



Washington State
Health Care Authority

Report to the Legislature

**RECOMMENDATIONS TO FUND INTEGRATED
SCHOOL NURSING SERVICES**

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- John LaCour, Director of Health Services from the Picard Center for Childhood Development and Lifelong Learning, University of Louisiana at Lafayette

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EXECUTIVE SUMMARY

A vibrant community needs healthy, educated families to thrive. Mounting evidence shows that health status affects learning outcomes, and educational success affects lifelong health outcomes. Moreover, both health and educational disparities follow similar patterns, and subsequently their solutions overlap.

As the State of Washington strives to create healthy communities and populations, successful collaboration of the health care and education systems is critical. A key component of this collaboration is the ability to provide health services to all students in a school setting. In a limited fiscal environment, schools must often make difficult choices between funding their academic mission and allocating funding for school health services despite the evidence that health is fundamental to learning. However, as schools seek to meet their academic mission they face increased challenges to secure effective school funding leading to a decline in school health services both in the number of school nurses and the availability of health care services for students. "School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge." [Carnegie Task Force on Education of Young Adolescents (1989)] Even when schools heed this message, the process by which school health services are financed and provided is burdensome to both the education and health care systems. Currently, health and education systems operate in silos are rarely able to effectively and efficiently coordinate across systems and deliver health services that meet the needs of all children.

The 2013-15 Washington State operating budget included a proviso (see page 5) requiring the Health Care Authority (HCA) and the Office of Superintendent of Public Instruction (OSPI) to collaborate and develop a joint report with recommendations to increase federal financial participation for providing integrated nursing services in schools, with the goals of improving outreach and nursing services and supporting improved nursing-to-student ratios. The proviso includes language about training for nurses to provide outreach and application assistance to enroll eligible students in Washington Apple Health for Kids and other social service programs. The proviso requires recommendations that will support one nurse for every four hundred fifty children in elementary schools and one nurse for every seven hundred fifty children in secondary schools.

The proviso requirements enabled joint agency learning and an exploration process about how to maximize delivery and financing of health services to achieve better health outcomes for all children in school. Through this joint agency effort, HCA and OSPI established a common understanding of the current landscape of school health services within Washington, developed a shared vision for desired outcomes, completed initial investigations regarding other state models and established alignment with the State Health Care Innovation Plan (SHCIP). In addition, OSPI and HCA have developed strategies to explore increasing the provision of outreach and the availability and quality of school nursing. This report also investigates strategies to provide primary care and behavioral health in school settings.

The recommendations below outline the key strategies to be investigated after the submission of this report. HCA and OSPI suggest key findings and implementation steps be reported out to the Legislature by January 31, 2015 as resources allow.

- Engage licensed health providers in the community to offer covered services in a school setting to all students in collaboration with school nursing services.

- Explore a school nurse driven model to offer expanded covered services in a school setting to all students.
- Investigate opportunities that arise from the State Health Care Innovation planning and implementation process.

Introduction

The Legislature directed OSPI and HCA to collaborate and develop recommendations for increasing federal financial participation for providing nursing services in schools with the goals of improving outreach and nursing services and supporting improved nursing ratios.

School Nursing Budget Proviso:

\$50,000 is provided to both OSPI and HCA “solely for the development of recommendations for funding integrated school nursing and outreach services. The office of the superintendent of public instruction shall collaborate with the healthcare authority to develop recommendations for increasing federal financial participation for providing nursing services in schools with the goals of integrating outreach and nursing services and supporting one nurse for every four-hundred fifty students in elementary schools and one nurse for every seven-hundred fifty students in secondary schools. The recommendations shall include proposals for funding training and reimbursement for nurses that provide outreach services to help eligible students enroll in apple health for kids and other social services programs. The authority and the office of the superintendent of public instruction shall provide these recommendations to the governor and the legislature by December 1, 2013.”

While the proviso has specific requirements, HCA and OSPI realized that recommendations that did not perpetuate the current administratively burdensome and costly system would need more creative thinking. It was also apparent that building a common understanding of existing barriers and shared desired outcomes was a necessary foundation before moving forward.

Simultaneously, Washington State was actively moving forward in the process to develop the State Health Care Innovation Plan (SHCIP), which lays out a five-year strategy for Washington to create better health and improve the quality of care for its citizens at a lower cost. SHCIP recognizes the need for engagement across sectors and systems, specifically education, and OSPI has been engaged in the planning process through a multi-agency governing board that guides the development of SHCIP planning and implementation. As we move into implementation of the SHCIP, the ability to leverage partnerships with schools and health systems in communities will be fundamental. HCA and OSPI have highlighted the synergy between some of the goals of this report and the desired strategies for SHCIP.

The evolution of the work above is highlighted in this report along with recommendations that require continued partnership between HCA and OSPI, as well as necessary engagement and partnering efforts from other agencies such as Department of Social and Health Services (DSHS), Department of Health (DOH), Department of Early Learning (DEL), and a number of external stakeholders.

Healthy Communities Need Healthy Schools: A Shared Vision for School Health Services

Establishing healthy behaviors during childhood is easier and more effective than trying to change unhealthy behaviors during adulthood.¹

¹ The second decade of life (10-19 years of age) is a critical period when patterns of health-promoting (for example, adopting physical activity habits or learning ways to cope with stress) or potentially health damaging behaviors (for example, whether or not to try cigarette smoking, or to experiment with illicit drugs) are established, and that these behaviors may have a substantial influence on health status (Summary of The Second Decade Summit, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health, Seattle, 2012).

Schools are key members of the health community and play a critical role in this by promoting the health and safety of children and helping them establish lifelong healthy behavior patterns.

Children need to be healthy to learn. Providing health services within a school district improves students' access to care, improves student health outcomes through care coordination services provided by the nurse, and ultimately results in improved academic performance and graduation rates, all of which lead to improved community health.

Building community partnerships can help schools:

- Improve academic outcomes due to improved attendance and behavior;
- Reduce intergenerational exposure to Adverse Childhood Experiences;
- Improve health literacy starting at an early age;
- Reduce the chance that children will make negative behavioral choices between ages 10 and 20 that could impact their own and their community's health over the course of their lives;
- Improve health outcomes for students including mental and behavioral health;
- Reduce the number of children identified as needing special education services;
- Reduce the number of children expelled or suspended;
- Improve job satisfaction for school faculty and staff;
- Increase and improve health services and care coordination for all children;
- Increase and improve outreach services;
- Reduce the utilization of medical services in the community (such as Emergency Departments);
- Control costs in the larger health care system, through improved health service outreach, delivery and care coordination in schools;
- Streamline services and decrease duplication of services; and
- Engage in other efforts to meet academic goals.

The vision explored in this report relies on elevating population health improvement and improved access to care at a lower cost. This will improve health and education outcomes and gain efficiencies across the community.

Overview of School Health Service Delivery

School Nursing Services

Currently, school nursing services are provided by a range of school staff including professional Registered Nurses, Licensed Practical Nurses, dedicated classified health room assistants, school secretaries, para-educators, teachers and school administrators. In addition, schools currently have variable access to a range of services provided by other licensed health professionals, specifically to serve students in Special Education. Services are supervised by a Registered Nurse who is often an Educational Staff Associate (ESA) certificated school nurse (a bachelor's prepared RN with additional training specific to the education setting including the provision of Special Education services).

School nurses provide a variety of health services in schools to support federal and state statutes for students with disabilities and provide care for well students. School nursing activities fall into four general categories:

- Care coordination for students with chronic health conditions;
- Risk management related to health;
- Episodic health room care; and
- Health promotion and illness prevention activities.

School nurses are responsible for the health needs of the entire school population, providing training and oversight of school staff, managing health needs in the classroom, on field trips, at recess, and during physical education classes. They supervise care delivered in the health room, mandated screenings, provide mandated training for school staff in recognizing and responding to emergencies, as well as delegate and train for medication administration and health treatments under nursing practice statutes.

