Free Care Policy Convening
June 12, 2015
Meeting Summary Document

The following document summarizes the Free Care Policy Convening which was co-hosted by Trust for America's Health and Healthy Schools Campaign, with support from the W.K. Kellogg Foundation.

WELCOME, INTRODUCTIONS AND MEETING BACKGROUND

The meeting opened with welcoming remarks from ***Jeff Levi****, Executive Director of the Trust for America's Health,* and ***Rochelle Davis***, *President and CEO of Healthy Schools Campaign*. They explained that this convening was taking place to discuss the recent clarification of the federal free care policy and the opportunity it presents to increase access to health care services in schools for children enrolled in Medicaid. ***Ms. Davis*** asked the group to think of school health services in the broadest sense possible, including services delivered by school nurses, mental health providers, school-based health centers, mobile clinics, community providers and others. She encouraged the group to think of the clarification of the free care policy as an opportunity to increase access to comprehensive and coordinated care for children and to consider opportunities for delivering care outside of the standard models.

A list of attendees and the meeting agenda are included at the end of this summary. There was strong representation from both the U.S. Department of Education and the Centers for Medicare and Medicaid Services.

The goals of the meeting were to:

- Utilize the recent clarification of the free care policy to identify opportunities to improve children's health and wellbeing in the school setting, particularly by increasing services for children who are Medicaid beneficiaries;
- Determine the changes needed at the state and local levels to leverage the benefits of the recent clarification of the free care policy for school age children; and
- Identify strategies for reaching out to and working with decision makers about the recent clarification of the free care policy and how it can be used to increase health services in the school setting.

Approximately 15-18% of children and adolescents have chronic health conditions, including asthma, untreated tooth decay and behavioral health disorders. There is a significant body of research demonstrating that school-based health services, including those delivered by mental health professionals, school nurses and school based health centers, can play an effective role in managing these health conditions through case management, medication administration and treatment and referral.

Many of the primary health conditions impacting students are priority areas for Medicaid and align closely with the health care quality measures for Medicaid and the Children's Health Insurance Program. As a result, schools can help states meet these health care quality measures.

Schools can play a key role in the goals of our health system—increasing access to care, improving quality and outcomes and decreasing costs. Health systems are working to identify

new strategies for providing access to quality care and schools can be an important partner in making this happen. Schools can partner with health providers to meet student health needs and schools can be a key location for community providers to deliver care. Given the free care rule recent clarification and the ongoing transformation of the health care system, there is an important opportunity for maximizing the role schools can play in delivering more comprehensive and coordinated care to Medicaid beneficiaries.

FREE CARE POLICY OVERVIEW AND CONTEXT

***Melissa Harris**, Acting Deputy for the Disabled and Elderly Health Programs Group at the Centers for Medicare and Medicaid Services (CMS)*, provided on overview of the free care policy and how it has been clarified by the December 2014 State Medicaid Director's letter issued by CMS.

Ms. Harris shared that, historically, CMS' guidance on the free care policy was that Medicaid payment was generally not available for services that are provided without charge to everyone in a community. The free care policy effectively prevented the use of Medicaid funds to pay for covered services delivered to Medicaid eligible beneficiaries when the provider did not bill non-Medicaid eligible individuals or any other entities legally liable for their services. This prevented schools from receiving reimbursement for the majority of the health services they delivered. There were some exceptions to this policy, such as health services included in a student's Individualized Education Program (IEP). The policy was expressed in a number of guidance documents, including the prior CMS guidance "1997 Medicaid and School Health: A Technical Assistance Guide," and the 2003 Medicaid School-Based Administrative Claiming Guide."

The free care policy was challenged and the U.S. Department of Health and Human Services Departmental Appeals Board concluded that this policy was not an interpretation of either the Medicaid statute or existing regulations. As a result, CMS issued a State Medicaid Director letter withdrawing its prior guidance on the free care policy as expressed in the School-Based Claiming Guide and other CMS guidance.

