

# SCHOOL HEALTH

## ISSUE BRIEF

### FINANCING BRIEF

#### INTRODUCTION

Delivering needed health care in schools not only helps to reduce health disparities, but it helps to mitigate inefficient health care spending. Schools are not simply a convenient place to offer minimal first-aid services. They are in fact critical health care access points. Without school-based health services, many New York children would receive neither the primary, preventive and behavioral health care nor the chronic disease management they need to learn. This brief explores the policy changes and infrastructure investments the City must make to ensure the financial sustainability of school health services in the years to come.

#### NEW YORK CITY SCHOOL HEALTH INITIATIVES

Over the past several years, New York City has introduced a number of programs aimed at expanding the delivery of health care services in schools. Both the Bloomberg and de Blasio administrations have allocated significant capital funding for the construction of school-based health centers (SBHCs) in high-need neighborhoods. These full-scale health care clinics located directly on school campuses are helping to connect more children than ever to deeply needed primary health care. Furthering the mission of co-located needed services in schools, Mayor de Blasio has aggressively pursued the creation of 130 Community Schools throughout the city. Community schools will help address poor learning outcomes by supplementing learning with access to a variety of services, particularly health and mental health services. Through the community school initiative, many schools will construct new SBHCs and school-based mental health centers (SBMHCs), and several others will pair with community-based organizations to provide services relating to asthma, vision, mental health, and more. Additionally, Mayor de Blasio has worked to further extend mental health coverage through *the Thrive NYC Behavioral Health Roadmap*. *Thrive NYC* initiatives include the placement of a Mental Health Consultant in all New York City Schools, the creation of SBMHCs in 52 additional schools beyond Community Schools, and the expansion of mental health training to Department of Education (DOE) staff.



Photo by Biljana Milenkovic, Children's Defense Fund

While investments to catalyze construction and implementation of school-based health services is a tremendous advance towards ensuring all children receive the care they need, elected officials, city-level agency staff, advocates and providers must work together to guarantee the long-term financial viability of these services. Without adequately financing the operating costs of these services, the school-based health care infrastructure is vulnerable to collapse. Such a breakdown would force many children to go without the care they need to succeed academically and socially.

## COST EFFECTIVENESS OF SCHOOL HEALTH SERVICES

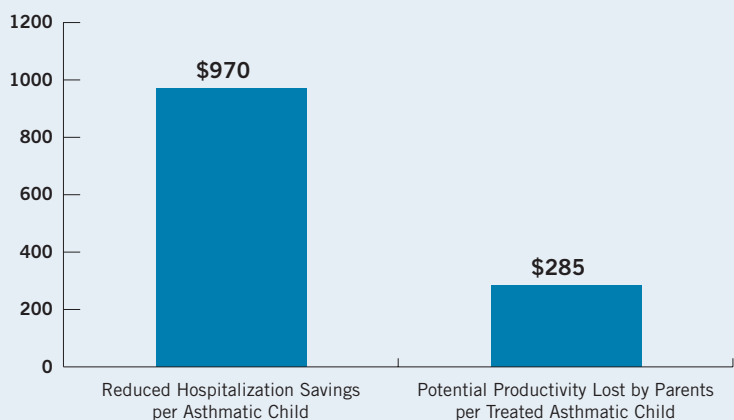
School-based health delivery produces significant positive returns through both decreased system-wide health expenditures and improved economic productivity resulting from caregivers missing fewer workdays to care for sick children and teachers being better equipped to do their jobs. A review of a \$79 million Massachusetts school nurse program concluded that the presence of school nursing services over the course of a single academic year generated a net savings of \$98.2 million when considering a \$20 million medical costs savings and nearly \$160 million in avoided parent and teacher productivity losses.<sup>1</sup>