The table below represents the health conditions of students in Washington Schools based on reporting from districts serving approximately 75% of total student enrollment.

Health Needs of Washington State Students (2012-1013) *			
Nursing Dependent ** (Survival depends on 1:1 nurse)	112	Medically Fragile ** (Daily risk of life-threatening emergency)	3,550
Medically Complex **	41,015	Vision/Hearing Referrals (RCW 28A.210.020)	34,066
Life Threatening Conditions (RCW 28A.210.320)	39,000	Asthma (RCW 28A.210.370)	65,125
Life Threatening Allergies (RCW 28A.210.380)	16,278	Diabetes (RCW 28A.210.330)	2,376
Medication Orders (RCW 28A.210.260)	63,496	Medical Treatment Orders	10,915
Health Conditions	262,121	26.72% of districts report high unmet need for direct nursing services	
* Represents approximately 75% of total 2012-13 enrollment			
** Staff Model for the Delivery of School Health Services (2000)			
http://www.k12.wa.us/HealthServices/pubdocs/SchHealth.pdf			

There are some school districts that, for economic reasons, place students with chronic health conditions in an assigned school where a school nurse is available every day. This concentration of “high-need” students can place a burden on other students, families and the school nurse staff. With increasing numbers of children coming to school with chronic conditions, the school nurse’s case load in these dedicated schools may exceed the recommended staffing levels in the OSPI/DOH Staff Model for Delivery of School Health Services. There are 226 of 295 school districts reporting an estimated deficit of 12,237 RN hours per week in order to provide school health services at a ratio of one nurse to fifteen hundred students. Please see the OSPI/DOH Staff Model for the Delivery of School Health Services at: <http://www.k12.wa.us/HealthServices/pubdocs/SchHealth.pdf> .

School nursing services are funded by a patchwork of resources ranging from basic education funding to local levies. Based on the 2012-2013 Assessment of District Student Health Services, of 251 school districts funding school nursing services:

- 174 rely on basic education funding;
- 133 rely on School Nurse Corps funding;
- 77 rely on local levy funding;
- 50 rely on special education funding;
- 16 rely on Medicaid Administrative Claiming contract with HCA;
- 12 rely on grants; and
- 7 rely on migrant funding.

School districts sometimes rely on more than one funding source to provide nursing services, therefore, some of these numbers may represent multiple funding sources being used in one school district.

School Nurse Corps

The School Nurse Corps program (recently awarded the Warren Featherstone Reid Award for efficiency in health care) supports the delivery of efficient and effective nursing services in schools. This program is overseen by the OSPI Health Services Program Supervisor and employs School Nurse Administrators in each of Washington's nine Educational Service Districts to provide:

- Direct nursing services in small, rural school districts;
- Technical and consultative support to all school nurses and school districts;
- Professional development to nurses and other school staff;
- Policy development;
- Data collection; and
- A framework for the effective delivery of health services in Washington state schools.

For additional information regarding the Assessment of District Student Health Services, please see the OSPI [Health Services](http://www.k12.wa.us/healthservices) website at: www.k12.wa.us/healthservices.

Overview of Community Based Health Services Provided in Schools

Existing School Community Based Providers:

A number of services are offered by community based providers in schools under a variety of billing structures, covering services such as, but not limited to, mental health, chemical dependency services and immunization clinics.

School Based Health Centers (SBHC):

SBHCs work cooperatively with school nurses and counseling staff to provide a comprehensive range of services to meet specific physical and behavioral health needs of the community. SBHCs provide primary health care, mental health and counseling, family outreach, and chronic illness management through a qualified health provider such as a hospital, health department, and social service or safety net medical providers such as federally qualified health centers (FQHCs). SBHCs employ a multidisciplinary team of providers including nurse practitioners, registered nurses, physician assistants, social workers, physicians, alcohol and drug counselors, and other health professionals to care for the students. Currently, there are 31

SBHCs in Washington, 22 are located in Seattle and are funded through the city's Families and Education Levy.

Overview of Existing Medicaid Programs Offered in Schools

Medicaid Administrative Claiming (MAC)

Some of Washington's most vulnerable children and families experience difficulty accessing needed medical care. Our school districts provide many services to children on a daily basis ensuring their overall well-being. Federal funds are available through HCA's MAC program to reimburse school districts for a portion of the staff costs incurred for performing allowable Medicaid administrative activities, when those activities support provision of services as outlined in the [Washington State Medicaid Plan](#). As the single state Medicaid agency, HCA has sole authority and responsibility for the administration of Washington State's Medicaid program.

The purpose of the MAC program is to:

- Conduct outreach to children and families with no or inadequate medical coverage;
- Explain benefits of the Medicaid program;
- Assist children and families in applying for Medicaid; and
- Link children and families to appropriate Medicaid covered services.

School participation in the MAC program is voluntary, and reimbursements the schools receive through the MAC program are not restricted and may be used as the school deems appropriate.

In order to participate in the MAC program, a school district or educational service district must:

- Enter into an interagency agreement with HCA;
- Participate in the Centers for Medicare & Medicaid Services (CMS) approved time study and claiming process; and
- Prepare and submit an invoice to request reimbursement from HCA.

The CMS approved time study is designed to identify the amount of time participating staff spend performing allowable Medicaid administrative activities during any given day. The results of the time study are used to calculate the reimbursement a school district can claim. Schools routinely engage in a variety of claimable activities that are not traditional educational or academic activities. About 100 of 295 school districts statewide currently participate in the MAC program. For school year 2011-2012, contracted school districts' MAC reimbursements totaled \$17.1 million. Many school districts do not participate in the MAC program because reimbursement is limited and the administrative cost of claiming for these activities outweighs the benefits of participating.

For additional information regarding the school MAC program, please see the CMS Medicaid School Based Claiming Guide at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/2003_SBS_Admin_Claiming_Guide.pdf, or visit the HCA MAC website at: <http://www.hca.wa.gov/medicaid/mac/pages/index.aspx>.

School-Based Health Care Services (SBHS)

The [Individuals with Disabilities Education Act \(IDEA\)](#), requires schools to educate children with disabilities. When a school health care professional believes a child aged 3 to 21 years may have a disability that adversely affects their educational performance, the child is entitled to an evaluation related to the suspected disability.

An Individualized Education Plan (IEP) must be developed for students with disabilities who require specialized instruction, to ensure they receive the specialized instruction and related services necessary for them to be successful in school. The IEP details specific health care related services needed to help the child adjust to their disability and reach their educational goals. Medicaid covered services described in the IEP must be provided by a licensed health care provider.

The SBHS program is an optional Medicaid program that the Washington State Legislature elected to reinstate and fund beginning July 1, 2011, and SBHS reimbursements to schools are consistent with [Section 1903 \(c\)](#) of the Social Security Act. Health care related services provided to a child with a disability are in accordance with [IDEA Part B](#).

In order to bill Medicaid for SBHS nursing services provided to children in special education through Washington State's [ProviderOne](#) payment system, those services must be:

- Determined medically necessary as part of an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) assessment;
- Provided by a licensed health care provider according to the Washington State Department of Health and [42 CFR 440.60](#); and
- Included in the child's current IEP.

SBHS reimbursement for nursing services is conducted through an [Intergovernmental Transfer \(IGT\) process](#). Under the IGT process, all non-federal matching funds (local tax-based dollars) must be sent to HCA before the federal Medicaid portion can be dispersed. When HCA's ProviderOne payment system places the claims into an "in process" mode, HCA's fiscal staff notifies the school district of their required local matching funds. The school district's match is submitted to HCA either via electronic fund transfer or in the form of a warrant (check), and when the required local match is received the claims are released for payment.

