SUPPORTING LEARNING THROUGH BETTER HEALTH:

A Strategy to Ensure Adequate and Stable Funding for School-Based Health Centers in New York State

June 2015

The Campaign for Educational Equity
TEACHERS COLLEGE COLUMBIA UNIVERSITY

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The extensive education reforms that state and national policymakers have instituted in recent years have tended to overlook the reality that poor health can substantially undermine students' academic success, especially for students from low-income households. Health conditions associated with poverty affect students' school attendance, their cognition, and their engagement with learning. Although children in low-income communities on average have greater health needs, they are much less likely to have access to regular medical, mental health, and oral health care.

School-based health centers (SBHCs) can help solve this problem. They offer health services responsive to student needs in a convenient setting where professionals can monitor whether student health is being addressed adequately and consistently. Evaluations of SBHC programs conducted since the model was implemented 40 years ago have demonstrated that SBHCs increase access to care and improve both health and academic outcomes.

Despite this record of success, SBHCs exist today in only about 2,000 schools nationwide, or 2% of all schools in the United States. The major reason there are so few SBHCs is that the funding available to support them is both inadequate and unstable. Medicaid is the largest source of SBHC revenue, since schools with SBHCs are frequently located in low-income neighborhoods. In New York State, 39% of SBHC patients are enrolled in Medicaid. On average, reimbursements for services covered by Medicaid total about 89% of the actual per visit costs of providing those services. However, many important services provided by SBHCs, such as case management, certain reproductive services, and health education services, are not eligible for Medicaid reimbursement.

Further, the complexities of the Medicaid application process prevent many eligible students from receiving benefits. SBHCs, which generally serve all children in the school, receive no reimbursement for Medicaid-eligible students who are not enrolled. In New York, a full 45% of SBHC patients are listed as being either uninsured (18%) or unspecified (27%). SBHCs provide important health services to these students, many of whom may, in fact, be Medicaid eligible, without reimbursement.

SBHCs have even greater difficulty obtaining reimbursement from the New York State Child Health Plus insurance program and from private insurance companies. For many services, Child Health Plus requires prior approval from managed care organizations (MCOs), which constitutes a major barrier for SBHCs. And, although 12% of SBHC patients are covered by private insurance, SBHCs receive only 5% of their revenue from this source, mainly because the state does not mandate that private insurance companies reimburse SBHCs. Overall, 30% of SBHC funding comes from state grants and state subsidies; foundation and other grants provide 10% of SBHC revenues; and in-kind contributions from the schools and other sponsoring organizations 10%.

This heavy financial reliance on state grants and private foundations explains why only a small fraction of the schools in low-income neighborhoods that need SBHCs actually have them. Since state and private foundation grants are limited and can be reduced or eliminated at any time, a school that establishes a SBHC that depends on these funding streams is taking a major financial risk.

The financing of SBHCs in New York State may become even more precarious in the near future because the state has announced its intent to include SBHCs in the state's Medicaid managed care system by July 2016. Years ago, New York State adopted a policy of disbursing all Medicaid payments through managed care organizations, but exceptions were made for SBHCs, homeless students, and a few other special categories. These groups presented special challenges that could not be worked out in negotiations between the state and the MCOs, and, therefore, they were "carved out" of the managed care system at the time.

A task force established by the New York State Department of Health is currently seeking to establish policies that would move SBHSs into the managed care system. Among the challenges that managed care poses for SBHCs that the task force is reviewing are (1) the need for SBHCs to enter into contracts and have each of their staff members credentialed by possibly dozens of MCOs operating in their area, (2) questions of confidentiality, especially for high school students receiving reproductive services, (3) prior authorization requirements, and (4) lack of coverage for the full range of SBHC services.

Including SBHCs in the Medicaid managed care system would likely lead to substantial reductions in revenues, service cutbacks, and, ultimately, the demise of many SBHCs. The Children's Defense Fund estimates that the transition to this more complex system could result in SBHC program revenue losses of up to $16.2 million statewide out of a current total of $30 million in Medicaid revenue on top of an existing deficit of $1.5 million. These cuts would most severely affect underserved low-income communities.

New York State is currently out of compliance with federal Medicaid laws and regulations for children and youth and may be vulnerable to legal challenges for these violations. Under federal Medicaid laws and regulations, there is a "mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue these problems with needed treatment" (*Stanton v. Bond*, 504 F.2d 1246, 1250-51 (7th Cir. 1974)). New York State is far from meeting the federal government's compliance target of 80% of Medicaid-eligible students receiving all of their diagnostic screening services. New York officials may also be susceptible to claims under state statutory provisions. New York State Education Law §901 requires school districts to provide "school health services," which include offering medical examinations, informing parents of the individual child's health conditions, and

"guiding parents, children and teachers in procedures for preventing and correcting defects and diseases." A substantial increase in the number of SBHCs operating in schools in low-income areas could effectively address these legal violations.

To overcome the financing challenges that are impeding the functioning and expansion of SBHCs in New York State, and to ensure the state's compliance with its legal obligations, we propose a financing strategy that would fill the gap between the insufficient revenues that SBHCs now receive and the actual costs of operating a SBHC that provides critical health services to all students in a public school. We call this approach the Guaranteed Sufficient Schoolwide Funding (GSSF) system. The GSSF approach provides adequate, stable funding for existing SBHCs through a mechanism that involves no additional per-student costs to the state; in fact, by maximizing federal reimbursements, this system would result in a reduction in the percentage of SBHC costs that the state is now paying. The assurance of adequate and stable funding should lead to a strong growth in the number of SBHCs, resulting in improved delivery of health services and greater school success for students from low-income households.

The guaranteed per-student rate would be based on the actual costs of providing medical, mental health, oral health, and reproductive health services, and would also factor in the expenses involved in the case management and coordination of follow-up services, as well as the health education and prevention activities a SBHC should undertake. The rate would also cover family outreach activities to maximize the number of students and families enrolled in Medicaid, Child Health Plus, and private insurance plans, especially those available under the Affordable Care Act Health Insurance Exchanges/Marketplaces.

Adoption of the GSSF system would require a number of changes in state laws and regulations and a number of Medicaid waivers and legal changes. There are relevant precedents to support these modifications. To test the feasibility and cost impact of this approach, the state should establish at least two demonstration projects, one upstate and one in New York City.

SCHOOL-BASED HEALTH CENTERS (SBHCs) CAN IMPROVE SCHOOL SUCCESS

Education is the key to a strong democracy, economic competitiveness and a world class standard of living. In recent decades, however, America has lost its place as a global leader in educational attainment in ways that will lead to a decline in living standards for millions of our children and the loss of trillions of dollars of economic growth.

—National Commission on Equity and Excellence in Education [1]

Student Health Substantially Affects Educational Outcomes

The growing gap in educational achievement and attainment between students from higher and lower income families is driving a decline in America's international standing in education. To deal with this crisis in education, state and national policymakers have focused on raising academic standards, improving teaching quality, ensuring adequate funding, and increasing accountability. Largely overlooked, however, have been the health issues that can undermine students' academic success, especially for students from low-income households.

Charles E. Basch, a professor of health and education at Teachers College, Columbia University, recently undertook a major review of the evidence linking student health and success in school.[2] His study focused on seven educationally relevant health areas: (1) vision; (2) asthma; (3) teen pregnancy; (4) aggression and violence; (5) physical activity; (6) breakfast; and (7) inattention and hyperactivity. According to Basch, educationally relevant health disparities in

[1] National Commission on Equity and Excellence, For Each and Every Child: A Strategy for Education Equity and Excellence 12 (2013).

[2] Charles E. Basch, Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap (2010).

each of these areas impede students' motivation and ability to learn through at least five causal pathways that they affect: sensory perceptions, cognition, connectedness and engagement with school, absenteeism, and dropping out.[3]

Each of the health areas Basch highlights affects a large portion of American youth. For example, more than one in five school-aged youth has some kind of vision problem;[4] one in three American female teens is expected to become pregnant.[5] The causal links between these conditions and success in school is apparent: children with vision problems have difficulty reading and seeing what teachers write on the board. Teen mothers are 10-12% less likely to complete high school and have 14-29% lower chance of attending college.[6] Even for those who manage to stay in school, pregnancy presents major obstacles to academic achievement.

