June 27, 2016

Vikki Wachino
Director
Center for Medicaid and CHIP Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Wachino,

Ongoing efforts to reform the nation's healthcare system have sought to improve individual care quality, reduce population health disparities and contain costs. As "an important service delivery and outreach point," in the words of the Government Accountability Office, and as the nation's de facto mental health service system for children, schools can help achieve these indicators of excellence. However, school-based Medicaid programs face many challenges. Often, local education agencies and state departments of health are not well-integrated into innovative initiatives and waiver programs. Additionally, some school-based Medicaid programs face unique limitations that are not imposed on care providers in more traditional clinical settings, such as requirements for physician referral.

Moreover, a dearth of sustainable funding frequently bars schools and districts from consistently linking children to high-quality healthcare and providers. Historically, the free care rule was an obstacle complicating LEAs' ability to proactively finance school-based health initiatives and achieve program excellence. Program quality is directly linked to health equity. Furthermore, improving student access to needed care supports their academic progress and ability to thrive.

The free care rule stated that Medicaid funds were not to be used to reimburse services provided to enrolled beneficiaries if the same care was available without charge to other students. Since school health providers serve the entire school community, many of the services they provide to Medicaid-enrolled children were considered not eligible for reimbursement. The free care rule did not apply to services included in a student's Individualized Education Plan or Individualized Family Services Plan, and to services provided by the Title V Maternal and Child Health Services Block Grant.

The free care rule has been the subject of dispute. In 2004, the U.S. Department of Health and Human Services Departmental Appeals Board ruled that the free care rule, as interpreted by the Centers for Medicare and Medicaid Services and applied to school districts, has no basis in federal Medicaid law, and that the rule, as applied to schools, is unenforceable. More recently, this ruling was affirmed when CMS agreed to reimburse the San Francisco Unified School District for health services delivered to the general student population by school health professionals.

On Dec. 15, 2014, CMS issued a letter to state Medicaid directors that clarified that the free care rule does not apply to school health services. The letter stated, "We are issuing this guidance to ensure that Medicaid payment is allowed for any covered services for Medicaid-

eligible beneficiaries. … The goal of this new guidance is to facilitate and improve access to quality healthcare services and improve the health of communities." This guidance removed one of the barriers that challenge schools' ability to ensure student access to quality healthcare services. The exact type of reimbursable school health services and allowable providers will be determined by each state's Medicaid plan, but it is likely that schools will now be able to seek reimbursement from Medicaid for critical services such as diabetes management, asthma management, prenatal care for teens and mental health services offered to enrolled beneficiaries.

The undersigned welcomed the letter and its clarification. We also recognize and appreciate HHS' efforts since its release to further support school-based health initiatives (e.g., highlighting the change in the free care rule at conferences and releasing the "Healthy Students, Promising Futures" letter and toolkit). We remain concerned, however, that districts, states and especially state Medicaid directors may still be wary of the complex steps ahead to implement the change.

We believe that by working with the U.S. Department of Education and providing increased technical assistance, CMS could enhance nationwide implementation of the clarification and support excellence in school-based Medicaid programs. For example, CMS could research and regularly report on school-based Medicaid programs. Specifically, we would appreciate CMS efforts to:

- **Revise relevant reports**, such as the GAO's 2000 "Medicaid in Schools" and 2010 "Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services," as well as your "Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits," or summarize lessons learned from the last 10 years of federal audits and reviews of school-based Medicaid programs. This may include conducting new data collection, such as recirculating the survey instrument GAO used with states in 2000.
- **Release comparative data** with indicators of interest, such as the:
    - Number of Medicaid beneficiaries served by school-based and school-linked programs, both with and without Individualized Education Programs, nationally, by state and by the largest 50 LEAs;
    - Ratio of claims submitted to claims covered for school-based billing programs;
    - Average federal financial participation and/or average annual reimbursement per participating beneficiary and service category, nationally, by state and by the 50 largest LEAs;
    - Proportion of state reimbursements awarded by commonly accessed services, nationally, by state and by the 50 largest LEAs;
    - Most common source or sources of the state share of reimbursement, and the most sustainable financial arrangements covering state share;
    - Potential benefits of school-based Medicaid programs in terms of indicators such as health status, instructional time and dollars spent or saved in various sectors; and

    - Potential costs of school-based Medicaid programs, such as the average cost of covering the state share of reimbursed claims and the administrative cost of denying redundant or noncompliant claims.
- **Discuss the potential costs and benefits** of a waiver from third-party liability requirements under reasonable circumstances, such as when the reimbursement from the third party is less than the administrative burden of seeking it.