Currently, there are approximately 220 out of 295 school districts statewide contracted to participate in the SBHS program, with an estimated \$10 million in reimbursements annually.

For additional information about the SBHS program, see the [SBHS Medicaid Provider Guide \(MPG\)](#) or the HCA SBHS website at: <http://www.hca.wa.gov/medicaid/schoolbased/pages/index.aspx>.

HCA Methodology for this Report

The HCA's Division of Health Care Services/Office of Community Services initially assessed the impacts of expanding existing programs, engaged the National Association of Medicaid Directors in a survey of models in other states, and investigated other states highlighted through OSPI's research.

Expansion of Existing Services in Washington

Although expanding existing programs such as MAC and SBHS to full school participation could meet some of the requirements of the proviso, this recommendation would not eliminate administrative burdens on schools or HCA, nor address the costs associated with the expansion. However, to fully understand the impacts of expanding existing services, administrative and financial impacts will need to be further assessed.

National Association of Medicaid Directors (NAMD) Survey

In the NAMD Survey (see Appendix A), HCA asked other states' Medicaid programs to identify creative funding opportunities or strategies implemented with CMS approval that support Medicaid funding opportunities in a school environment, with emphasis on nursing services, outreach and application assistance, and care coordination activities. We received responses from the states of Georgia, Arizona, and Massachusetts.

All three states use a combination of already existing SBHS services and MAC programs and the cost reimbursement methodology is processed utilizing Certified Public Expenditures (CPEs). These states used a Random Moment Time Study (RMTS) to identify direct services and administrative reimbursable costs. The RMTS captures time spent on administrative activities and direct services and the results are used to calculate the percentage of costs that can be claimed.

Other State Research

In addition to information received from the NAMD survey, HCA independently and in conjunction with OSPI, looked into a number of states trying to move similar strategies forward. States that stood out in this research are Louisiana and California. Additional investigation is needed, but initial findings are promising and helped in developing some of our recommendations.

Louisiana

In the state of Louisiana, a State Plan Amendment (SPA) was approved by CMS for school-based nursing services for all Medicaid eligible children (IDEA and non-IDEA students). While this SPA is not yet fully operationalized or implemented in the school districts, it potentially opens the door to new innovative opportunities to offer nursing services to all Medicaid children in schools provided by school nursing staff.

HCA and OSPI are committed to exploring models under development in other states such as Louisiana and others (see Appendix B). The Louisiana model provides services for all Medicaid children in schools through a hybrid approach of expanding access to services through school nursing services and partnerships with FQHCs and hospitals. FQHCs or hospitals provide off-site healthcare services (including behavioral health) in schools, as prescribed by a licensed

health care provider, and then bill Medicaid. The Louisiana model is simultaneously using the FQHC encounter rate and/or hospital Upper Payment Limit methodology to develop a more complete and coherent reimbursement system to help fund additional school nurses. As mentioned above, although Louisiana has not fully implemented this plan, it offers interesting possibilities and questions for Washington State to explore.

California

California's Medicaid school based services program provides useful information guiding possible options for exploration. In California, children receiving Medicaid school based services are not required to have an IEP; any medically necessary service included in the state plan provided to a Medicaid eligible child may be billed to Medicaid if other federal requirements are met. School districts pay for direct medical services they provide to Medi-Cal eligible students and are reimbursed at cost. State law also requires funds from Medi-Cal based services to be reinvested in medical services at schools.

There are some unique features to California's program that will need to be further researched. First, California has its own unique school based administrative claiming guide. Also, the California Department of Education has organized over 1,000 Local Education Agencies (LEA) into eleven Local Education Consortia (LEC). Each LEC has a contract with California's Department of Health Care Services (DHCS) to coordinate a Medi-Cal Administrative Activities program for each school district in its region. All claiming units that want to participate in the school based administrative claiming program must contract through one of three entities including the Superintendents Educational Services Association, local LECs, or their local county government.

In 2005, the California legislature passed SB 231, which requested DHCS reduce the gap in per child recovery for Medicaid school based reimbursements between California and the three states recovering the most per child from the federal government. In addition to the overarching task, it requires DHCS to amend the SPA to eliminate barriers for LEA reimbursement, do comparative studies with other states, provide robust technical assistance and engage multiple stakeholder groups including state agencies, school nursing staff, school administrators and community providers.

While this process has increased access to Medicaid school based services to all children and alleviated some of the billing challenges at the individual school level, issues remain. As recently as last year, CMS and DHCS were developing solutions to respond to an audit carried out between 2010-2011 which found lack of appropriate claiming, lack of internal controls to ensure compliance with appropriate codes, and lack of operating procedures and financial oversight to ensure administrative costs aren't duplicative of costs claimed for direct medical services. Consequently, DHCS was requested to pay back approximately \$4 million. As we review California's model, Washington must be diligent in adapting it to a system that enables increased access to school based services while being prudent in how those are administrated and financed.

OSPI Methodology for this Report

Previous School-Based Health Staff Funding Recommendations

Any discussion of school nurse ratios must be based on an understanding of the current school basic education funding plans that would affect these ratios.

In 2009, the Legislature passed ESHB 2261, which among other things, created the Quality Education Council. The Council is charged with making strategic recommendations to the Legislature and the Governor with regard to the implementation of the evolving program of basic education and the funding necessary to support that program. Funding for health and social services, including nurses is a part of the program of basic education, and in 2010 the Council provisionally adopted full funding recommendations for these staff at each school level. The Council recommended that the Legislature provide funding for 1 FTE for every 400 students in grades K-6, 1 FTE for every 432 students in grades 7-8, and 1 FTE for every 600 students in grades 9-12, as outlined in the table below. According to the timelines outlined in ESHB 2261, if adopted by the Legislature, these full funding recommendations should be implemented in school year 2017-18.

Prototypical School Model							
		Currently Funded			QEC provisionally adopted end value		
		Elementary	Middle	High	Elementary	Middle	High
Health and Social Services							
School Nurses		0.076	0.06	0.096	0.563	0.882	0.814
Social Workers		0.042	0.006	0.015	0.311	0.088	0.127
Psychologists		0.017	0.002	0.007	0.126	0.029	0.059
	Total	0.135	0.068	0.118	1.000	1.000	1.000

OSPI staff reviewed available literature on the expansion of school health services, and members of the Washington State School Nurse Corps participated in the national Johnson and Johnson School Health Leadership Program to develop a community initiative (“Enduring Change Plan”), to assess the health care needs of students in Washington State schools which also informs this report.

Also, OSPI contracted with Mr. John LaCour, the Director of Health Services from the Picard Center for Childhood Development and Lifelong Learning, University of Louisiana at Lafayette, a subject matter expert with an operational knowledge of public health financing and clinical services. Mr. LaCour’s role was to assist in the development of an understanding of potential, viable health care financing and clinical services options for school districts.

OSPI convened a series of four briefings by Mr. LaCour about the Louisiana school Medicaid expansion project, from a document entitled “A School and Community Health Care Model Integrating Services and Finances” (see Appendix B).

Briefings were attended by:

- Legislative Education and Health Care Committee staff and Caucus staff;
- Members of the leadership and staff from the Office of Superintendent of Public Instruction;

- Staff from the Health Care Authority (from the division that supervises both direct service billing and Medicaid Administrative Claiming, and the division that recently prepared the State Health Care Innovation Plan);
- Representatives of the Medicaid Managed Care plans;
- Executive Director of the Washington Association of Community and Migrant Health Centers;
- A representative of Public Health Seattle-King County;
- The Washington State School Nurse Corps,
- Seattle Public Schools; and
- A representative of the School Nurse Organization of Washington.

Participants reacted with interest, and there were several requests for follow-up information and conversations with Mr. LaCour.

