School-Community Health Alliance of Michigan

A Whitepaper to Propose Financing Options for Supporting School Health Teams

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Acknowledgements

A wide group of stakeholders was convened to define and explore critical areas of interest related to the School Health Team vision and financing options. We would like to offer a special "thank you" to those who brought innovative ideas, practical expertise, and solid research to our meetings.

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Disclaimer

Financing Options for Supporting School Health Teams is a resource to support schools in their efforts to secure and maintain long-term funding to either expand or provide health care services including—at a minimum—access to mental health services, school nursing, general and preventative care, and a range of other support services to students and their families.

This resource was prepared for the School-Community Health Alliance (SCHA-MI) by a group of experts and partners: Health Management Associates (HMA), Michigan Council for Maternal Child Health (MCMCH), Mousetrap Consulting, Michigan Department of Education (MDE), and the Michigan Department of Health and Human Services (MDHHS) with funding from the Michigan Health Endowment Fund (MHEF). This document is designed to provide an overview of the health care needs of Michigan's children, status of health care providers and/or services in schools, financing strategies used to support school health services in other states, and potential financing strategies that could be used or leveraged within Michigan. Special attention was paid to the potential use of federal Medicaid matching strategies to support the delivery of ongoing comprehensive health services, including mental health to school-aged children.

The contents of this document are solely the responsibility of the authors and do not necessarily represent the official views of the Michigan Health Endowment Fund, Michigan Department of Education, and Michigan Department of Health and Human Services.

Prologue

The Michigan Health Endowment Fund (MHEF) awarded a grant to the School-Community Health Alliance of Michigan (SCHA-MI) on behalf of the Michigan Department of Health and Human Services and Department of Education to explore long-term financing strategies that would support a continuum of health care services for school-aged children. MHEF sought to engage in such a project as the result of a large number of grant requests from school districts to fund school health services, including school-based health centers, mental health services, school nursing, etc. While MHEF has funded a number of these projects, they quickly recognized that their funding was only a short-term solution to a problem that required a long-term financing solution.

As a result, a School Health Financing Workgroup was convened to identify sustainable funding strategies for school health services with a focus on mental health, school nursing, oral health, vision and hearing, and school-based health centers. A team of experts were engaged to take this challenge on with leadership provided by "retired" State Medicaid Directors, Steve Fitton and Eileen Ellis, who are both now with Health Management Associates (HMA). Other critical experts included Rick Murdock and Dominick Pallone with Michigan Association Health Plans (MAHP), Robert Sheehan of the Community Mental Health Association of Michigan (CMHAM), Kyle Guerrant (MDE), Carrie Tarry (MDDHS), Amy Zaagman (MCMCH), Deb Brinson (SCHA-MI), Oliver Kim of Mousetrap Consulting, and Cathy Kaufmann (HMA). Additionally, a robust group of stakeholders inclusive of school superintendents, school associations, health plan representatives, Michigan's Children, the Michigan Association of School Nurses, and the Michigan School of Social Workers contributed to the findings of the School Health Financing Workgroup.

Over the last year and half, the Financing Workgroup has met to diligently explore a wide range of potential financing strategies including examining what other states are doing related to financing school health services. Four other states have sought a Medicaid waiver seeking match opportunities and billing options to support school health services. Two states have obtained CMS approval while the remaining two states are awaiting approval. Each of them has a strong potential of being replicated, helping to lay the foundation for strategies to seek match opportunities in Michigan. HMA helped lead the way in identifying and validating potential Medicaid match of general fund dollars at the local level used to purchase limited non-special education health services through school districts. Under the direction of MAHP, a "School Health Team" model of care was drafted that puts the student at the center of care allowing schools to determine types and level of care for its students. Promising practices were identified, with general fund Medicaid match being the strongest. Relationships with Medicaid health plans was another.

However, the Parkland School shootings sadly brought to the nation's attention the need for a serious conversation regarding mental health services within schools, and Michigan has engaged in such discussions. With an increased focus on school safety as the result of school shootings across the country, along with repeated threats in many school districts across the state, several school safety plans and recommendations have been released. The increased interest for mental health services has forced us to move up our initial timeline for sharing and

discussing Medicaid match opportunities for mental health services. We recognize and agree with the need to resource many of the issues identified in the Governor's and legislative plans. We strongly believe that to address the critical mental health and other school health concerns, long-term solutions must be thoroughly explored and thoughtfully implemented.

Michigan legislators and its leaders have a unique opportunity to significantly impact services for children and youth—especially related to mental health services—by specifically looking to leverage federal match on any general funds appropriated for mental health services. This will bring much-needed mental health services to approximately 1,500 schools with the long-term potential of bringing health services to almost all schools. This would serve as a strong and vibrant starting point for institutionalizing access to mental health and school health services for *all* school-aged children in Michigan.

Michigan's shortage of school-based mental health providers and school nurses is one of the worst in the nation, resulting in a serious health crisis for children lacking or with limited access to care outside of school. Michigan lawmakers and policy leaders should consider taking immediate action to address this crisis. Schools are an ideal setting in which to provide mental health services, school nursing care, general and preventative care services, health screenings, dental work, etc. Without access to care in schools, children are more likely to go without important services, miss more school, have worse academic outcomes, and increase the burden of teachers and school officials who must address these health issues in the classroom, including behavioral health. Additional funds—some of which can be achieved through strategies outlined within this whitepaper—are critical to promoting and supporting the health and education of Michigan's children, particularly those who experience health disparities because of the communities in which they live, or who are at risk for mental and behavioral health issues due to adverse childhood experiences and childhood trauma.

Overview

Few K-12 initiatives provide the robust returns seen by school health programs. Studies across the U.S. have shown that high-quality health services have a proven impact on student learning by improving attendance rates, improved behavior, reduced dropout rates, and stronger academic outcomes. It is certainly no secret that when children are feeling well and stress-free, they are better prepared to learn and more likely to be successful learners.

In an era of tough budgets, state and local policymakers have had to make many painful choices. While health, nursing and counseling programs are easy to overlook as unnecessary "extras," academic achievement suffers when kids aren't healthy. Consider these statistics from the Michigan League for Public Policy (2017):

- Adolescents with poor general health are less likely to graduate on time or pursue post-secondary education.
- Michigan's poor-performing students are twice as likely to be obese, nearly four times as likely to attempt suicide, and almost twice as likely to be bullied at school.
- 27% of Michigan youth report symptoms of depression and 16% report having seriously considered suicide.
- 25% of Michigan's high school students have been bullied on school property, and 19% report electronic bullying.

Often, schools serve as the place where community partners, parents, and agencies come together to deliver and receive support, tightening the link between health and education. When adequately funded and supported, this network of partners comprises a continuum through which children, parents, teachers, and other key supports gain access to the tools and services they need to succeed in the classroom, work, and life.

Lack of consistent and reliable funding has stymied the full integration of health services into Michigan's educational framework. Currently, only 92 school-based health programs serve students in Michigan, meaning that just 10% of our state's learners have access to them. Even more concerning, Michigan has a student-to-school nurse ratio of 6,607 to 1—the worst in the nation. Furthermore, the American School Counselor Association reports that there are 729 students for every school counselor in Michigan, the third-highest student-to-counselor ratio in the nation. While these health professionals are helping to manage an increasing array of physical and developmental issues, they are doing so in an uncoordinated and often shoestring manner, resulting in a patchwork of inconsistent and unreliable service delivery around the state.

The Status of Michigan's Children

School-aged children and adolescents have unique health care needs: Many chronic physical, mental health, and substance use conditions first emerge during this period of life. However, they also tend to appear and feel generally healthy, and, consequently, may not seek out general care, behavioral, and preventive health services. In fact, school-aged children and adolescents remain the most medically underserved population in our country. This is particularly unfortunate, because early identification of problematic conditions and behaviors can lead to earlier referral and subsequent treatment.

Each year, the Annie E. Casey Foundation produces a national data book called *Kids Count*. This data compilation provides a longitudinal view of factors that contribute to the well-being of children in the United States. It includes profiles of each state, noting performance year-over-year and comparing the state to national trends. This nonpartisan report is considered a sentinel document on the status of child and adolescent well-being, and often serves as the starting point for public policy and human service improvement and change.

In 2018, *Kids Count* reported some favorable statistics about Michigan, the result of strategic initiatives directed at improving childhood outcomes for the state's youngest residents. For example, a focused effort to expand Medicaid enrollment reduced the number of uninsured children in Michigan to the national average of just 3%. Efforts to improve prenatal care in Michigan resulted in the instance of low-birthweight babies decreasing to the national average of 8.5%, while the number of Michigan teens who abuse alcohol and drugs has remained consistent with other peer states at 5%.

However, when considering other factors of child well-being, Michigan's peer-parity paints a very different picture of health and wellness, ranking Michigan dead last among Great Lakes states. Socioeconomic factors such as the proportion of children living in high-poverty areas (17% versus a national average of 14%), children whose parents lack stable income (32% versus 29%), and children living in poverty (22%) paint an abysmal picture for almost a quarter of Michigan's children. While Michigan's rate of Medicaid coverage has grown to an impressive rate over the last six years, it does not ensure nor guarantee access to care.

Not only is Michigan ranked last in the Great Lakes states for child well-being, but children in Michigan also face adverse childhood experiences (ACEs) at a rate higher than the national average. These children witness abuse, live in a household with poor economic resources, or live with a family member who has a substance-use disorder or mental illness. These adverse experiences can and consistently do negatively affect their future success and overall well-being.

According to the Michigan Department of Community Health (2013):

- Michigan is above the national average for children who are facing two or more adverse family childhood experiences (28.5% in Michigan, versus 22.6% nationally).
- Michigan children are more likely to experience ACEs regardless of race, family structure, or household income.
- Approximately one-fifth of Michigan children have one or more emotional, behavioral, or developmental conditions.

- Astonishingly, the only area where Michigan children report lower ACEs than the national trend is for children living in a household with income over 400% of the federal poverty level.

Researchers have recognized how social determinants of health affect a child's well-being and development. In addition to adverse family experiences, too many children also are exposed to high-risk, violent situations. While the drug and alcohol use of Michigan's teens trends at the national average of 5%, this equates to nearly 40,000 children under 18 abusing drugs or alcohol each year. Homicide is the leading cause of death in the state among African American youth between the ages 15 and 24 and the second leading cause of death for all Michigan youth in the same age bracket.

Finally, Michigan's youth face health obstacles due to the state's aging infrastructure. Michigan is among the states with the oldest housing stock in the nation, exposing Michigan children to environmental health hazards like lead, mold, and vapors daily and increasing their susceptibility to diseases like asthma. Michigan has the tenth-highest prevalence of youth asthma in the country, and African American youth face a higher rate (14.3%) than their white (12%) and Hispanic (11.5%) counterparts.

Meeting Kids "Where They Are At" in Neighborhood Schools

Despite troubling statistics about childhood well-being in Michigan, there is good news. Ninety-seven percent of eligible children are enrolled in Michigan Medicaid programs, making them eligible to receive services that can improve their overall physical and emotional health. This is a positive first step in ensuring that the economic structure exists to support a system of care delivery for at-risk and high-risk children as well as for all children. A key way to improve children's health while increasing educational success is by helping them access the health care system in a way that is more expedient and tailored for them and their families. Schools are not only part of a known social determinant of health (after all, educational achievement is a key determinant), but schools also can and should be a critical tool and essential partner in addressing health disparities. The Centers for Disease Control and Prevention (CDC) has established that a healthy student is more likely to be a successful learner who develops into a productive member of the community.[1]

However, for many families, accessing care and managing chronic physical and behavioral health conditions requires a degree of service coordination that is difficult and, in some cases, impossible for parents to effectively manage during the school day. Parents must trust school personnel to help manage chronic and/or emergency care, which is often overseen or administered by an unlicensed professional—whose primary intervention response is to call the parent. This creates a stressful dynamic for the child, school staff, and parents which frequently results in unnecessary absenteeism for

the student and lost wages and hours for the parent. It is a situation that could be avoided if better coordination and care management resources existed within the school setting.

Further, for many families, access to care is another barrier to health management, particularly in the case of behavioral health services. Many areas of the state suffer from provider shortages, creating long gaps between referrals and appointments, and in many cases requiring significant travel to receive services. Again, the coordination, time commitment, and expense (in terms of both lost wages and travel) can present insurmountable barriers to working families.

The obvious answer to these problems is to improve care management and access to services by meeting children "where they are at." On average, Michigan students spend six hours per day in a school setting for an average of 180 days per year. Integrating behavior and physical health management and access into a school setting presents an opportunity and answer to improve children's health.

Schools are a natural place to provide health care and support services, where children and families spend at least half of their waking hours. Why not provide an integrated, systems-based approach to identifying and serving people where they are at?

A Vision for Children's Health: A Model that Supports the Behavioral and Physical Needs of Michigan Children

Over the past 30 years, Michigan has supported different approaches to improving care management and access within schools including school nursing, on-site clinics, health department partnerships, oral health, and telemedicine. None of these approaches have achieved sufficient scale or sustainable funding to fully integrate these programs as part of a health care delivery system. The result is a patchwork of services that varies depending on where you live, versus a solidified continuum of services.

The school-based health care team model is a powerful tool for improving health and education outcomes for children. School nurses, school mental health providers, and school-based health centers place critically needed health services directly in schools, making it easier for kids to get the care they need—when and where they need it. When this care is available at school, students are more likely to have improved educational and health outcomes.

Many families with limited access to care also encounter challenges in taking a child to a primary care provider—either because of affordability, lack of transportation, or the inability to take time off from work to attend a medical appointment. These families increasingly rely on schools as their main health care provider. Schools are also a trusted neighborhood resource, making them a natural place for families to turn for their children's needs. School nurses, school mental health providers, and school-based health centers provide a continuum of services to support children where they already spend a significant portion of their day.

We share a vision of utilizing neighborhood schools as a means to ensure that every school-aged child and adolescent has access to comprehensive health care services, including mental health. This vision must extend to every student beginning with those covered through Michigan's Medicaid program. Guided by parental and community input, schools could be a

source for students to receive mental health services, care coordination, general and preventative care services, and a wide range of other services.

Using a School Health Team model, schools could adopt an approach to student health and well-being that provides meaningful, consistent, qualified care *while children are in school*. The goal of the School Health Team model is not to replicate or replace primary or specialty care, but to partner in the delivery of care in a way that improves medical management, improves health outcomes and leaves children, parents, and school partners feeling strong and confident in their approach to physical and behavior health issues.

School Health Teams and the Care Continuum: How Does This Work?

To build a true School Health Team for Michigan children and adolescents, it is important to understand what currently exists and what it would take to make this vision a reality.

While many Michigan school districts offer some of the components of a School Health Team model, none has fully addressed the critical components of both service delivery and funding sustainability. To build a meaningful, statewide School Health Team culture, services must be rooted within the schools in a manner that offers responsive and qualified care while being in partnership with local service providers and/or health care institutions, including mental health providers.