CMS could provide direct technical assistance to states interested in pursuing changes in their Medicaid state plan, as well as any parallel policy language or complementary documentation, such as statutory language. This technical assistance could be provided via the Medicaid Innovation Accelerator Program. Specifically, we would appreciate CMS efforts to:

- **Revise general guidance documents**, such as "Medicaid and School Health: A Technical Assistance Guide" and the "Medicaid School-Based Administrative Claiming Guide," with the goal of iterating relevant federal guidance in a single place, especially for challenging issues such as:
    - Annual family consent;
    - Billing for care for children with autism;
    - Compliance with third-party liability requirements, cost-settlement claiming documentation/random moment time studies, the Health Insurance Portability and Accountability Act, and the Family Educational Rights and Privacy Act;
    - Federally recognized credentials for speech pathologists, school psychologists and other specialized instructional support personnel; and
    - Specialized transportation.
- **Develop plain language tools** that state agencies can widely distribute to stakeholders about:
    - Health equity, such as how school-based Medicaid programs can better align with Healthy People 2020 goals, the National Prevention Strategy, the Affordable Care Act, the "Connecting Kids to Coverage" campaign, the "Every Student, Every Day" initiative and new opportunities in the Every Student Succeeds Act; and
    - Sites that may be impacted by the free care rule change, such as preK-12 school campuses, public higher education campuses, school-based health centers, school-linked mobile health service sites, early childhood education settings and local health departments.
- **Clarify the nature and extent of technical assistance available** to states related to school-based Medicaid programs and specifically the free care rule change, such as assistance to:
    - Identify elements of existing state Medicaid plan language that limit school-based billing programs to Medicaid beneficiaries with an IEP or IFSP;
    - Map the landscape of states' school-based and school-linked Medicaid providers, including qualified school district employees, community schools partners, school-based health centers and managed care organizations that

include schools or districts; and identify the number of currently qualified school-based personnel who may bill for services provided;
    - Amend and adopt approved language of Louisiana's state plan amendment, with access to any rejected language, with an explanation of the rationale for rejection, and/or exemplary language from California's pending state plan amendment, as well as access to any rejected language, with an explanation of the rationale for rejection; and
    - Structure, accept and fulfill retroactive claims, where the state plan and statutory landscape allow for them.

Furthermore, CMS could provide direct technical assistance to LEAs, or build states' capacity to assist and advise LEAs, especially those with high concentrations of students enrolled in or eligible for the state Medicaid program. Specifically, we would appreciate CMS efforts to:

- **Identify a threshold of likely financial sustainability** for districts and consortia considering participating in, or expanding participation in, a state's school-based billing program, including for rural schools and other areas with low population density. Such a threshold may be based on student Medicaid enrollment or eligibility. For example, the U.S. Department of Agriculture requires school clusters and/or districts to certify the eligibility of at least 40 percent of students in order to participate in the Community Eligibility Provision program, which helps participating schools offer universal breakfast and lunch and eases program administrative burdens.
- **Offer assistance for the creation, leadership and maintenance of a statewide task force** to advise and provide feedback on the implementation of school-based Medicaid programs or guidance about other methods of stakeholder engagement, especially for nongovernmental stakeholders interested in establishing and sustaining relationships with overseeing state agencies.
- **Offer assistance to develop and implement a training schedule** for end users and practitioners in school-based Medicaid programs, with an emphasis on challenging issues such as ICD-10 coding and claiming, documentation, the use of contractors and consultants, special education transportation, care for children with autism, third-party liability, annual family consent, cost-settlement claiming documentation, HIPAA and FERPA, and communication channels between and among schools, districts, special education cooperatives and the state agency, as well as roles in oversight processes, including auditing.
- **Articulate allowable uses and best practices for the use of federal financial participation** awarded to school-based Medicaid programs by addressing the use of reimbursements in a district's "general fund" and the role of private firms.

Finally, CMS could highlight early adopters of the December 2014 clarification and innovative school-based Medicaid programs to clearly communicate that this work is important *and* possible. For example, California's process and infrastructure, established by supportive state legislation (SB 276), provide an example of what is possible with robust engagement of federal, state, LEA and local stakeholders. The Department of Health Care Services annually develops state-by-state comparisons of school-based Medicaid claims and federal financial

participation, tracks relevant reports from federal entities and improves the program with input from diverse entities. In a decade, California has reduced administrative burden, developed numerous state plan amendments and maximized support to LEAs and health-related school personnel. The same infrastructure helped DHCS integrate the free care rule change into ongoing efforts to achieve excellence in its school-based Medicaid program and submit a state plan amendment in late 2015.

The December 2014 letter offered states a chance to strengthen important work to promote children's health in and with schools. We are eager to continue dialogue with CMS, the U.S. Department of Education and other stakeholders to identify, scale and standardize excellence in school-based Medicaid programs.

Sincerely,

Action for Healthy Kids
American Council for School Social Work
American Federation of Labor-Congress of Industrial Organizations
American Federation of Teachers
American School Health Association
Association of Asthma Educators
Asthma and Allergy Foundation of America
Center for Health and Health Care in Schools, Milken Institute School of Public Health, the George Washington University
Childhood Asthma Leadership Coalition
Council of Administrators of Special Education, Inc
Futures Without Violence
Healthy Schools Campaign
Institute for Educational Leadership
LEAnet (a national coalition of local education agencies)
Mental Health America
National Alliance of Specialized Instructional Support Personnel
National Association of Pediatric Nurse Practitioners
National Association of Pupil Services Administrators
National Association of School Nurses
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education
National Center for Learning Disabilities
National Education Association
School Social Work Association of America
School-Based Health Alliance