State Health Care Innovation Planning (SHCIP) Process and Implementation

In April 2013, the Centers for Medicaid and Medicare Innovation Center (CMMI) granted Washington nearly \$1 million to build a five-year state plan to spur health innovation to achieve the triple aim of better health and better care at a lower cost. The SHCIP is also preparing Washington for an upcoming State Innovation Model testing grant opportunity from CMMI, which could provide up to \$50 million over three to five years. The SHCIP process is spearheaded by HCA, but advised by a twelve agency governance committee, and the Executive Management Advisory Council (EMAC), which includes OSPI as a member. EMAC provides a natural venue to strengthen partnerships across agencies.

Washington's State Health Care Innovation Plan will change how health care is purchased, financed, delivered and linked to communities. The plan also aims to align health systems with community transformation initiatives and support the underpinnings of lifelong health. The SHCIP will explore opportunities to better administer and pay for services so services can be delivered at the right place, by the right person and at the right time, such as in a school, by a nurse, during the school day. The SHCIP also elevates and recognizes the critical role of school, school districts and educational service districts in regional and local strategies to improve health. As the state works with regions to develop Accountable Collaboratives of Health (ACH), they should be looked to as venues to facilitate cross-system and sector partnerships to build regional solutions and strategies.

Findings

OSPI and HCA continue to work together to clarify and analyze current realities and develop a shared understanding of each agency's key questions in order to move toward innovative solutions. Key findings below reflect answers and/or discussion items raised during the two agencies' work together.

HCA

- Encouraging Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening in a school setting "makes sense" because this is where children can be found. HCA currently encourages all providers to offer appropriate EPSDT screenings.
- Many school districts participating in the SBHS program do not bill for nursing services even though the services are clearly outlined in a child's IEP and provided by a licensed nurse, because reimbursement rates are low and it is administratively burdensome.
- Schools are mandated by the Legislature to provide state matching funds to HCA through an IGT process for services provided and reimbursed through the SBHS program. HCA must receive the IGT transfer before reimbursing schools for provided services. Schools and HCA report the IGT process is administratively burdensome and delays payment. A number of other states utilize a CPE process to verify state matching funds that is reportedly much less administratively burdensome than the IGT process.
- Washington state schools participating in the MAC program complete a five-random-day time study. Staff capture 100 percent of their time each random day in 15-minute increments using a paper based system.

- All qualified providers must have an NPI number to bill for services rendered; some school districts do not have NPI numbers. HCA has shared the process to apply for and receive an NPI number with school districts.
- HCA consulted with CMS Region X and asked if it was aware of innovative school nursing models that Washington State could explore. CMS was unable to provide any recommendations and reiterated the following CMS requirements:
 - Schools must demonstrate they billed all other available insurances for health care related services before billing Medicaid. Schools may choose not to bill Medicaid for services provided to children in Special Education who have private insurance; however, when third-party insurance is available, schools must bill that insurance first as Medicaid is the payer of last resort.
 - Children in both regular and Special Education programs receive school health services in public schools. Medicaid rules restrict payments for medically necessary services administered to children if such services are also provided to regular education children in a school setting at no charge (see [Social Security Act Title XIX](#)). This restriction is often referred to as the 'No Free Care Rule'.
 - As the single state Medicaid agency, HCA must receive all federal Medicaid funding and all Medicaid programs must have approval from CMS before adding and paying for any new programs or services with Medicaid funds. If the legislature allocates state funds for a new Medicaid program or service, HCA cannot administer or pay for the program or service without CMS approval of a State Plan Amendment (SPA), Waiver, or Cost Allocation Plan (CAP).
 - Any school staff wishing to bill Medicaid must be licensed and can only provide services within the scope of their license.
- Most SBHS participating schools contract with billing agents to process Medicaid claims in accordance with federal and state Medicaid policies. School districts rely on their billing agents to check for Medicaid eligibility, to code services using ICD-9 and CPT coding, and to process the claims.
- Schools providing nursing services to all Medicaid eligible children outside of Special Education must have a physician oversee and determine medical necessity, establish an efficient billing process to bill other insurances, and determine how they would bill correctly. School nurses are not allowed to self-bill or bill Medicaid directly without a physician's order. If a nurse is a licensed or certified advanced nurse practitioner, they can bill through a physician's office or health home agency.

OSPI

- Approximately 46.1 percent of all 1.1 million school children statewide are eligible for Free and Reduced Price Lunch.
- The school nurses who attended the briefings with John LaCour expressed interest in alternative models of school health services delivery to all students, including implementation of a population health model and care coordination with community health care providers.
- School districts, Educational Service Districts (ESD), and OSPI have been identified as potential key partners of Accountable Collaboratives of Health, a key component of the SHCIP to help build healthy populations and communities.
- Schools offer support for students in areas that have impacts beyond education. These include health and fitness, nutrition, and health literacy.
- Of 243 school districts, 90% are currently using a computer program designed to collect health data.

- Of 242 school districts, 58% ranked direct nursing service time as a high or medium unmet need.
- OSPI elevated a number of questions that still need to be asked of schools, school districts and ESDs, such as:
 - Please describe the organizational structure of health services in the school district.
 - Please describe the school nursing activities provided in a typical day.
 - Please describe the care coordination activities provided to students.
 - Are behavioral and mental health services available to students at school?

Recommendations: Medicaid Funding Opportunities and Innovative Strategies

OSPI and HCA are committed to investigate the following recommendations to meet the proviso requirements and build strategies to improve access to health services for all students in school settings.

To embark on these recommendations, HCA and OSPI need to engage a number of stakeholders to discuss possible solutions and next steps. These stakeholders include:

- Other agencies:
 - Department of Health
 - Department of Early Learning
 - Department of Social and Health Services
- Relevant Governor's Taskforces and Councils, such as the recently formed Governor's Council for the Healthiest Generation formed to better coordinate efforts to improve the health of children in Washington.
- Medicaid Managed Care Plans
- Washington Association of Community and Migrant Health Centers and FQHC representatives (specifically those already engaged as School Based Health Center sponsors)
- Washington Alliance for School Based Care
- Washington State Hospital Association and hospital membership engaged in school based service sponsorship
- Other health providers, such as private practices, local public health jurisdictions, community mental health agencies
- Educational service districts, school districts and schools
- Educational professional organizations, risk management organizations, and school business officers

In addition, all recommendations will need to be assessed for potential fiscal impact and include factors such as current state basic education funding, changes proposed under the prototypical schools model and impact of expansion of existing school health services.

Also, as noted in earlier sections of this report there is experience in other states engaging in innovative strategies to improve access to health services in schools. It will be critical to build on initial investigations to take away best practices, lessons learned, avoidable pitfalls, etc. It will be necessary to stay engaged with CMS to assess the options the two agencies might implement to understand what, if any, changes may be needed to the Medicaid State Plan or if a Waiver is required.

Recommendation 1: Engage licensed health providers in the community to offer covered services in a school setting to all students in collaboration with school nursing services.

Currently, licensed health providers are not providing services in schools in all communities across the state. Also, these services are not being provided to all students (only students who are covered by IDEA currently receive services.)

It has been noted a number of times within this report that schools are obvious locations to provide comprehensive health services from prevention and screening to primary care and

behavioral health services; however, there is a gap in access to provide the much needed services within a school setting. It is promising that licensed health providers in the community could have their own licensed staff provide services in a school setting now without the need for a SPA or CMS review and approval. This recommendation would require building strong partnerships across communities to engage locally based providers to offer services within a school setting, or to develop a school based health center.

This recommendation would immediately engage external partners, especially those provider types that have experience in engaging with the school system. The role of the State would also have to be determined in facilitating these partnerships, creation of working agreements and ensuring duplication with the SBHS and MAC programs does not occur.

Recommendation 2: Explore a school nurse driven model to offer expanded covered services in a school setting to all students.