Other researchers have identified additional health factors that directly affect students' capability and motivation to learn. These include hearing problems, poor oral health, lead exposure, and inadequate nutrition.[7] Studies have also identified a link between childhood obesity and low self-esteem, which is often related to lower academic achievement.[8] Often the health factors are interrelated, and their collective impact on education is even more detrimental.

Children from low-income households are about three times more likely to have unmet health needs than more affluent children.[9] For example, 50% or more of low-income and minority children have vision problems that interfere with their academic work.[10] Even when diagnosed as having vision problems, these children receive fewer and less intensive eye care services.[11] Vision screening in schools usually entails only testing for nearsightedness and not for farsightedness or for difficulty with tracking.[12] Even when testing leads to optometric referrals, children from low-income households are less likely to receive follow-up care to get prescriptions for lenses and are less likely to wear glasses if they obtain them.[13]

---

[3] *Id.* at 4.

[4] *Id.* at 12.

[5] *Id.* at 27.

[6] *Id.* at 29.

[7] Each of these factors, and the research supporting their relationship to schooling, are discussed in RICHARD ROTHSTEIN, CLASS AND SCHOOLS: USING SOCIAL, ECONOMIC AND EDUCATIONAL REFORM TO CLOSE THE BLACK- WHITE ACHIEVEMENT GAP 37-45 (2004).

[8] James B. Hunt Institute for Educational Leadership and Policy, *Childhood Obesity and Academic Outcomes: A Brief Review of Research (2008)*, **http://www.hunt- institute.org/elements/media/files/Hunt_Obesity_Memo.pdf**

[9] Paul W. Newacheck, Dana C. Hughes, Yun-Yi Hung, Sabrina Wong & Jeffrey J. Stoddard, *The Unmet Health Needs of America's Children,* 105(3) PEDIATRICS 989 (2000).

[10] ROTHSTEIN, *supra* note 7 at 37.

[11] BASCH, *supra* note 2, at 13.

[12] ROTHSTEIN, *supra* note 7, at 38.

[13] *Ibid*.

The ongoing difference in regular pediatric care is probably the reason [that] poor children lose 30% more days from school than non-poor on average.

Similar disparities occur in most other health areas. Children from low-income households have higher rates of asthma,[14] dental caries,[15] and obesity.[16] They are also more likely to be diagnosed with attention deficit disorders, lead poisoning, anemia,[17] and clinical depression.[18]

Many of these health problems are related to the fact that children in low-income households and communities are less likely to have access to regular medical care.[19] As Richard Rothstein notes,

> An analysis of California communities found that urban neighborhoods with high poverty and high concentrations of black and Hispanic residents had one primary care physician for every 4,000 residents. Neighborhoods that were neither high poverty nor high minority had one primary care physician for every 1,200 residents.... These gaps are mirrored nationwide. Low-income families, with or without insurance, are more likely to use emergency rooms and less likely to use primary care doctors, even for routine care...This ongoing difference in regular pediatric care is probably the reason why poor children lose 30% more days from scho ol than the non-poor on average. The difference in school attendance, attributable to differences in access to health care alone, causes a difference in average achievement between black and white children.[20]

---

[14] Christopher B. Forrest, Barbara Starfield, Anne W. Riley & Myungsa Kang, *The Impact of Asthma on the Health Status of Adolescents*, 99(2) PEDIATRICS 1 (1997).

[15] Dana C. Hughes, Karen G. Duderstadt, Mah-J Soobader & Paul W. Newacheck, *Disparities in Children's Use of Oral Health Services*, 120(4) PUBLIC HEALTH REP. 455 (2005).

[16] In New York State, while more than one-third (36%) of public school students were overweight or obese, the rate of obesity was significantly higher in school districts with a higher proportion of students eligible for free or reduced price lunch. Additionally, the rate was nearly twice as high in school districts above the 75th percentile in need compared with districts in the 25th percentile in need. New York State Department of Health, Division of Chronic Disease; see Information for Action # 2013-06, **http://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2013 -06_ifa_report.pdf**

[17] Janet Currie, *Healthy, Wealthy, and Wise: Socioeconomic Status, Poor Health in Childhood, and Human Capital Development*, 47(1) J. ECON. LIT. 87 (2009).

[18] Elizabeth Goodman, Gail B. Slap & Bin Huang, *The Public Health Impact of Socioeconomic Status on Adolescent Depression and Obesity*, 93(11) AM. J. PUBLIC HEALTH 1844 (2003).

[19] Michelle L. Mayer et al., *Unmet Need for Routine and Specialty Care: Data from the National Survey of Children with Special Health Care Needs*, 113(2) PEDIATRICS 109 (2004).

[20] ROTHSTEIN, *supra* note 12, at 41-42.

SBHCs Can Improve Students' Health and Their Ability to Learn

In low-income communities with a critical lack of readily available health resources, school-based health centers can be an effective way to overcome students' health problems by making health services available in a place where children and youth spend most of their days. SBHCs provide basic health examinations, routine health services, and referrals for specialized services to students in a familiar school setting. In addition, working with teachers and other school staff, SBHCs can oversee follow-up care and provide important health education services:

> For children in low-and middle-income working families, SBHCs offer working parents the opportunity to obtain routine and preventive medical services for their children without losing income, or potentially their jobs, for taking time off from work for medical visits. For middle or high school students, SBHCs offer services addressing sensitive problems, such as substance abuse, mental health or reproductive health that they might not seek out from other primary care providers or from parents.[21]

The idea of bringing health services into the schools originated in the early 1900s when New York City's Board of Health decided to place a number of school nurses in the public schools to deal with an outbreak of contagious diseases. Over time, the role of the school nurses broadened to include health screenings, immunizations, referrals, and health education. In the 1960s and 1970s physicians in Massachusetts and Minnesota brought more extensive forms of health service into the schools by establishing "neighborhood health centers" in school buildings to care for underserved children and to provide prenatal care and parenting support for pregnant teenagers.[22]

---

[21] Robert Wood Johnson Foundation, *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*, RWJF Program Results Report 1, 12 (2007) **http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2007/rwjf70141**. For interesting case studies of how school based health centers, working with teachers, administrators and other school personnel can effectively integrate physical and mental health care with preventive, follow-up and environmental modification activities in regard to obesity, mental health, asthma and oral health issues, *see*, Serena Clayton et al., *Different Setting, Different Care: Integrating Prevention and Clinical Care in School-Based Health Centers*, In School-Based Health Care: Advancing Educational Success and Public Health (Terri D. Wright & Jeanita W. Richardson, eds. 2012).

[22] See Victoria Keeton et al., *School-Based Health Centers in an Era of Health Care Reform: Building on History*, 42 (6) Curr. Probl. Pediatr. Adolesc. Health Care 132, 136-138 (2012).

Since then, the number of SBHCs has expanded to almost 2,000 centers in 46 states.[23] In New York State, there are currently 231 approved, operating SBHCs, serving 214,723 students;[24] a majority of them (80%) are located in urban areas.[25] Nationally, the vast majority of the centers (94.4%) are located in school buildings or on school grounds, with the remaining programs in nearby facilities (3.5%) or in mobile locations (2.1%).[26] In order to be able to refer students with acute or chronic medical needs and to provide health care coverage during days and hours when schools are closed, SBHCs are generally affiliated with hospitals or community health centers.

SBHC services are provided by a multi-disciplinary team, which, in New York State, must include a collaborating, supervisory physician (usually part time), a nurse practitioner or physician's assistant, a mental health professional, and a health assistant. SBHCs may also have additional staff such as a nutritionist, dentist, community outreach worker, and/or health coordinator.[27]

The number of staff depends on the number of students enrolled in the SBHC and the services provided. SBHCs typically offer comprehensive, age-appropriate, primary health and mental services including:

- comprehensive physical health and mental health assessments;
- chronic conditions (e.g. asthma);
- screenings (e.g., vision, hearing, dental, nutrition, tuberculosis;
- routine management of chronic diseases (e.g. asthma and diabetes);
- health education;
- mental health counseling and referral;
- immunizations;
- working papers and sports physicals;
- referral and follow up;
- population-based primary prevention; and
- reproductive counseling and services.[28]

---

[23] School-Based Health Alliance, 2010-2011 *Census Report of School-Based Health Centers* 1, 12 (2012), **http://www.sbh4all.org/site/c.ckLQKbOVLkK6E/b.8778055/k.FgF5/20102011_Census_Report.htm** [hereinafter 2010-2011 Census Report].

