PROVIDING HEALTH SERVICES DURING SCHOOL CLOSURES

Lessons Learned + Recommendations for Action

March 2021

HEALTHY SCHOOLS
CAMPAIGN

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The Healthy Students, Promising Futures Learning Collaborative informed the development of this brief. Healthy Schools Campaign convenes the Learning Collaborative with the goal of creating healthier students by increasing Medicaid services in schools and promoting safe and supportive school environments. Fifteen cross-sector state teams currently participate in the Learning Collaborative; members include representatives from state education agencies, state Medicaid agencies, school districts, public health agencies, and state and local advocates.

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Healthy Schools Campaign
Healthy Schools Campaign (HSC) works to ensure that all students have access to healthy school environments, including nutritious food, physical activity and essential health services, so they can learn and thrive.

Photos by Allison Shelley for American Education:
Images of Teachers and Students in Action

NOTE FROM THE AUTHORS

Our research on the delivery of school-based health services during the COVID-19 pandemic has led to an indisputable conclusion: The country is failing students in low-income communities who depend on their local schools for physical, behavioral and mental healthcare.

The current patchwork delivery structure causes access disparities both among and within states. Some school districts have resources but are restrained by rules. Other districts lack funds and guidance to address the increased health needs of students in their homes. Many are unable to ensure that students who are medically frail can safely return when buildings reopen.

We believe that the strategies we have identified and the recommendations that follow can improve healthcare access and outcomes. Yet we also acknowledge that neither is achievable unless state and federal policymakers treat this as a public health emergency. Immediate action is needed to address funding and regulatory barriers that make it difficult, if not impossible, for schools to meet student health needs. And in those places where the flexibility already exists, our recommendations lean on policymakers to make the choice to accelerate best practices.

Schools are in the midst of a crisis with no clear end. Reopening school buildings places increased demand on school health professionals, especially given the role they are expected to play to mitigate the effects of the pandemic. Many school districts historically have lacked adequate staffing to meet basic student health needs—at least half of all public schools don't have a dedicated school nurse or counselor, let alone the number of providers needed to address health issues related to isolation, decreased family income and COVID-related family illness or death.

This makes it more urgent than ever for states to leverage education, Medicaid and public health funding to ensure schools have an adequate number of health providers in place. Counties and states also need to develop a coordinated approach that maximizes available funding and resources.

Without a national plan for safely reopening schools, states and school districts are managing the best they can with the resources they have. The least we can do is ensure public policy is not an impediment to public health.

Alex Mays and Lena O'Rourke

INTRODUCTION

Millions of children across the country rely on school-based health services for preventive and ongoing physical, behavioral and mental healthcare. When the novel coronavirus forced school buildings to close, causing a massive disruption in the delivery of these services, it exposed the extent to which schools function as an essential component of a comprehensive health system, particularly for children in low-income communities.

In response to the closures, state and federal decision-makers implemented policy and regulatory adjustments to ensure school-based health providers are permitted to deliver services remotely, and that payment systems, including Medicaid, are in place for reimbursement. Administrative, technological and regulatory barriers were promptly identified and addressed on a state-by-state basis.

School districts did their best, but the results were inconsistent and incomplete. Six months later, states faced a series of new challenges—and new pressure on old challenges—as schools moved to reopen. Today, the COVID-19 pandemic continues to cause uneven disruptions across the country.

This issue brief examines the role of state and federal policies in supporting school health services during the pandemic, including how state Medicaid programs are responding to ensure reimbursement and funding. It documents emerging best practices and key lessons learned thus far, and it offers recommendations for immediate action and future planning.

FEDERAL AND STATE-LEVEL RESPONSES TO COVID-19

As schools began shifting to remote learning in March 2020, federal agencies and state governments quickly issued guidance to support schools and school personnel and modified or clarified policies to facilitate the remote delivery of educational programming, healthcare services and other critical supports.

At the federal level, the U.S. Department of Education (ED) launched a series of informational briefs and resources for schools, students and families. These include questions and answers on providing services to students with disabilities, information on protecting the civil rights of students and information on protecting student privacy under the Family Educational Rights and Privacy Act (FERPA). It continues to be updated regularly with new resources.