Mental Health Services in Schools

Nationally, 20% of children have a mental, emotional, or behavioral disorder.[1] Rates are expected to continue to increase, and there is a growing unmet need for mental and behavioral health services for children. The World Health Organization estimates that by 2020, neuropsychiatric disorders in children will increase 50% compared with other health-related problems, making them one of the five leading causes of childhood illness, disability, and death. Children in low-income neighborhoods are at increased risk for mental health issues. Fifty-seven percent of children with mental health problems come from households living at or below the poverty level.[2]

Sadly, as many as 80% of children and youth who need behavioral health services do not get the care they need.[3] The consequences of this can be devastating, impacting both health and education outcomes. Unaddressed mental health issues are associated with poor academic performance, dropping out of school, substance use disorder, and involvement with the corrections system. Lack of access to mental and/or behavioral health care also adds to the increasing burden on teachers and negatively impacts all children in a classroom. Teachers have described "disruptive behavior [by students with mental health disorders] and teachers' lack of information and training in mental health issues as major barriers to instruction."[4]

Barriers to care are even higher for children from racial and ethnic minorities or who are in families who face language barriers. One study found as few as 13% of children from communities of color receive mental health services.[5] Systemic disadvantages in socioeconomic status—along with greater exposure to adverse childhood experiences and neighborhood stressors, such as levels of violence—contribute to disparities in health and mental health for racial and ethnic communities, which are exacerbated by a lack of access to care.

Schools are an ideal setting in which to deliver mental health services to children. In fact, the vast majority of children who do receive mental health services, receive those services at school.[6] Research has shown that students are more likely to access mental health services when they are available in school.[7] Schools are a safe environment in which mental health providers, school nurses, and educators are able to develop ongoing supportive relationships with students and their families. Because they are able to observe and interact with students on a daily basis, they can spot behavior changes, and screen and identify students in need of help and support. Given that the majority of mental and behavioral health issues begin in childhood, early intervention and support in schools provides children the help they need to grow into healthy, productive adults.

School-based mental health services range from universal prevention and education, to targeted screening, evaluation and referrals, to collaboration in treatment plans for children and youth with severe and persistent mental or behavioral health needs. Although all school-based mental health providers work across the continuum of care in a school-based setting, each provider has a distinct role and value. Mental health services in schools are provided by school social workers or school psychologists who work mainly with special education students and not the general education student population. They focus on helping the child to be a successful learner in the classroom. School counselors are also a part of the school environment; in addition to providing career guidance, school counselors work to ensure that students are following school curriculum guidelines in order to graduate.

As with school nurses, most states face shortages of school-based mental health providers. Lack of funding or budget cuts have resulted in too few positions opened and high caseloads for the mental health professionals who are employed by schools, which then leads to high rates of attrition. The recommended ratio of school counselors-to-students is 1:750, but during the 2013-2014 school year, the average ratio nationally was 1:491.[8] In Michigan, the ratio was a staggering 1:732.[9] Michigan also faces a critical shortage of school psychologists, forcing many schools to share school psychologists and/or social workers. This leaves school counselors and/or social workers with caseloads too high to effectively manage, while severely limiting the access to their services for students in need of support.

School Nursing and the School Health Team Model

School nurses are a critical provider of health care services in schools—and they are playing an increasingly important role in promoting the health and well-being of children. The role of school nurses originated in the early part of the last century to reduce absenteeism by intervening with children and their families on health care needs related to communicable disease.[10] Today, school nurses are frequently responsible for providing a far more complex array of health services, from surveillance and chronic disease management to behavioral health assessment, health education, and more.

As school nurses must address more and more complex health needs of students, fewer and fewer students have access to a school nurse when they need one. The school nurse-to-student ratio is increasing at an alarming rate. According to NASN, only 39% of the nation's schools have a full-time registered nurse for at least 35-hours per week, while 25% have no nurse at all.[11]

In their latest position statement, the NASN and the National Association of State School Nurse Consultants (NASSNC) state that every child should have direct access to a school nurse. They recommend using a "multifactorial health assessment approach that includes not only acuity and care but also social determinants of health to determine effective school nurse workloads for safe care of students."[12] The American Academy of Pediatrics recommends a minimum of one full-time nurse in every school with medical oversight from a physician in every school district as the optimal staffing to ensure the health and safety of students during the day.

Michigan has one of the lowest school nurse-to-student ratios (1:6,607) in the nation. About 800,000 kids across the state—slightly more than half of all public school students—attend classes in buildings without a school nurse. According to a survey by the NASN, Michigan has the third lowest ratio of school nurses to students in the nation. There are some districts who report not having a school nurse at all, and only one district has the 1:750 ratio previously recommended by NASN.

Research has found that dedicated school nursing service has a demonstrable positive effect on student attendance and academic achievement. Yet only 45% of the nation's public schools have a full-time on-site nurse; 30% have one who works part-time, often dividing his or her hours between several school buildings; and 25% have no nurse at all. Michigan falls well below even this alarming national statistic; in a 2014 survey of 798 school districts (representing nearly 95% of districts in the state), only 23% reported having access to a school nurse. Further, Michigan's incredibly high nurse-to-student ratio (1:6,750) leaves many of the available nurses managing nonclinical, unlicensed aides, in lieu of directly providing health care to students in need.

But medical management of children's and adolescent's health is no small undertaking. Students require monitoring, intervention plans, and attention for a variety of issues, including:

- **Asthma:** Asthma is one of the leading causes of school absenteeism for Michigan children. In 2014, there were 17,331 asthma-related hospitalizations for children under 18.

- **Diabetes:** Approximately 215,000 children and youth under age 20 have diabetes in Michigan. Diabetic children require daily oversight and coordination to ensure that blood glucose tests, carb counting, and insulin treatments occur throughout the day.
- **High blood pressure:** High blood pressure in Michigan's children and adolescents is a growing health problem that is often overlooked by physicians. In children 3 to 18 years of age, the prevalence of prehypertension is 3.4% and the prevalence of hypertension is 3.6%.
- **Depression:** According to the 2015 Michigan Youth Risk Behavior Survey, 31.7% of the state's high school students reported feeling sad or helpless every day for two or more weeks in a row, to the extent that they stopped doing usual activities.
- **Mental illness:** Approximately one in six school-aged youth in Michigan experiences impairments in life functioning due to mental illness. Half of mental illnesses emerge during or before adolescence, yet less than half of young people receive adequate treatment.

In many cases, the responsibility for assisting children with health needs when no nurse is present does not simply go away but instead shifts to teachers, principals, and support staff. Given that many of these professionals are not trained to deliver health care—and that they already have a full slate of duties during the day—both quality and consistency of care management suffer.

School-Based Health Centers and the School Health Team

Michigan has been a long-time supporter of Child and Adolescent Health Centers (CAHCs), health centers located on or near a school campus. In 2017, 123 school-based or school-linked centers and programs existed in Michigan. Last year, in fact, over 200,000 Michigan children and adolescents used CAHCs for services such as immunizations, mental health care, general and preventative care, and health education services.

Also referred to as "school-based health centers" (SBHCs), CAHCs are sponsored by different entities such as school districts themselves or provider organizations such as health systems, local health departments, and community health centers. CAHCs can function like pediatric offices, staffed by mid-level practitioners such as nurse practitioners or physician assistants who provide general and preventative care in addition to care management or walk-in services. CAHCs can be school-based or school-linked—off campus and serving more than one nearby school.

The state evaluates CAHCs against a core set of standardized measures to determine their effectiveness, efficiency, and quality in child and adolescent health care. An evaluation by Michigan State University found that over a three-year period, CAHCs were "associated with various health and health behavior benefits for the student population… including fewer symptoms of discomfort, fewer individual risks, and fewer negative peer influences. In addition, use of CAHC services was associated with health and health behavior benefits… such as greater

satisfaction with health, engaging in more physical activity, and eating more healthy foods." CAHCs also work closely with a child's primary care services to ensure continuity of care.

Less than half of Michigan counties currently have a CAHC serving adolescents, and not every school district can feasibly support a CAHC due to the size of their student population. However, the benefits this service provides both to students and to the community is clear, and their ability to provide qualified services in close proximity to schools makes them uniquely suited to support the continuum of care envisioned by a School Health Team.

Services in the School Setting: Prevention, Early Identification, Education, and Referrals through the School Health Team Model

It is no secret that early identification of health concerns is a critical factor in ensuring that children receive and properly manage health conditions in order to be better learners. Schools, where children spend the majority of their waking time, are often considered to be the most trusted and available resource to help parents and students recognize and develop strategies to act on potential health risks, including mental health concerns. Schools can support this continuum of care through screening and referral efforts and coordinated service delivery.

Vision and Hearing Screening

Early detection of vision and hearing impairments is considered a top priority for Michigan children. Michigan law requires that all children complete a vision and hearing test during preschool and prior to entry into kindergarten or first grade. These programs are typically administered through partnerships with local health departments, with health department nurses conducting the screenings on school campuses.

Each year, the Michigan Vision Screening Program screens more than 669,000 preschool and school-age children and makes more than 70,000 referrals to eye doctors. Similarly, the Michigan Hearing Screening Program screens 650,000 children at least once between the ages of 3 and 5 years and every other year between the ages of 5 and 10 years. About 5% of all children screened require a medical referral to a pediatrician, ear-nose-and-throat (ENT) physician, or an audiologist.

Oral Health Services

In 2016, 54.3% of Michigan's third-grade children suffered from dental decay, a condition which can lead to poor nutrition, minimal sleep, irritability, and trouble concentrating during school hours.

Because timely preventive oral health services can reduce and even eliminate dental decay, it is an important service on the health care continuum. Dental sealant services, fluoride varnishing, and education about daily home care are simple, widely accepted, and cost-effective prevention measures suitable for school delivery. In fact, Michigan has a long history of school-dental partnerships through project *SEAL! Michigan*, a program adopted by the state that offers dental sealant services to students through school-based care in high-risk communities.

The success of these school-dental partnerships has helped to improved sealant rates among Michigan children and, in many cases, has expanded the availability of dental services by heightening community awareness of need. In some areas, students are now offered dental

screenings in addition to sealants and fluoride varnishes and have the opportunity to engage in preventative education through their school dental partnership. These screenings can expedite urgent referrals and help to avoid costly emergency room care.

Coordinated Service Delivery

Many areas of the state suffer provider shortages that range from primary care to dental and specialty care. Long waits, long drives, and complicated care plans makes oversight and health management a challenge. This is particularly true as it relates to behavioral health. In 2016, a taskforce convened by Governor Rick Snyder to look at student behavior released a set of recommendations pointing to research which found that "students with severe behavior problems account for a relatively small portion of the school population (1% to 5%), [but] they often generate greater than 50% of office and discipline referrals, taking up a significant amount of educator and administrator time."

Greater resources are needed to ensure that behavioral health services are available as part of any School Health Team initiative. An outpatient psychotherapy model, for example, is one successful school-based behavioral health intervention that could be extremely beneficial for all students, including at-risk students in under-resourced schools and communities.

In this model, the student is screened via a brief, problem-and crisis-focused consultation with a school psychotherapy partner. This consultation occurs with the school and general and preventative care staff, after which screening, triage, and linkage to more intense home and community-based behavioral health care is provided. The school psychotherapist partner also acts as a stabilizing resource for students as they transition (step down) from more intense home- and community-based behavioral health care services to the level of care that can be monitored and supported by the school-based psychotherapist. Such brief psychotherapy provided in a school setting can serve as a solid resource for crisis intervention, case finding/initial contact, screening, and stabilization.

In cases where provider shortages prevent access to care, schools can help families access care (behavior and physical) through telemedicine using tools such as Skype or other online services. Telemedicine covers a range of services from counseling or medication check-ins via webcam to computer-connected otoscopes and stethoscopes which are used to check ears, nose, throat, and heartbeat over a video uplink.

Telemedicine programs are making inroads in schools, where students who are referred to a nurse are connected with a physician by webcam. In some cases, it is helping children connect with a specialist when one is not available in their area.

Lack of Funding for School Health Leads to Missed Opportunities

200,000 Michigan children and adolescents used school-based health centers for immunizations, mental health care, and general and preventative care in 2017.

School-based health services make important contributions to the health and well-being of students. Michigan has several models of health care provided in school settings or on school grounds. School-based and school-linked health centers represent the most comprehensive model of health care services for general education students. Children and young adults with special health care needs, including mental health services, often receive many health care and health-related services in school settings. The scope of these services is usually established as part of an Individualized Education Plan (IEP), which is a plan for educational and other services for children with special needs. School nurses may be present in larger schools on a full- or part-time basis to deal with minor health care issues, including illnesses and injuries that occur during the school day.

Significant evidence exists to support the role of school nurses. Research shows that school immunization rates are higher when a school nurse is engaged in outreach and support. They also have been found to help students "stop smoking, lose weight, avoid pregnancy, and improve their mental health—all factors that influence student learning."[13]

A shortage of school nurses means that students may not be getting the full range of services they need, nor the highest quality services. When students are healthy, they learn better. Lack of health services ultimately impacts education. Without access to a school nurse, students miss school or go home from school at greater rates. About one-third of children miss more than a month of school for various physical, social, economic, environmental and health reasons.[14] Various studies have shown that school nurses reduce absenteeism and a higher nurse-to-student ratio improves attendance.[15]

To compensate for the lack of a school nurse, schools often delegate medical services to teachers or office staff, who do not have appropriate medical training. This places students at risk and increases a school's liability. Researchers have found that when school nurses provide medication to students, fewer medication errors occur. School nurses are far more likely to keep children in school rather than sending them home unnecessarily. One study found that students were more than three times as likely to be sent home when they were seen by an unlicensed school employee instead of a school nurse.[16]

There is growing evidence that full-time school nurses result in cost savings as well as improved outcomes for students. Appropriate school nurse staffing allows teachers and principals to spend more time on education rather than student health needs. One study of an urban school system found that for every dollar spent, $1.84 was saved.[17] With a school nurse in the building, the principal saved nearly one hour and clerical staff about 46 minutes that they otherwise would have spent on attending to student health. Teachers were also able to devote more time to instruction when a school nurse was present. This analysis did not include savings outside the school.

Another study found that for every dollar spent on school nurses, $2.20 was saved in teacher time, loss of work time for parents, and reduced health care costs.[18] The researchers estimated cost-savings associated with medical procedures, parents' lost productivity, and teachers' lost productivity. These savings were realized without factoring in school nurses' prevention and health promotion efforts and don't include estimates of other potential savings in the health care system, such as a reduction in avoidable emergency room visits and hospitalizations.

Impact of Mental Health Services in Schools

There is also a growing body of evidence showing the positive impact of school-based mental health services. School mental health programs have a positive impact on emotional and behavioral outcomes as well as educational outcomes. Studies show improvements in behavioral and emotional symptoms for children who accessed services, as well as increases in school attendance, grade point average, and standardized reading and math test scores.[19] School-based mental health services reduce emotional and behavioral disorders such as attention deficit/hyperactivity disorder, depression, and conduct disorder.[20] School-based mental health services help to address issues of health equity, providing access to services for children and youth from communities facing disparities in access to and quality of mental health care.

Lastly, all students benefit when schools are able to promote and support social, emotional, and behavioral health, as well as school violence prevention. School-based mental health services and the individuals who provide these services promote universal prevention and self-care strategies, as well as positive discipline and stronger feelings of safety in schools. They are also able to identify students with unmet behavioral health needs which leads to early intervention.

Financing Strategies: Potential Options

Despite the mounting evidence that paying for school health is a smart investment, school districts across the nation, including Michigan, struggle to identify sufficient and sustainable funding sources. Financing school health services is a persistent challenge, forcing schools to develop a range of delivery and reimbursement models. Most states use a combination of funds to support school health services. The majority of school health providers are funded from regular and special education funds as well as Medicaid billing.[21] These financing strategies have allowed for the delivery of health care services for students receiving special education services but not for students eligible for Medicaid or non-special education students. Michigan's superintendents and principals continuously express the need for ongoing health services including at minimum mental health and nursing for all of its students where funding is stable and consistent.