Ms. Harris highlighted that schools are the biggest stakeholder group impacted by this clarification and that Federal Financial Participation (FFP) is available for Medicaid payments for school health services as long as all other Medicaid requirements are met. ***Ms. Harris*** indicated that the requirements for FFP for Medicaid payments are listed in the State Medicaid Director letter and include that the individual is a Medicaid beneficiary, the service is a covered Medicaid service, the provider is Medicaid-participating provider and third party liability (TPL) requirements are met.

To put it simply ***Ms. Harris*** stated that there is no free care requirement now for school health services and that the door is open to bill Medicaid for health services delivered in schools. If two students show up to receive the same school health service, one enrolled in Medicaid and one not enrolled in Medicaid, Medicaid can be billed for the service delivered to the Medicaid enrollee even if the service is provided without charge to the other child. While parents must have the ability to choose the Medicaid provider they would like to treat their child, a school-based provider is one viable option.

Ms. Harris emphasized the need for schools to fulfill all requirements, including appropriate documentation to legitimize each claim, such as verification that the service was delivered to a Medicaid enrollee. She also reminded the group that the specific services that are reimbursable will vary by state and that states may require a state plan amendment to allow schools and school-based providers to bill Medicaid for health services delivered to students. She also emphasized how important it is for schools to understand the Medicaid provider requirements, including the state process for recognition as a Medicaid provider.

Ms. Harris then discussed the TPL section of the State Medicaid Director letter and clarified that schools are not considered to be legally liable parties. While Medicaid is typically the payer of last resort, schools would not be required to cover the bill for a given Medicaid service as long as the Medicaid principles in the letter were met. This does not absolve school providers from determining if reimbursement is available by a private insurer prior to billing Medicaid.

Ms. Harris emphasized the need for school systems to develop a relationship with state Medicaid agencies and shared that state Medicaid agencies will usually turn to CMS for clarification on issues. ***Ms. Harris*** said CMS is willing to have these conversations with states and school districts to facilitate understanding and implementation of the free care policy clarification. While CMS is not likely to issue additional guidance on implementation of this policy change, CMS will support their colleagues at the U.S. Department of Education (ED) should they develop and disseminate guidance.

Some of the key questions ***Ms. Harris*** recommended that schools research and ask their state Medicaid agency include:

- What is the current landscape of health services delivered in schools?
- What is the reimbursement rate for health services delivered in schools?
- How can a school-based provider become recognized as a provider in a given state?
- What is the local delivery system?
- Is there a managed care environment in the state?
- How is the state going to come up with the state share of the Medicaid match?
- How does the state define medical necessity?

Ms. Harris shared that CMS is meeting with the U.S. Department of Education to discuss the free care policy clarification and that she is happy to connect individuals with their state Medicaid contact.

Ms. Harris clarified how the free care policy change applies to the student population that does not have an IEP. Students who do not have an IEP who are receiving ongoing health services in school should ideally have some type of written health care plan to ensure adequate documentation if Medicaid is going to be billed for the services the student receives. She said that CMS basic stance is that medically necessary services need to be provided and if there is a state level barrier preventing that from happening, CMS can be contacted.

LEARNING FROM CURRENT EFFORTS TO DELIVER HEALTH SERVICES TO MEDICAID ENROLLEES IN SCHOOLS

Representatives from two school districts and one state provided an overview of the health services that schools are currently delivering in their communities and how these could be enhanced with the recent free care policy clarification:

***Janet Lowe**, Assistant Administrator for St. Paul Public Schools,* shared that there are 39,241 students in St. Paul Public Schools with 16% (6,454 students) in special education and a significant population enrolled in Medicaid. Maximizing Medicaid reimbursement is critical to the sustainability and support for the provision of Individualized Education Program (IEP) health related services that include nursing, speech and language, occupational therapy, physical therapy, social work/mental health, school psychology, assistive technology and personal care services. Over 700,000 IEP heath related services were provided in the 2013-2014 school year. Minnesota has been successful in developing a cost based reimbursement system for IEP health related services in collaboration with the Minnesota Department of Human Services and the Minnesota Department of Education. In addition to children who have IEPs, there are many non-IEP children who receive a significant number of physical and mental healthcare services including immunizations, health assessments, and chronic disease management. She and her team have developed a number of unique partnerships with local managed care organizations and the Minnesota Department of Human Services to support the delivery of health care services and improve access. She sees the clarification of the free care policy as an opportunity to maximize reimbursement for covered healthcare services provided by qualified providers to non-IEP students which is the majority of the students in the school district.

Diana Bruce**, Director of Health and Wellness for DC Public Schools,* encouraged the group to think about four items as it works to support implementation of the free care policy clarification: what should schools be providing directly and what should be provided with the help of outside partners; what services are schools legally required to provide during the school day; what additional health services can be provided that have a direct impact on academic achievement; and, what kind of care coordination will be needed to ensure students are not missing as much school as they currently are. DC Public Schools contracts with community providers to deliver Medicaid services in schools. The schools provide the space for the providers to deliver care and the providers seek reimbursement directly from Medicaid. ***Ms. Bruce shared that DC Public Schools, the state Medicaid agency and department of health have established a Memorandum of Agreement (MOA) to coordinate and share data in an effort to identify unmet needs and disparities in the provision of EPSDT services. She emphasized that it is important to think about other leaders, in addition to the state Medicaid agency, to engage to support implementation of the free care policy clarification, including the Mayor's Council, representation from the local business community and National Governors Association.

Kim Erickson**, Executive Director of The Consortium*, shared that in 1997 the state of Colorado passed legislation that allowed school districts to get reimbursed for health services delivered to Medicaid beneficiaries and further specified that all revenue from billing Medicaid for student health services had to be reinvested in student health and wellness programming. In 2005, the state was told by CMS that because of the free care policy, Medicaid could only be billed for services included in students' IEPs. ***Ms. Erickson shared that Colorado has moved from a fee-for-service billing model to a cost reconciliation model which has increased their revenue from $6 million to $25 million. She shared that states are concerned about the potential need to open up their state plan amendment process to implement the clarification of the free care policy;

states need reassurance that other key provisions in the state plan will not change as a result of the process.

IMPLEMENTATION CHALLENGES AND OPPORTUNITIES

Below are common themes and key points of discussion that emerged from the dialogue following the panelists' presentations:

Covered Services – The free care rule clarification provides an opportunity to expand Medicaid services for children without an IEP and expand the scope of Medicaid billable services for those with an IEP. The group discussed the necessity of determining what services are included in the state Medicaid plan and which providers are qualified to provide specific services. If specific services that are needed in schools are not included in the state plan, the school system may be able to work with Medicaid to consider an expansion of covered services.

Given the level of need for behavioral health services, expansion of those services for Medicaid enrollees in the school setting is an opportunity.

While states may be hesitant to ask CMS for permission to revise their state plans, as noted above, ***Ms. Harris*** noted that only a small portion would be opened through the amendment process (e.g. if page 12 includes the language around schools billing for IEP health services, only page 12 would be opened for additional changes). CMS is moving towards an automated process for state plan amendments that would automatically bring up all sections that are related to one another. CMS is very willing to provide technical assistance to states before they open a state plan amendment. A state's provider manuals, health plan materials and Medicaid administrative claiming guide would also need to be updated if anything changes when implementing the updated free care policy.

Coalitions to Aid in Implementation -- All of the panelists indicated that collaboration is critical for this work and, for that reason, a coalition is in place in their state. ***Ms. Lowe*** shared that a coalition was created by legislation in Minnesota in 2000 which included the state departments of health and education, ***Ms. Erickson*** shared that the Consortium supports this work in Colorado and ***Ms. Bruce*** shared that the group that came together to develop the MOA still exists and now includes three managed care organizations and the deputy mayors of health and education.