ED also issued a Q&A document explaining that schools may obtain parental consent electronically for special education services and for Medicaid claiming. This was a critical development, as parental consent is required before a school can deliver the service. This document did not impose additional requirements beyond those included in applicable law and regulations, but it did make clear that public agencies may accept an electronic or digital signature to indicate parental consent.

In addition, the Centers for Disease Control and Prevention (CDC) issued resources and guidance for school and program administrators and parents/caregivers. The current focus is on reopening schools and operating during COVID-19, and resources include a K-12 Readiness and Planning Tool. The CDC also hosted and recorded regular conference calls to review CDC guidance and provide an opportunity for stakeholders to ask questions.

The Centers for Medicare & Medicaid Services (CMS) played a key role in supporting school health providers and providing information on Medicaid reimbursement. Specifically, CMS

Department of Education

- COVID-19 Resources for Schools, Students and Families
- Q&A Document: Individuals with Disabilities Education Act

Centers for Disease Control and Prevention

- COVID-19 Resources for Schools and Child Care Programs
- K-12 Schools: Readiness and Planning Tool

Centers for Medicare and Medicaid Services

- COVID-19 FAQs: State Medicaid and CHIP Agencies

established a COVID-19 FAQ for State Medicaid and Children's Health Insurance Program (CHIP) Agencies that addresses such topics as the delivery of school telehealth services and use of Medicaid funds for COVID-related activities.

At the state level, the response also was swift. Most state education departments released guidance for remote learning and provided a framework for how districts should proceed with school closures, based on the best information and science available at the time. Education departments also released limited guidance on the continued delivery of school health services, often in collaboration with state Medicaid agencies and/or state public health departments. This guidance primarily focused on the delivery of special education services as required by the Individuals with Disabilities in Education Act (IDEA). While IDEA requirements were not waived during the pandemic, many states recognized the challenges of ensuring students with disabilities receive a free, appropriate public education during school closures and encouraged school districts to do their best to adhere to IDEA requirements.

Obstacles

From a policy perspective, states have had to navigate numerous challenges while figuring out how to support districts in their delivery of school health services.

For example, as schools reopen, one of the biggest challenges facing school administrators and health providers is figuring out how to handle contact tracing and surveillance for staff and students. An effective COVID-prevention and contact-tracing program is resource intensive and requires a range of school health professionals and administrative support. Because most contact-tracing resources are available through the state and county departments of public health, schools must partner with their region's public health department in order to add additional staffing and support. Also, as CMS clarified in this COVID-19 FAQ, certain contact-tracing and surveillance activities may be a reimbursable administrative service under Medicaid, *if a state opts to cover it*.

Studies show that health services provided in schools, including physical, mental and behavioral health services, can improve both health and academic outcomes.

Other significant challenges facing schools during the pandemic have included:

- School health services provided via telehealth or remote communications are not always a billable Medicaid service through the school-based Medicaid program.
- The traditional mechanisms for reimbursement in some states rely on a statistical sampling of services provided, and this data isn't always available or reliable during a pandemic.
- ED requires schools to obtain written parental consent to provide health services and to bill Medicaid, yet there is no standard or approved method for obtaining consent remotely.
- Student Individualized Education Plans (IEPs) are typically put in place before the start of the new school year. When schools are closed, there are challenges in determining how best to facilitate IEP meetings between the school team and the family.
- Many students are behind on well-child visits and vaccinations due to lack of access to regular health care visits or concerns around visiting primary care providers due to COVID. Districts are forced to weigh relaxing these requirements as families and healthcare systems "catch up" without dismissing these requirements altogether.

Federal and state policymakers have tried to address these challenges, but the response has been a patchwork of state- and district-specific solutions. The rest of this brief will examine in more detail the various ways that three specific strategies—expanding telehealth, navigating parental consent and adapting Medicaid billing practices—can be used to ensure students receive the care they need.

INSIGHT: STRATEGIES FOR IMPROVING DELIVERY OF HEALTH SERVICES

Telehealth

Overview

Telehealth is a method of delivering health care services through specialized technology in remote settings. Many physical and behavioral health services are delivered remotely using telehealth; prior to the coronavirus pandemic, many school districts had already been exploring telehealth as a way to increase student access to remote healthcare providers.