Over the last year and half, the financing workgroup (under the guidance of Health Management Associates) has been exploring potential financing mechanisms and strategies that would support access to health care services for all school-aged children and youth across the state of Michigan; ideally, these funding sources would be long-term and sustainable rather than grant-based and competitive. Three specific strategies emerged meeting that criteria: (1) incurring a fee for service claiming/special education financing; (2) leveraging federal Medicaid funding to match state and local funding for health services; and, (3) contracting with Medicaid Managed Care Organizations. A change in the Free Care Rule by the Center for Medicaid and Medicare opened new financing options for states to consider in serving more Medicaid students with a broader array of services.

While each of these financing strategies will offer the opportunity for long-term sustainable funding in serving Medicaid students, it does not allow for funding of services for non-Medicaid eligible students. In order to serve all students, school districts and/or the state would have to contribute a certain amount of general fund dollars for match which would allow those dollars to be used for delivery of care. In many school districts, they are already allocating some level of funding for limited health services.

In addition, each of these financing options will require extensive system work to implement and maintain—all of which can be accomplished with a robust work plan and commitment by all parties including the legislature. The federal Medicaid matching fund design, approval, and implementation will require time to work with federal partners to establish the process. This process will include negotiations with the federal government, modification of the state plan, and putting into place a new reporting module at the local and state level.

New Clarification of the Free Care Rule

A significant change to Medicaid funding for health services in schools occurred when the "Free Care Rule" was issued by the Center for Medicaid and Medicare Services. In the past, Medicaid also reimbursed schools for covered health services for children enrolled in the program; however, in 1997, the Centers for Medicare and Medicaid Services (CMS) established the Free Care Rule, which clarified that Medicaid would no longer pay for health services for Medicaid beneficiaries if those services were available at no cost to others. An exception was provided for children with special education plans (Individualized Education Plans or IEPs); if a child was a Medicaid beneficiary and enrolled in an IEP, then health services provided that are related to the IEP could still be reimbursed. Without Medicaid funds to pay for broader health services, schools were forced to focus health services on children enrolled in special education.[22]

The Free Care Rule was appealed and essentially struck down in 2004,[23] but it wasn't until ten years later (December 2014) that CMS issued new guidance regarding the policy. In a letter sent to State Medicaid Directors, CMS informed states that the Free Care Rule no longer applied, once again allowing schools to bill Medicaid for the covered services they provide to Medicaid-eligible students.[24] These funds could go a long way toward improving student health and education

outcomes by potentially increasing the number of school nurses, mental health professionals, and other health care providers able to serve student health needs.

In order for a school to receive Medicaid reimbursement for health services, three key criteria must be met:

1) the student must be eligible for Medicaid (based on family income or student disability);
2) the health professional must be qualified to provide the service; and
3) the service must be reimbursable according to the state's Medicaid guidelines.

However, many states, including Michigan, have Medicaid plans and rules that mirror the old Free Care Rule or pose other indirect barriers. Changes to these plans will be required before states can take advantage of the rule change. In many states, this will necessitate a state plan amendment (SPA) to be submitted to and approved by CMS. States may submit a SPA that expands coverage to all Medicaid-enrolled students, rather than limiting it to children receiving special education services. They may also expand the list of school-based services in the state plan that can be reimbursed, and/or expand the type of providers in the state plan who can deliver school-based services.[25]

Following are brief descriptions of the process by which four states have introduced SPAs in hopes of reimbursing schools for services to all Medicaid-eligible students in need.

Louisiana

Louisiana's SPA builds on a change made in 2011 that authorized Medicaid to reimburse school nurses for covered services delivered to students with Individualized Education Programs (IEPs). The state received approval in January 2016 for changes to provisions governing school-based health services in order to transition these services out of managed care and into the group of school-based Medicaid services provided by Local Education Agencies (LEAs).[26] The state plan now allows the state to reimburse LEAs for Medicaid-eligible services for all children. Given the high rate of Louisiana children who are enrolled in Medicaid, the impact for schools is likely to be significant. The state has developed a handbook for reimbursement to help guide LEAs in how to enroll, implement, and maintain a Medicaid reimbursement program, including a description of the different types of school-based services for which Medicaid reimbursement may be claimed, as well as an explanation of the procedures and documentation necessary to claim reimbursement.[27]

Massachusetts

In July 2017, Massachusetts received approval of an SPA (with an effective date of July 2016) removing the language in the state plan that specifically limited reimbursement to Medicaid students with IEPs.[28] The SPA also expands the types of providers and services for which the state may seek reimbursement in school settings, adding nutritional, physician, respiratory, optometry, and fluoride varnish services, as well as injury assessment. Lastly, it allows for a new Medicaid penetration rate calculation and association cost methodology, which appears to allow schools to calculate IEP related and non-IEP related covered services separately. This will benefit schools concerned about adverse consequences of a combined rate.[29] Massachusetts is still

developing guidance for how the approved SPA will be implemented. MassHealth is anticipated to release this guidance in 2018.

California

In September 2015, California submitted an SPA to CMS to allow LEAs to qualify for Medicaid reimbursement for covered services provided to all Medicaid eligible students, regardless of whether the services are part of an IEP. This SPA is still pending approval from CMS. The California SPA also expands the list of assessments, treatments, and qualified rendering providers. Assessments included in the proposed SPA were expanded to include respiratory therapy, as well as orientation and mobility assessments. Treatment was expanded to include personal care services, orientation and mobility services, and respiratory therapy. Lastly, the state included an expanded list of qualified providers in the SPA, adding personal care assistants, registered speech-language pathology assistants, licensed physical therapy assistants, licensed occupational therapy assistants, orientation and mobility specialists, licensed respiratory therapists, registered marriage and family therapist interns, and registered associate clinical social workers. In addition to these services and providers, the state initially planned to include "interpreter services, dental screening services, specialized assessments, and some behavioral health services." However, these services were removed from the SPA to avoid duplication of Medi-Cal services available through other Medi-Cal programs.[30]

Georgia

In July 2017, Georgia submitted an SPA to allow LEAs, including charter schools, to be reimbursed for covered services provided to all Medicaid eligible students. The SPA is still pending CMS approval. The state proposes to create a Medicaid School-Based Claiming Program that would consist of a Direct Service Claiming (DSC) Medicaid reimbursement program component. This would allow LEAs to receive reimbursement for Medicaid-covered direct medical services provided by school nurses to PeachCare or Medicaid eligible students.[31] Georgia school nurses are currently funded with state dollars through the Quality Basic Education Act, which specifies a distribution funding mechanism to the LEAs. These state dollars can be matched with Medicaid funding by determining the penetration rate of Medicaid and PeachCare (Georgia's CHIP program) members for each school and drawing down the federal match for services (75% for the provision of direct medical services) to pass through to schools for the direct provision of nursing services to Medicaid and PeachCare members. The state estimates this could bring in $48.6 million in additional federal dollars, and more than double the number of school nurses.[32]

Financing Issue One: Federal Medicaid Claiming

Medicaid is an important funding mechanism for school health services because, on average in Michigan, 40% of a district's students are eligible for free and reduced lunch which makes them eligible for Medicaid. Currently, schools have two options for Medicaid billing: Medicaid Administrative Claiming (MAC) and Covered Service Claiming. These mechanisms are primarily used to support the delivery of health services for special education. Medicaid is a federal matching program, meaning that reimbursement using either billing method will draw a matching federal funding contribution. With the new interpretation of the Free Care Rule,

Medicaid is now a potential source of revenue for health care activities and services for non-special education students who are Medicaid eligible.

Medicaid Administrative Claiming can apply to a broader set of Medicaid activities than claiming for covered services. Activities such as Medicaid outreach, assistance with applying for Medicaid, and coordinating the other agencies providing services to children in school would all qualify under MAC. Typically, the financial methodologies employed determine the cost of Medicaid activities and federal funding supports 50% of the costs. Even with claiming for services, as described next, MAC is available as a complementary methodology to draw down federal funding for activities that don't strictly qualify as "covered services."

Most qualified health professionals bill the Medicaid agency directly for covered health services. This is known as "fee-for-service claiming." Under fee-for-service claiming, schools must track and submit claims for each direct service provided to each student enrolled in Medicaid. The Medicaid agency then reimburses for the direct service—the amount is determined by the Medicaid agency's fee-for-service reimbursement schedule. However, schools may only bill Medicaid directly for the covered health services that have been deemed "medically necessary" by the state Medicaid agency. Each state has the ability to develop its own criteria to determine which services are considered medically necessary.

In Michigan, these services are claimed using a cost-allocation methodology as an acceptable alternative to fee-for-service billing. The methodology relies on random moment data gathering where qualified school professionals record their activity at that moment, including the nature of the service and student receiving the service. These moments are then used as the basis for determining how much of the total costs of these qualified professionals is dedicated to Medicaid eligible students receiving Medicaid covered services.

Currently in Michigan this method is only used for children with special education plans, not all children enrolled in Medicaid. Medicaid services provided by Michigan schools are determined medically necessary when all of the following criteria[33] are met:

- the service addresses a medical or mental disability;
- the service is needed to attain or retain the capability for normal activity, independence, or self-care;
- the service is included in the student's IEP or Individualized Family Services Plan (IFSP) treatment plan; and
- the service is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his/her practice under state law. The written order/referral must be updated at least annually. A stamped signature is not acceptable.

This approach is in line with the Free Care Rule, which previously limited school-based services Medicaid would cover to children with IEPs. However, the interpretation of this policy

has changed in recent years which means Michigan's policy is more restrictive than necessary but can be changed to align with the new federal policy.

Covered services claiming is a structure that could be used to secure federal funding to help support the delivery of comprehensive health care services for Medicaid students attending school districts while school districts use general funds for non-Medicaid students. This financing mechanism builds on the existing state/federal agreement for the special education population which would help ease the path for federal approval, and there is a state time reporting and billing process and infrastructure already in place. The covered services claiming arrangement has the advantage of a higher federal Medicaid matching rate (approximately 65%) for services.

The current financing mechanism for special education students utilizes a cost reimbursement methodology and interim payments to schools. This same methodology can be used to expand federal Medicaid claiming to the general education student population. Familiarity with this approach should make the transition easier for school districts and the Medicaid agency. However, even with a defined process in place, this strategy would require several steps and approval processes for full and successful implementation.

Financing Issue Two: State and Local Funding

Medicaid is a state/federal program which requires that there be a state funding match for virtually all Medicaid activities and services. As observed above, Medicaid services in Michigan draw down federal funds which cover about 65% of their costs (or payments). Administrative activities usually draw down federal funding of 50% of their costs. A major issue for states and their local partners is how to obtain the funding to serve as the "state match."

The most straightforward way to generate state match for Medicaid expenditures is to appropriate general funds to the Medicaid agency. This approach provides the majority of state funding to match federal funding in supporting Medicaid services. However, there are other sources of state funding that legally can be used to match federal funding. This includes health care specific taxes (e.g., on hospitals) as well as other sources of state and local funding that support qualifying health care services provided by governmental agencies.

The Michigan Department of Education, Intermediate School Districts (ISDs), and local school districts are all government entities and, as such, can provide state and local funding as "state match" for Medicaid expenditures. In reviewing local data, we have found that there are significant expenditures for social work, psychology, and nursing services provided by local school districts. As explained above, under federal guidelines, local funding can be used as a source of match if used to provide approved services for Medicaid enrolled children. These funds could potentially be used to leverage federal funds, but have not in the past. Upon review of data from the Michigan Department of Education, millions of dollars are allocated at the local school district level for the delivery of approved Medicaid services and could be matched. HMA has reviewed the data and concurs that this is a major opportunity to draw down substantial federal revenue using existing state and local funding.

The use of existing local school district funds will require additional steps to ensure that the federal match opportunity is available to all schools. Reporting and data provided by schools suggest substantial expenditures for targeted health services, but the proportion of those funds

used for such services needs to be determined to see what would qualify as eligible for federal match. Achieving broad coverage throughout schools across the state will require an assessment of the spending for health services by school district and a strategy that accounts for inequities in resources while attempting to maximize new federal funds.

Financing Issue Three: Determining Optimal Long-Term Approach with Consideration of School Health Programs Through Managed Care

Building on the current federal matching methodology used for special education services is our recommended strategy for the near term because it is already well established with the participating entities. It is not necessarily clear that this is the optimal long-term approach. After the implementation of the near-term strategy is established across the state (at least a year from now), there should be an assessment of the success of the strategy and whether there are other opportunities that should be pursued. Obviously, other strategies should be judged to have the potential to significantly improve on what has been achieved.

One longer term strategy that has been described would use state and local funds to leverage federal match through the Medicaid health plans. This financing strategy will define, establish, and sustain a School Health Team initiative (that is consistent with federal Medicaid managed care rules) to serve the approximately 700,000 school-age children currently enrolled in Medicaid. This would be carried out through an existing managed care rate approval process or, if necessary, a waiver negotiation (between MDHHS and CMS) to adopt and implement an acceptable program that meets CMS rules. Such a program also would advance MDHHS policy for Medicaid Health Plans by implementing payment reform, addressing population health/social determinants of health and disparities, and by embracing integration. This would be similar to the incorporation into the Medicaid Health Plan contract of MiPCT (Michigan Primary Care Transformation) using patient-centered medical homes.

Bundled services for a School Health Team could be delivered within the school setting as authorized by participating local school districts. There is opportunity to partner with local hospitals, Federally Qualified Health Centers (FQHCs), or other community based entities. School Health Teams should establish the minimum services to be provided (enabling each program to supplement based on local needs), the essential data elements, referral arrangements with local service providers, and administrative capacity for entities agreeing to be an administrative (fiduciary) partner.

Recommended Financing Strategy Summarized

With heightened concerns about school safety, educational attainment, and children's health in Michigan, improving and increasing mental health services in schools in a systematic and sustainable way has become a recognized priority by Michigan's Legislature. This presents an opportunity to implement and secure federal match on any general fund appropriation for mental health services. A complementary effort is to identify health services provided to the

general education population which are supported by state and local funding. Expenditures for these services can draw down federal Medicaid funding to offset local spending, thereby freeing up funds to expand local school mental health services.

This first phase would build upon the existing state/federal agreement for reimbursement of health-related services for the special education population. This promises to be an easier and faster path to federal approval given the financing and operational structures that are already in place. This would allow for mental health services to be deployed in a short period of time. It would be important to note that this strategy is only using the financing and operational structures in place and not the staff that currently serve the special education population. There must be a clear distinction between staff and services provided to special education and non-special education students, and this understanding must be well established among the schools utilizing this financing method.

The second phase would be to develop the best long-term strategy for health services in schools. This would require consideration of other services including nursing, other service delivery models like School Health Teams in which health professionals work together, and systemic linkages with other health care organizations such as FQHCs, local health departments, hospitals, school-based health centers, and managed care organizations. Before implementation, it would also be necessary to determine whether a service claiming strategy is viable so that the 65% federal match can be accessed during this phase.

The issues identified in this phase reflect broader goals with more significant impacts. The shortage of school nurses in Michigan is particularly glaring. Learnings from the initial phase will be critical in working through these longer-term issues and developing recommendations.

Staffing and Model Considerations

Staffing and services must also be considered when exploring and implementing financing methods. Repeatedly, school superintendents have shared that they need comprehensive health services that are responsive to the needs of students and families, are sustainable over time, and available to all schools year-round. Medicaid will only pay for approved services which are classified as approved provider types.

Core services would need to be identified and approved by Medicaid and CMS along with provider types and responsibilities. These services and providers would affirm the focus of comprehensive services for school-aged children that can be provided by school nurses, mental health providers, general and preventative care clinicians, and other providers as determined and approved. They would be driven by the needs of students and children. Schools would have the option to either provide the service directly or through contractual arrangements in order to meet the minimum service requirements and provider standards. This would allow school districts to exercise local decision making with regard to strategies for providing services. The state's Medicaid office—along with key stakeholders—will need to identify needed services, and Medicaid will need to submit and obtain approval for additional services to CMS.