Currently, school nurses are not able to provide and bill for all services covered by their license in a school setting. Also, these services are not being provided to all students (only students who are covered by IDEA currently receive services.) In addition, HCA and OSPI hear repeatedly that billing is challenging and administratively burdensome to all parties.

This recommendation would involve exploring strategies to have licensed school nursing staff provide direct services to all Medicaid eligible students in a school setting. There are two potential models within this recommendation to explore, and both would likely require at least CMS review and possible CMS approval through a SPA or Waiver:

- A. Expand the current State Plan Amendment for SBHS program to all Medicaid students (IDEA and non-IDEA).

Currently school based health services are reimbursed on fee for service basis and require IGT for the state matching funds. This recommendation will explore a reimbursement strategy that eliminates “fee for service” billing and moves towards a “cost based reimbursement” payment methodology, which would reimburse schools in a lump sum for Medicaid services and activities provided. CMS must approve a cost based reimbursement methodology. In addition, HCA and OSPI recommend a implementing a CPE rather than IGT process to provide state matching funds.

- B. Explore having licensed health care providers subcontract directly with schools to have licensed school staff provide direct services in the school setting. Arrangements could be explored with any healthcare provider, with emphasis on FQHC and managed care organizations. These strategies may require schools to develop (or contract with ESDs or other partners for) an extensive billing infrastructure, including electronic health record systems, and contracts and working agreements with health care service providers.

Recommendation 3: Investigate opportunities that arise from the State Health Care Innovation planning and implementation process.

Currently, schools and health systems struggle to see themselves as partners in improving the health of the community, and thus do not reap the mutual benefits that are possible through collaboration in improving health and educational outcomes. While there are examples across

the state of fruitful collaborations between schools and health systems, they are not the norm and are stymied by challenging financial and administrative barriers.

The State Health Care Innovation Plan and a subsequent State Innovation Model testing grant provide opportunities to test and implement innovative strategies, such as creative administrative and funding options, an increased community role in Medicaid purchasing policy and a more formal recognition of broader regional partners, such as schools, districts and ESDs engaging as core partners in improving health. As the State moves forward with implementation of the SCHIP, it will consider how the innovative strategies implemented can include improved access to health services in schools and address the request of the proviso.

Conclusion

Exploring new opportunities for schools to increase federal financial participation and provide integrated nursing services through the above recommendations requires time, staffing resources, and extensive stakeholder engagement. A comprehensive strategy must be developed that delves more deeply into other state systems, and engages external stakeholders such as managed care organizations, FQHCs, hospitals and other agencies. In addition, experience has shown that some of the recommendations may need CMS to review and approve SPAs and/or a Waiver, which could take up to a year or more. In addition, implementing the SHCIP is very fluid process and will be carried forward over 2014 and over the next five years.

Since there is still more work to be done, HCA and OSPI would like to present our findings regarding the three recommendations to the Legislature by January 31, 2015. As resources allow, HCA and OSPI will collaborate on further recommendations that meet the requirements of the proviso and the broader goal of improving access to health services in a school setting.

However, HCA and OSPI would like to highlight that the first recommendation in this report could potentially be implemented immediately as it would not require CMS review and approval. The challenge would be to identify willing health care providers to pilot with school districts. If the second recommendation is preferred, HCA and OSPI could pilot the idea using state funds only. As noted above, working with CMS to pursue federal matching funds could take a year or longer before approval.

HCA and OSPI look forward to continuing this innovative work to build a bridge to the future that identifies the potentially expanded role schools can play to assure the health care needs of Washington's children are met.

ATTACHMENTS

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Appendix A: National Association of Medicaid Director (NAMD) Survey

HCA asked the NAMD to survey other states' Medicaid programs to identify creative funding opportunities or strategies implemented with CMS approval that support Medicaid funding opportunities in a school environment, with emphasis on nursing services, outreach and application assistance, and care coordination activities. We received responses from the states of Georgia, Arizona, and Massachusetts. All three use a combination of already existing SBHS services and MAC programs.

Georgia

The state of Georgia's Department of Community Health reimburses schools for direct services provided to children enrolled in special education, including some administrative activities related to school based health care and outreach activities. The cost reimbursement methodology is processed utilizing Certified Public Expenditures (CPEs).

Time spent on administrative activities and direct services are captured through a Random Moment Time Study (RMTS). The time study results are used to calculate the percentage of costs that can be claimed.

Arizona

The state of Arizona's Health Care Cost Containment System contracts with Public Consulting Group (PCG) as their third party administrator. Annually, PCG is required to audit participating Local Education Agencies (LEAs) to ensure they are billing appropriately for medically necessary services.

Arizona's cost reimbursement methodology is processed utilizing CPEs. Direct services are reimbursed at a fee-for-service rate. A RMTS methodology is used quarterly to identify allowable direct service and administrative costs, and to allocate time spent in these activities.

Massachusetts

The State of Massachusetts School-Based Services program reimburses for direct services and administrative activities. The cost reimbursement methodology is processed utilizing CPEs.

Direct services must be:

- Ordered by a physician
- Provided by a registered nurse or licensed practical nurse
- Directly related to an IEP or Individualized Family Service Plan (IFSP)

A RMTS is used to identify direct services and administrative reimbursable costs. Both direct and administrative claiming is processed through a Medicaid Management Information System. Direct service cost reports are submitted annually to the state of Massachusetts for services delivered the previous fiscal year.

Appendix B

A School and Community Healthcare Model Integrating Services and Finances

Developed by the Cecil J. Picard Center for Child Development and John LaCour, Director of Health Services from the Picard Center for Childhood Development and Lifelong Learning, University of Louisiana at Lafayette

Introduction

Communities recognize the inextricable link between a prosperous future and the educational success of their children. It is equally clear there is a relationship between the health of children and their academic performance; CDC uses academic markers as measures of health. In states like Louisiana, where there are approximately 1,400 public schools and 700,000 students, school-based healthcare has become more complex while the model providing these services has changed little. About 60% of the students are enrolled in Medicaid but many face barriers accessing care. There are only 350 school nurses to serve all of the students in these schools. Few attempts have been made to provide any form of organized behavioral health services for students. Instead, school districts depend on state services that are being reconfigured and are difficult to access.

School districts can be a remarkably efficient platform for healthcare. Students are readily available, which provides an opportunity to manage their care in a population health model. However, the healthcare demands from students are more multifaceted than in the past. For example:

- Today's children face more medically complex health conditions and chronic illnesses than ever before.
 - Overall, 13 to 18 percent of children and adolescents have a chronic health condition; nearly half of whom could be considered disabled. The percent of students in federally supported special education programs increased by 62 percent from 1977 to 2008.
 - Among adolescents aged 12 to 19 years old, the prevalence of pre-diabetes and diabetes increased from 9 percent to 23 percent between 1999 and 2008.
- In 2008, more than 10 million children in the United States had asthma.
- The top 5 health problems of children in the United States are now mental health problems, not physical problems.
- Approximately one in five children and adolescents has a diagnosable mental health disorder in the course of a year.

Between 2000 and 2010 there has been a heightened need to manage care, with the prevalence of:

- Developmental delays increasing by 72%
- Other health impairments rising by 127%
- Autism increasing by 306%

Research suggests that the increase in the number of children living with developmental challenges is due to the improved medical technologies that support neonatal care and other medical interventions. Successful efforts in states have also made it easier to serve children with disabilities in communities instead of institutions.

The shift of children with significant health issues attending public schools has concurrently shifted the costs in services. For example, these children often require ventilators, tube feedings, medication, and other complex nursing care. School health professionals must provide case management for chronically ill children as well as other prescribed treatments, typically directed by primary care physicians [PCP's]. While states now mandate certain standards of care for children, including providing EPSDT screens, reporting, and surveillance, most do not have a dedicated funding stream [including Louisiana] to support this service provision.