In a school-based setting, telehealth virtually links the student with an external provider who can offer diagnosis and treatment. Specialized equipment is needed—some schools and districts have received donated equipment from local healthcare providers or local telecommunications companies.

Telehealth services require complicated funding streams, often braiding together several funding sources. In some states, both the school and the telehealth provider may be able to seek reimbursement, with Medicaid reimbursing schools for the time involved with a facility fee, and also paying the health provider for delivering the service. While the facility fee may not cover the full costs of the program, it is a sustainable revenue source that helps maintain staffing and services.

Telehealth Expansion During COVID-19

When the stay-at-home orders first took place, the broader healthcare system quickly switched to delivering many services remotely, causing a dramatic expansion in the types of health providers using telehealth and the array of services available. Because Medicaid reimbursement is regulated at the state level, and each state makes decisions on what types of providers can be reimbursed for telehealth and what services are covered, some states were not fully prepared for the reimbursement implications of a massive switch to remote delivery of services.

Telehealth can be used to deliver a range of school health services, including acute healthcare services, mental and behavioral healthcare, chronic-disease management, speech-language pathology, and occupational and physical therapy.

By summer, almost all states had dramatically expanded their Medicaid telehealth programs, at least for the duration of the public health crisis, allowing some school-based healthcare providers to become eligible for reimbursement. This provided a financial incentive for offering services to students remotely.

Ohio, for example, implemented emergency rules in March 2020, at the onset of school closures, promoting care at a distance and allowing a wide range of practitioners, including school health providers, to bill Medicaid for these services. Oregon released a series of telehealth guidance FAQs for each type of school-based provider with a special focus on student privacy.

But the pivot to telehealth came with some challenges. School-based providers and school districts had to adapt without warning to serving students remotely and to developing best practices. School districts have had to tackle issues ranging from both students and providers lacking the tools and technology needed to participate in telehealth, to obtaining parental consent to deliver and bill for services. And there's always the issue of possible student reluctance to attend another online appointment.

By fall, as more schools started to reopen, school districts were just starting to fully leverage telehealth as a way to deliver remote health services—and to bill Medicaid. Despite the complications, it continues to hold great promise for the remainder of the pandemic, and beyond. States are charting a path forward and making decisions around the continuation of school-based telehealth.

Future Considerations

The COVID-19 shutdowns have shown that it is critical, for both student and community health, to develop and maintain robust coverage of healthcare services while students are learning remotely. While CMS can encourage telehealth expansion, Medicaid telehealth coverage remains a state-level decision. It is crucial that states consider how to maintain the telehealth expansions tied to the pandemic that may expire when the public health emergency subsides.

Future planning should focus on best practices and policies to encourage telehealth in schools, both for regular delivery of services and during future disasters. States should release "best practices" guidance to school districts for each type of health service provider, similar to what Oregon did, and in partnership with each licensing board's recommendations.

States also should support districts in building partnerships with external providers for telehealth services and make funding available to ensure school districts have the needed technology, equipment and training. It is also crucial to maintain the telehealth expansions tied to the pandemic that may expire with the public health emergency.

Parental Consent

Overview

In order for districts to deliver and bill for services to students, the school must obtain written parental consent, per ED guidelines. Parental consent (or student consent, if the student is age 18 or older) not only confers permission to provide diagnostic and treatment services within the school, but it is also required to bill the student's health insurance plan, including Medicaid.

Parental consent also facilitates the sharing of information between healthcare providers and education agencies under state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

Written parental consent is not required by CMS. The Medicaid application process requires the disclosure of all personally identifiable information (PII) including first name, last name, date of birth and Social Security number. To be clear: When districts bill Medicaid, they are not disclosing any additional student information to Medicaid beyond what parents/guardians have already provided.

Parental consent processes—and the implications for families and school reimbursement—vary by state. Obtaining signed parental consent forms can be difficult for schools even in good times, and there are few established mechanisms for obtaining

HIPAA is a federal law that protects the privacy of patient health information held by covered entities.

FERPA protects the privacy of students' personal records held by educational agencies or institutions that receive federal funds through Education Department programs.

For additional information, view the CDC's HIPAA vs. FERPA infographic.

them remotely or through electronic signature. The pandemic has made it harder to secure the needed parental consents in order to treat students.