Additional Information: Financing Addenda for Review

Included in the appendix are three documents that provide more details related to financing strategies outlined in this paper, along with additional information as to the need for such services. These papers include: (1) HMA paper – *Opportunities to Support School Health Services*; (2) HMA paper – *Model to Expand School Mental Health Services*; and: (3) MAHP paper – *School Health Home Medicaid Match Concept*.

Conclusion

Michigan's children face unique pressures and stressors to growth and development, many of which are heavily influenced by social determinants of health. Michigan can help reduce the disparities between Michigan children and their national counterparts by pursuing a system of health care delivery that accommodates their physical and emotional needs—from prevention through treatment—in a safe, accessible environment. By implementing a sustainable funding model for school health using the School Health Team model, Michigan can take an important step in addressing a critical factor in child and adolescent well-being.

Providing health care services where kids spend their days just makes sense. Schools are an important part of a family's neighborhood. Providing health education and prevention, general and preventative care services, and mental health care in schools will allow more children to access the care they need when they need it. School-based health services are a wise investment. Children with access to care in school have improved educational and health outcomes. School health providers reduce absenteeism and support educators by keeping children healthy and ready to learn. They also help prevent and treat chronic conditions, such as obesity, diabetes, and asthma. They provide students with access to mental health services, which can support lifelong mental health through early intervention. Lastly, they reduce avoidable health care costs, such as hospitalization and emergency health care usage.

Our vision is that every child in every Michigan school has access to health services that provide them responsive and compassionate care when and where they need it.

Recommendations for Michigan

Address the extreme shortage of school-based mental health provider and school nurses. Michigan's ratio of school-based mental health providers and school nurses to the general student population is one of the worst in the nation. This has resulted in a serious health crisis for children without access to care outside of school. Michigan lawmakers and policy leaders should take immediate action to address this crisis. Schools are an ideal setting in which to provide basic health services, health screenings, care coordination, and mental health care. Without access to care in schools, children go without important services, miss more school, have worse academic outcomes, and increase the burden on teachers, who must address behavioral health issues in the classroom. Additional funds, some of which can be achieved through the strategies outlined in this paper, are critical to promoting and supporting the health of all Michigan's children.

Make targeted investments in school-based mental health services. Although a significant (20%) and growing number of children in the country have a mental, emotional, and/or behavioral health disorder, as many as 80% of children and youth who need behavioral health services do not get the care they need. Of the few who do get care, many receive those services in school. Michigan lawmakers should make targeted investments into school-based mental health. School mental health programs have a positive impact on emotional and behavioral outcomes, educational outcomes, and they make schools safer. School-based mental health services reduce emotional and behavioral disorders such as attention deficit/hyperactivity disorder, depression, and conduct disorder. Furthermore, all students benefit when schools are able to promote and support social, emotional, and behavioral health, and prevent school violence.

Leverage the Free Care Rule policy clarification. The Michigan Department of Health and Human Services should make the necessary changes to its State Plan and Medicaid rules so that schools may fully leverage the Free Care Rule policy. This policy allows Medicaid to pay for services that are provided without charge (or with nominal charge) to the public at large. The provision of services in schools—from Medicaid outreach and enrollment support to direct general and preventative care and mental health services—can improve outcomes for children enrolled in Medicaid in the state. In order to help expedite and prioritize this change, the Michigan Legislature should direct the agency to complete the changes as soon as possible.

Increase school utilization of Medicaid reimbursement. Although many schools in the state participate in Medicaid billing, it is primarily used for health services through special education programs. These reimbursement programs remain underutilized, especially in light of the Free Care policy. Once Michigan makes the necessary changes to its Medicaid State Plan and rules, health services may expand through partnerships with school districts and health care entities. Outreach and technical assistance will need to be provided to make schools and communities aware of the new opportunities, and to support their implementation. Because Medicaid billing is complicated and time-consuming, technical assistance and training to support best practices in Medicaid billing will help schools and health care partners be more successful. Heath care partners and key stakeholders should also be encouraged to learn and share best practices in maximizing Medicaid Administrative Claiming for administrative activities regarding vision,

hearing, mental health, and other health services. Engagement with Medicaid Health Plans, including increased federal matching, should be explored and implemented as appropriate. Finally, policy leaders and lawmakers should consider allocating financial resources to update the state's IT/CHAMPS system and direct state officials make needed payment system changes as a high priority.

Explore partnerships to expand school-based health services. Policy leaders and lawmakers should encourage Managed Care Organizations (MCOs) to develop partnerships with school districts. Schools provide the perfect setting to reach children in need of care. School and local health partners can develop strategies that connect children to care, leverage funds for services, and help MCOs and providers meet performance targets to improve the health of the children under their care. Michigan policy leaders and lawmakers should look to the New Mexico School-Based Health Center/Managed Care Organization project as an example of a successful partnership between Medicaid managed care plans, the state Medicaid agency, and school districts to increase funding for and access to school-based health services for children enrolled in MCOs.

The Voices of Michigan's Schools

"Healthy kids learn better. It's that simple. Our school based health center has improved the health and well-being of our students physically and mentally, instilling a greater sense of hope in their future."
—Tom Livezey, Superintendent, Oakridge Schools

"Our students face many challenges each day that simply cannot be addressed by the current systems we have in place. The ability to provide care coordination for physical health as well as access to mental health services in all of our buildings would be a game changer in the educational world."
—Michael Yokum, PhD, Assistant Superintendent, Oakland Schools

"Without fail, when a group of school administrators gets together, we hear them talk about the overwhelming need for additional health support services in schools. They don't want another grant—they want financing options that are sustainable and can be built into their systems permanently for all students."
—Tina Kerr, PhD, Deputy Executive Director, Michigan Association of School Administrators

"School nurses serve a critical role as a part of the school's multi-disciplinary team to bridge the gap between health, wellness, and learning. Working with parents, other health professionals, and school staff, school nurses provide services for students that promote optimum health for academic success. School nurses provide the expertise to identify, assess, plan, implement, and evaluate the health needs of the school community."
—Phyllis Yoder, BSN, RN, NCSN, President, Michigan Association of School Nurses

"So many students are at risk of not succeeding in school because their chronic illness may interfere with their attendance. School nurses collaborate with parents and healthcare providers to create care plans for students with special health needs. If we want to see all of our children succeed, we have to meet their individual needs and help them stay in the classroom."
—Patricia K. Bednarz, RN, MN, FSASN, Legislative Chair, Michigan Association of School Nurses

"Early identification and treatment for mental illness works and can prevent hugely negative outcomes including becoming involved with the criminal justice system, substance abuse, or even suicide. Schools offer the ideal environment for prevention, intervention, and regular communication with students and their families."
—Mollie Reynolds, LMSW, Region E Representative, Michigan Association of School Social Workers

"Due to the incredible work done by researchers on Adverse Childhood Experiences (ACEs) we know that the brain's architecture is built over time and from the bottom up, much like a house. Exposure to traumatic experiences without the support of caring adults can cause toxic stress responses in children, which can weaken the brain's architecture, leaving children vulnerable to a range of health, learning, and behavioral problems across their lifespan. Fortunately, research also suggests that there are things that we as educators, health professionals, and community members can do to buffer toxic stress, preventing or reversing its effects."
—Terri Czerwinski, RN, MSN, School Health/Nurse Consultant, Wayne RESA, Michigan ACE Initiative Master Trainer

"As a community, the school-based health programs increase health knowledge and the availability of care to all ages of students. Health is so much more than just not being sick—it's about physical, mental, and social well-being. Habits that promote lifelong health need to be taught at a young age and encouraged through a person's life. This is truly the Lakeview Youth Clinic's goal for the community of Lakeview Students and it is an obvious passion of the people who work there. I feel fortunate that my community has a school-linked clinic and that it can benefit a large group of my peers that may not have access to healthcare any other way."
—Student, Lakeview Health Center, Calhoun County Health Dept.

"They have people that we can come talk to and get advice from without being judged which gives me hope. I was once in the shadows but I have slowly lighted my personality because of the access I have had to the opportunities the school-based health clinic have provided for students like me."
—High School Student, Intercare, Benton Harbor

"The School Wellness Program's unique ability to provide high quality mental health treatment to students in the school setting made it possible to help both Aiden and his family in the familiar and more typical setting of his school. This made it possible to help Aiden collaboratively within the school and with the other services needed while minimizing the disruption of his learning experience."
—Middle School Student, Durand School Wellness Program

"Feeling like a little mouse, my therapist was exactly what I needed. The more I saw her, the more comfortable she made me feel, and the more skills she taught me to handle scary problems."
—High School Student, Jackson, MI

"She's been there when I've been at the lowest, knowing everything about me, my past, my present even knowing what I dream of becoming in the future. She's been there for just about everything. If I didn't have a school health center to go to, I would be lost."
—11th Grade Student, Harbor Beach Health Center

"Over the course of his middle school experience, the student revealed he'd experienced ongoing deep-rooted feelings of inadequacy, mood swings, episodic states of depression, and increased anxiety about his ability to succeed. His social awkwardness made him feel alone and as an outsider. In a collective effort with the parent, the Earhart therapist worked closely with his teachers to develop a treatment plan to help him better cope in his new school environment as well as to prepare for his transition into high school."
—Henry Ford Health System, Earhart Elementary/Middle School

"With the help that I've received from the staff at the school clinic, I have been able to overcome many things that used to hinder me from being a successful student. Working with my nurse practitioner and my counselor, I have been able to learn how to get through the anxiety attacks that used to send me home from school, stay on track with my classes, and how to cope with my depression."
—Middle School Student, Sturgis Health Center

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Appendix

- **School Health Team Financing Stakeholders Group Roster**
- **School Health Services Finance Workgroup Contact List**

Three papers providing more details related to financing strategies:

1) ***Opportunities to Support School Health Services*** **(HMA)**
2) ***Model to Expand School Mental Health Services*** **(HMA)**
3) ***School Health Home Medicaid Match Concept*** **(MAHP)**

School Health Team Financing Stakeholders Group Roster

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HMA

HEALTH MANAGEMENT ASSOCIATES

Opportunities to Support School Health Services

PREPARED FOR

SCHOOL COMMUNITY HEALTH ALLIANCE OF MICHIGAN

JULY 2018

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

School-based health care is a powerful tool for improving health and education outcomes for children. School nurses, school mental health providers and school-based health centers place critically needed health services directly in schools, making it easier for kids to get the care they need when and where they need it. When this care is available at school, students are more likely to have improved educational and health outcomes. School health providers also play an important role in community health through prevention and health promotion activities.

The need to invest in school-based health services is all the more critical due to the increasing rates of chronic health care needs among children. National data show a dramatic increase in chronic and acute illnesses in children over the past two decades, including asthma, diabetes, epilepsy, obesity and behavioral health concerns[1]. Nationally, 20% (1 in 5) of children have a mental, emotional or behavioral disorder[2]. Rates are expected to continue to increase, with a growing unmet need for mental and behavioral health services for children. As the number of students with chronic conditions and mental or behavioral health disorders grows, the need to assure access to health care in school has become all the more urgent.

Furthermore, low-income families and their children with limited access to care or challenges in taking a child to a primary care doctor – either because of affordability, lack of transportation or the inability to take time off from work to attend a medical appointment – increasingly rely on schools as their main health care provider. Schools are also a trusted neighborhood resource, making them a natural place for families to turn for their children's needs. School nurses, school mental health providers and school-based health centers provide a continuum of services to support children where they already spend a significant portion of their day.

Despite the mounting evidence that school-based health services are a smart investment, school districts across the nation struggle to identify sufficient and sustainable funding sources. Schools feel the pressure to increase the availability of health services but can only make limited resources go so far. Particularly in light of recent reports of school violence, many states and school districts are considering how to develop sustainable financing strategies for physical and mental health services. This paper explores the role of school nurses, school mental health providers and school-based health centers in supporting student health, examines financing strategies and provides recommendations to Michigan to support and strengthen school-based health services in school districts across the state.

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School Nurses

School nurses are a critical provider of health care services in schools – and they are playing an increasingly important role in promoting the health and well-being of children. The role of school nurses originated in the early part of the last century to reduce absenteeism by intervening with children and their families on health care needs related to communicable disease.[3] Today, school nurses are frequently responsible for providing a far more complex array of health services, from surveillance and chronic disease management to behavioral health assessment, health education and more.

Unfortunately, as school nurses must address more and more complex health needs of students, fewer and fewer students have access to a school nurse when they need one. The school nurse-to-student ratio is increasing at an alarming rate. According to NASN, only 39 percent of the nation's schools have a full-time registered nurse for at least 35-hours per week, while 25 percent have no nurse at all.[4]

In their latest position statement, the NASN and the National Association of State School Nurse Consultants (NASSNC) state that every child should have direct access to a school nurse. They recommend using a "multifactorial health assessment approach that includes not only acuity and care but also social determinants of health to determine effective school nurse workloads for safe care of students".[5] The American Academy of Pediatrics recommends a minimum of one full-time nurse in every school with medical oversight from a school physician in every school district as the optimal staffing to ensure the health and safety of students during the day.

[3] National Association of School Nurses. (2016). *The role of the 21st century school nurse* (Position Statement). Retrieved from https://www.nasn.org/advocacy/professional-practice-documents/position-statements/ps-role

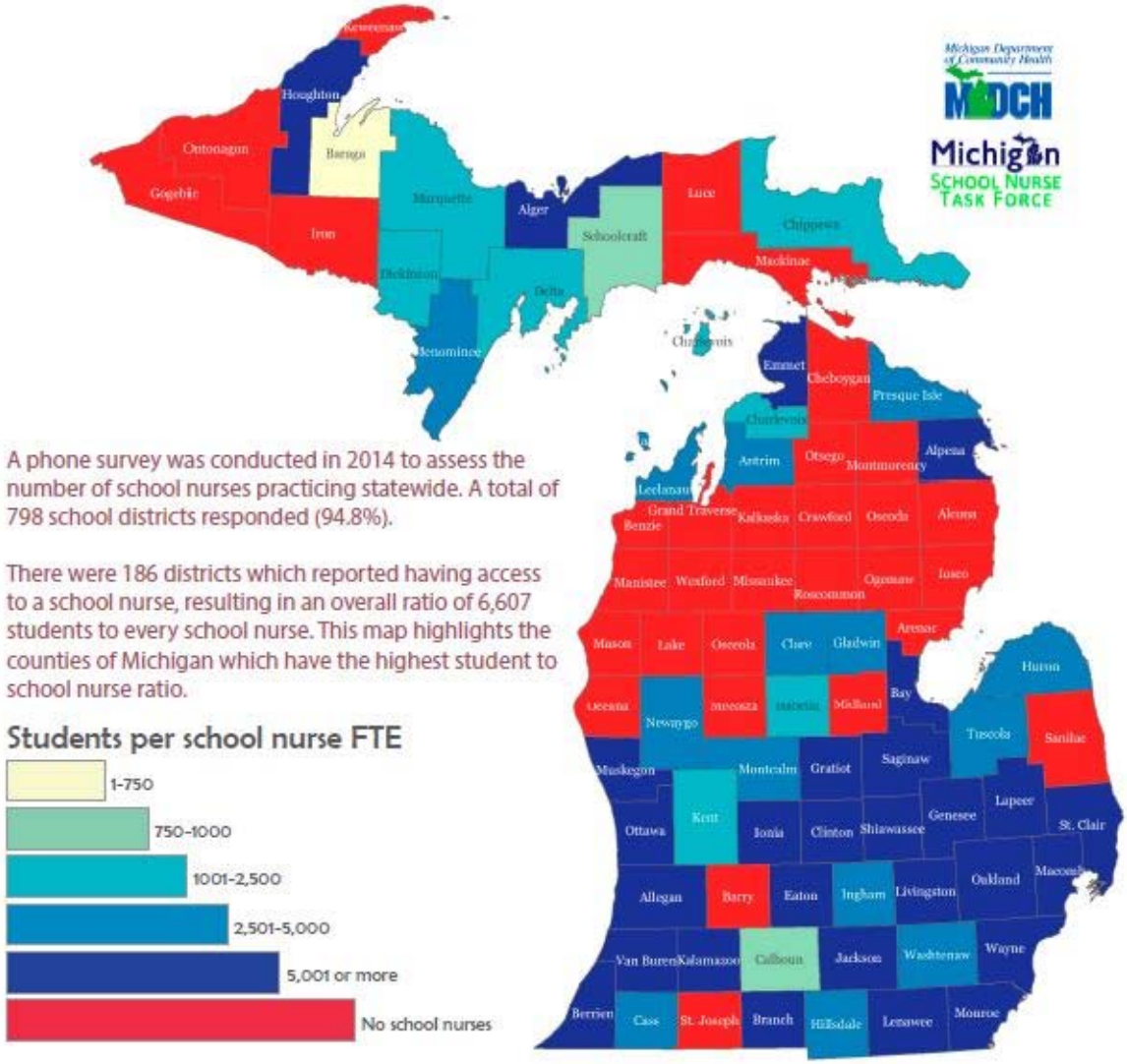
[4] National Association of School Nurses. (2017). *School Nurses in the U.S* Retrieved from https://higherlogicdownload.s3.amazonaws.com/NASN/3870c72d-fff9-4ed7-833f-215de278d256/UploadedImages/PDFs/Advocacy/2017_School_Nurses_in_the_Nation_Infographic_.pdf

