Background: Health, Education and Inequity

Children's health and well-being are impacted by a patchwork of policies at the local, state and federal levels. These policy decisions create a fragmented system of health care for children that can, at times, impede children's access to high-quality care and good health. Low-income children and children of color are disproportionately impacted by misaligned policies[1] — policies that result in prevention coming too late and chronic care services that are disparate and uncoordinated. Medicaid, a public health insurance program for low-income people, can play an important role in improving children's access to coordinated care.

Research shows that a neighborhood where a child lives is a dominant indicator of his or her health trajectory—simply put, poverty in this country is highly concentrated and highly correlated with poor child health.[2] Notably, children of color face a higher incidence of chronic illness including asthma and obesity—concurrently associated with neighborhood segregation, poverty and limited access to a range of services needed to support healthy living.[3] Simultaneously, mounting evidence recognizes early brain development as key to long-term health outcomes; the weight of this research demands an emphasis on needed health interventions for children in their earliest years.[4] Children's health advocates are key players in driving a health equity agenda. Working toward a seamless system of pediatric services where multiple entry points are connected makes access to a full continuum of care possible for children. This vision supports connecting children to services wherever they are in their community—and *local schools* are the central hub for children.

Over 52 million children attend public schools in this country and over a quarter of them face a health challenge[5]; 27 percent of children under the age 19 face one or more chronic health condition ranging from asthma to disorders of the jaw or teeth.[6] Schools play a big role in

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[1] Julia Paradise, "The Impact of the Children's Health Insurance Program (CHIP): What Does the Research Tell Us?" *Kaiser Commission on Medicaid and the Uninsured*, July 14, 2014, accessed, April 15, 2016.
[2] Sara Rosenbaum and Robert Blum, "How Healthy are Our Children?" *The Future of Children,* vol. 25, no.1 (2015):11-34.
[3] James H. Price, Jagdish Khubchandani, Molly McKinney, and Robert Braun, "Racial/Ethnic Disparities in Chronic Diseases of Youths and Access to Health Care in the United States," *BioMed Research International*, vol. 2013, Article ID 787616, 12 pages, 2013. doi:10.1155/2013/787616.
[4] See "The Science of Early Childhood Development" and the Working Papers from the National Scientific Council on the Developing Child: www.developingchild.harvard.edu/library/ accessed, April 22, 2016.
[5] Erin Maughan, "Building Strong Children: Why We Need Nurses in Schools," *American Educator* Spring (2016):19-25.
[6] Gerard Anderson, et al. *Chronic Care: Making the Case for Ongoing Care* (Robert Wood Johnson Foundation and Johns Hopkins Blumberg School of Public Health 2010) p. 11-13, accessed April 15, 2016.

children's lives; children spend most of their time in school, from classroom learning to after school and enrichment activities. Because of this, schools can also play a leading role in children's health. According to the National Association of School Nurses (NASN), only half of the schools in this country have access to a full-time nurse (30 hours per week); 18 percent have no nurse at all.[7] This means many schools are under-resourced when it comes to addressing student health.[8] Schools offer us a unique opportunity to blend health and education, resulting in improved outcomes for both. With this in mind, **one emerging opportunity is to better leverage Medicaid programs and funding to enhance health services inside schools**.

Thanks to a clarification by the Centers for Medicare and Medicaid Services (CMS) regarding the "free care" rule in December 2014, schools can be reimbursed for services provided to Medicaid-eligible students.[9] This provides an opportunity for schools to expand their support of school-based health services, and provide better integration within the health care system while advancing health equity. The following document provides a brief history of the Medicaid "free care" rule and its implications on school-based health services.

A Brief History

Prior to 1997, public schools in the United States were able to receive Medicaid payments for health services provided to Medicaid-enrolled students. However, because of the status of the Medicaid program as the payer of last resort, schools had to comply with third-party liability requirements.[10] In other words, schools were obliged to collect payments from all other sources—such as private health insurance and employer-sponsored insurance—if applicable, before billing Medicaid.

In 1997, CMS established the "free care" rule clarifying that Medicaid would not pay for health services that were available at no cost to the general public even if these services were provided to Medicaid beneficiaries.[11] With an exception for health services in a child's special education plan, schools were no longer allowed to bill Medicaid for health services provided to

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[7] Erin Maughan, "Building Strong Children: Why We Need Nurses in Schools," *American Educator* Spring (2016):19-25.
[8] National Association of School Nurses, "Position Statement: School Nurse Workload: Staffing for Safe Care" (January 2015), accessed April 12, 2016.
[9] HHS, CMS (December 2014). Letter to State Medicaid Director regarding Medicaid payment for services provided without charge.
[10] Social Security Act §1902(a)(25) defines third parties to include health insurers, self-insured plans, group health plans, service benefit plans, managed care plans, pharmacy benefit managers, and other third parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a healthcare item or service.
[11] The Free Care rule was highlighted in a number of federal guidance documents, including the 1997 "Medicaid and School Health: A Technical Assistance Guide," and the 2003 "Medicaid School-Based Administrative Claiming Guide."

Medicaid-enrolled students.[12] The narrowing of Medicaid reimbursement shifted emphasis to children enrolled in special education. To qualify for Medicaid reimbursement, school health services had to meet three requirements: 1) the child is Medicaid eligible; 2) the child is enrolled in an Individualized Education Plan (IEP); and 3) health services provided are related to the IEP. Without designated Medicaid funds, schools faced significant barriers to funding school health services. This not only created a financial burden for schools attempting to provide much-needed health services to low-income children, but it also created a disincentive to grow and enhance school nurse programs as the health demands of communities shifted over time.

The free care rule continued to be debated between state and federal agencies; Oklahoma successfully appealed the prohibition of billing Medicaid to the Department of Health and Human Services Departmental Appeals Board (DAB) in 2004.[13] While the rule was effectively struck down, there was no subsequent guidance that provided clarity to states regarding their implementation of the free care rule and its interaction with third party liability. At the very end of 2014, CMS issued a state Medicaid director letter providing long-needed clarification. The letter informed states that the free care rule was reversed and that schools were able to bill Medicaid for health services for Medicaid-eligible children, opening up the door to improving the health of millions of low-income children across all states.

The Opportunity

Since CMS' clarification of the free care rule in 2014, a handful of states have either changed their billing practices for schools or are in the process of determining how to alter their billing practices to enable school systems to access Medicaid funding for school health services. The opportunity requires some due diligence on the part of state governments and their respective agencies that interact with health and education. In many states this will include a state plan amendment (SPA). States pursuing full implementation of the clarification have an opportunity to enhance their current health services in schools, as well as an opportunity to broaden the scope of services provided in schools and better integrate school health services into larger health delivery system reform efforts. The adoption of the rule also offers potential improvements in health care access and chronic care management for millions of low-income children across the country. The impact is immeasurable. Consumer advocates, especially those focusing on children's health, can play a key role in advancing a "healthy schools" agenda that strengthens the connection between education and health, ensuring our most vulnerable children access to high quality health services.

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[12] Exceptions include services provided under the Maternal and Child Health Services Block Grant program, covered under the Special Supplemental Nutrition Program for Women, Infants and Children, and provided as part of an Individualized Education Program (IEP).
[13] Susannah Vance Gopalan and Elizabeth Karan, "A Change in Federal Policy Allows for More Access to Preventive and Primary Health Care Services," *The Network for Public Health Law blog*, June 8, 2015, accessed, April 17, 2016.