Parental Consent Adaptation During COVID-19

As described above, ED, in response to COVID-19, issued a Q&A document stating that schools may obtain parental consent electronically for special education services and for Medicaid claiming. While some states had already included information regarding electronic parental consent in their guidance, this federal clarification reassured states that this was an appropriate interpretation of the applicable statutory or regulatory requirements.

California's FAQ on COVID-19 School Closures and Services to Students with Disabilities is one example of a guidance document that clearly allows the use of electronic consent. The FAQ provides the following directive for school districts:

> *LEAs [local education agencies] that wish to utilize electronic or digital signatures for consent may do so if they choose. Options for electronic signatures or digital signatures could include but are not limited to use of applications such as HelloSign, DocuSign, Adobe Sign, as well as scanned copies or photographs of signed signature pages. For record keeping purposes, it is recommended that LEAs maintain documentation as proof of consent, including printed or mailed copies of signed documents.*

Oregon's FAQ, Student Privacy Considerations and Distance Learning For All, made a similar clarification about obtaining consent:

> *Electronic signatures are allowed by FERPA provided certain conditions are met (see below)...The statutes do not make reference to the platform to be utilized to obtain consent; that decision is up to district policy and security protocols. Signed and dated written consent under this part may include a record and signature in electronic form that:*
>
> *1. Identifies and authenticates a particular person as the source of the electronic consent; and*

2. Indicates such person's approval of the information contained in the electronic consent.

Virginia's Department of Education's Special Education and Student Services FAQ provides guidance about electronic signatures:

> *The Virginia Regulations (8 VAC 20-81-170.I) permits the use of electronic signatures and references another portion of the Code of Virginia, the Uniform Electronic Transactions Act (UETA), to spell out the details of what can be an electronic signature. The UETA provides that an electronic signature is a symbol, a sound, or a process logically associated with a record, that is adopted by a person with the intent to sign. Additional consultation and a plan for documentation with counsel or a division's school board attorney is strongly recommended.*

At this time, it appears that many school districts have put in place systems to obtain remote parental consent, though there is currently little tracking available and districts report a lack of guidance from the state on the best way to do this. Furthermore, parents and families continue to be confused about what they are signing, suggesting that parental education continues to be important.

Future Considerations

ED should immediately issue guidance to states encouraging them to adopt remote parental consent, including best practices for what this may look like and how districts could operationalize it. This guidance should permit states to allow remote parental consent on an ongoing basis, in order to remove barriers to participation for parents with special needs or limited availability.

State education departments should explicitly waive the written parental consent requirement to bill Medicaid during a national public health emergency—and preferably permanently. States should also encourage school districts to put in place best practices for obtaining parental consent, and create specific plans to obtain consent remotely should a future disaster or emergency again necessitate long-term school closures.

Medicaid Reimbursement Financing

Overview

Medicaid provides a significant amount of funding in almost every state for school health services, particularly for children with disabilities, although it's only a small proportion of Medicaid's overall expenditures.

Many states use a cost settlement methodology for school Medicaid reimbursement. Cost settlement generates reimbursement for services based on both payments for services rendered (interim payments) and a settlement of the costs associated with the provision of services. A statistically valid process called the Random Moment Time Study (RMTS), which provides a sampling of time spent delivering eligible school health services, is one of the methods used for calculation. (Additional information regarding RMTS is available on page 32 of A Guide to Expanding Medicaid-Funded School Health Services.)

Adapting Medicaid Billing During COVID-19

When schools closed and health services started being delivered remotely, two issues quickly emerged. First, since the RMTS process requires a large pool of data to be statistically significant, schools worried they would not have enough "moments" in their samples. Second, it was not clear for which services school-based health professionals and administrators could bill. Could services provided for telehealth be considered as "moments"? Could schools get an administrative match for new services like COVID surveillance?

CMS responded to these concerns with concrete policy fixes. These were documented in school waivers and in FAQs from CMS to state Medicaid agencies and included the following clarifications:

- States would be allowed to waive certain cost settlement requirements and, for Q3 2020, to use Q2 data as the baseline.
- The waivers permitted states to use their Q2 2020 data from before the pandemic began for as long as the public health emergency continues in order to ensure consistency.