[5] National Association of School Nurses. (2015). *School nurse workload: Staffing for safe care* (Position Statement). Retrieved from https://www.nasn.org/advocacy/professional-practice-documents/position-statements/ps-workload

School Nurses in Michigan

Michigan has one of the lowest school nurse to student ratios (1:6,607) in the nation. About 800,000 kids across the state - slightly more than half of all public school students - attend classes in buildings without a school nurse. According to a survey by the NASN, Michigan has the third lowest ratio of school nurses to students in the nation. There are some districts who report not having a school nurse at all; and only one district has the 1:750 ratio previously recommended by NASN.

Figure 1



Mental Health Services in Schools

Nationally, 20% of children have a mental, emotional or behavioral disorder.[6] Rates are expected to continue to increase, and there is a growing unmet need for mental and behavioral health services for children. The World Health Organization estimates that by 2020, neuropsychiatric disorders in children will increase 50 percent compared with other health-related problems, making them one of the five leading causes of childhood illness, disability and death. Children in low-income neighborhoods are at increased risk for mental health issues. Fifty-seven percent of children with mental health problems come from households living at or below the poverty level.[7]

Unfortunately, as many as 80% of children and youth who need behavioral health services do not get the care they need.[8] The consequences of this can be devastating, impacting both health and education outcomes. Unaddressed mental health issues are associated with poor academic performance, dropping out of school, substance use disorder and involvement with the corrections system. Lack of access to mental and/or behavioral health care also adds to the increasing burden on teachers and negatively impacts all children in a classroom. Teachers report, "disruptive behavior [by students with mental health disorders] and teacher's lack of information and training in mental health issues as major barriers to instruction."[9]

Barriers to care are even higher for children from racial and ethnic minorities or who are in families who face language barriers. One study found as few as thirteen percent of children from communities of color receive mental health services.[10] Systemic disadvantages in socioeconomic status, along with greater exposure to adverse childhood experiences and neighborhood stressors, such as levels of violence, contribute to disparities in health and mental health for racial and ethnic communities, which are exacerbated by a lack of access to care.

Schools are an ideal setting in which to deliver mental health services to children. In fact, the vast majority of children who do receive mental health services, receive those services at school.[11] Research has shown that students are more likely to access mental health services when

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[6] Perou R, Bitsko RH, Blumberg SJ, Pastor P, Ghandour RM, Gfroerer JC, Hedden SL, Crosby AE, Visser SN, Schieve LA, Parks SE, Hall JE, Brody D, Simile CM, Thompson WW, Baio J, Avenevoli S, Kogan MD, Huang LN; Centers for Disease Control and Prevention (CDC). Mental health surveillance among children – United States, 2005—2011. MMWR Suppl. 2013 May 17;62:1-35.

[7] Howell, E. 2004. Access to Children's Mental Health Services under Medicaid and SCHIP. Washington, DC: Urban Institute.

[8] Kataoka, S.; Zhang, L.; Wells, K. 2002. Unmet Need for Mental Health Care among U.S. Children: Variation by Ethnicity and Insurance Status. American Journal of Psychiatry 159(9): 1548-1555.

[9] Kataoka, S.H., Rowan, B., & Hoagwood, K.E. (2009). Bridging the Divide: In Search of Common Ground in Mental Health and Education Research and Policy. Psychiatric Services. 60(11): 1510-1515.

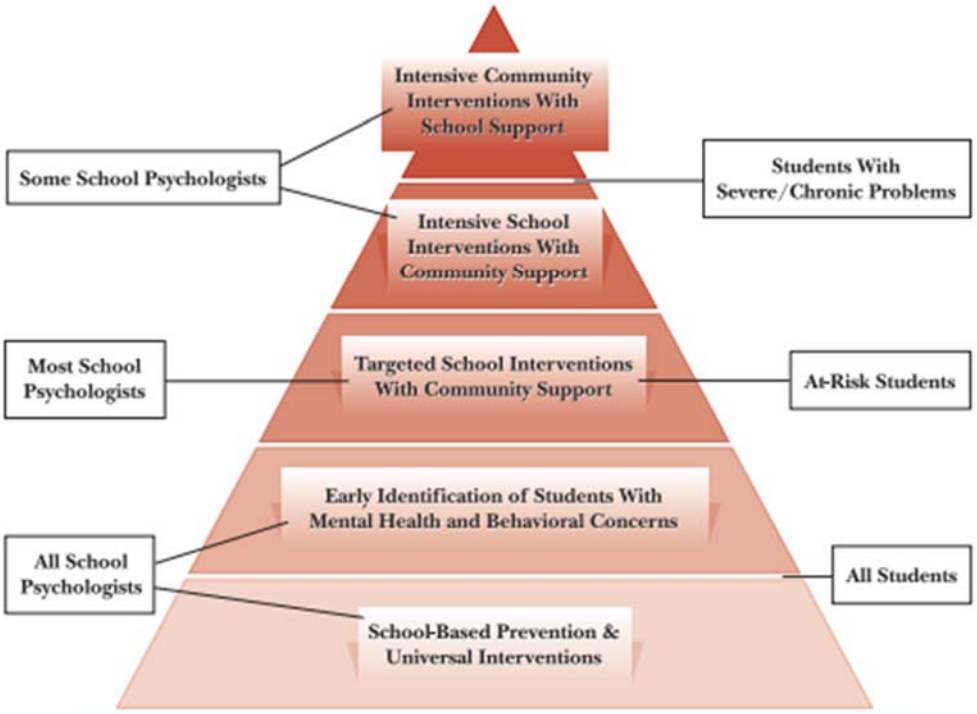
[10] Ringel, J. S.; Sturm, R. 2001. National Estimates of Mental Health Utilization and Expenditures for Children in 1998. Journal of Behavioral Health Services & Research 28(3): 319-333

[11] Brenner, N.D., Martindale, J., & Weist, M.D. (2001). Mental Health and Social Services: Results from the School Health Policies and Programs Study 2000. Journal of School Health 7(7), 305-312.

they are available in school.[12] Schools are a safe environment in which mental health providers, school nurses and educators are able to develop ongoing supportive relationships with students and their families. Because they are able to observe and interact with students on a daily basis, they can spot behavior changes, and screen and identify students in need of help and support. Given that the majority of mental and behavioral health issues begin in childhood, early intervention and support in schools provides children the help they need to grow into healthy, productive adults.

School-based mental health services range from universal prevention and education, to targeted screening, evaluation and referrals to collaboration in treatment plans for children and youth with severe and persistent mental or behavioral health needs. The National Association of School Psychologists has identified the following continuum of school-based mental health services (see Figure 2):

Figure 2



From "Communication Planning and Message Development: Promoting School-Based Mental Health Services" in *Communiqué*, Vol. 35, No. 1. National Association of School Psychologists, 2006

School-Based Prevention and Universal Interventions: All children benefit from school-based prevention and other universal interventions, including mental health and wellness education,

[12] University of Maryland, School of Medicine. *The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcome*. Available online at: http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/CSMH-SMH-Impact-Summary-July-2013-.pdf

school violence and bullying prevention, and the promotion of social-emotional learning, such as conflict resolution skills.

Early Identification of Students with Mental Health and Behavioral Concerns: School mental health providers play an important role in early identification of students with mental and/or behavioral health concerns and working with families to develop and monitor support plans.

Targeted School Interventions with Community Support: Schools can provide at-risk children and youth with targeted interventions to address mild to moderate mental health and/or behavioral health needs.

Intensive School Interventions with Community Support: School mental health providers frequently provide more intensive services to children with severe needs, including those with special education plans. These direct services include counseling, behavior planning and support, as well as consultative services for families and teachers. These students are best supported when school-based providers work with community supports in a coordinated, integrated approach.

Intensive Community Interventions with School Support: For students with severe or chronic mental or behavioral health issues that exceed the capacity of the school mental health providers, schools can serve as an important partner to the community-based providers.

School Mental Health Providers

Mental health services in schools are provided by school psychologists, school social workers or school counselors who are specifically trained to work within a school setting. Although all school-based mental health providers work across the continuum of care in a school-based setting, each provider has a distinct role and value.

School Counselors: School counselors work with all students, teachers and school staff to support academic achievement and promote mental health. Counselors help with a variety of issues, from bullying to strategies to deal with learning disabilities or classroom behavioral problems. They provide schoolwide prevention and intervention services, as well as academic and career guidance. School counselors tend to be employed by the school, rather than the school district.

School Social Workers: School social workers are trained mental health providers (typically with a master's degree in social work) who provide assessment and array of intervention strategies for children and their families, including group or individual counseling and behavior planning. School social workers consider the factors in a student's home and community that impact the student's education and work with students and families to address barriers. They are often seen as a liaison between the school and the family as they frequently conduct outreach, home visits and connect families to community-based resources.

School Psychologists: School psychologists are masters or doctoral-level behavioral health providers who conduct psycho-educational assessments, provide psychological counseling, coordinate intervention strategies and consult with teachers and families on behavioral challenges. School psychologists are typically employed by the school district and shared across many schools.

All of these types of school-based mental health providers play an important role in the continuum of services that can be offered through schools to support the health and well-being of children

and youth. As with school nurses, most states face shortages of school-based mental health providers. Lack of funding or budget cuts have resulted in too few positions opened and high caseloads for the mental health professionals who are employed by schools, which then leads to high rates of attrition. The recommended ratio of school counselors-to-students is 1:250, but during the 2013-14 school year the average ratio nationally was 1:491.[13] In Michigan, the ratio was a staggering 1:732.[14] Michigan also faces a critical shortage of school psychologists, forcing many schools to share school psychologists and/or social workers. This leaves these mental health professionals with caseloads too high to effectively manage, and severely limiting the access to their services for students in need of support.

School-Based Health Centers

School-based health centers (SBHCs) are health care centers based in schools which provide a full range of services for students and their families. There are over 2,000 SBHCs throughout the country.[15] Services vary from one community to another, but they typically include primary care, oral health care, behavioral health care, and health education. SBHCs are often operated as a partnership between the school and local health care organization, such as a hospital, local health department or community health center.

SBHCs and school nurses are partners who play different roles in providing school-based health care. As the School-Based Health Alliance describes it:

> "The school nurse is the building's health ambassador, on the frontline for day-to-day oversight and management of the school population's health. School-based health care complements the work of school nurses by providing a readily accessible referral site for students who are without a medical home or in need of more comprehensive services such as primary, mental, oral, or vision health care".[16]

School-Based Health Centers in Michigan

There are 123 school-based or school-linked centers and programs in Michigan.[17] Michigan School-based health centers are a pediatric office located in a school staffed by mid-level practitioners

[13] American School Counselor Association. Student-to-School-Counselor Ratio 2013-14. Accessed online at: https://www.schoolcounselor.org/asca/media/asca/home/Ratios13-14.pdf

[14] Ibid.

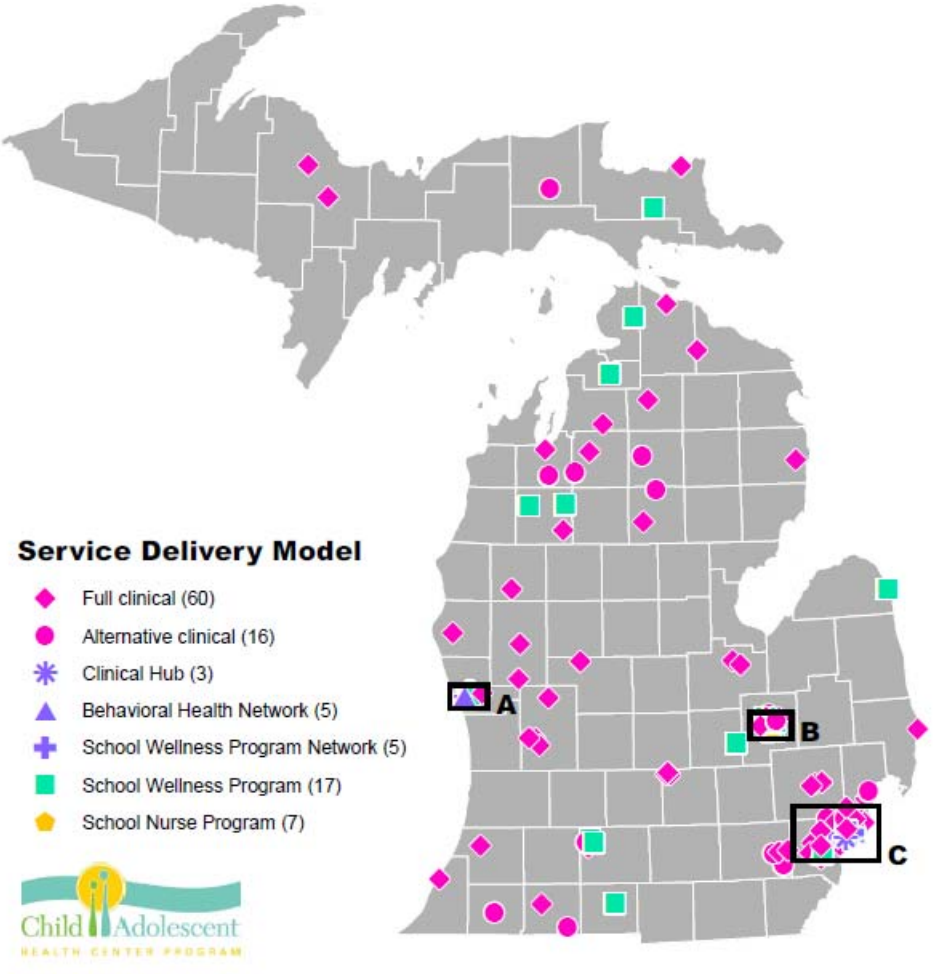
[15] National Assembly on School-Based Health Care. School-based Health Center Census 2013-14. http://www.sbh4all.org/school-health-care/national-census-of-school-based-health-centers/

[16] School Based Health Alliance. www.sbh4all.org

[17] School-Community Health Alliance of Michigan. http://scha-mi.org/

(nurse practitioners and physician assistants). Just under half (45%) of Michigan counties have an adolescent school-based health program.[18]

Figure 3



Lack of Funding for School Health Leads to Missed Opportunities

School-based health services make important contributions to the health and well-being of students. Michigan has several models of health care provided in school settings or on school grounds. School-based and school-linked health centers represent the most comprehensive model of health care services for general education students. Children and young adults with special health care needs, including mental health services, often receive many health care and health-related services in school settings. The scope of these services is usually established as part of an

[18] Ibid.