[24] New York State Department of Health, School Based Health Center Fact Sheet, **https://www.health.ny.gov/statistics/school/skfacts.htm** [hereinafter SBHC Fact Sheet].

[25] *Ibid*.

[26] 2010-2011 Census Report, *supra* note 23, at 3.

[27] New York State Department of Health, Principles and Guidelines For School Based Health Centers in New York State 9-13 (2006)

[28] New York State Department of Health, School-Based Health Centers Program Description, **https://www.health.ny.gov/facilities/school_based_health_centers/skprogram.htm**

Because many SBHCs were originally intended to address problems of teenage mothers and reduce teen pregnancy, at one time a majority of them were located in high schools. [29] However, today, an increasing number of centers operate in elementary and middle schools, as well, in order to facilitate comprehensive health care approaches for all school-aged children and youth. About 30% of the centers provide primary care, 33% provide primary care and mental health services, and 47% provide primary care, mental health, and additional services such as dental, health education and nutrition.[30] The majority of the students served by SBHCs come from low-income households, and almost 70% of SBHCs are located schools that receive federal Title I funding because they have large numbers of students from low-income households.[31]

School-based health centers have proved effective in meeting the health needs of these students. "Various evaluations of SBHC programs have been conducted since the model was implemented 40 years ago, and have demonstrated increased access to care, improved health and education outcomes, and high levels of satisfaction with care."[32] Among other things, specific studies have found:

- SBHC users were more likely than nonusers to have made primary care visits, were less likely to have used emergency care, and were more likely to have received immunizations. [33]
- On average, SBHC enrollees used health services four times a year, while other children sought care less than once every two years at other health facilities.[34]
- SBHC users had more medical visits and substantially more mental health visits than adolescents who used community health centers.[35]
- Children enrolled in schools with SBHCs had lower rates of hospitalization and missed fewer days of school because of asthma than students in enrolled in schools that did not have SBHCs.[36]
- Students in schools with SBHCs were more likely to receive confidential counseling and treatments for sexually transmitted diseases, HIV/AIDS, and birth control than students in schools with no SBHCs.[37]

[29] Keeton, *supra* note 22,

[30] 2010-2011 Census Report, *supra* note 23, at 4.

[31] *Id.* at 3.

[32] Keeton, supra note 22, at 17. Keeton also calls for more rigorous randomized control designs, but notes the difficulties in conducting these types of studies, given the high turnover rates in many of these schools and applicable confidentiality restrictions.

[33] Manday A. Alison et al., *School-Based Health Centers: Improving Access and Quality of Care for Low-Income Adolescents,* 120(4) PEDIATRICS E887 (2007).

[34] Robert Wood Johnson Foundation, *supra* note 21, at 3.

[35] Linda Juszczak, Paul Melinkovich, & David Kaplan, *Use of Health and Mental Health Services by Adolescents Across Multiple Delivery Sites*, 32(6) J. ADOLESC. HEALTH 108 (2003).

[36] Mayris P. Webber et al., *Burden of Asthma in Inner-City Elementary School Children: Do School-Based Health Centers Make a Difference?* 157(2) ARCH. PEDIATR. ADOLESC. MED. 125 (2003).

[37] Jonathan D. Klein et al., *Measuring Quality of Adolescent Preventive Services of Health Plan Enrollees and School-Based Health Center Users*, 41(2) J. ADOLESC. HEALTH 153 (2007).

- Increased access to and use of health services [38] in schools with SBHCs has led to significant increases in attendance rates and student grade-point averages.[39]
- African-American male SBHC users were three times more likely to stay in school than their peers who did not use the SBHC.[40]

[38] Students who used SBHCs were more satisfied with their health and engaged in a greater number of health- promoting behaviors than did students who did not use SBHCs. Miles A. McNall, Lauren F. Lichty & Brian Mavis, *The Impact of School-Based Health Centers on the Health Outcomes of Middle School and High School Students*, 100(9) AM. J. PUBLIC HEALTH 1604 (2010).

[39] Sarah Cusworth Walker et al., *The Impact of School-Based Health Center Use on Academic Outcomes*, 46(3) J. ADOLESC. HEALTH 251 (2010). Use of medical services was most strongly associated with increases in attendance and use of mental health services was correlated more directly with grade point gains. A useful summary and overview of the research regarding SBHCs and improved academic performance is contained in SARAH P. GEIERSTANGER & GORETTE AMARAL, SCHOOL-BASED HEALTH CENTERS AND ACADEMIC PERFORMANCE: WHAT IS THE INTERSECTION? 1 (2005), **http://www.eric.ed.gov/PDFS/ED539815.pdf.**

[40] Marcella T. McCord, Jonathan D. Klein, Jane M. Foy & Kate Fothergill, *School-Based Clinic Use and School Performance*, 14(2) J. ADOLESC, HEALTH 91 (1993).

FINANCIAL IMPEDIMENTS HINDER SBHC OPERATIONS

Current Financing Mechanisms Impede Expansion of SBHCs

Although their numbers have grown over the past several decades, SBHCs still exist in only about 2% of all schools in the United States. New York State is one of the three states with the greatest number of centers, but, even in New York, there are SBHCs in fewer than 5% of the schools.

The main reason there are so few SBHCs, despite their clear benefits, is that the funding available to support them is both inadequate and insecure. As one recent analysis of this problem put it, "these centers struggle to remain viable not because there is a question of their value, but most often because of insufficient financial backing."[41] One of the major problems in this regard in New York State is a failure to take full advantage of potential Medicaid funding. Medicaid is the largest source of SBHC revenue, since schools with SBHCs are frequently located in low-income neighborhoods. In New York State, 39% of the students who use SBHCs are covered by Medicaid, and 4% are covered by Child Health Plus,[42] New York State's health insurance program for students whose family income is low, but somewhat above Medicaid eligibility levels. [43]

On average, Medicaid reimburses about 89% of the actual cost of the average visit of a Medicaid-enrolled student.[44] The reimbursement rate varies, however, depending upon the type of entity with which the SBHC is affiliated. In New York, currently 50% of SBHC sites are sponsored by hospitals, 35% by federally qualified health centers (FQHCs), and 15% by state-authorized diagnostic and treatment centers (DTCs).[45] Each of these entities has a different Medicaid reimbursement rate, with the rate for DTCs being approximately 20% below the hospital rate.[46] Furthermore, many important services provided by SBHCs are not eligible for Medicaid reimbursement. For example, SBHCs generally have costs for staff time needed to provide health education, case management, and many other preventive services that are not covered in typical hospital, FQHC or DTC rates.[47]

---

[41] Rick Mudock et al., *Michigan's Medicaid Matching Initiative: Lessons Learned* in School-Based Health Care: Advancing Educational Success and Public Health, Supra, N. 21 At 250.

[42] SBHC Fact Sheet, *supra*, n. 24.

[43] Students are eligible for Medicaid if their family income is less than 133% of the federal poverty level. Students whose family income is below 160% of the federal poverty level are eligible for Child Health Plus on a no fee basis. Students whose family income is above that level may obtain Child Health Plus services by paying a sliding scale fee. New York State Department of Health, *Who Is Eligible?* **https://www.health.ny.gov/health_care/child_health_plus/who_is_eligible.htm**

[44] Children's Defense Dund, School-Based Health Centers in New York State: Ensuring Sustainability and Establishing Opportunities for Growth 14 (2014).

[45] *Id*. at 13.