States cannot expect school districts and Departments of Education to have the resources to develop a contemporary model of delivering and financing healthcare services. Such a model will require increasing capacity for providing needed services, creating a sustainable funding mechanism, and developing infrastructure for care coordination. Each of these elements has specific demands for organizational support. The task of transforming existing school healthcare is daunting but possible through partnerships with community and state healthcare leaders and stakeholders.

The U.S. Centers for Disease Control [CDC] has long recognized these issues and, subsequently, has provided limited funding to multiple state Departments of Education to create Coordinated School Health Programs [CSHP]. The intent of CSHP is to provide school districts with health and academic information to guide the creation of health services in each district that addresses:

1. Nutrition
2. Health Education
3. Physical Education
4. Staff Wellness
5. Early Childhood [a Louisiana addition]
6. School Health Services
7. Counseling, Psychological, and Social Services
8. Family and Community Involvement with Health
9. Healthy School Environment
10. Administration and Organization [a Louisiana addition]

Working together, these elements of CSHP can address individual clinical issues as well as population health concerns. The model elements that follow concentrate on the funding and development of nursing services, behavioral health services, and the infrastructure that supports their effectiveness. Coordinating services with these professional health providers and supporting the organizational structures will provide the mechanisms to implement other CSHP elements. For example, increasing the availability of nursing staff will harness their ability to provide chronic disease management that addresses obesity, which also intersects with the goal of improving nutrition and health education. Creating a fiscally sustainable model of care will generate changes in administration and organization that improve overall effectiveness.

Model Elements

Most school districts have a few nurses who are itinerant, providing services at more than one school. Typically, they provide episodic care, develop and implement health plans for children with disabilities and children in special education, while responding to emergent needs. School nurses usually perform in silos because there is no means to implement care coordination or

manage students as a population. Most schools do not have a systematic link to healthcare partners such as PCPs. In addition, the infrastructure does not typically exist to allow data sharing and its aggregation through an electronic medical record [emr] or to capture recoverable costs. While the education realm is experiencing major shifts in learning practices, the healthcare sector is processing and responding to dramatic changes in the provision and management of the delivery of care. In order for schools to continue to provide health services, they must align with the larger healthcare community, become more effective, and support public health policy.

These changes are in progress in the Lafayette Parish School System (LPSS) in Lafayette, Louisiana. The district has 30,000 students in 44 schools; about 70% are enrolled in Medicaid. The Superintendent, Dr. Pat Cooper, is aggressively restructuring the system, including the healthcare provision. We will use his district as an example of how to design a cost-effective, high-quality healthcare delivery mechanism in schools.

Capacity

Each district will need to determine the number of staff required to provide adequate access to health services for all of its students. The LPSS model includes one Registered Nurse (RN) and one Licensed Clinical Social Worker (LCSW) for every 450 children; one nurse practitioner (NP) for every 4 RNs. This translates to 67 RNs and LCSWs, and 16 NPs in the school district. In effect, **each** school will offer the services now provided only at a school based health center (SBHC).

Care Coordination

Increasing the capacity of professional health staff who can serve students is necessary but not sufficient. It is critical to build infrastructure that organizes and manages the delivery of health services. This is a key component of care coordination: the “deliberate organization of patient care activities between two or more participants [including the patient] involved in a patient’s care to facilitate the appropriate delivery of health care services.....and is often managed by the exchange of information....” *Agency for Healthcare Research and Quality, June, 2007*. This is also a requirement in the Louisiana Medicaid State Plan describing payment support for school nurses. The provision of care coordination includes 3 elements:

1. Electronic Student Health Records [eSHR]: This will make it easier to share health information with community partners, such as hospitals, and will result in a better quality of care for patients (students). eSHR is also necessary to provide service documentation to third party payers, such as Medicaid and private health insurance plans.
2. Quality Assurance: This uses information collected through eSHR to ensure that providers follow the correct protocols in an effort to reduce LPSS liabilities and assure fidelity and effectiveness of health services. It provides feedback loops to identify the progress of business plan targets and measures the impact of services on academic performance.
3. Chronic Disease Management. This targets services to the most in-need children by providing the technology and technical assistance to assure the best outcomes for children with chronic diseases.

Sustainability

The fundamental question is how do we pay for these personnel and services?

- Nurse Practitioners and LCSWs. These health professionals can generate sufficient revenue in partnership with Federally Qualified Health Centers [FQHCs] to offset their costs. FQHCs can provide off-site services in schools through Medicaid reimbursements, which cover their full costs. FQHCs will bill for all of the services, with the exception of a related service on an IEP. The FQHC and the LEA ultimately share the generated revenue.
- RNs. These can receive payments from Medicaid that will cover 35-40% of their costs through the Louisiana State Medicaid plan. LPSS has 21 RN's currently employed; Medicaid will pay about \$456,000 for their services.
- A second payment methodology is called Upper Payment Limits [UPL]. This is a Medicaid funding strategy common to many states and is provided through a Low Income and Needy Collaboration Agreement. It involves a public entity with taxing authority. In this case, LPSS may identify state or local funds it is willing to transfer to the State Medicaid Agency. These funds will be matched by Federal funds and sent to a private hospital or hospital consortium. This group will act on behalf of LPSS and contract with those funds for healthcare services that will benefit LPSS. Potentially, \$35,000 sent to the State Medicaid Agency would result in a check for \$100,000 to the hospital consortium to use to contract for services for LPSS. It is important to note that revenue generated in this manner can be used for a wide variety of healthcare services including [but not limited to] care coordination, healthcare personnel, and durable medical equipment.

The various payment strategies can be used simultaneously if the school district wants to move to develop a more complete and coherent healthcare system.

Health Networks and Partnerships

A sustainable school healthcare system needs to engage a variety of partners to achieve its full capacity requirements and build the supporting care coordination infrastructure. The mix of partners, their roles, and benefits they receive can vary. See below for examples of possible partners.

School Districts

Role:

- Provide cost-effective platform for child and family health
- Optimally organize and manage services and funding

Benefits:

- Improved student academic performance
- Reduction in absenteeism and dropouts
- Improved parent and community satisfaction
- Highly cost-effective school-community health program

Federally Qualified Health Centers

Role:

- Provide school-based supports/services with nurse practitioners, LCSW's, and clinical services

Benefits:

- Coherent community partnership that is a cost-effective full scale extension of the mission
- Improved revenue streams
- Increased breadth of services, including integration into the community healthcare system

Medicaid

Role:

- Provide a revenue source to pay for healthcare services

Benefits:

- Access to strategic information
- Replicable healthcare model that improves health and school outcomes through cost-effective community and state partnerships
- Lower utilization/costs of insured students and families
- Improved service comparability and access to care

The Office of Public Health

Role:

- Align policies to better integrate school based health center into district healthcare services
- Provide relevant planning and outcome data
- Provide institutional leadership for population health management

Benefits:

- Real-time surveillance system
- Comprehensive platform and healthcare structure for provision of public health services to children and families, including, immunizations, EPSDT screens, nurse-family partnership services, special needs clinics, management of communicable diseases, WIC services, disaster relief, and pre/postnatal care

Coordinated Care Networks [these are Medicaid managed care companies]

Role:

- Data sharing and support of care coordination
- Linkage to PCPs
- Potential funding for eSHR and outcome measurement

Benefits:

- Extensive network of low/no cost primary care and prevention services for enrolled children/families in partnership with their physician and hospital panel
- Lower health service utilization by plan members
- Access to better planning and treatment information
- Effective care coordination
- A model that is replicable in other business relationships
- Stronger community presence

Community Hospitals

Role:

- Provide nursing support, upstream clinics, hospital, and ancillary services
- In concert with school districts, create and implement UPL funding structures

Benefits:

- Reduction in the over-utilization of services such as the emergency room
- Reduction in long-term community health costs through early intervention and prevention of chronic diseases
- Improved awareness of hospital services
- Improved primary care infrastructure to support hospital services
- Access to healthcare data to guide/improve service development
- Network of primary care partners to support PCP and hospital treatment plans
- Revenue optimization

Blue Cross, Foundations, Other Health Providers

Role:

- Provide access to non-Medicaid enrolled students
- Fund eSHR, evaluations, technical assistance [TA] as needed

Benefits:

- Significant improvements in the implementation of the EPSDT requirements
- A cost-effective community primary care program
- Reduced CCN costs
- A model that is scalable and fundable
- Access to data that describes improved processes and outcomes
- A viable eSHR that is available to support the Health Information Exchange [HIE]

The Picard Center

Role:

- Provide TA to partners, including disease management training, project management, evaluation ,eSHR development and support

Benefits:

- Fulfills the mission of the Picard Center and the legislative intent of state funding
- Provides extremely relevant and valuable applied research information
- Strengthens the University of Louisiana at Lafayette's research initiative including the
- Each district determines its mix of partners by inviting them into a relationship with the district and identifying how each party can best support the plan to improve student health outcomes. Developing and managing these relationships are critical skills as in any joint venture.

Organizing the Model Elements

Each of the 4 elements described, 1) capacity, 2) care coordination, 3) sustainability, and 4) health networks/partnerships is a critical part of the system of services proposed. Extensive discussion, policy and regulatory research, fiscal analysis, and negotiation has helped paint a clear picture about the way in which each of these components fit in the healthcare model. This concept is the result of conversations with multiple partners who have willingly shared their expertise and best judgments to build this model. The details are not complete; Louisiana is waiting for CMS approval of state plan amendments describing the new payment methodology for school nursing services. Efforts to encourage effective collaboration between LPSS and an FQHC continue. LPSS is also in the process of reaching initial agreements regarding the use of UPL. Each element requires a number of working parts to identify and implement that align with the other elements to achieve the goal of this model: improving health and learning outcomes and lowering overall costs.

The challenge is not to identify each detail required to make the model functional, but rather to figure out how to fit this new model of healthcare into the activities of a school district and to find sufficient leadership within districts willing to develop and manage a system that will look more like a computer than a pencil. This model requires changing roles and accountabilities; securing effective business, clinical, and academic outcomes; and finding a fit within an evolving, healthcare environment.

Appendix C
State of Louisiana Medicaid State Plan Amendment

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Dallas Regional Office
1301 Young Street, Suite 833
Dallas, Texas 75202



DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

September 6, 2013

Our Reference: SPA LA 12-02

Ms. Ruth Kennedy, State Medicaid Director
Department of Health and Hospitals
Bienville Building
628 North 4th Street
Post Office Box 91030
Baton Rouge, LA 70821-9030

Attn: Darlene Adams
Jodie Hebert

Dear Ms. Kennedy:

We have reviewed the proposed amendment to your Medicaid State Plan submitted under Transmittal Number 12-02. The state plan revises the reimbursement methodology for the EPSDT program to establish coverage for school-based nursing services rendered to children enrolled in Louisiana schools.

Transmittal Number 12-02 is approved with an effective date of January 1, 2012 as requested. A copy of the HCFA-179, Transmittal No. 12-02 dated February 17, 2012 is enclosed along with the approved plan pages.

If you have any questions, please contact Ford Blunt III at ford.blunt@cms.hhs.gov or by phone at (214) 767-6381.


Sincerely,

A handwritten signature in black ink that reads 'Bill Brooks'.

Bill Brooks
Associate Regional Administrator

Digitally signed by Billy D. Brooks -S
DN: c=US, o=U.S. Government,
ou=HHS, ou=CMS, ou=People,
0.9.2342.19200300.100.1.1=20000390
50, cn=Billy D. Brooks -S
Date: 2013.09.26 12:01:56 -0500

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL		1. TRANSMITTAL NUMBER: 12-02	2. STATE Louisiana
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDIC AID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE January 1, 2012	
5. TYPE OF PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 441, Subpart B		7. FEDERAL BUDGET IMPACT: a. FFY <u>2012</u> \$2,273.40 (\$783.99) b. FFY <u>2013</u> \$2,845.71 (\$994.00)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Item 4b Pages 19 and 19a Attachment 4.19-B, Item 4b Pages 6, 7, 8, and 9		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): None (New Pages) None (New Pages)	
10. SUBJECT OF AMENDMENT: The purpose of this amendment is to revise the reimbursement methodology for the EPSDT program to establish coverage for school-based nursing services rendered to children enrolled in Louisiana schools.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: The Governor does not review state plan material.	
12. SIGNATURE OF STATE AGENCY OFFICIAL:		16. RETURN TO:	
13. TYPED NAME: Bruce D. Greenstein		State of Louisiana Department of Health and Hospitals 628 N. 4th Street PO Box 91030 Baton Rouge, LA 70821-9030	
14. TITLE: Secretary			
15. DATE SUBMITTED: February 14, 2012			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 17 February, 2012		18. DATE APPROVED: 6 September, 2013	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 January, 2012		20. SIGNATURE OF OFFICIAL:  <small>ONLINE OFFICIALS: ONE COPY TO THE GOVERNOR'S OFFICE (MIS, OAR/CMS), ONE COPY TO THE PEOPLE'S OFFICE (100-100-11-1000019950), ONE COPY TO THE SECRETARY'S OFFICE</small>	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS: The State requests the above changes to Blocks 7 and 8. Please make a pen and ink change to Form 179 as shown above.			

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

School-Based Services

State: Louisiana
Date Received: 2/17/12
Date Approved: 9/6/13
Date Effective: 1/1/12
Transmittal Number: LA 12-02

- A. Effective on or after January 1, 2012, payment for EPSDT school-based nursing services shall be based on the most recent school year's actual cost as determined by desk review and/or audit for each local education agency (LEA) provider.
1. Each LEA shall determine cost annually by using DHH's Cost Report for Nursing Service Cost form based on the Direct Services Cost Report.
 2. Direct cost shall be limited to the amount of total compensation (salaries, vendor payments and fringe benefits) of current nursing service providers as allocated to nursing services for Medicaid special education recipients.
 3. Indirect cost shall be derived by multiplying the cognizant agency indirect cost unrestricted rate assigned by the Department of Education to each LEA. There are no additional indirect costs included.
 4. In order to calculate the ratio of total Medicaid students in the LEA, the numerator should be the students with an Individualized Education Plan (IEP) that are eligible for Medicaid and the denominator should be the total number of students with an IEP. Cost data is subject to certification by each LEA. This serves as the basis for obtaining Federal Medicaid funding.
- B. For the nursing services, the participating LEAs' actual cost of providing the services shall be claimed for Medicaid Federal Financial Participation (FFP) based on the following methodology.
1. The state shall gather actual expenditure information for each LEA through its Payroll/Benefits and Accounts Payable System.
 2. Develop Direct Cost - The Payroll Cost Base. Total annual salaries and benefits paid, as well as contracted (vendor) payments, shall be obtained initially from each LEA's Payroll/Benefits and Accounts Payable system. This data shall be reported on DHH's Nursing Services Cost Report form for all nursing service personnel (i.e. all personnel providing LEA nursing treatment services covered under the state plan).

TN# 12-02 Approval Date 9/6/13 Effective 1/1/12
Supersedes
TN# New Page

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

State: Louisiana
Date Received: 2/17/12
Date Approved: 9/6/13
Date Effective: 1/1/12
Transmittal Number: LA 12-02

3. Adjust the Payroll Cost Base
The payroll cost base shall be reduced for amounts reimbursed by other funding sources (e.g. federal grants). The payroll cost base shall not include any amounts for staff whose compensation is 100 percent reimbursed by a funding source other than state/local funds. This application results in total adjusted salary cost.