Parent advocacy organizations should be included in the coalitions. Parents need to be bought in to the conversation about increasing access to school health services for their children and having parent support will be key to moving implementation along at a faster speed. In addition, inclusion of human services and child welfare in these coalitions would be helpful.

Reimbursement Rates – The panelists discussed the different Medicaid claiming programs they currently use including fee-for-service, cost reconciliation and administrative claiming. Participants discussed the need for an analysis to be done to determine what reimbursement rates would be necessary to support the sustainability of a school health services program. In addition, participants discussed the need for guidance on what school health services and programs would be eligible for reimbursement through the administrative claiming program given the change in the free care policy.

There may be a threshold at which a school district can recover their costs for billing Medicaid for school health services. For example, under the community eligibility provision established by the USDA, school districts with 40% or more low-income students can provide universal, free school meals to all students. Would a similar set up for school health services work? What percentage of students would need to be enrolled in Medicaid for this to work?

Guidance – The participants identified a need for additional guidance and technical assistance resources for states from the U.S. Department of Education. For example, schools need guidance on HIPAA and FERPA privacy regulations and guidance on consent. Disseminating examples of how some states move forward to leverage the free care policy change and increase the provision of Medicaid services in schools would be very helpful to other states.

Managed Care – Medicaid managed care contracting can be an opportunity for increasing the provision of health services in schools, since managed care organizations have the ability to deliver and reimburse for services in schools settings.

FACILITATING OPPORTUNITIES FOR LEVERAGING NEW FLEXIBILITY FOR IMPROVING HEALTH, WELL BEING AND ACADEMIC ACHIEVEMENT

A set of key principles emerged from the meeting that can be used to help guide strategies to support increased access to school health services.

1. Making the Case

The case needs to be made to both health and education about how increased access to school health services will help them achieve their specific goals, including reducing disparities. States and communities need to understand what measures matter to the education sector (e.g. academic progress, attendance) and to the health sector (e.g. improved access, reduced costs and improved quality of care) in their communities. Local data is important to making the case. Federal leadership is also needed to stress the importance of the education and health sectors working together to achieve their own, as well as mutual, goals.

A financial case also needs to be made. Educators will need to be convinced why they should go above and beyond the services they are already providing and the health community will need to be convinced that investing in school health services can help improve outcomes and quality and reduce overall expenditures by increasing access to primary care, chronic disease management services and decreasing emergency room visits. In addition, it is important for communities to understand what school health services are already being provided using local dollars. Increased Medicaid reimbursement for school health services means that these local dollars can potentially be reinvested elsewhere in a community. For example, in DC, $17 million of local funds go to support school nurse services.

Key questions to consider addressing in making the case include:

- Why is implementing the clarification of the free care policy a good thing to do?
- How can leveraging this opportunity help education and health both meet their goals?
- What is the financial case for school districts and state Medicaid agencies?

- Why is this good for kids and why is it good for academics?
- What school health services are already being provided and supported using local dollars?

It is also important to make the case that implementing this policy change does not necessarily mean more work, but instead may mean being able to seek reimbursement for the things school health providers are already doing.

2. Leadership and Collective Impact

There needs to be political leadership to give the signal to encourage conversations between health and education to take place. In addition, political leadership can play an important role in helping to create incentives for increasing access to school health services. State Medicaid agencies are usually willing to have conversations about opportunities like these, but the challenge is getting it high enough on the priority list to actually be implemented. State Medicaid agencies are cautious of unintended consequences from opening up the state plan amendment process. If a state agency is not willing to implement this change, it would be appropriate to reach out to CMS for help.

