

## **Medicaid Reimbursed Rehabilitative Behavioral Health Services in Schools: A South Carolina Case Study**

### **Overview**

This case study examines the implementation of Medicaid managed care school-based behavioral health services in South Carolina. This case study will look at the changes made by the South Carolina Department of Health and Human Services (SCDHHS) in coordination with the state’s Medicaid managed care organizations (MCOs), alongside efforts made by the South Carolina Department of Education (SCDE) and local education agencies (LEAs) in the state to support this change. The case study will also highlight key lessons learned that can inform the efforts of other states choosing to coordinate school-based health care with Medicaid managed care programs.

### **Introduction**

Beginning in 2016, the South Carolina Department of Health and Human Services (SCDHHS), in an effort to provide comprehensive and coordinated care to its members, made key changes to the state’s Rehabilitative Behavioral Health Services (RBHS) program. This change involved moving their school-based Medicaid behavioral health services into their Medicaid managed care program. This is known as “carving-in” services into managed care organizations (MCOs).

This case study outlines the main features of the carve-in and the roles played by key stakeholders, including the state Medicaid agency, the South Carolina Department of Education (SCDE), local education agencies (LEAs), MCOs, and behavioral health service providers. It also examines the unique issues and challenges that came up during the implementation of this policy change, and highlights lessons learned around planning and self-study, administrative innovations around contracting and care, credentialing, billing systems and relationship-building among stakeholders.

The South Carolina experience highlights many important lessons that other states can learn from as they consider changing the way school districts<sup>1</sup> interact with Medicaid and MCOs. The case study highlights the importance of preparation, training, communication, and flexibility between the school districts and the MCOs as they navigate the challenging process of change.

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<sup>1</sup> School districts are also frequently referred to as Local Education Agencies, or LEAs. Throughout this document, these terms are used interchangeably.

## *Managed care “carve-out” vs. “carve-in”*

In most states, school-based Medicaid services are not the responsibility of the MCOs; this is commonly known as being “carved out.” Instead, school districts, or LEAs, directly bill the state Medicaid department for the services they provide, and the Medicaid department provides the reimbursement

If school-based Medicaid services are included in the MCO contract (“carved-in”) as behavioral health services now are in South Carolina, the MCOs’ capitation rate reflects the included services, and the state will not pay LEAs for those services. In states where school-based Medicaid is carved into MCOs, LEAs must contract with the plans to seek reimbursement. In these cases, the LEA operates as a contracted provider to the MCO.

## **“The Way We Were”: South Carolina Medicaid School-based Behavioral Health Services Prior to July 1, 2016**

Before July 1, 2016, behavioral health services covered by the RBHS program for South Carolina students were managed through a contract between SCDHHS and 33 South Carolina school districts. SCDHHS served as the gatekeeper to identify the services eligible for reimbursement and providers eligible to provide services, and served as the payor of appropriately documented medically necessary services. The SCDE, through a contract with the SCDHHS, provided the training, technical assistance and quality assurance reviews required for the school district providers of behavioral health services. Within the school districts, these services were provided through appropriately trained behavioral health providers, hired directly by the school districts or by contracted Medicaid-approved providers in the community.

## **“The Times They Are A Changing”: Behavioral Health Carve-in and SC Medicaid School-based Services from July 1, 2016-Present**

In 2016, in order to provide comprehensive and coordinated care, the state Medicaid agency “carved-in” RBHS to the five MCOs. This carve-in led to dramatic changes to the way Medicaid school-based behavioral health services were delivered.

Under this change, SCDHHS contracted with each MCO to provide a specific bundle of services to beneficiaries assigned to the MCO by the state Medicaid agency. School-based behavioral health services were included in this carve-in arrangement, and the rate paid to the MCOs by the state included RBHS delivered in and/or by the LEAs. The remaining and larger number of

school-based rehabilitative therapy services, including physical therapy, nursing, occupational therapy and a variety of other services remained carved out, or directly billed to the Medicaid agency.

From the perspective of students receiving services, nothing changed: they still received mental health services such as psychological assessments, crisis intervention and individual/group therapy as they did prior to the carve-in.