[46] The current average payment per claim is $160.86 for FQHCs, $153.97 for hospitals and $130.54 for diagnostic and treatment centers. New York State Department of Health, School-Based Health Centers: Transition to Managed Care (2013). Medicaid reimbursements range from covering 44% to 123% of the actual cost of a visit; on average they cover 89% of the actual cost per visit to the SBHC. Children's Defense Fund, *supra* note 44, At 14.

[47] Alanna Beckman & Lois K. Backon, Report on Financial Sustainability 13 (2013).

An additional problem is that many parents of students who are eligible for Medicaid do not complete the complicated application process.[48] Although most SBHCs in New York State are located in neighborhoods in New York City and other communities where up to 90% of the students have family incomes low enough qualify for free or reduced price school lunches,[49] only 43% of SBHC patients are enrolled in Medicaid or Child Health Plus. Most of the rest are listed as uninsured (18%) or unspecified (27%).[50] Presumably many of the students listed as "uninsured" or "unspecified" would be enrolled in Medicaid if the application process were simpler or if SBHCs had the personnel to reach out to them and facilitate the enrollment process.

Although the federal government reimburses 65% of the costs of health services provided to students covered by Child Health Plus,[51] SBHCs receive virtually no revenues from this source. To qualify for reimbursement, services provided to enrolled students must have prior authorization from the student's primary care provider (PCP), and many of these PCPs — who are usually affiliated with managed care organizations — are reluctant to grant the SBHCs permission they need. In some cases, the PCP has a distinct financial incentive not to provide SBHCs with authorization to provide services "because … the designated PCP is being reimbursed for the billable services that the SBHC is providing…."[52] In fact, SBHCs so rarely receive their due reimbursement from third-party payers other than Medicaid that many choose not to bill them at all.[53] The difficulty of obtaining Child Health Plus funding provides SBHCs with little incentive to work with parents to enroll their children in this program, which likely explains why so few SBHC patients — only 4% — are enrolled.[54]

Some 12% of SBHC patients are covered by private insurance, but SBHCs receive only 5% of their revenue from this source, mainly because the state does not require insurance companies to reimburse SBHCs. The state provides 30% of overall SBHC funding through state grants and New York State Health Care Reform Act direct payments; foundation and other grants provide 10%; and in-kind contributions from the schools and other sponsoring organizations 10%.[55]

New York State's willingness to provide such substantial support to SBHCs explains why the state has proportionately more SBHCs than other states. But it also explains why, even in New York, only a small fraction of the schools in low-income neighborhoods that need SBHCs actually have them. Because state and private foundation grants are limited and can be reduced or eliminated at any time, a school or institution that establishes a SBHC that relies on these funding streams is taking a major financial risk.

---

[48] *Id.* at 15.

[49] Students whose family's income is at or below 185% of the federal poverty level are eligible for free and reduced price lunches, U.S. Department of Agriculture, Income Eligibility Guidelines, Vol. 79 No. 43 FEDERAL. REGISTER. 12467 ((2014); as indicated above in n.42, families with incomes at or below 160% of the federal poverty level are eligible for free services under Medicaid or Child Health Plus.

[50] SBHC Fact Sheet, *supra* note 24.

[51] Child Health Plus rates for New York State are set forth in Vol. 79 No. 13 FEDERAL REGISTER 3387 (2014), **http://www.gpo.gov/fdsys/pkg/FR-2014-01-21/pdf/FR-2014-01-21.pdf.**

[52] ALANNA BECKMAN & LOIS K. BACKON, *supra* note 47, at 11.

[53] *Ibid*.

[54] SBHC Fact Sheet, *supra* note 24.

[55] NEW YORK STATE DEPARTMENT OF HEALTH, SCHOOL-BASED HEALTH CENTERS: TRANSITION TO MANAGED CARE (2013).

The State's Plan to Include SBHCs in Medicaid Managed Care Will Further Jeopardize Their Future

The financing of SBHCs in New York State may become even more precarious in the near future because the state has announced its intent to include SBHCs in the its Medicaid managed care system by July 2016. Years ago, New York State adopted a policy of disbursing all Medicaid payments through managed care organizations (MCOs), but exceptions were made for SBHCs, homeless students, and a few other special categories. These groups were "carved out" of the managed care system at the time because they presented special challenges that could not be worked out in negotiations between the state and the MCOs.[56] Recently, the New York State Department of Health convened a statewide work group of MCOs, SBHC representatives, advocacy groups, and state officials to try once again to find a way to overcome these problems and to allow SBHCs to be included in the managed care system. If this change were to occur, all Medicaid payments to SBHCs would be routed through for-profit or not-for-profit managed care organizations.

SBHC inclusion in Medicaid managed care has the potential to improve care coordination between SBHCs and primary care physicians affiliated with MCOs. But such a "carve in" would also raise a host of potential financial and bureaucratic problems for SBHCs. Currently, payments for services provided to Medicaid-enrolled SBHC patients are paid directly to the SBHC's sponsoring entity by the state's Medicaid office. Under the proposed new system, reimbursement for Medicaid services provided by a SBHC would be made by the specific MCO in which patient is enrolled. To be eligible for reimbursement by any given MCO, the SBHC or its sponsoring agency would have to be enrolled in the MCO's network, meet the MCO's qualification criteria, and agree to its rules for service authorization.

The work group established by the New York State Department of Health is trying to deal with the range of issues that ending the managed-care carve out for SBHCs would entail. The five major sticking points appear to be the following:

1. Credentialing. In large cities where the families of students in any particular school are likely to be enrolled in a broad array of managed care plans (in New York City, there are at least 21 MCOs), each SBHC would need to negotiate a separate contract with each of these MCOs, and each of their physicians and other employees would need to undergo an individual credentialing process with each of the MCOs that are covering students in their school.

[56] *See, e.g.*, Letter from Dennis R. Whalen, Executive Deputy Commissioner, New York State Department of Health to "Dear Colleague" (Jan. 4, 1999) (Indicating difficulties of negotiating an arrangement for SBSCs to be "carved into" the managed care system and postponing the date for any such carve-in.)

2. Coverage of Key Services. There is significant concern that managed care organizations will "cherry pick" the services for which they will reimburse SBHCs. Managed care contracts generally do not cover some of the services that are frequently utilized by SBHC patients, such as mental health, health education, and dental care; MCOs may also resist paying SBHCs for physical exams and maintenance visits for children with chronic illnesses. Denial of the ability of SBHCs to provide such services would undermine the strength of their service model and much of their ability to relate directly to the major needs of the student populations that they serve.

3. Confidentiality. Confidentiality is a major issue in access to care for adolescents, especially in the sensitive areas of birth control and the prevention and treatment of sexually transmitted infections. SBHCs have generally been able to ensure students a high level of confidentiality, and this has been a major inducement for high school students to utilize SBHC reproductive and other health services. Teenagers who fear that medical records will be less confidential if this information must be reviewed by an MCO and/or an affiliated primary care provider may be reluctant to use SBHC services. [57]

4. Preauthorization**.** SBHCs are not currently required to obtain prior authorization from the state before they provide a Medicaid-reimbursable service. However, many managed care plans do require such preauthorization for many services provided by physicians enrolled in their plans, and, if SBHCs are "carved into" the managed care system, some of these requirements may also apply to them. Prior authorization requirements could prove devastating to SBHCs. The need to follow differing procedures to obtain prior approval from many different MCOs would present major administrative burdens for SBHCs and impede the kind of prompt, effective care that is an important feature of school-based operations. Payments through the Child Health Plus system are currently provided through managed care, and, as noted earlier, to obtain reimbursement for services provided to Child Health Plus-covered students, SBHCs must receive prior approval. As a result, SBHCs receive virtually no payments for services provided to students enrolled in Child Health Care Plus.