There also needs to be a structure to engage people and bring different sectors together to strategize about how to leverage the opportunity presented by this policy change to support the health and well-being of children. Ideally, this would be done in alignment with larger discussions that are taking place around building healthier communities or as a part of existing coalitions. A new group or coalition is not always required to move this forward. In many states and districts, there are coalitions already in place that can take on this issue and act as the convener. Additional conveners could be local philanthropy or the local health department. The convening group can make key decisions, including what school health services need to be available and what infrastructure will be needed to deliver services beyond those included in student IEPs.

There also needs to be a strategy in place for engaging people on the front lines. Bringing their voice to the conversations taking place around implementing the clarification of the free care policy will be critical to moving this effort forward.

3. Determining How Services will be Delivered

It is key for each community to understand how the delivery of school health services fits into the larger health care delivery system in their community and state. In addition, communities should consider the following questions:

- What does the current state plan say about school health services? Does it restrict schools from billing Medicaid for services outside of the IEP?
- If the services targeted for delivery in schools are not included, will a state plan amendment be required?
- What services are currently being provided in the district and who is providing them? What are the best practices?
- Does the school district want to deliver the school health services on their own or contract out for delivery of the services?

- Does the school district want to contract with managed care and if so, how would that contract be structured?
- Who are the current school health service providers? What technology are they using? What additional training will they need to support increased access to school health services?
- What is the proposed reimbursement model?
- What will be the process for quality assurance?

4. Understanding Data System Issues

The challenges presented by data sharing and lack thereof, consent and data infrastructure were expressed throughout the meeting and recognized as a barrier to implementation of the free care policy change.

The group agreed that there is a key role for federal agencies in providing better guidance around navigating HIPAA and FERPA requirements such as providing fact sheets on HIPAA and FERPA, sample MOAs (such as what was created in DC Public Schools) and strategies for obtaining parental consent. It is also critical to provide support and guidance to schools as they work to determine Medicaid eligibility of students and leverage existing data systems to better coordinate the scope of health services children are receiving both inside and outside of schools. Systems are also needed for provider communication and referral.

5. Providing Workforce Training

A key need for workforce training was identified by the group. Training will be required to educate the workforce about the change in the free care policy and reassure them that they can now bill for non-IEP school health services. Training will also be needed on how to identify the need for services, refer and coordinate the care. In addition, significant training will be required to ensure the workforce understands the Medicaid documentation requirements and understands how to bill for the new services being delivered.

It is important for a community to look at their existing training program and determine how it can be modified to meet these training needs. The cost of providing training should not be underestimated but the return on investment can be significant.

It is also important for a community to understand that they do not have to implement the entire package on at once. They may want to consider how to implement this change in stages, for example by starting with a select set of services or just the services delivered by school nurses.

6. Building Momentum and Supporting Dissemination

There is a need for models, toolkits and technical assistance to educate the field about how to leverage an opportunity like the clarification of the free care policy to support increased access to school health services. It would be worth considering if there is an opportunity for federal agencies to provide pilot money to states and/or districts that are ready to move forward with implementing this policy change so that best practices and strategies can be identified and disseminated. It is also critical to show stakeholders that this can be done and provide a framework for accomplishing it.

The group also discussed the need for stories from parents, students, teachers and other school stakeholders highlighting what increased access to care means for students and schools.

It is also important to develop a better understanding of what the current state of play is for states (i.e., which states are ready to move forward with implementation and which will need additional support).

NEXT STEPS

The group agreed that they are interested in continuing the dialogue that began at the meeting and checking in on a semi-regular basis as they continue to work to move this issue forward. It was agreed that future conference calls would be hosted to provide a place for continuing this dialogue.

The following steps for moving this work forward were identified:

- Identify a handful of states that can serve as early adopters and are more ready than others to move forward with implementing the change in the free care policy and rally behind these states to support their efforts.
- Develop the principles outlined by the group into a framework for guiding efforts to implement the change in the free care policy.
- Create a list of questions that a school district or stakeholder group should ask before they move forward with implementation of this change.

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