Another study compared costs of establishing and operating SBHCs with the value that they could save or create and found that the use of SBHCs amounted to a net \$35 reduction in Medicaid expenditure per child per year, a reduction likely due to establishing a source of primary care for children who may not have otherwise accessed primary care and relied instead on hospital and emergency care.<sup>2</sup> One study conducted in California schools found up to an eight percent decrease in use of hospitals for routine care among students attending schools with a SBHC.<sup>3</sup>

Asthma provides a clear example of the health and financial efficacy of school-based health services. One study found that among children with asthma, the risk of hospitalization was less than half the rate for those without access to a SBHC.<sup>4</sup> The savings of such reduced hospitalizations amounted to \$970 per asthmatic child per school year. Further, researchers estimated that parents' loss of productivity amounted to \$285 per year per asthmatic child (**Figure 1**).<sup>5</sup>

Figure 1

### Projected Savings Among Asthmatic Students Attending Schools with an SBHC (per child annually)



Source: Wang, L. Y., Zhong, Y., & Wheeler, L. (2005). Direct and indirect costs of asthma in school-age children. *Preventing Chronic Disease*, 2(1), 1-10.

## RECOMMENDATIONS FOR ENSURING FINANCIAL SUSTAINABILITY

In New York State, the health care landscape is undergoing a major overhaul. Reforms, such as Affordable Care Act implementation, Medicaid Redesign, the Delivery System Reform Incentive Program (DSRIP) and others, are forcing stakeholders to rethink how providers deliver care, consumers receive care, and payers reimburse care. Accordingly, school-based health services must adapt to this changing landscape. The following recommendations outline a path upon which school-based health services can sustain and even expand their operations.

### **Ensure an Appropriate Transition to Medicaid Managed Care**

The New York State Department of Health has scheduled school-based health center providers to transition into a Medicaid managed care reimbursement model by July 1, 2017. Typical managed care protocols require providers to perform more care coordination activities — often in the form of seeking prior authorization for services, obtaining referrals and establishing contracts with each managed care organization. The slated transition has the potential to weaken the financial viability of school-based health centers. Additionally, the reimbursement rates used by managed care organizations typically fall below the state's existing school-based health center financing methodology, the Ambulatory Patient Group rate. CDF-NY's report showed that a transition to typical managed care rates would draw approximately \$14 million from SBHCs in the downstate region.

In order to preserve financial viability of SBHC providers who already face a difficult financial landscape, the transition to managed care will need to ensure that providers can secure guaranteed reimbursement for services delivered to students. While it is acceptable to require SBHC providers to secure prior authorization and submit to care coordination requirements for primary and preventive services; chronic disease management, urgent, behavioral, and reproductive care will need to remain accessible without first securing authorization from managed care organizations. Additionally, the state must ensure that managed care organization reimburse SBHCs at sustainable rates. Clearly, average managed care rates would lead to the closure of some SBHC sites in New York City and would make expansion of the program nearly impossible. Lastly, in order to be prepared by the July 1, 2017 deadline, SBHCs will need to be able to contract with managed care organizations and credential providers in an expedited fashion. The ability to adequately bill providers will be essential to securing any Medicaid revenue.

### **Develop a Pathway for SBHCs to Bill for Services Delivered to Children Covered by Child Health Plus**

As SBHCs transition into Medicaid managed care, they will need to develop the capacity to bill multiple managed care organizations. With only minimal extra resources, this capacity can easily translate into the ability to more easily bill private insurance companies and Child Health Plus (CHPlus) plans. More complete billing will enable SBHCs to secure a greater amount of revenue and decrease the amount of uncompensated care delivered. Many private and CHPlus plans do not reimburse primary care services not provided by a child's primary care provider (PCP). SBHCs, however, typically provide complementary, rather than duplicative, services. State administrators, plan managers and SBHC providers must create a rate structure that reimburses SBHCs for the complementary services provided by a non-PCP SBHC provider that improve a child's health outcomes.