[57] Jennel Harvey et al., School Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues 22 (2002)

5. Rate reduction. Finally, and perhaps most importantly, carving SBHCs into the Medicaid managed care system would likely lead to a reduction in the Medicaid reimbursement rates received by SBHCs, an outcome that would severely impede their ability to function and, indeed, would likely lead to the demise of many of them. Managed care organizations have per-visit Medicaid reimbursement rates that are substantially lower than the rates that SBHC providers receive under the current system.[58] The Children's Defense Fund–New York reports that the transition to this more complex system could result in program revenue loss of up to $16.2 million per year statewide on top of an existing deficit of $1.5 million, most severely affecting underserved low-income communities.[59]

For all of these reasons, the Robert Wood Johnson Foundation, which had sponsored a major multi-year program to expand SBHC services in nine states, concluded years ago that "SBHCs, with their emphasis on safety-net services, wide access and generally modest data collection capacities, [are] not a good match for managed care."[60]

"SBHCs, with their emphasis on safety-net services, wide access and generally modest data collection capacities, [are] not a good match for managed care."

[58] CHILDREN'S DEFENSE FUND, *supra* note 44, at 19.

[59] *Id.* SBHCs in the downstate region would be most detrimentally affected by this change. *Id*. at 20. The New York State Department of Health has committed to maintaining the current SBHC reimbursement rates for two years to minimize disruption during a transition to manage care, but, significantly, it makes no pledge concerning a rate structure on an on-going basis. *See* Letter from Jason A. Helgerson, Medicaid Director, Office of Health Insurance Programs to SBHC Workgroup Members (March 30, 2015). The Department has also indicated that because of issues related to confidentiality and managed care plan pharmaceutical formularies, reproductive health services will not be carved in at this time. *Id*.

[60] Robert Wood Johnson Foundation, *supra* note 21, at 7.

New York State Is Not Meeting Applicable Legal Mandates for Children's Health Care

The preceding sections of this report have described the critical role that SBHCs play in providing health services to students from low-income households and the difficulties SBHCs face in trying to survive in a deteriorating funding environment. The current inadequate and unstable mechanisms for funding SBHCs — even without the additional threat posed by the state's contemplated Medicaid managed care carve-in — create a dysfunctional system that substantially undermines the potential of SBHCs to improve both the health and the academic success of millions of students from low-income families. The state has a legal obligation to take affirmative action to deliver health services and educational opportunity to these students, and maintenance of a dysfunctional SBHC funding system constitutes a violation of both federal and state law.

Under the federal Medicaid statute, states are required to provide or to pay for "early and periodic screening, diagnostic and treatment" (EPSDT) services to all Medicaid-enrolled children under 21 years of age and to "correct or ameliorate a defect, physical or mental illness, or a condition identified by [the] screening."[61] The specific services covered by this mandatory statute are:

> 1 Screening services—
>
> A which are provided—
>
> (i) at intervals which meet reasonable standards of medical and dental practice... and
>
> B which shall at a minimum include—
>
> (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
>
> (ii) a comprehensive unclothed physical exam, (iii) appropriate immunizations ...
>
> (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and
>
> (v) health education (including anticipatory guidance).
>
> 2 Vision services—
>
> A which are provided—
>
> (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
>
> (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
>
> B which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

[61] 42 U.S.C. § 1396d(r)(5).

3 Dental services—

A which are provided—

(i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

B which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

4 Hearing services—

A which are provided—

(i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and

(ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and

B which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids.

5 Such other necessary health care, diagnostic services, treatment, and other measures ... to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.[62]

In 2011, the U.S. Government Accountability Office (GAO) reported to Congress that its most recent surveys had indicated that about 42% of children eligible for an EPSDT service had not had one over a two-year period.[63] This number was far below the federal government's 80% compliance goal.[64] A follow-up survey in nine states by the Office of Inspector General of the Department of Health and Human Services also found that 41% of Medicaid-enrolled

---

[62] *Ibid*.

[63] Katherine Iritani, Acting Director, Health Care to Hon. Max Baucus and Hon. Fred Upton (April 5, 2011), **http://www.gao.gov/new.items/d11293r.pdf** [hereinafter Iritani Letter].

[64] U.S. Government Accountability Office, GAO-09-578, Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services (2009), **http://www.gao.gov/assets/300/293989.pdf**. The problems that failure to carry on the mandatory screenings can cause is illustrated by the high incidence of obesity among Medicaid -eligible children. The GAO reports that according to examinations conducted from 1999 through 2006, nearly one in five children in Medicaid (an estimated 18 percent) were obese. Yet about half of these children who are obese reported that they had not previously been diagnosed as being overweight. One -third of the states do not provide any services to address obesity. *Id*.

children did not receive any of the required medical screenings, and 76% did not receive one or more of the required EPSDT medical, vision, or hearing screenings.[65] The most frequently cited barriers to children obtaining the necessary screenings were that "[S]ome parents think preventive screenings are not necessary, believe children need to go to the doctor only when sick, and have concerns about taking time off work. Other barriers cited include limited access to providers, incorrect beneficiary contact information, and failure of beneficiaries to keep appointments."[66]

New York was one of the states that committed to take action to correct this problem. It promised to improve its compliance rate by providing enhanced payments for managed-care providers and improving certain office-based procedures.[67] The New York plan, however, gave no consideration to expanding the number of SBHCs, though such an expansion would be a fast and effective means for substantially increasing the number of young people who receive the mandatory screenings and examinations. SBHCs are uniquely equipped to deal with the precise impediments to access to youth screenings that the Inspector General identifies.

The federal courts have on a number of occasions issued strong orders to enforce the states' affirmative obligation to ensure that all children receive their periodic screenings and follow-up treatments. As the U.S. Court of Appeals for the 7th Circuit put it, there is a "mandatory obligation upon each participating state to aggressively notify, seek out and screen persons under 21 in order to detect health problems and to pursue these problems with needed treatment."[68] The courts have also made clear that EPSDT services provided must be "reasonably effective" and that "every type of health care or service necessary for EPSDT corrective or ameliorative purposes ... are provided when screening reveals that they are medically necessary for a child."[69] New York State, which is far from meeting the federal government's compliance target of 80% of Medicaid-enrolled students receiving all of their EPSDT services, may be vulnerable to litigation challenging these violations.

New York officials may also be susceptible to claims under state law. New York State Education Law §901 requires all school districts, except the New York City school district, to provide "school health services" including, but not limited to, the services of a registered professional nurse. The statute specifies that "school health services" means:

---

[65] Department of Health and Human Service, Office of Inspector General, Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services (2010). The report does not identify the specific nine states that were surveyed.

[66] *Id*. at 18.

[67] Iritani Letter, *supra* note 63, Enclose III, Table 3.

[68] *Stanton v. Bond*, 504 F.2d 1246, 1250-51 (7th Cir. 1974) (emphasis added). *See also, e.g., Dajour B. v. City of New York*, No. 00 CIV.2044 (JGK), 2001 WL 830674, at *4 (S.D.N.Y. 2001) (emphasis added) (the state and the city must "ensure that effective outreach, informing, screening, diagnosis and treatment are provided to all EPSDT - eligible children.")

> [T]he several procedures, including, but not limited to, medical examinations, dental inspection and/or screening, scoliosis screening, vision screening and audiometer tests, designed to determine the health status of the child; to inform parents or other persons in parental relation to the child, pupils and teachers of the individual child's health condition subject to federal and state confidentiality laws; to guide parents, children and teachers in procedures for preventing and correcting defects and diseases; to instruct the school personnel in procedures to take in case of accident or illness; to survey and make necessary recommendations concerning the health and safety aspects of school facilities and the provision of health information.

New York State's failure to provide students the full range of screenings required under the federal Medicaid statute may also constitute a violation of the health-screening requirements of Education Law §901 — and under the state law, these requirements apply to all students, and not just those who are Medicaid enrolled. Furthermore, many schools in New York State that maintain only the part-time or full-time services of a registered nurse may not be meeting the additional mandates beyond screenings and examinations that are set forth in §901, such as health information and guidance on prevention and follow-up actions to correct defects and diseases.[70] These are, of course, among the services that SBHCs are particularly well positioned to offer.

New York City is explicitly excluded from the coverage of Education Law §901. Apparently this is because analogous services are expected to be provided in the city's schools by the city's Department of Health and other municipal agencies pursuant to the New York City Charter and the New York City Health Code. To the extent that the city officials are not actually providing these services, affected students and their parents may have a valid equal protection claim based on the city's explicit exemption from the requirements of Education Law §901. In fact, the city has adopted a policy of not providing school nurses in schools that have a SBHC on the premises on the apparent expectation that necessary nursing services will be provided by the SBHC. No payment is provided to the SBHCs for these services — further undermining their financial viability and sustainability.