Individualized Education Plan (IEP), which is a plan for educational and other services for children with special needs. School nurses may be present in larger schools on a full or part-time basis to deal with minor health care issues, including illnesses and injuries that occur during the school day.

Significant evidence exists to support the role of school nurses. Research shows that school immunization rates are higher when a school nurse is engaged in outreach and support. They have also been found to help students "stop smoking, lose weight, avoid pregnancy, and improve their mental health, all factors that influence student learning".[19]

A shortage of school nurses means that students may not be getting the full range of services they need, nor the highest quality services. When students are healthy, they learn better. Lack of health services ultimately impacts education. Without access to a school nurse, students miss school or go home from school at greater rates. About one-third of children miss more than a month of school for various physical, social, economic, environmental and health reasons.[20] Various studies have shown that school nurses reduce absenteeism and a higher nurse- to-student ratio improves attendance.[21]

To compensate for the lack of a school nurse, schools often delegate medical services to teachers or office staff, who do not have appropriate medical training. This places students at risk and increases a school's liability. Researchers have found that when school nurses provide medication to students, fewer medication errors occur. School nurses are far more likely to keep children in school rather than sending them home unnecessarily. One study found that students were more than three times as likely to be sent home when they were seen by an unlicensed school employee instead of a school nurse.[22]

There is growing evidence that full-time school nurses result in cost savings as well as improved outcomes for students. Appropriate school nurse staffing allows teachers and principals to spend more time on education rather than student health needs. One study of an urban school system found that for every dollar spent, $1.84 was saved.[23] With a school nurse in the building, the principal saved nearly one hour and clerical staff about 46 minutes that they otherwise would have spent on attending to student health. Teachers were also able to devote more time to instruction when a school nurse was present. This analysis did not include savings outside the school.

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[19] Maughan, E.D.. (2016). *Building Strong Children: Why We Need Nurses in Schools.* American Educator. Retrieved from https://www.aft.org/sites/default/files/ae_spring2016school-nursing.pdf

[20] Balfanz, R., & Byrnes, V.. (2012). *The importance of being there: A report on absenteeism in the nation's public schools*. Johns Hopkins University Center for Social Organization of Schools. Baltimore, MD. Retrieved from https://new.every1graduates.org/wp-content/uploads/2012/05/FINALChronicAbsenteeismReport_May16.pdf

[21] Maughan, E.. (2003). *The impact of school nursing on school performance: A research synthesis.* Journal of School Nursing. Retrieved from http://www.rmc.org/wpdev/wp-content/uploads/2012/12/THe-impact-of-school...2.pdf

[22] Pennington, N. & Delaney, E.. (2008). *The number of students sent home by school nurses compared to unlicensed personnel.* Journal of School Nursing. Retrieved from http://journals.sagepub.com/doi/pdf/10.1177/1059840508322382

[23] Baisch, M.J., Lundeen, S.P. & Murphy, M.K.. (2011). *Evidence-based research on the value of school nurses in an urban school system.* Journal of School Health. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21223274

Another study found that for every dollar spent on school nurses, $2.20 was saved in teacher time, loss of work time for parents, and reduced health care costs.[24] The researchers estimated cost-savings associated with medical procedures, parents' lost productivity, and teachers' lost productivity. These savings were realized without factoring in school nurses' prevention and health promotion efforts and don't include estimates of other potential savings in the health care system, such as a reduction in avoidable ER visits and hospitalizations.

Impact of Mental Health Services in Schools

There is also a growing body of evidence showing the positive impact of school-based mental health services. School mental health programs have a positive impact on emotional and behavioral outcomes as well as educational outcomes. Studies show improvements in behavioral and emotional symptoms for children who accessed services, as well as increases in school attendance, grade point average and standardized reading and math test scores.[25] School-based mental health services reduce emotional and behavioral disorders such as attention deficit/ hyperactivity disorder, depression, and conduct disorder.[26] School-based mental health services help to address issues of health equity, providing access to services for children and youth from communities facing disparities in access to and quality of mental health care.

Lastly, all students benefit when schools are able to promote and support social, emotional, and behavioral health and prevent school violence. School-based mental health services support improved school safety. School mental health providers promote universal prevention and self-care strategies, as well as positive discipline and stronger feelings of safety in schools. They are also able to identify students with unmet behavioral health needs and support early intervention.

Financing Strategies

Despite the mounting evidence that paying for school health is a smart investment, school districts across the nation struggle to identify sufficient and sustainable funding sources. Financing school health services is a persistent challenge, forcing schools to develop a range of delivery and reimbursement models. Most states use a combination of funds to support school health services.

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[24] Wang L.Y., Vernon-Smiley, M., Gapinski, M.A., Desisto, M., Maughan, E., Sheetz, A. (2014). *Cost-benefit study of school nursing services.* JAMA Pediatrics. Retrieved from http://www.shankerinstitute.org/sites/shanker/files/Cost-Benefit-Study-of-School-Nursing-Services%20June%2012%20short.pdf

[25] University of Maryland, School of Medicine. *The Impact of School Mental Health: Educational, Social, Emotional, and Behavioral Outcome*. Available online at: http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/CSMH-SMH-Impact-Summary-July-2013-.pdf

[26] Hussey, D. L., & Guo, S. (2003). Measuring behavior change in young children receiving intensive school-based mental health services. Journal of Community Psychology, 31, 629-639.

The majority of school health providers are funded from regular and special education funds as well as Medicaid billing.[27] Medicaid is an important funding mechanism for school health services. Schools have two options for Medicaid billing: Medicaid Administrative Claiming (MAC) and Fee-for-Service Claiming.

Medicaid Administrative Claiming (MAC)

Through the MAC program, schools or school districts may be reimbursed for some of the activities their employees perform that directly support the Medicaid program. Reimbursable activities include those "directed to individuals and families to provide information about the Medicaid Program, encourage individuals to apply, and assist in obtaining Medicaid services from available resources and providers of medical care."[28] Examples of some school health services that may be eligible for reimbursement include: conducting Medicaid outreach or helping a student and/or family complete Medicaid enrollment forms, providing students or families about the services provided by Medicaid, providing information about Medicaid services available through the Early and Periodic Screening Diagnosis and Treatment (EPSDT) policy, coordinating health-related services, and making referrals for a student to receive necessary medical/ mental health screenings, evaluations or examinations.

Schools must have an interagency agreement with the Medicaid agency in order to claim federal matching funds. Billing/claiming can be done by the state or local education agency, the health department, or even a private company based on the agreement with the state Medicaid agency.

Fee-for-Service Claiming

Schools may also bill the Medicaid agency directly for covered health services provided by qualified school-based health professionals. This is known as "fee-for-service claiming." Under fee-for-service claiming, schools must track and submit claims for each direct service provided to each student enrolled in Medicaid. The Medicaid agency then reimburses for the direct service -- the amount is determined by the Medicaid agency's fee-for-service reimbursement schedule. However, schools may only bill Medicaid directly for the covered health services that have been deemed "medically necessary" by the state Medicaid agency. Each state has the ability to develop its own criteria to determine which services are considered medically necessary.

Medicaid covered services billed by schools include:

- Evaluations and tests performed for assessments
- Occupational Therapy Services
- Orientation and Mobility Services

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[27]Oregon Health Authority, Oregon School Nurse Task Force. (n.d.) *Nationwide School Nurse Funding.* Retrieved from http://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Youth/HealthSchool/Documents/TFSN/Nationwide_School_Nurse_Funding_and_Requirements_Comparison.pdf

[28] Centers for Medicare & Medicaid Services. (2003). *Medicaid School-based Administrative Claiming Guide.* Retrieved from https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf

- Assistive Technology Device Services
- Physical Therapy Services
- Speech, Language and Hearing Therapy Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatrist Services
- Personal Care Services
- Targeted Case Management (TCM) Services
- Specialized Transportation Services

In Michigan these services are only billable for children with special education plans, not all children enrolled in Michigan. Medicaid services provided by Michigan schools are currently determined medically necessary when all of the following criteria[29] are met:

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self-care;
- Is included in the student's IEP/IFSP treatment plan; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his/her practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually. A stamped signature is not acceptable.

This approach is in line with the "free care rule," which previously limited school-based services Medicaid would cover to children with Individualized Education Plans (IEPs); however, the interpretation of this policy has changed in recent years which means Michigan's policy is more restrictive than necessary.

New Clarification of the Free Care Rule

In the past, Medicaid also reimbursed schools for covered health services for children enrolled in the program; however, in 1997, the Centers for Medicare and Medicaid Services (CMS) established the "free care rule," which clarified that Medicaid would no longer pay for health services for Medicaid beneficiaries if those services were available at no cost to others. An exception was provided for children with special education plans; if a child was a Medicaid beneficiary and enrolled in an IEP, then health services provided that are related to the IEP could still be reimbursed. Without Medicaid funds to pay for broader health services, schools were forced to focus health services on children enrolled in special education. [30]

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[29] Michigan Department of Health and Human Services (MDCH)- School Based Services Manual. Available online at: http://www.monroeisd.us/downloads/medicaid/school_based_services_20150622_164616_15.pdf

[30] Community Catalyst. (2016). *Advocates Guide to the Medicaid Free Care Rule*. Retrieved from https://www.communitycatalyst.org/resources/toolkits/Full-Free-Care-Toolkit-4-27-16.pdf

The Free Care rule was appealed and essentially struck down in 2004,[31] but it wasn't until ten years later (December 2014) that CMS issued new guidance regarding the policy. In a letter sent to State Medicaid Directors, CMS informed states that the free care rule no longer applied, once again allowing schools to bill Medicaid for the covered services they provide to Medicaid-eligible students.[32] These funds could go a long way towards improving student health and education outcomes by potentially increasing the number of school nurses able to serve student health needs.

In order for a school to receive Medicaid reimbursement for health services, three key criteria must be met:

1. The student must be eligible for Medicaid (based on family income or disability);
2. The school health professional must be qualified to provide the service; and
3. The service must be reimbursable according to the state's Medicaid guidelines.

Despite the rule reversal, barriers continue to exist.

A Michigan-specific barrier is the inability of nurses, based on state law on their scope of practice, to bill directly for services they provide.

Another barrier is lack of awareness on the part of educators. The letter from CMS was only sent to state Medicaid directors, with no corresponding communication from the Department of Education. The lack of communication to educators has left many of them unaware of the new opportunity. In addition, many states have Medicaid plans and rules that mirror the old free care rule or pose other indirect barriers. Changes to these will be required before many states can take advantage of the rule change. In many states this will necessitate a state plan amendment (SPA) be submitted to and approved by CMS. A 2016 analysis by the National Health Law Program (NHeLP), found that at least 31 states had language in their state plans that would likely require changes in order to expand reimbursement to schools.[33]

States may submit a SPA that expands coverage to all Medicaid-enrolled students, rather than limiting it to children receiving special education services. They may also expand the list school-based services in the state plan that can be reimbursed, and/or expand the type of providers in the state plan who can deliver school-based services.[34]

Since the free care rule reversal, four states have submitted SPAs: Louisiana and Massachusetts have received approval, while Georgia and California's are pending. Others are in the process of

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[31] *Ibid.*

[32] Centers for Medicare & Medicaid Services. (2014). *State Medicaid Director Letter #14-006 Re: Medicaid payment for services provided without charge (free care).* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

[33] Somers, S.. (2016). *Medicaid's "Free Care Policy": Results from Review of State Medicaid Plans.* National Health Law Program. Retrieved from https://healthyschoolscampaign.org/wp-content/uploads/2016/10/MedicaidFreePolicyCare.revd_.10.20.pdf

[34] Healthy Schools Campaign. (2018). *Expanding Access to School Health Services through the Free Care Policy Reversal (Webinar).* Retrieved from: https://healthyschoolscampaign.org/hsc-event/school-health-services-free-care-policy-update/

determining how to alter their billing practices to enable school systems to access Medicaid funding for school health services.

Louisiana

Louisiana's State Plan Amendment (SPA) builds on a change made in 2011, that authorized Medicaid to reimburse school nurses for covered services delivered to students with Individualized Education Plans (IEPs). The state received approval in January 2016 for changes to provisions governing school-based health services in order to transition these services out of managed care and into the group of school-based Medicaid services provided by Local Education Agencies (LEAs).[35] The state plan now allows the state to reimburse LEAs for Medicaid-eligible services for all children. Given the high rate of Louisiana children who are enrolled in Medicaid, the impact for schools is likely to be significant. The state has developed a handbook for reimbursement to help guide LEAs in how to enroll, implement and maintain a Medicaid reimbursement program, including a description of the different types of school-based services for which Medicaid reimbursement may be claimed, as well as an explanation of the procedures and documentation necessary to claim reimbursement. [36]

Massachusetts

In July 2017, Massachusetts received approval of a SPA (with an effective date of July 2016) removing the language in the state plan that specifically limited reimbursement to Medicaid students with IEPs.[37] The SPA also expands the types of providers and services for which the state may seek reimbursement in school settings, adding nutritional, physician, respiratory, optometry and fluoride varnish services, as well as injury assessment. Lastly, it allows for a new Medicaid penetration rate calculation and association cost methodology, which appears to allow schools to calculate IEP related and non-IEP related covered services separately. This will benefit schools concerned about adverse consequences of a combined rate.[38] Massachusetts is still developing guidance for how the approved SPA will be implemented. MassHealth is anticipated to release this guidance in 2018.

California

In September 2015, California submitted a SPA to CMS to allow LEAs to qualify for Medicaid reimbursement for covered services provided to all Medicaid eligible students, regardless of whether the services are part of an IEP. This SPA is still pending approval from CMS. The California SPA also expands the list of assessments, treatments and qualified rendering providers.