### **Develop the Necessary Infrastructure to Claim Medicaid Reimbursement for non-SBHC Services**

Since 2009, the New York City DOE has claimed only a small portion of the Medicaid reimbursement for which it is eligible. Currently, DOE is eligible for Medicaid services it provides under the New York State Department of Health's Preschool/School Supportive Health Services Program (SSHSP). The SSHSP provides the following services to ensure that students with an Individualized Education Program (IEP) can receive the education to which they are entitled:

- Medical Evaluations
- Medical Specialist Evaluations
- Psychological Evaluations
- Audiological Evaluations
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Psychological Counseling
- Skilled Nursing
- Special Transportation

A recent study from the City Comptroller reports that DOE has lost \$356 million in potential Medicaid reimbursement because of insufficient data collection and overly burdensome federal and state regulations.<sup>6</sup> The City should not use its limited resources on services for which federal and state dollars are available.

**Following a federal audit, the State Department of Health (DOH) tightened its guidelines for claiming SSHSP reimbursement. As of September 2009, DOH requires school health providers to document student health encounters in more detail, including the Current Procedural Technology (CPT) codes for each service delivered.**

The DOE can better position itself to generate the Medicaid dollars for which it is eligible by improving its data collections systems and investing in the administrative support need to appropriately claim this reimbursement. Following a federal audit, the State Department of Health (DOH) tightened its guidelines for claiming School Supportive Health Services Program (SSHSP) reimbursement. As of September 2009, DOH requires school health providers to document student health encounters in more detail, including the Current Procedural Technology (CPT) codes for each service delivered. The Special Education Student Information System (SESIS) currently used by DOE to collect information on IEP related interventions does not have sufficient capacity to track this information closely enough to bill Medicaid for all the reimbursement for which DOE is eligible. DOE must invest in SESIS to guarantee that school health providers can appropriately document student health encounters and draw down deeply needed state and federal matching funds.

The DOE must also invest in the administrative support needed to bill Medicaid. Even with improvements to SESIS, school health providers will need assistance with the time consuming tasking of documentation and medical coding and billing. DOE should review its current reimbursement process and identify what particular supports are needed to ensure that school health providers can continue delivering the same level of high-quality care, while also securing needed funds. While such an investment may be costly, the heightened capacity to generate Medicaid revenue will make the investment financially beneficial to the City.

### **Implement the Free Care Policy Change in New York State**

To enable an increased investment in school health services, New York City would likely need to draw down more federal and state dollars. CDF-NY suggests exploring the free care policy as a way of doing so. In December 2014, the Centers for Medicare and Medicaid Services (CMS) reversed a long-standing policy that heavily restricted school districts' ability to bill Medicaid for preventative, evaluative and medically necessary health and mental health services offered to all students at no cost. Previously, the free care policy stated that Medicaid would not pay for services provided free to a student body, with the exception of children with an IEP. For instance, if a school were to provide immunizations on site they would be unable to bill Medicaid eligible children, neither would they be able to bill for any administrative activities associated with those services, even though these immunizations would be covered if administered at the doctor's office or even in an Article 28 school-based health clinic. This policy is reflected in the New York State Medicaid Plan and implemented through the SSHSP. The federal-level policy change ends this restriction and enables school districts to bill Medicaid for a host of preventive and primary care services for all Medicaid-eligible students, not just those with an IEP.

The immediate value of the free care policy change is the opportunity for the New York City Department of Education to more broadly bill Medicaid for preventative, evaluative and medically necessary health and mental health services. In particular, this policy change would allow the New York City schools to:

- Integrate the functions of SBHCs and school nurses in more sites across the five boroughs to ensure improved coordination of services,
- Provide behavioral health assessments at critical points in students' lives,
- Expand access to dental screenings given traditionally low access rates for oral health, and
- Ensure a baseline of preventive services and screenings for all New York City students.

To utilize the opportunities made possible by the free care policy, DOE would likely need to work with its state counterparts to file a Medicaid State Plan Amendment in order to allow school districts to bill Medicaid for certain services. While both the city and state would need to carefully proceed in developing a plan to bill for services under the free care policy, the CMS letter opens up the potential for schools to receive reimbursement for things like universal asthma screenings and behavioral health assessments. The potential influx of state and federal Medicaid dollars would better enable the Office of School Health to more deeply invest in school-based health services.