---

[69] *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1158-59 (9th Cir. 2007).

[70] Schools in New York State are also required to provide a semester of health education to students in grades 7-8 and in high school. 8 NYCRR §§ 100.4(c)(1)(viii), 100.5(a)(3)(vi), 135.3(x). Since the funding cutbacks that have occurred in the wake of the 2008 recession, many schools, and especially those serving students from low-income backgrounds, have laid off health teachers and are not, in fact, meeting these requirements. *See* Campaign for Educational Equity, Deficient Resources: An Analysis of the Availability of Basic Educational Resources in High-Need Schools in Eight New York State School Districts (2012). Even in schools where the two half semester courses are being provided, it is questionable whether schools that lack the permanent presence of a SBHC can provide the on-going, comprehensive kind of guidance, support and health education that is contemplated by this statute.

Many areas of New York State, including New York City, are also failing to meet the needs of students with emotional and behavioral disabilities and of other students needing mental health services, as required under the federal Individuals with Disabilities Education Act.[71] School-based health centers and mental health services are required under state regulations to address the mental health needs of their students either through on-site services or through referrals.[72] Affording SBHCs the resources to provide primary prevention, individual mental health assessments, treatment, and follow-up, as well as crisis intervention and short-term and long-term counseling is likely the most effective and cost-efficient way to provide all of these services.[73]

To provide necessary services to all students in a public school, SBHCs need a system that can guarantee sufficient schoolwide funding.

[71] 20 U.S.C.A. §§ 1400 et seq., N.Y. Educ. Law § 4401 et. seq.

[72] New York State Department of Health, Principles and Guidelines for School-Based Health Centers in New York State, Section II A 3 (D).

[73] Citizens Committee for Children, A Prescription for Expanding School-Based Mental Health Clinics in New York City Elementary Schools (2013). The lack of adequate mental health services in the schools has led to a substantial increase in the number of students who are now being sent by ambulances to hospital emergency rooms for acting out behaviors that in many cases could have been handled by an SBHC. A law suit that challenged this practice in federal court in the Southern District of New York was recently settled by a stipulation that calls for substantial increases in mental health services and staff training in certain schools. *T.H. v. Farina*, 2013 Civ. 8777 (S.D.N.Y. 2013), Stipulation approved December 15, 2014.

A PROPOSED SOLUTION FOR ADEQUATE AND STABLE FUNDING FOR SBHCs

The Guaranteed Sufficient Schoolwide Funding System

To fill the gap between the insufficient funding that SBHCs now receive and the actual cost of operating SBHCs that can provide necessary and appropriate services to all students in a public school, a system that can guarantee sufficient schoolwide funding (GSSF) is needed. The financing strategy we propose is designed to ensure sufficient, stable funding for existing SBHCs, promote strong growth in the number of SBHCs operating throughout the state, and result in improved delivery of health services and greater school success for students from low-income households. The GSSF system maximizes federal reimbursements and private insurance payments, while reducing the proportion of overall SBHC funding that the state now provides. It will also promote full compliance with applicable federal and state laws, in a cost-effective manner.[74]

We recommend that the state take the following actions to implement a guaranteed sufficient schoolwide funding system (GSSF) for school-based health centers: (1) provide an adequate annual per-student rate; (2) expand services covered; (3) maximize federal and private insurance reimbursements; (4) obtain necessary federal waivers; and (4) establish a GSSF demonstration project.

Provide an Adequate Annual Per-Student Rate

As discussed above, SBHCs are currently compensated on a fee-for-service basis for many, but not all, of the services they provide to students who are enrolled in the state's Medicaid programs; they receive virtually no reimbursement for services provided to students covered by Child Health Plus, and they receive only pennies on the dollar from private insurers. Furthermore, the Medicaid reimbursement rates vary depending on the medical facility with which the SBHC is affiliated and do not fully cover the actual costs of providing those services. In order to maintain SBHCs, the state currently provides grant subsidies for many of them.

Adequate and stable funding for SBHCs can best be achieved by providing each SBHC a reasonable annual per-student rate that covers the actual cost of efficiently providing the full range of necessary and required health services. An effective SBHC funding system must start from the premise that all the services provided by SBHCs in accordance with the state department of health guidelines are valuable and that SBHCs should be guaranteed adequate revenues that will allow them to provide these services in an effective manner. SBHC financing cannot rationally be based on medical funding concepts that were developed for the delivery of services in hospitals or community health facilities and do not take into account the realities of providing services in a school setting. To fund SBHCs through a medical model that does not

[74] In the long run, any increased investments that the state may make to expand the number of SBHCs will result in higher student achievement, higher high school graduation rates, and substantial dividends to the state and to society in terms of higher earnings, higher tax payments, and lower welfare and lower Medicaid costs. *See, e.g.*, THE PRICE WE PAY: ECONOMIC AND SOCIAL CONSEQUENCES OF INADEQUATE EDUCATION (Clive Belfield & Henry M. Levin, eds., 2007); Jeff J. Guo et al., *School Based Health Centers: Cost-Benefit Analysis and Impact on Health Care Disparities* in SCHOOL-BASED HEALTH CARE: ADVANCING EDUCATIONAL SUCCESS AND PUBLIC HEALTH, *supra*, n. 21 at 397.

value or reimburse SBHCs for many of the vital services they provide is, in essence, to attempt to place a square peg into a round hole.

Clearly SBHC services should be available to all students in a school, and the SBHC funding mechanism must take this reality into account. Accordingly, SBHC funding should be based on an annual per-pupil rate determined by calculating the total reasonable, efficient costs that the center incurs in a base year and dividing that amount by the number of students in the school. The SBHC's state funding for the current year would then be that rate times the number of students currently enrolled. There should, of course, be periodic audits and accountability requirements to ensure that all of the services that are included in the rate calculation are appropriate and that they are being provided effectively and efficiently.

The annual per-pupil rate would be based on the actual costs of providing medical, mental health, and other appropriate services, such as dental and reproductive services, and would also factor in the expenses involved in case management and for the health education and prevention activities a SBHC should undertake, in coordination with teachers and other school personnel. The rate should also cover outreach activities to maximize the number of students and families enrolled in Medicaid and Child Health Plus and to promote maximum use of private insurance policies, especially those available under the Affordable Care Act Health Insurance Exchanges/ Marketplaces. The state would reimburse SBHCs for services provided to students in each school periodically throughout the school year and and obtain reimbursements from Medicaid, Child Health Plus, and private insurance programs for all services that are covered by these programs.

Expand Services Covered

With adequate, stable funding, SBHCs would be expected to provide a full range of appropriate services for all students effectively and efficiently. To this end, each school-based health center would be expected to employ a community health coordinator to manage services and to serve as a liaison with the school's principal, teachers, and other staff for follow-up and health education and preventive activities.

Together with the school staff, the SBHC would be expected to (1) undertake a comprehensive assessment of student health needs, with a strategic focus on health issues that are affecting learning and school success; (2) develop a set of goals and strategies to address those needs; and (3) collect data and track outcomes related to those goals, including information on student utilization of health services, the effectiveness of those services in addressing students' health issues, and the impact of health services on attendance, achievement, and graduation rates. The costs associated with these services would be included in the GSSF rate.

To ensure access to health services, SBHCs would be expected to be open beyond traditional school closing hours, in accordance with community needs. National census data indicate that, currently, 73% of SBHCs are open after school and 61% before school. Guidelines established by the New York State Department of Health require SBHCs to arrange with hospitals, mental health centers, or community health centers to guarantee 24-hour, 12-month medical coverage for all hours that the SBHC is not open and to provide backup arrangements for conditions that the SBHC cannot serve. The SBHC would function as the primary care provider for children whose parents choose to have them do so and as a critical component of every child's medical home in partnership with all primary care providers in the community.