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[35] Centers for Medicare & Medicaid Services. (2016). *State Plan Amendment Louisiana (15-0024).* Retrieved from http://ldh.la.gov/assets/medicaid/StatePlan/Amend2015/15-0024_CMS_Approval.pdf

[36] Louisiana Department of Education. (2016). *Handbook for School-Based Medicaid Services.* Retrieved from https://www.louisianabelieves.com/docs/default-source/school-choice/school-based-medicaid-handbook.pdf?sfvrsn=2

[37] Centers for Medicare & Medicaid Services. (2016). *State Plan Amendment Massachusetts (16-012).* Retrieved from https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-16-012.pdf

[38] Community Catalyst. (2017). *CMS Approves State Plan Amendment for Massachusetts, Creating New Opportunity for School-based Medicaid.* Retrieved from https://www.communitycatalyst.org/resources/publications/document/2017/MA-SPA-Brief_FINAL_12-12-17.pdf

Assessments included in the proposed SPA were expanded to include Respiratory therapy and orientation and mobility assessments. Treatment was expanded to include personal care services, orientation and mobility services and respiratory therapy. Lastly, the state included an expanded list of qualified providers in the SPA, adding personal care assistants; registered speech-language pathology assistants; licensed physical therapy assistants; licensed occupational therapy assistant; orientation and mobility specialists; licensed respiratory therapist; registered marriage and family therapist interns; and registered associate clinical social workers. In addition to these services and providers, the state initially planned to include "interpreter services, dental screening services, specialized assessments, and some behavioral health services. However, these services were removed from the SPA to avoid duplication of Medi-Cal services available through other Medi-Cal programs". [39]

Georgia

In July 2017, Georgia submitted a SPA to allow LEAs, including charter schools, to be reimbursed for covered services provided to all Medicaid eligible students. The SPA is still pending CMS approval. The state proposes to create a Medicaid School Based Claiming Program that would consist of a Direct Service Claiming (DSC) Medicaid reimbursement program component. This would allow LEAs to receive reimbursement for Medicaid-covered direct medical services provided by school nurses to PeachCare or Medicaid eligible students.[40]

Georgia school nurses are currently funded with state dollars through the Quality Basic Education Act, which specifies a distribution funding mechanism to the LEAs. These state dollars can be matched with Medicaid funding by determining the penetration rate of Medicaid and PeachCare (Georgia's CHIP program) members for each school and drawing down the federal match for services (75% for the provision of direct medical services) to pass through to the schools for the direct provision of nursing services to Medicaid and PeachCare members. The state estimates this could bring in $48.6 million in additional federal dollars, and more than double the number of school nurses.[41]

Vision and Hearing Screening

Local public health departments provide vision and hearing screenings to all students in Michigan schools. Before the free care rule clarification, this meant health departments could not bill Medicaid for these services for children enrolled in Medicaid (because other students were receiving the same service at no cost.) Now that health departments do have the ability to bill for

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[39] *Ibid.*

[40] Georgia Department of Community Health. (2017). *Public Notice: Department of Education Direct Nursing Services Administrative Agreement.* Retrieved from https://dch.georgia.gov/sites/dch.georgia.gov/files/PN%20School%20Admin%20Direct%20Nursing%20Serv.pdf

[41] Tagami, T.. (2017). *Georgia to ask feds for $49 million for school nurses.* Atlanta Journal-Constitution. Retrieved from https://www.ajc.com/news/state--regional-education/georgia-ask-feds-for-million-for-school-nurses/v15EQcq6q6Vj2jq543W0LL/

these services, it provides an opportunity to draw down federal match for critical health services and help make sure children get these important screenings.

Medicaid pays for services to Medicaid-eligible children under its Early Periodic Screening Diagnostic and Treatment (EPSDT) benefit. Through EPSDT, children have guaranteed access to comprehensive and preventive health services, including well-child exams and other services to treat illnesses and disabilities, as well as hearing, vision and dental screenings. Children and adolescents enrolled in Medicaid should receive both vision and hearing screenings at each well-child check-up, but many do not. Schools can step in to help make sure children get these important screenings. If the state permits, local health departments can bill for these services as an enrolled Medicaid provider (through fee-for-service or administrative claiming) or work in partnership with Medicaid managed care organizations and/or Medicaid providers to bill for these services. For example, New Mexico was highlighted by the Center for Medicaid and Medicare Services (CMS) for its School-Based Health Center/Managed Care Organization project. [42] Through the project, SBHCs provide a range of services, including EPSDT screening services and asthma, diabetes and depression management, to school-age children.[43] 52 of the state's SBHCs are able to bill Medicaid through a contract with the Department of Health and coordination with the MCOs to avoid duplication of services.

Administrative Capacity and Challenges

Although the reversal of the free care rule provides schools with an exciting opportunity for increased funding for important health services, they will need to prepare for the resources required to bill Medicaid. Districts will have to assess their current practices and determine whether they have the capacity to bill Medicaid. New investments in training, technology and administrative staff may be required to do this work. They will also have to determine how best to submit claims for reimbursement – for each beneficiary or for each service. As the American Federation of Teachers notes, "What works for hospitals and doctors' offices isn't necessarily what works best for schools and districts."[44] A key concern among school districts in states that allow Medicaid billing is that the reimbursement does not always come back to the school health program or even to the school district. Ensuring that the work associated with billing results in more resources for the school health services is central to pursuing this strategy.

Implications for Michigan

In the NHeLP analysis on State Medicaid Plans mentioned above, Michigan was determined to be a state likely to require a SPA in order to expand services to school health settings because of current

[42] CMS. Vision and Hearing Screening Services for Children and Adolescents. Accessed online at: https://www.medicaid.gov/medicaid/benefits/epsdt/v-and-h/index.html

[43] New Mexico Human Services Department. http://www.hsd.state.nm.us/LookingForInformation/school-based-health-center-managed-care-organization-project.aspx

[44] American Federation of Teachers. (n.d.).. *Dismantling barriers to school health.* Retrieved from https://www.aft.org/linking-childrens-health-education/access/free-care-rule

provisions related to EPSDT services that could present a barrier to reimbursement for coverage.[45] Further complicating matters, the Michigan Department of Health and Human Services released a bulletin effective August 2017 to clarify billing guidelines for free or reduced-price care. However, this guidance appears to preserve the limits on billing for free care. The bulletin states, "when a provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public (customary charge), the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met."[46] **An additional challenge is that school nurses are not currently able to be registered providers for Medicaid, a policy that must change in order to expand school health services for Medicaid beneficiaries**.[47]

Michigan Medicaid currently enrolls psychologists, clinical social workers, and some other behavioral health practitioners (such as marriage therapists) as providers who can directly bill Medicaid for their services. For nurses the situation is different. Michigan Medicaid only enrolls Nurse Practitioners (and Nurse Mid-wives) for direct reimbursement.

To effectively take advantage of the free care rule reversal, the state will need to submit a SPA allowing Medicaid reimbursement for school health services for all Medicaid eligible students and expanding providers in the state plan to include school nurses. The development of a SPA creates an opportunity for the state Medicaid agency to consider how schools can become a more integrated provider of health services and support efforts to better coordinate care and reducing avoidable costs.

Alignment with Michigan MCOs

School districts may also wish to consider developing partnerships with Medicaid Managed Care organizations in the state. Most states contract with managed care organizations (MCOs) to administer health benefits and services to Medicaid beneficiaries, including a large proportion of children enrolled in Medicaid and CHIP. In 2014, 77 percent of Medicaid and CHIP enrollees received care through a managed care arrangement. Although MCOs have been slow to recognize the value of school-based health services, the idea of a provider who can provide care where the children are will be appealing to many. Because they are paid a capitated rate, MCOs seek to shift services from treatment to prevention, keeping members out of emergency rooms and reducing avoidable costs, like hospital stays than could have been prevented through adequate primary care. Managing chronic disease and integrating behavioral and physical health care are also high priorities. More and more, MCOs are also recognizing the need to address social determinants of health in order to contain costs. School-based health services could prove to be valuable partners to MCOs in these

[45] Somers, S.. (2016). *Medicaid's "Free Care Policy": Results from Review of State Medicaid Plans.* National Health Law Program. Retrieved from https://healthyschoolscampaign.org/wp-content/uploads/2016/10/MedicaidFreePolicyCare.revd_.10.20.pdf

[46] Michigan Department of Health and Human Services. (2017). *Billing for Free or Reduced-Price Care (MSA 17-21).* Retrieved from http://www.michigan.gov/documents/mdhhs/MSA_17-21_577336_7.pdf

[47] Michigan Department of Health and Human Services. (n.d.) *New Individual Provider Enrollment Instructions.* Retrieved from http://www.michigan.gov/documents/mdch/New_Provider_Enrollment_Instructions_476796_7.pdf

efforts. One place for initial discussions could focus on performance measures with which schools can help MCOs.

Like other states, Michigan requires managed care plans to submit HEDIS and CAHPS measures, and other performance monitoring data. The state rewards high performing plans by auto-assigning a greater proportion of Medicaid enrollees to the plan that reports the highest quality scores. The state also awards performance bonuses to plans that meet certain HEDIS and CAHPS and other quality measure targets and can impose penalties and sanctions on plans that fail to comply with performance requirements.

Crosswalk: HEDIS Measures with Nurse Activities

Below is a cross walk of HEDIS requirements and scopes of school nurses.

Michigan Medicaid HEDIS 2016 Required Measures for Child & Adolescent Care	**School Health Activities, Competencies and Responsibilities**
• Childhood Immunization Status—Combinations 2–10 • Well-Child Visits in the First 15 Months of Life—Six or More Visits • Lead Screening in Children • Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life • Adolescent Well-Care Visits • Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td) • Appropriate Treatment for Children with Upper Respiratory Infection • Appropriate Testing for Children with Pharyngitis • Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase • Children and Adolescents' Access to Primary Care Practitioners—Ages 12 to 24 Months, Ages 25 Months to 6 Years, Ages 7 to 11 Years, and Ages 12 to 19 Years • Medication Management for People with Asthma—Medication Compliance 50%—Total and Medication Compliance 75%—Total • Asthma Medication Ratio—Total	• The school nurse generally administers medication to students and provides extended first aid and care for those children with minor injuries or illness during the school day. In any given day, the school nurse may see as many as 50-100 or more students and must also have the professional judgment and skills necessary to: • Develop individualized healthcare plans and emergency plans for children with special healthcare needs; • Prepare plans for healthcare needs of the school community in the event of a disaster or lock down situation; • Assess lung sounds of an asthmatic student and provide a nebulizer treatment if indicated; • Communicate with parents/guardians, teachers, or physicians regarding the effectiveness of medication for a student with any health condition (i.e. Attention Deficit/Hyperactivity Disorder, diabetes, asthma); • Care for a child with a seizure; • Perform a complex treatment for a child with special health care needs, such as suctioning • Tracheostomy or administering medication via a feeding tube or intravenous port;

	• Respond to a school related emergency, such as a playground accident, a school bus accident or some • Other critical incident that affects the health and safety of students or staff; • Attend a parent/guardian conference or Individual Education Plan or 504 meeting if student health • Concerns are affecting learning; • Provide supplemental classroom instruction and materials on various health related topics; • Provide one-on-one health counseling to individual students; • Serve as a resource for families in need of support through community or social agencies or Programs; • Be confident and prepared to handle every health-related incident that may occur.

Source: Michigan Department of Health & Human Services, *2016 HEDIS Aggregate Report for Michigan Medicaid.* Retrieved from http://www.michigan.gov/documents/mdhhs/MI2016_HEDIS-Aggregate_F1_552834_7.pdf

Source: Centers for Medicare & Medicaid Services. (2014). *Managed Care in Michigan.* Retrieved from http://www.michigan.gov/documents/mde/Frequently_Asked_Questions_4-30-13_419264_7.pdf

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/michigan-mcp.pdf

Providing Health Care Where Kids Are

Providing health care services where kids spend their days just makes sense. Schools are an important part of a family's neighborhood. Providing health education and prevention, primary care services and mental health care in schools will allow more children to access the care they need when they need it. School-based health services are a wise investment. Children with access to care in school have improved educational and health outcomes. School health providers reduce absenteeism and support educators by keeping children healthy and ready to learn. They also help prevent and treat chronic conditions, such as obesity, diabetes and asthma. They provide students with access to mental health services, which can support lifelong mental health through early intervention. Lastly, they reduce avoidable health care costs, such as hospitalization and emergency health care usage.

Recommendations for Michigan

Address the crisis of school nurse and school-based mental health provider ratios: Michigan's shortage of school nurses and school-based mental health providers is one of the worst in the nation, resulting in a serious health crisis for children without access to care outside of school. Michigan lawmakers and policy leaders should take immediate action to address this crisis. Schools

are an ideal setting in which to provide primary care services, health screenings and mental health care. Without access to care in schools, children go without important services, miss more school, have worse academic outcomes and increase the burden on teachers, who must address behavioral health issues in the classroom when children aren't able to access care elsewhere. Additional funds, some of which can be achieved through the strategies outlined below, are critical to promoting and supporting the health of Michigan's children, particularly those who experience health disparities because of the communities in which they live or are at-risk for mental and behavioral health issues because of adverse experiences and childhood trauma.

Make Targeted Investments in School-based Mental Health Services: Although a significant (20%) and growing number of children in the country have a mental, emotional and/or behavioral health disorder, as many as 80% of children and youth who need behavioral health services do not get the care they need. Of the few who do get care, most receive those services in school. Michigan lawmakers should make targeted investments into school-based mental health. School mental health programs have a positive impact on emotional and behavioral outcomes as well as educational outcomes. School-based mental health services reduce emotional and behavioral disorders such as attention deficit/ hyperactivity disorder, depression, and conduct disorder. Furthermore, all students benefit when schools are able to promote and support social, emotional, and behavioral health and prevent school violence.

Leverage the free care rule policy clarification: The Michigan Department of Health and Human Services should make the necessary changes to its State Plan and Medicaid rules so that schools may leverage the free care rule policy. Making the necessary changes will enable schools to provide more school-based health care services through increased reimbursement opportunities. The provision of services in schools, from Medicaid outreach and enrollment support to direct primary care and mental health services, can improve outcomes for children enrolled in Medicaid in the state. In order to help expedite and prioritize this change, the Michigan Legislature should direct the agency to complete the changes as soon as possible.

Increase school utilization of Medicaid Reimbursement: Although many schools in the state take advantage of Medicaid billing, either through Medicaid Administrative Claiming for administrative tasks or direct billing for students with special needs, these reimbursement programs are still underutilized. Once Michigan makes the necessary changes to its Medicaid State Plan and rules, as well as its agreements with school districts, districts may expand Medicaid direct billing to all students enrolled in Medicaid. However, school districts will need outreach to make sure they aware of the new opportunities, as well as support for implementation. Because Medicaid billing is complicated and time consuming, technical assistance and training to support best practices in Medicaid billing will help schools be more successful. School districts should also be encouraged to learn and share best practices in maximizing Medicaid Administrative Claiming for administrative activities.

Explore partnerships to expand school-based health services: Policy leaders and lawmakers should encourage Managed Care Organizations to develop partnerships with school districts. Schools provide the perfect setting to reach children in need of care. School and local health partners can develop strategies that connect children to care, leverage funds for services and help MCOs and providers meet performance targets and improve the health of the children under their care.

Michigan policy leaders and lawmakers should look to the New Mexico School-Based Health Center/Managed Care Organization project as an example of a successful partnership between Medicaid managed care plans, the state Medicaid agency and school districts to increase funding for and access to school-based health services for children enrolled in MCOs.

HEALTH MANAGEMENT ASSOCIATES

Model to Expand School Mental Health Services

Prepared By: Steve Fitton, Principal

BACKGROUND AND INTRODUCTION

Over the last year a group of organizations have been meeting to create a model of care for the delivery of school health services that would be supported with sustainable funding. Steve Fitton, Principal with Health Management Associates (HMA), has been leading the way in identifying potential Medicaid match strategies that would leverage federal funds to support a coordinated system of care for school-aged children and youth. That would help bring much needed support services to schools in a systematic and sustainable way.

With heightened concerns about school safety, educational attainment, and children's health in Michigan, improving and increasing mental health services in schools has become a recognized priority. **This paper proposes an approach to designing and implementing a model of expanded mental health services with a state appropriation of $15 million.** The two key design elements are: (1) the initial implementation phase, with emphasis on achieving rapid deployment, and (2) a process that will enable Michigan to further expand the initiative by leveraging federal Medicaid funding to match a portion of both state and local funding for these services. Because the federal funding process takes time to secure, we are suggesting three phases for this program implementation.