### **Develop Appropriate Data Tracking Tools to Demonstrate Value**

Both the state's DSRIP program and the State Health Innovation Plan (SHIP) seek to have 80 percent of Medicaid payments reimburse providers under a value-based payment structure. Simply, value-based payments are those that seek to reward the value of care delivered more so than the volume of care delivered. For example, under the current volume-driven payments structures typical in New York, a payer would reimburse a provider separately for each service, lab test, and treatment delivered during an episode of care. Under a value-based model, that payer might continue reimbursing each element of a visit independently, but provide a payment bonus for a provider who manages to secure a certain level of quality outcomes.

SBHCs and other school health providers provide tremendous benefits to provider networks transitioning to value-based payment mechanisms. The services delivered by school-based health providers already work to integrate a diverse team of providers in a way that fosters integrated, outcome based care. For example, SBHCs have worked to reduce hospitalizations associated with asthma attacks. Often these hospitalizations can be avoided with proper self-management education and appropriate medical attention in the SBHC setting. Such a capacity to reduce unnecessary emergency room visits and hospitalizations aligns school health providers as key partners in the changing health care landscape.

To appropriately demonstrate this value, school-based health providers must develop accurate data-tracking tools. These tools will help to empirically prove that school-based health delivery systems consistently generate the type of high-quality primary and preventive health care outcomes that value-based payment mechanisms will reward. With the ability to clearly and strongly articulate their ability to achieve high-quality outcomes, SBHCs and other school health providers will not only position themselves to receive enhanced reimbursements, but they will best position themselves to be active players in the future of New York's Medicaid delivery system.

## CONCLUSION

Children spend the majority of their time outside of home in school, and it is the environment in which they learn many health-related behaviors. When children are sick, they are unable to function to the best of their abilities and risk falling behind in school. School-based health delivery offers accessible, high quality preventive and primary care services for students, many of whom may not otherwise receive care. By maximizing available funds, New York City can more strategically deploy its limited resource to extend a baseline of school health services to all students and provide more intensive follow up services where demand is highest. These needed investments in school-based health services will help secure the academic success and the long-term health and wellness of all New York City students.

## ENDNOTES

<sup>1</sup> Wang, L. Y., Vernon-Smiley M., Gapinski MA, Desisto, M., Maughan, E., Sheetz, A. (2014). "Cost-benefit study of school nursing services." JAMA Pediatrics, 168(7):642–648.

<sup>2</sup> Guo, J. J., Wade, T. J., Pan, W., & Keller, K. N. (2010). "School-based health centers: Cost-benefit analysis and impact on health care disparities." American Journal of Public Health, 100(9), 1617-1623. doi:10.2105/ajph.2009.185181

<sup>3</sup> Brindis, C. D., & Sanghvi, R. V. (1997). School-based health clinics: Remaining viable in a changing health care delivery system. Annual Review of Public Health, 18, 567-587. doi:10.1146/annurev.publhealth.18.1.567

<sup>4</sup> Guo, J. J., Jang, R., Keller, K. N., McCracken, A. L., Pan, W., & Cluxton, R. J. (2005). Impact of school-based health centers on children with asthma. Journal of Adolescent Health, 37(4), 266-274. doi:10.1016/j.jadohealth.2004.09.006

<sup>5</sup> Wang, L. Y., Zhong, Y., & Wheeler, L. (2005). Direct and indirect costs of asthma in school-age children. Preventing Chronic Disease, 2(1), 1-10.

<sup>6</sup> Office of the New York City Comptroller. (2014). Money Left on the Table: A Review of Federal Medicaid Reimbursement to the New York City Department of Education (1sted.). New York, NY: Scott Stringer.

The Children's Defense Fund Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.