process of adopting performance incentives for plans and providers around kindergarten readiness.[78] States can also require Medicaid MCOs to pay for school-based health center visits for Medicaid-enrolled students even when the clinics are not within the MCO provider network. Four states—Louisiana, Maryland, Michigan and New Mexico—have such policies.[79]

The state of Ohio launched a pilot program in 2018 that creates incentives for managed care organizations (MCOs) to invest in school-based health services. The state education and Medicaid departments identified 40 schools across the state and assigned MCOs with students in those schools to bring in programs or clinics that address mental and physical health needs. Based on improvements on certain metrics, such as reductions in absenteeism or disciplinary actions, the MCOs will receive financial rewards.

Source: Ohio Office of Innovation, available at https://www.healthtransformation.ohio.gov/Portals/0/18-19%2017%20Promote%20student%20success%20through%20better%20health.pdf?ver=2017-02-10-143450-263.

☑ Recommendation 4:
Help schools serve as resource "hub" for families and caregivers in underserved or remote areas.

For the same reasons that it makes sense to serve children in schools, it also makes sense to serve families and caregivers there, particularly in remote, rural areas and in other areas where providers are in short supply. Strategies include developing community schools and expanding the use of telehealth in schools.

☑ Create more "community schools" that provide health supports to both students and their families.

Community schools provide a more comprehensive and holistic way for schools to support the needs of students as well as their families. Also called full-service schools or full-service community schools, under this model schools work closely with local nonprofits and public agencies to provide an array of social, academic and health services for children and their families. Beyond more typical services like afterschool programs and health care, community schools may also address such family needs as housing and transportation, child care and early education, and adult education. Many school districts, from New York City to Oakland, California, support Community Schools in their budgets. Philanthropic organizations often contribute funds or convene community partners. ESSA provides funding so schools can hire a coordinator to help identify needs and manage the various school-community partnerships. In addition, ESSA also includes the Full-Service Community Schools competitive grant program to help schools plan, implement and operate community schools.

Another approach to aligning school and community is using a school health coordinator, a position recommended as part of the CDC's Whole School, Whole Community, Whole Child school health framework.[80] Supported by CDC grants, this role helps to coordinate school health policies, align all district or school health resources and services and link internal and external stakeholders. School health coordinators are well-suited to support community school initiatives.

☑ Expand the use of telehealth in schools.

Telehealth, a service delivery method that uses video technology to link patients with remote health-care providers, can provide a cost-effective way to meet student health needs, particularly in rural schools and in urban settings facing a shortage of qualified providers in the community or on the school staff. Improvements in technology and decreasing equipment costs have made this a more feasible option over the past several years. About half of states currently authorize Medicaid payment for telehealth services provided in schools,[81] although some states include restrictions that can make it more challenging, such as covering telemedicine only when a doctor or nurse practitioner is present with the student. Some schools are discovering that this method of service delivery allows them to provide a broader range of health services than supporting face-to-face encounters for every type of need. It also helps minimize school absences since students are not leaving campus for health appointments. Schools are increasingly adopting telehealth programs to tackle student depression and violence. This provides an opportunity for schools to meet the growing unmet need for access to mental health services due to severe workforce shortages and transportation barriers. School-based telepsychiatry programs can help fill this critical gap and improve access to behavioral health care for children and adolescents.[82] Schools are also using telehealth to provide speech therapy and oral health services.[83]

Research shows a positive impact of telehealth services for school-age children.[84] State education and health stakeholders should review Medicaid rules for telehealth, including how payment works to cover both the costs to the school and the health care provider, to determine if investment in digital health could provide a cost-effective solution.[85]

> The Children's Hospital of Philadelphia has developed an in-school telehealth program that allows students to connect with healthcare providers without leaving the school nurse's office. Equipped with an iPad and digital equipment needed for virtual examination, the school nurse reaches out to providers, who log on the computers to communicate. They can take temperatures, listen to a child's lungs and review digital images of the inside of a child's ear. The technology is particularly useful for managing chronic diseases, such as asthma and diabetes.
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> Source: Children's Hospital of Philadelphia, https://www.chop.edu/digital-health/school-nurse-and-chop-provider-ease-kayla-s-pain-virtual-visit.

Conclusion

Schools represent a critical untapped resource that can help improve the health of children and families in communities across the country. With the right partnerships and resources, schools can help families and children enroll in health coverage, screen children for potential health issues and provide needed health services in a trusted environment and a convenient location. Policies that expand the ability of schools to address student health needs can help improve health outcomes and ultimately support schools' primary goal: increased academic achievement. And policies that promote authentic partnerships between the health and education sectors improve the health and vibrancy of the entire community.

About this Series

This issue brief is seventh in a series of papers from Georgetown University Center for Children and Families on the future of children's health coverage. Other briefs in the series include:

The Future of Children's Coverage: Children in the Marketplace. Focuses on ways to improve marketplace coverage and the associated financial assistance for children.

Fulfilling the Promise of Children's Dental Coverage. Focuses on pediatric dental coverage and ways to improve children's oral health.

How Medicaid and CHIP Shield Children from the Rising Costs of Prescription Drugs. Focuses on how Medicaid and CHIP protect most children from the rising costs of prescription drugs.

Promoting Young Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP). Focuses on ways that state and federal policymakers can use Medicaid and CHIP to more effectively put young children on the best path for success in school and in life.

How to Strengthen the Medicaid Drug Rebate Program to Address Rising Medicaid Prescription Drug Costs. Focuses on the effectiveness of the Medicaid Drug Rebate program and how to improve it.

The Questions to Ask When Assessing the Impact of Coverage Expansion Proposals on Children. Focuses on a number of key questions to help assess the relative merits of coverage expansion proposals from the perspective of children.

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Resources

Enrollment in Coverage

Connecting Kids to Coverage National Campaign: School-Based Outreach and Enrollment Toolkit, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
https://www.insurekidsnow.gov/downloads/library/misc/toolkit-schoolbasedoutreachandenrollment.pdf

Guide to School-Based Outreach for Health Coverage Enrollment, Center on Budget and Policy Priorities
https://www.cbpp.org/research/health/guide-to-school-based-outreach-for-health-coverage-enrollment

Insure All Children Toolkit: AASA, The School Superintendents Association and Children's Defense Fund
http://www.insureallchildren.org

School Health Policies and Practices

Bright Futures Guidelines, American Academy of Pediatrics
https://brightfutures.aap.org/materials-and-tools/Pages/default.aspx

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State Efforts to Implement the Free Care Policy Reversal, Healthy Schools Campaign, Community Catalyst, Trust for America's Health
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