Maximize Federal and Private Insurance Reimbursements

As indicated above, under the current system in New York State, Medicaid provides 45% of SBHC revenues; the state provides about 30% through state grants; private insurance pays about 5%; foundation and other grants provide 10%; and in-kind contributions from the schools and other sponsoring organizations about 10%.[75] Under the GSSF plan, the state and "other" grants and in-kind contributions would be eliminated; instead, the state would guarantee basic SBHC funding. The state would, however, recoup more of the costs from the federal government and private insurers, so that even though it is guaranteeing payment for services rendered to all students in the school, its share of the per-student costs of operating this valuable health delivery system would actually decrease.

The costs to the state under the proposed GSSF system would further be reduced by eliminating the duplicate payments that the state now makes for many services provided by SBHCs to Medicaid-enrolled students whose families are also enrolled with Medicaid managed care organizations. The state makes a direct fee-for-service payment to the SBHC or its sponsoring organization for services the SBHC actually provides, while, at the same time, it also pays a full capitation rate to the MCO for every child that is listed on its roster. (Eliminating such duplicative payments is one of the state's motivations for seeking to include SBHC services in the Medicaid managed care system.) A better and fairer way to avoid duplicative payments, and one that would not jeopardize the future of SBHCs and the students who rely on them, would be for the state to make adjustments in MCOs' capitation rates to reduce the rate for students attending schools that are served by SBHCs in accordance with the value of the average annual amount of services that are, in fact, provided by SBHCs.

The state also does not currently maximize opportunities for reimbursement from the federal government for health services provided to students eligible for Medicaid and Child Health Plus. The main areas where SBHCs currently operate are high poverty locales like New York City, Buffalo, Rochester, and rural counties. Many of the patients who are listed as either "uninsured" (18%) or "unspecified" (27%) on SBHC rosters likely are either eligible for Medicaid or Child Health Plus but are not enrolled because the SBHC is unaware of, or has been unable to document, their eligibility. Under the GSSF system, SBHCs, being fully funded and fully staffed, would have the capacity to make maximum outreach efforts to enroll all eligible students, and they would be expected to do so.[76] For every one of these students that a SBHC enrolls, the state would be reimbursed by the federal government for at least 50% of the value of all Medicaid-covered services and 65% and for each Child Health Plus covered service.[77]

At the present time, 4% of SBHC patients are enrolled in Child Health Plus, though it is likely that considerably more of them are eligible. Virtually no SBHC revenues are derived

---

[75] New York State Department of Health, School-Based Health Centers: Transition to Managed Care (2013).

[76] Medicaid rates can be adjusted to include outreach services. Rick Mudock et al., *Michigan's Medicaid Matching Initiative: Lessons Learned* in School-Based Health Care: Advancing Educational Success and Public Health, *supra*, n. 21 At 252.

[77] The federal government's reimbursement to New York State for both Medicaid and Child Health for the year beginning October 1, 2014, are set forth in **http://aspe.hhs.gov/health/reports/2014/FMAP2015/fmap15.pdf**. Note that the reimbursement rate for individuals who newly qualify for Medicaid under the Affordable Care Act will be 100% for the next three years and 90% thereafter. *Id*.

from the 4% of currently enrolled patients. There is clearly an opportunity to increase SBHC revenues substantially by increasing the number of students enrolled in Child Health Plus and fully collecting the 65% reimbursement payments from the federal government. The GSSF system could maximize this revenue source because, with the state guaranteeing payments to SBHCs for all services provided, prior authorization requirements, which currently are the major impediment in this area, would no longer apply. And if the state provides SBHCs sufficient resources to promote maximum enrollment of both Medicaid and Child Health Plus, it would directly reap the benefits of the increase in federal payments. Since under the GSSF system, the state would be guaranteeing a defined adequate rate to the school, all increases in federal payments would be used to offset the state's guaranteed payment amounts to the SBHC.

Under GSSF, the state would also benefit from increased payments by private insurers. Under the current system, SBHCs generally lack the staff and technological capacity to meet prior authorization and other requirements set forth in the web of differing private insurance policies that cover students in its school. Nor do SBHCs have the administrative capacity to follow through to ensure payment of outstanding claims. For these reasons, although 12% of SBHC patients in New York State are covered by private insurance policies, and 11% of SBHC services are provided to them,[78] only 5% of SBHC revenues come from private insurers.

Furthermore, many SBHC patients who currently are listed as either "uninsured" (18%) or "unspecified" (27%) are likely covered by private insurance policies. Now that the federal Affordable Care Act is fully in effect, an even higher proportion of SBHC patients should be covered by private insurance policies.

Since all increases in private insurance payments would also offset the state's payment guarantees, the state could and should develop systems to allow private insurers to pay all valid claims for services provided by SBHCs, without prior authorization or other cumbersome requirements. One feasible way of doing this might be to require private insurance companies to make annual payments to the state based on the percentage of children enrolled in schools with SBHCs that are insured by each plan in New York State. Each plan would be responsible for the percentage of total SBHC costs represented by the services provided annually to students covered by their policies. The state could then credit the insurance payments to each SBHC, based on their percentage of all privately ensured SBHC patients in the state. Another approach might be for the state to require insurance companies to issue cards that students could swipe each time they receive a SBHC service and require the particular insurance company to pay an established per-service amount based on the SBHC's per-pupil GSSF rate for each service recorded in this way.

Under the proposed GSSF system, the state would be responsible for guaranteeing a per-student annual payment that covers all reasonable, efficient SBHC costs, but the increase in federal reimbursements and private insurance payments that the state would realize under this system would likely reduce the average net percentage of total SBHC expenditures that the state now pays. We estimate that the state is now paying about 52.5% of total SBHC revenues through state Medicaid reimbursements and direct grant subsidies (see Table 1).

[78] SBHC Fact Sheet, *supra* note 24.

Table 1. Current State Share of SBHC Costs

Revenue Source	Percentage of Costs	State Share of Costs	Net Cost to State
Medicaid	45%	50%	22.5%
Child Health Plus	0	0	0
Private insurance	5%	0	0
State grants or subsidies	30%	100%	30%
Other grants and in-kind contributions	20%	0	0

TOTAL STATE SHARE: 52.5%

Under the GSSF system, the net cost to the state would fall from 52.5% of total costs to 47% or less. This would occur because under the GSSF system, we expect that private insurers would pay the full costs for the 12% of the SBHC patients that they insure, and the federal government would reimburse 65% of the costs of services to Child Health Plus students. We believe that SBHCs' more aggressive enrollment outreach efforts would also result in at least two-thirds of the 45% of the SBHC patients who are currently listed as "uninsured" or "unspecified" either being enrolled in Medicaid, or Child Health Plus, or being identified as being covered by private insurance. If that were the case, an additional 21% would be enrolled in Medicaid, an additional 2% enrolled in Child Health Plus, and an additional 6% insured privately would result from the additional 30% of SBHC patients covered proportionately from those programs.[79] Under these assumptions, the state's share of total SBHC costs would be reduced by 5.5%, from 52.5% to 47% (see Table 2).

[79] These assumed figures are quite conservative. The Affordable Care Act as it is being implemented in New York State is likely to further expand Medicaid eligibility (and, for the next three years, the federal government will be paying 100% of the costs for the newly eligible students), and insurance exchanges are increasing the number of families covered by private policies. Therefore, overall Medicaid payments will, on average, exceed 50%, and the number of students covered by private insurance policies will probably substantially exceed 6%. In addition, the above analysis assumes that all foundation grants, other federal grants like the Maternal and Child Health Block Grant and all in-kind support will be eliminated, although some of these grants and in-kind contributions (*e.g.*, free rent in the school building) are likely to continue.

Table 2. Projected State Share of SBHC Costs Under New GSSF System

Revenue Source	Percentage of Costs	State Share of Costs	Net Costs to State
Medicaid	60%	50%	30%
Child Health Plus	6%	35%	2%
Private insurance	18%	0	0
Uninsured/ undetermined	15%[80]	0	15%

TOTAL STATE SHARE: 47%

Obtain Necessary Federal Waivers

If New York State were to adopt the GSSF system, at least on a demonstration basis, certain waivers from existing Medicaid regulations would be needed to make this system work. The state would need to modify applicable state regulations, and specific waivers would be required from the federal government in a number of areas. The Obama administration has generally been supportive of school-based health centers,[81] and expanding access to health care for low-income families certainly has been one of the administration's policy priorities, so there is every reason to believe that a request for such waivers would be received sympathetically by the federal authorities.[82]

First, the federal government should be asked explicitly to allow Medicaid reimbursement for case management, health education, prevention, follow-through, reproductive, and other health related services provided by SBHCs, even if such services are not normally provided by other Medicaid providers or are not relevant in hospitals or other traditional Medicaid settings.