I. PHASE ONE – RAPID DEPLOYMENT OF MENTAL HEALTH SERVICES

An initial appropriation of $15 million would support rapid deployment of mental health services through two vehicles. Child and Adolescent Health Centers (CAHCs) have capacity to quickly hire and deploy licensed behavioral health providers and they have strong partnerships with their local school districts including the intermediate districts. For this reason, we propose that $5 million be directed to CAHCs specifically for mental health services to be provided in schools. The number of schools receiving mental health services will increase by 100 with each worker covering two schools. The delivery of mental health services can begin July 1, 2018 if funding is appropriated in May.

The remaining $10 million will be allocated to schools to support between 100 and 133 new full-time equivalent licensed behavioral health providers (assuming an average annual cost of $75,000 – $100,000 including benefits and indirect costs) supporting an additional 200-266 schools with at least part time support. We are proposing that the Michigan Department of Education and Department of Health and Human Services work together in partnership with an external workgroup to establish criteria for selection of schools including: commitment to maintain services, agreement to implement the state's federal Medicaid match methodology, a minimum local contribution, commitment to maintenance of effort, proof of established relationships with community health providers, and lack of current behavioral health services for the general education population.

For the implementation to have immediate impact, we propose that the funding distribution occur as soon as possible. Simultaneously, negotiation and operationalization of an arrangement with the federal

government to gain Medicaid matching funding will proceed (estimated to take an additional 3 months). The process for identifying target districts and hiring within those districts will be achieved by October 1.

Phase One Action Steps:

- Legislature appropriates general fund for this program purpose including boilerplate;
- Legislature directs MDE and MDHHS to work cooperatively to develop criteria for selection of schools using an external workgroup;
- SBHC selection and contract execution;
- District selection and contract execution;
- District hiring or other procurement of social work staff.

II. PHASE TWO – BRINGING MENTAL HEALTH SERVICES TO SCALE

The federal Medicaid matching fund design, approval, and implementation requires more time to work with federal partners to establish the match process. We propose a two-tiered approach. The first stage will be to build on the existing state/federal agreement for the special education population which should lead to an easier and faster path to federal approval and where there is a state time reporting and billing process already in place. This method should provide the federal match rate for qualifying Medicaid covered services, approximately 65% of expenditures. Even this simpler path will involve negotiation with the federal government, modification of the state plan (the Medicaid contract between state and fed), and putting a new reporting module in place at multiple levels of education and state government in Michigan. For that reason, our target date for gaining this initial level of federal matching funds is January 1, 2019.

School districts targeted with the initial $10 million in general fund should be required to put the claiming processes in place as a condition of the funding award. That would provide $7 million in federal revenue which supports an additional 70 to 90 new behavioral health providers.

There are several steps that need to occur in order to provide the federal Medicaid match opportunity to all schools. Reporting from the different levels of the education system suggest substantial expenditures for social work services but we do not know what proportion would qualify as services eligible for a Medicaid claiming process. Federal requirements dictate that the funding source must be non-federal and dedicated to services for Medicaid enrolled children. The other significant factor is that this spending varies considerably by school district. To achieve broad coverage of school buildings will require an assessment of this variance and a strategy that accounts for inequities in resources while attempting to maximize new federal funds. The process for drawing down federal funds with local expenditures will be phased in between January 1 and June 30 of 2019.

A Medicaid policy step required for this stage is a revision to the Free Care policy to bring it in line with federal guidance. This enables public entities to claim Medicaid matching funds even though the services are available for free or a nominal charge to the general public.

Phase Two Action Steps:

- Medicaid Free Care policy is revised;
- A State Plan Amendment is developed, submitted, and then approved by CMS;
- The Medicaid time reporting and billing process is operationalized and phased in across the state;
- Local maintenance of effort is established for this phase.

III. Phase Three

The final stage will be to develop the best long-term strategy for health services in schools. This includes consideration of: other health services, particularly nursing; other service delivery methods like school health teams where health professionals work together; systemic linkage with other health care organizations such as School-Based Health Centers, FQHCs, local health departments, community mental health agencies, and managed care organizations; and whether there is an alternative claiming strategy or methodology that would increase the amount of federal matching funds.

Before launching into some of the broader goals introduced above, there needs to be an assessment of the progress and remaining need from the initial efforts to provide mental health services to the general school population across Michigan. Using the more simplified methodology in Phase 2 will enable us to better understand the total opportunity and the depth of distributional differences. Components of the analysis are a calculation of the total increase in mental health resources and the new funding that supports them, the impact of the services, the total additional state and federal funding required to achieve full statewide coverage, and the optimal methodology in light of resource inequities between school districts, including a minimum local match and maintenance of effort requirement. This analysis will provide the substantive information to develop a plan for moving forward with the mental health service component.

The issues identified in the first paragraph for this phase reflect broader goals with more significant impacts. The shortage of school nurses in Michigan is particularly glaring. The various issues are intertwined and designs that would expand services (e.g., school health teams) could benefit from a different organizational and financing structure. The learnings from Phase 1 and 2 will be critical in working through these longer-term issues and developing recommendations. The target date for implementing this stage is January 1, 2020 although July 1, 2020 would be more realistic if the desired solution is on the more complex side.

Phase Three Action Steps:

- Assess the increased mental health resources and their impact to date, the expenditure to support them, and the increased amount of federal funding;
- Develop a long-term plan(s) that considers both how to more fully meet school mental health needs and broader school health goals that identify the most desirable service and organizational configurations along with funding requirements that maximize federal revenue;

Model to Expand School Mental Health Services

Prepared By: Steve Fitton, Principal

- Make decisions considering best impact on Michigan's school children and resource requirements;
- Move to implement the desired model with legislation, funding, and operational efforts.

Updated 7/13/18

School Health Home Concept Paper

Medicaid Health Plan Federal Match Strategy

Prepared By: Rick Murdock, R. B. Murdock Consulting, LLC

Objective: Create Michigan Medicaid Policy and Resource Strategy that will define, establish and sustain a "School Health Home" initiative consistent with federal Medicaid managed care rules to serve the nearly 900,000 children current enrolled in Medicaid.

SAMHSA Chart on Health Homes

(With Adaption in italics Related to Medicaid Managed Care Rules)

	Medicaid Health Home—"*School Health Home*"
Target Population	Individuals with chronic conditions. Chronic conditions listed in the statute include mental health, substance abuse, asthma, diabetes, heart disease and being overweight. Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval -- *Can target populations with common characteristics—cannot target by age. Participant selection criteria is to have one chronic condition and are at risk for a second. Children with adverse Childhood Experience, ACE scores would presumably automatically be considered at risk.*
Typical Providers	May include primary care practices, community mental health organizations, addiction treatment providers, federally qualified health centers, and other safety-net providers. *May include school settings, and school nurses.*
Payer(s)	Currently a Medicaid-only construct. *Either Tradition Medicaid (Fee for Service) or direct from Medicaid Managed Care Plans*
How Care is Organized	Team-based, whole-person orientation with explicit focus on integration of behavioral health and primary care
Provider Requirements	State Medicaid determined—*by Medicaid Policy Bulletin and/or Medicaid Health Plan Contract and/or Waiver and/or State Plan Amendments.*
Payment	Usually PMPM for six required services with more intensive care coordination and patient activation. *Alternative Payment Models are encouraged in managed care by CMS and under the existing Medicaid Health Plan Contract as a performance standard.*

1. Through existing managed care rate approval process or waiver or negotiation (if necessary between MDHHS and CMS) adopt and implement the proposal of an acceptable program that meets CMS rules and which advances MDHHS Policy for Medicaid Health Plans that implements payment reform, addresses population health/social determinants/disparities and embraces integration. This would be similar to the incorporation into the Medicaid Health Plan contract of MiPCT (Michigan Patient Transformation) using patient center medical homes.

2. Dedicated funding would be from State School Aid (categorical or formula) and transferred to the Medicaid Program as state match for Managed Care (earning $1.84 for every dollar of state match). Medicaid health plan rates, including source of match, must be submitted for prior approval by

CMS—MDHSS may consider to initiate the program under FFS if necessary to get this underway using the administrative match at 50% --This option may require State Plan Amendment or Waiver.

3. Consistent with the Federal Managed Care Rules provide for a process to incorporate funding into Medicaid health plan rates at the rate cell level. Program objectives would be established and incorporated into contract expectations and contract amendments—target population would be TANF/CHIP under age 19. If appropriate, program design can model after PCMH using the conversion that New York State has implemented.

4. Operationally, Health Plans would make quarterly payments based on enrollment to the administrative entity of the "School Health Homes" via electronic transfer (similar to process of making payments for similar initiatives)—Presumably these administrative "entities" would be in the same or nearby location where school aid funding was targeted and used in the match.

5. Bundled Services for "School Health Home" could be delivered within the school setting as authorized by participating local school districts, but could be implemented/administered by local hospitals, FQHC or other community based entities. Under federal guidance the required services include:

    - Comprehensive care management
    - Care coordination
    - Health promotion
    - Comprehensive transitional care/follow-up
    - Patient & family support
    - Referral to community & social support services

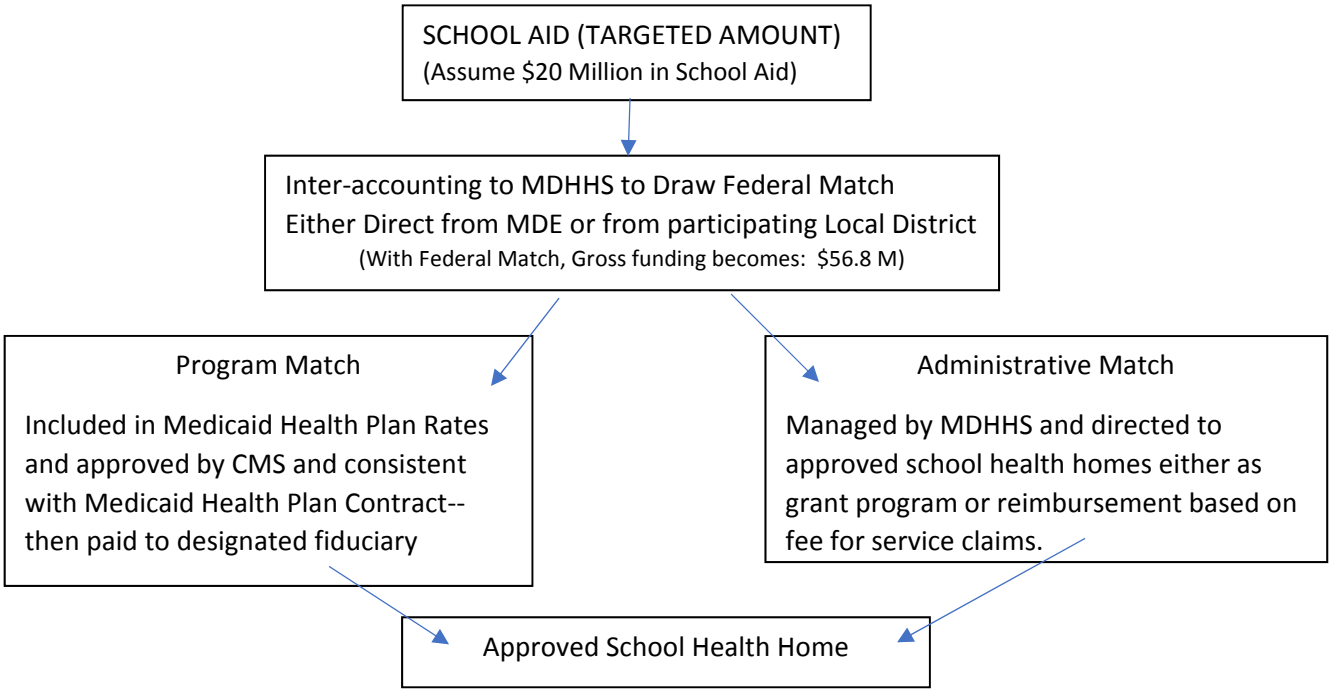
School Health Home model development should establish the minimum services to be provided (enabling each program to supplement based on local needs), data elements, referral arrangements with local service providers, and administrative capacity for entities agreeing to be administrative (fiduciary) partner.

This Concept would affirm the focus of comprehensive services for school age children that can be provided by school nurses, other adolescent health providers, and referral arrangements. Current initiatives in Medicaid (School based services, Autism, Adolescent Center match program) should remain separate but have expectation for coordination. Option may be also to include Michigan Model for Comprehensive Health Education as one of the components.

OPERATIONAL CONSIDERATIONS

Flow of Funds:

Utilizing funds from state appropriations for school aid (categorical or formula), Michigan can design and dedicate funding to support a comprehensive school health home. The funds would flow through MEDICAID in order to secure federal match with the total amount subject to the model: (administrative match at 50% or program match at about 65%). This effort **would be in addition** to the current Medicaid funded programs (through Medicaid health plans) for adolescent health centers and (through fee for service) for school based services, SBS.



Consideration	Program Match	Administrative Match
Match Amount	Federal Match at current rate .6478% meaning $1 M in School aid would generate $1.84 M in federal Match for total, $2.84 M —more revenue to state if other state taxes on health plan revenue are in place. Under example, $20 M in school Aid generates federal match of $36.8M.	There likely would be a program level match for regular reimbursement (i.e., reimbursable service to recognized provider) but unless there is state plan amendment or waiver, the "home" wouldn't be funded. If "waived", then admin match –e.g. $1 M School Aid leverages $1 M in federal.
Federal Approval steps	Health Plan Rates are annually approved by CMS—Under rules to be actuarially sound at rate cell level—if questioned about ability to "pass through" or direct funds, this may qualify as meeting the contract standards for such areas as population health, social determinants, and alternative payment methods.	…if under Federal waiver/State Plan Amendment, the administration match would be 50%. Under traditional FFS the service would have to be reimbursable—the challenge is creating a global fund stream

State Medicaid Contract Language

Overall Contract Objective:

Contractors must fully participate with MDHHS-directed **payment reform initiatives** implemented throughout the term of the Contract including, but not limited to, episodic payment, participation with Accountable Systems of Care including partial and global capitation, **and the expansion of patient centered medical homes**. Contractors must fully participate with MDHHS-directed initiatives to integrate systems of care and ensure all Medicaid beneficiaries, particularly those with complex physical, behavioral, and social service needs, **are served by person-centered models across all health care domains**. Contractors are encouraged to propose and pilot innovative projects.

Requirements for Value-Based Payment Models

1. Consistent with MDHHS's policy to move reimbursement from FFS to value-based payment models, Contractor agrees to increase the total percentage of health care services reimbursed under value-based contracts over the term of the agreement.

2. Contractor recognizes value-based payment models as those that reward providers for outcomes, including improving the quality of services provided, promoting provision of appropriate services, and reducing the total cost of services provided to Medicaid beneficiaries. Value-based payment models include, but are not limited to:
   a. Total capitation models
   b. Limited capitation models
   c. Bundled payments
   d. **Supplemental payments to build practice-based infrastructure and enrollee management capabilities**
   e. Payment for new services that promote more coordinated and appropriate care, such as care management and community health work services, that are traditionally not reimbursable

NEXT STEPS

1. Validate available Funds within School Aid and Options for transfer to Medicaid Program to secure match with understanding that the "investment of Aid for local districts would be returned in the form of School Health Home support.
2. Confirm School Health Home approach with Medicaid Director and Staff and determine if any waiver or state plan amendment is necessary—or if the rate certification process will suffice;
3. Begin defining elements of School Health Home in terms of services and staffing and reporting and develop state policy for its implementation (Medicaid Policy bulletin).
4. Brief Lawmakers and Staff
5. Hold Operational meetings with Local Districts, Medicaid Health Plans, and related advocate organizations.