4. Determine the Percentage of Time to Provide All Nursing Services
A time study which incorporates the CMS-approved Medicaid Administrative Claiming (MAC) methodology for nursing service personnel shall be used to determine the percentage of time nursing service personnel spend on nursing services and General and Administrative (G&A) time. This time study will assure that there is no duplicate claiming. The G&A percentage shall be reallocated in a manner consistent with the CMS approved Medicaid Administrative Claiming methodology. Total G&A time shall be allocated to all other activity codes based on the percentage of time spent on each respective activity. To reallocate G&A time to nursing services, the percentage of time spent on nursing services shall be divided by 100 percent minus the percentage of G&A time. This shall result in a percentage that represents the nursing services with appropriate allocation of G&A. This percentage shall be multiplied by total adjusted salary cost as determined B.4 above to allocate cost to school based services. The product represents total direct cost. A sufficient number of nursing service personnel shall be sampled to ensure results that will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall. The CMS approval letter for the time study will be maintained by the State of Louisiana and CMS.

5. Determine Indirect Cost
Indirect cost shall be determined by multiplying each LEA's indirect unrestricted rate assigned by the cognizant agency (the Department of Education) by total adjusted direct cost as determined under B.3 above. No additional indirect cost shall be recognized outside of the cognizant agency indirect rate. The sum of direct cost and indirect cost shall be the total direct service cost for all students receiving nursing services

TN# 12-02 Approval Date 9/6/13 Effective 1/1/12
Supersedes
TN# New Page

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

State: Louisiana
Date Received: 2/17/12
Date Approved: 9/6/13
Date Effective: 1/1/12
Transmittal Number: LA 12-02

6. Allocate Direct Service Cost to Medicaid

To determine the amount of cost that may be attributed to Medicaid, total cost as determined under B.5 above shall be multiplied by the ratio of Medicaid students in the LEA to all students in the LEA. This results in total cost that may be certified as Medicaid's portion of school-based nursing services cost.

C. Reconciliation of LEA Certified Costs and Medicaid Management Information System (MMIS) Paid Claims.

Each LEA shall complete the Nursing Services Cost Report and submit the cost report(s) no later than five months after the fiscal year period ends (June 30), and reconciliation shall be completed within 12 months from the fiscal year end. All filed nursing services cost reports shall be subject to desk review by the Department's audit contractor. The department shall reconcile the total expenditures (both state and federal share) for each LEA's nursing services. The Medicaid certified cost expenditures from the nursing services cost report(s) will be reconciled against the MMIS paid claims data and the department shall issue a notice of final settlement pending audit that denotes the amount due to or from the LEA. This reconciliation is inclusive of all nursing services provided by the LEA.

D. Cost Settlement Process.

As part of its financial oversight responsibilities, the department shall develop audit and review procedures to audit and process final settlements for certain LEAs. The audit plan shall include a risk assessment of the LEAs using available paid claims data to determine the appropriate level of oversight.

1. The financial oversight of all LEAs shall include reviewing the costs reported on the Nursing Services Cost Reports against the allowable costs, performing desk reviews and conducting limited reviews.
2. The Department will make every effort to audit each LEA at least every four years. These activities shall be performed to ensure that audit and final settlement occurs no later than two years from the LEA's fiscal year end for the cost reporting period audited. LEAs may appeal audit findings in accordance with DHH appeal procedures.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

3. The Department shall adjust the affected LEA's payments no less than annually, when any reconciliation or final settlement results in significant underpayments or overpayments to any LEA. By performing the reconciliation and final settlement process, there shall be no instances where total Medicaid payments for services exceed 100 percent of actual certified expenditures for providing LEA services for each LEA.
4. If the interim payments exceed the actual certified costs of an LEA's Medicaid services, the department shall recoup the overpayment in one of the following methods:
 - a. Offset all future claim payments from the affected LEA until the amount of the overpayment is recovered;
 - b. Recoup an agreed upon percentage from future claims payments to the LEA to ensure recovery of the overpayment within one year; or
 - c. Recoup an agreed upon dollar amount from future claims payments to the LEA to ensure recovery of the overpayment within one year.
5. If the actual certified costs of an LEA's Medicaid services exceed interim Medicaid payments, the department will pay this difference to the LEA in accordance with the final actual certification agreement.

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Date Received: 2/17/12
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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED

LIMITATIONS ON THE AMOUNT, DURATION AND SCOPE OF CERTAIN ITEMS OF PROVIDED MEDICAL SERVICES ARE DESCRIBED AS FOLLOWS:

CITATION
42 CFR
447.201
42 CFR 441.57

Medical and
Remedial
Care and
Services
Item 4b
(Cont'd)

School-Based Medicaid Nursing Services

Effective on or after January 1, 2012, EPSDT school-based nursing services are provided by a registered nurse (RN) within a local education agency (LEA). The goal of these services is to prevent or mitigate disease, enhance care coordination, and reduce costs by preventing the need for tertiary care. Providing these services in the school increases access to health care for children and youth resulting in a more efficient and effective delivery of care.

Eligibility

School-based nursing services will be provided to those medically eligible recipients under 21, and who are enrolled in a public school:

1. Are Medicaid eligible when services are provided;
2. The recipient's need for treatment has been ordered by a licensed physician; and
3. The recipient receives the service(s) in the public school setting and the services are part of an Individualized Education Program (IEP).

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- A. RNs providing school-based nursing services are required to maintain an active RN license with the state and comply with the Louisiana Nurse Practice Act.
- B. School boards and staff shall collaborate for all services with the Medicaid recipient's BAYOU HEALTH plan and ensure compliance with established protocols. In a fee-for-service situation, for the non-Bayou Health individuals, staff will make necessary referrals.

Covered Services

Nursing services are those medically necessary services that are directly related to an IEP or IFSP under IDEA and based on a physician's written order. The following school-based nursing services shall be covered:

1. **Chronic Medical Condition Management and Care Coordination**

This is care based on one of the following criteria:

- a. The child has a chronic medical condition or disability requiring implementation of a health plan/protocol (examples would be children with asthma, diabetes, or cerebral palsy). This service will only be covered when the child is on an IEP. There must be a written health care plan based on a health assessment performed by the RN.

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PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICES

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN ARE DESCRIBED AS FOLLOWS:

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Date Received: 2/17/12
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The date of completion and the name of the person completing the plan must be included in the written plan. Each health care service required and the schedule for its provision must be described in the plan.

b. Medication Administration

This service is scheduled as part of a health care plan developed by either the treating physician or the school district LEA. Administration of medication will be at the direction of the physician and within the license of the RN and must be approved within the district LEA policies.

c. Implementation of Physician's Orders

These services shall be provided as a result of receipt of a written plan of care from the child's physician/BAYOU HEALTH provider or an IEP/health care plan for students with disabilities.

NOTE: All recipients have free choice of providers (per section 4.10 of Medicaid State Plan).

2. EPSDT Program Periodicity Schedule for Screenings

A nurse employed by a school district may perform any of these screens within their licensure for BAYOU HEALTH members as authorized by the BAYOU HEALTH plan; or, as compliant with fee-for-service for non-BAYOU HEALTH individuals. The results of these screens must be made available to the BAYOU HEALTH provider as part of the care coordination plan of the district. The screens shall be performed according to the periodicity schedule including any inter-periodic screens. This service is available to all Medicaid-individuals eligible for EPSDT.

3. EPSDT Nursing Assessment/Evaluation Services

A nurse employed by a school district may perform services to protect the health status of children and correct health problems. These services may include health counseling and triage of childhood illnesses and conditions.

Consultations are to be face-to-face contact in one-on-one sessions. These are services for which a parent would otherwise seek medical attention at physician provider's office. This service would only be covered when the individual is on an IEP or IFSP under IDEA.

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