Second, the federal government should be asked to allow SBHCs to use the Medicaid funds generated by the Medicaid-enrolled students in the school to provide services to all students in the school, whether or not they are Medicaid eligible, as long as a threshold proportion of those students (perhaps 40%) are Medicaid enrolled. New York State properly requires SBHCs to serve all students in the building, not just those who are enrolled in Medicaid. Under these circumstances, current requirements that limit the use of federal funds only to particular children result in unnecessary and inefficient tracking, reporting, and accountability requirements.

---

[80] Numbers add to 99% because of rounding errors.

[81] *See, e.g.*, 42 U.S.C.A. § 280h-4 (authorizing $200 million for the construction of school-based health centers).

[82] The Secretary of Health and Human Services has broad authority to issue waivers for experimental, pilot or demonstration projects under 42 U.S.C.A. § 1315.

The federal government has in analogous contexts recognized the need to permit such a holistic use of federal funds in a school setting. Initially federal funds to support programs for economically disadvantaged students under Title I of the Elementary and Secondary Education Act of 1965[83] had to be spent solely for programs in which only those students were enrolled. This practice had the effect of stigmatizing students from low-income households and created major scheduling and administrative problems for the schools; it also arbitrarily denied needed services to students who were on the borderline of eligibility, in and out of eligibility, or whose eligibility had not been properly documented. Therefore, in 1978, Congress amended the Act to provide that schools with high concentrations of students from low-income households (currently at least 40%) could use Title I funds to deliver services on a schoolwide basis.[84] Similarly, under the federal school lunch program, funds may be used to provide meals to all students in schools where at least 40% of all students are eligible.[85] A comparable accommodation should be made for Medicaid payments for services provided by SBHCs.

The calculation of the number of Medicaid-eligible children for federal reimbursement purposes should include not only those children in schools who are actually enrolled in the Medicaid program, but also the number of children in these schools who are not formally enrolled but likely eligible because their families are enrolled in federal assistance or other programs for low-income households. Such a procedure is currently permitted for counting numbers of reimbursable students in the federal school lunch program.[86]

---

[83] 20 U.S.C.A. § 6301 et seq.

[84] 20 U.S.C. § 6314. As Joseph Califano, the Secretary of Health, Education and Welfare at the time, put it:

> [It] makes little sense and is cumbersome to enforce requirements that Title I funds serve only Title I children, or that Title I services be supplemental in character. To develop and implement separate programs for title I children causes considerable administrative demands on teachers, for example, in scheduling and record keeping, that may detract from educational services. Further, when a school contains such a large proportion of eligible children, sound educational practice suggests planning of the curriculum focusing on the entire program.
>
> To Extend the Elementary and Secondary Education Act of 1965, and for Other Purposes: Hearing on S. 1753 before the subcommittee on Education, Arts and Humanities of the committee on Human Resources of the United States Senate. 95th Cong., 2d Sess., 117 (1978) (statement of Joseph Califano).

[85] 42 U.S.C.A § 1759(a)(1)(F). Under this provision, school districts or schools having a minimum of 40% of their students eligible for free meals in the prior year may serve lunches and breakfasts to all students, and cover with state funds the costs of providing free meals to students above the amounts provided through federal assistance.

Establish a GSSF Demonstration Project

The proposed GSSF strategy to provide adequate and stable funding for SBHCs should be initially established as a demonstration project in at least two parts of the state, New York City and one or more sites elsewhere in the state having high proportions of Medicaid-eligible students. Various mechanisms for determining actual efficient costs and different audit and accountability systems can be tested in this way. The actual costs of operating a stable, adequately funded system can be more precisely determined through such a demonstration. This experiment can also assess the extent to which increased state payments can be offset by enhanced federal Medicaid and Child Health Plus reimbursements and private insurance payments. Based on the insights gained from these demonstration projects, the GSSF system can be modified as necessary and then implemented more broadly on a statewide basis.

Assuring adequate and stable funding for SBHCs would likely lead to lower health costs, improved health, and enhanced school success for thousands of students.

[86] Under the federal school lunch program, students who are eligible for Medicaid, or who are from families that receive benefits from the federal Temporary Assistance for Needy Families (TANF) or other federal programs can automatically be included in the count of students eligible for the free and reduced price lunch program, even if their families did not specifically apply for the free lunch program. 42 U.S.C.A § 1759(a)(1)(F)(1); 7 C.F.R § 245 (6)(a).

CONCLUSION

Eliminating achievement gaps between advantaged and disadvantaged students is the prime educational policy of both the federal and state governments. Among the main impediments to school success for students from low-income households and communities are neglected health needs that adversely affect students' cognition, engagement with learning, and attendance. School-based health centers are uniquely positioned to deal with these issues and to ensure that these students' health needs are adequately addressed.

Given their proven success and their potential for further reducing student health deficits, SBHCs should be operating in virtually all schools in low-income neighborhoods. In fact, however, only about 2% of the nation's schools currently offer these services. The prime reason for this enormous underutilization of SBHCs is the inadequacy and instability of the current system for funding them. Because the Medicaid reimbursement system was created to cover purely medical needs and with hospital administrative procedures in mind, it does not respond to the needs and funding realities of school-based operations. SBHCs are unable to obtain full reimbursement for their actual costs from Medicaid and private insurers, and the subsidies they currently receive from state and foundation sources are unstable and unreliable.

The proposed GSSF system would remedy this situation by providing stable funding for SBHCs based on the actual costs of providing health delivery and health education services in a school setting in an efficient manner. By maximizing federal reimbursements and payment of claims by private insurers, the GSSF approach would actually reduce the proportion of SBHC costs that New York State currently pays. Assuring adequate and stable funding for SBHC operations would also likely lead over time to a significant expansion in the number of SBHCs throughout the state, and in the long run to substantial dividends to the state in terms of lower state and federal health costs, improved health, and enhanced school success for thousands of students.

Acknowledgments

This report was written by Michael A. Rebell, executive director of the Campaign for Educational Equity (CEE) with editorial assistance from Jessica R. Wolff, CEE's policy director, and research assistance from Linda Moon. Judith K. Dimon provided the inspiration and original idea of ensuring adequate and stable funding for school-based health centers upon which this report was based. David Appel, M.D., director of the School Health Program, Albert Einstein School of Medicine, Montefiore Hospital, provided valuable comments and suggestions. The author is grateful to the James and Judith K Dimon Foundation for its support of this research. This report does not reflect the views of Teachers College, its trustees, administrators, or faculty, or of any advisors or funders associated with this report.

About the Campaign for Educational Equity

The Campaign for Educational Equity is a nonprofit research and policy center at Teachers College, Columbia University that champions the right of all children to meaningful educational opportunity and works to define and secure the full range of resources, supports, and services necessary to provide this opportunity to all children. Founded in 2005 by educational law scholar and advocate Michael A. Rebell, who successfully litigated the landmark school funding lawsuit, *CFE v. State of New York*, CEE pursues systems change through a dynamic, interrelated program of research, legal analysis, policy development, coalition building, curriculum development, and advocacy dedicated to developing the evidence, policy models, curricula, leadership, and collaborations necessary to advance this agenda at the federal, state, and local levels.

To learn more about the work of the Campaign for Educational Equity, please go to our website, www.equitycampaign.org, or write to equity@tc.columbia.edu.

The Campaign for Educational Equity
Teachers College, Columbia University
525 W. 120th Street, Box 219
New York, NY 10027

Follow the Campaign for Educational Equity!

www. facebook.com/CampaignforEducationalEquity
twitter.com/EduEquity (@EduEquity)
http://educationalequityblog.org