Financial and other barriers may prevent families from scheduling doctor and dental appointments. These delays can affect a child's health and learning potential, starting at an early age. When children have access to healthcare at school, they are more likely to learn and thrive.

- CMS clarified that administrative staff still working during the pandemic may use their moments for the RMTS.
- CMS clarified that administrative staff not working as a result of the pandemic may mark their time as paid or unpaid.

States were encouraged to add language to their RMTS manuals and/or school guidance on Medicaid claiming, clarifying that the RMTS would not be conducted in case of a state of emergency that causes extended statewide school closures and impacts statistical validity. Instead, the average of the RMTS results from all previous statistically valid quarters during the same fiscal year should be applied to the quarter(s) occurring during the emergency. Multiple states updated their manuals to reflect this language (for example, see page 4 of Virginia's RMTS Manual).

Separately, CMS clarified that states *can* get an administrative match for COVID-related activities, including surveillance. Though this guidance does not specifically address schools, it is reasonable to assume that schools could bill for these services as appropriate. For further reading, Massachusetts School-Based Medicaid Program COVID-19 Updates includes examples of communications between the state Medicaid agency and school districts regarding these changes.

Future Considerations

CMS should move forward with an internal process to ensure that school-based Medicaid is considered in all disaster-related guidance. As part of this consideration, CMS should issue guidance that automatically allows states to use the last full quarter of RMTS data for any school district experiencing a public health or natural disaster emergency.

CMS also should issue formal guidance clarifying which activities are eligible for reimbursement and strongly encouraging state Medicaid agencies to recognize contact tracing as a Medicaid-eligible activity. Currently, this guidance appears in a CMS FAQ.

STATE AND FEDERAL POLICY RECOMMENDATIONS

The following recommendations are designed to support the continuous delivery of school-based health services during the present pandemic, and during future health crises and natural disasters.

The recommendations cover both school closures and school reopenings.

Given the patchwork response across states and schools at this time, these recommendations are designed to build a federal, state and local ecosystem that ensures students get the services they need—either in school or remotely—and that Medicaid plays an ongoing role in financing these services.

It is important to acknowledge that each state structures its school-based Medicaid program differently, and school districts may exercise significant control over the implementation of policies and delivery of services. Therefore, these recommendations provide broad guidance on the types of support needed during and after long-term school closures. We fully expect each state and locality will design the programs best suited to their situation.

These recommendations are informed by the contributions of the Healthy Students, Promising Futures Learning Collaborative, based on members' experiences during the coronavirus pandemic.

Pandemic/Disaster General Recommendations	
State Agencies	**Federal Agencies**
· State education agencies should work with school health providers on a comprehensive plan for addressing physical and mental needs during a prolonged shutdown or hybrid reopening, including meeting pre-existing needs and addressing acute trauma. · State education agencies must provide guidance and funding to embed telehealth into the school health programs, and state Medicaid departments must remove barriers to reimbursing school health providers through Medicaid. · State Medicaid agencies should add pandemic-related services (i.e., contact tracing) to the Medicaid state plan, so these services are reimbursable. · State education agencies should work with public health agencies on guidance detailing best practices for maintaining student and staff health and safety during school closures and when schools reopen, including providing information on how to access additional supports, such as food and shelter.	· CMS should develop an internal process to ensure that school-based Medicaid is included in all disaster-related guidance and that issues unique to schools are considered. · CMS and SAMHSA should jointly release guidance for meeting behavioral health needs during extended school closures, including the role that school-based health providers and Medicaid can play. · CMS should state whether school-based providers are eligible (or ineligible) for provider relief grants. · CMS should offer weekly calls on school-based Medicaid and encourage interstate sharing and communication of challenges and best practices. · ED should release guidance on how relief funds for school systems can be utilized to support the delivery of school health services.

Telehealth Services	
State Agencies	**Federal Agencies**
· State education agencies should designate funding to support the continuous delivery of school health services, including helping schools expand or improve technological resources and internet access so students can access telehealth services. · State education agencies should issue guidance to school districts about best practices in partnership with each licensing board's recommendations (see Oregon's guidance by provider type), including mechanisms to monitor the delivery and quality of telehealth services and to ensure appropriate feedback mechanisms are in place between districts and the state.	· CMS should approve all waivers to ensure that school-based Medicaid programs are able to adapt to the unique situation of the disaster or pandemic by expanding telehealth.

Meeting Special Needs	
State Agencies	**Federal Agencies**
· State education agencies should encourage school districts to plan how to provide behavioral health services capable of supporting students who need differing levels of care and support (often referred to as a Multi-Tiered System of Support) during extended school closures. · State education agencies should develop guidance to facilitate virtual IEP meetings between the school team and families in order to ensure a continuation of services.	· ED should issue guidance on providing services to students with disabilities during school closures, including the provision of school health services. This guidance should address the development of IEPs during school closures.

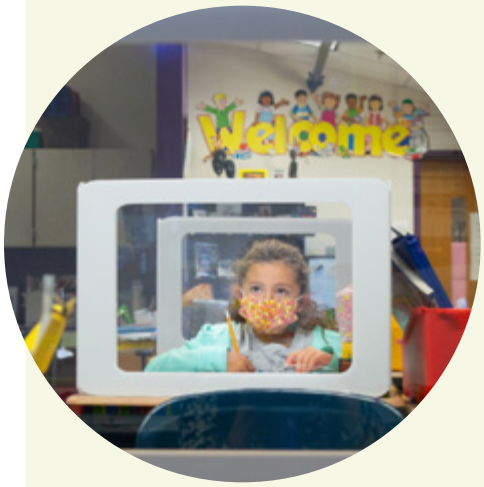
Data and Documentation	
State Agencies	**Federal Agencies**
· State Medicaid agencies should provide guidance to school districts on how to document services outside of a traditional school setting. For example, services delivered outside of normal school hours are permitted by CMS, but additional documentation is required in the case of an audit. · State education agencies should clearly define the impact of school closures on the definition of "attendance days." An attendance day is often required for Medicaid payment, but the definition does not clarify how remote learning aligns with that definition.	· CMS should issue guidance that automatically allows states that do not have a public emergency plan in their RMTS methodology to use previous RMTS data for any school district. This could be the last full quarter of RMTS data available or the average of two preceding quarters.

School Enrollment Requirements	
State Agencies	**Federal Agencies**
· State education agencies and state public health agencies should collaborate to create flexible time frames for healthcare services required for school enrollment during an emergency (e.g. immunizations, well-child visits, etc.). While flexibility is important, these requirements should not be waived.	

Parental Consent	
State Agencies	**Federal Agencies**
· State education agencies should apply to ED to waive the requirement that parental consent be obtained to bill Medicaid. · State education agencies should develop standing policies to allow parental consent to be obtained remotely.	· ED should release guidance on how to protect student privacy, including best practices for securing remote parental consent. · ED should allow states to waive the requirement that parental consent be obtained to bill Medicaid.

Contact Tracing & PPE	
State Agencies	**Federal Agencies**
· State Medicaid agencies should add contact tracing and surveillance services delivered by school-health providers to the Medicaid state plan. · State public health agencies should provide funding to schools to meet additional health and safety requirements upon reopening, including purchasing PPE, and hiring additional staff for surveillance and monitoring activities. · State education agencies, along with public health, Medicaid and emergency management agencies, should coordinate school-based responses, including a strategy for pursuing federal revenue for costs associated with PPE and extra sanitation workers. · State education agencies should support school districts in building and maintaining partnerships with public health departments in order to implement contact tracing.	· CMS, ED and CDC should make emergency funding available to states and localities to support the delivery of school health services and preparations for the safe reopening of schools, including PPE and contact tracing.

CONCLUSION



Given the national reliance on school health services as part of a comprehensive healthcare system, and the impact school closures have on student health (particularly mental health), state and federal agencies must leverage lessons learned from the COVID-19 pandemic in order to make urgent short-term improvements and to build a strong foundation to support expanded access to school health services in-person and remotely. In addition to implementing policy changes, this work must include enhanced communications between the federal government and the states.

The findings and recommendations outlined above can play a key role in ensuring policies are in place to promote access to and resources for school health services—both during our nation's long recovery and in the case of a future pandemic or disaster that forces schools to close yet again.

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