The changes for LEAs, however, were dramatic. Under the carve-in, schools became a “place of service” just like a doctor’s office, with all the same requirements. Schools and LEAs who participated in the school-based Medicaid program were required to become in-network contracted providers with each MCO, and to meet all the MCO criteria to participate in the behavioral health program. LEAs needed to contract with MCOs to become part of the provider network, establish billing and reimbursement protocols and manage eligibility and other authorization requirements. Some specific requirements included:

- Schools were required to obtain Prior Authorization (PA) for all behavioral health services. A PA is a clinical review of services to determine that the service is medically necessary before it is rendered.
- Schools became subject to post-utilization reviews to ensure that patients get the care they need, that the care is delivered via proven methods and that it is delivered in appropriate settings. If it is determined that services were not delivered based on contractual agreements and best practice, payments are required by law to be recouped.
- Schools needed to meet MCO credentialing standards. Credentialing is the process by which insurance networks obtain and evaluate documentation regarding a medical provider's education, training, work history, licensure, regulatory compliance record and malpractice history before allowing that provider to participate in their network.

MCOs also needed to make adjustments to their practices and expectations. Because healthcare is not the major focus of school districts, MCOs needed to develop new flexibility and make a sustained investment of time and energy as LEAs worked to implement changes such as adjustments for credentialing of school-based providers.

Many LEAs did not have the capacity to participate in this new environment, and LEA participation in RBHS dropped from 33 school districts to 12 school districts in the first 12-month carve-in period. The causes for the reduction were varied. Some school districts had claims processing vendors that could not handle third party liability (TPL) claims, while others could not justify the financial investment to hire administrative staff based on their estimated

utilization. Perhaps the most difficult hurdle for LEAs was understanding the world of managed care.

Some successful strategies for navigating the challenges that emerged during this process are outlined below.

## **“You’re Going to Be OK”: Key Strategies**

### **Planning and Self-Study**

Led by SCDHHS, the carve-in of LEA behavioral health services to the MCOs was introduced several months in advance of the ‘go live’ date, and relevant policy directives were made available for all stakeholders to absorb. This gave LEAs an opportunity to review the percentage of their students in each MCO plan and estimate the number of students that would need behavioral health services. It also allowed for LEAs to perform a readiness assessment to determine the level of resources available for implementation of the carve-in, consider the financial advantage of enrolling with the various plans and estimate the fiscal impact of state policy changes to their programs.

During the planning and self-study period, LEAs were also reminded that they did not have to deliver all behavioral health services to students. School districts were able to use this opportunity to pool resources with other LEAs and community providers to maximize services and reimbursement. For instance, LEAs learned that many community-based providers—including community-based clinics with the Department of Mental Health, Federally Qualified Health Centers (FQHCs) and private RBHS providers—were already credentialed with the MCOs. Understanding how these and other providers could have a positive impact on meeting the needs of students contributed significantly to improved Medicaid managed care school-based behavioral health service delivery.

### **Administrative Innovations for Contracting and Care**

Most school districts were not organized to contract with healthcare providers, and LEAs and MCOs both had complex existing internal systems for dealing with issues around care provision. Finding ways to simplify the merging of these systems was essential. To help LEAs navigate the changes necessitated by contracting with multiple MCOs, SCDE in conjunction with SCDHHS developed a boilerplate for managed care contracting. SCDE also developed standardized forms to replace individual forms from each MCO for prior authorization of services, documentation of treatment progress and requests for continued services. The standardized forms facilitated MCO approval of service requests, such as diagnostic assessments and 90-day progress reports.

MCOs provided support to contracted LEAs, including working with contracted LEAs to train them on prior authorization, documentation of medical necessity, measurement of treatment progress and incorporation of care coordination in the treatment experience of each covered beneficiary.

### **Navigating credentialing**

Credentialing of providers—a standard MCO practice to ensure that clinical staff are properly trained, licensed and certified to provide safe and competent care—involved unexpected challenges for LEAs. MCO provider network executives provided key support in this area, working with the LEAs to identify the steps involved in the credentialing process, including learning what information is required by each MCO; gathering application documents such as verification of state licenses and board certifications; reviewing and submitting applications; and following up between LEA administrative staff and MCO account executives to remove any barriers to full credentialing of staff.

MCOs also needed to prepare for some changes to their credentialing process. For example, MCOs normally require outpatient behavioral health providers to be credentialed by the Commission on Accreditation of Rehabilitation Facilities (CARF), but in South Carolina, school districts were exempted from this requirement as part of a National Committee for Quality Assurance (NCQA) rule exception. Instead, school districts were required to obtain an annual visit from SCDE and some MCOs made their own site visits.

### **Billing Systems**

Prior to the carve-in, school districts submitted claims only to SCDHHS; now, billing had to be submitted to five separate MCOs. LEAs reviewed their claiming practices in order to make them more efficient and effective in obtaining MCO reimbursement. LEAs focused on learning which students were enrolled with which MCO, increasing rates of parental consent, documenting the medical necessity of treatment requests and services delivered, and addressing TPL requirements by seeking reimbursement from other programs or entities before billing Medicaid.

LEAs also evaluated options for navigating the complexities of reimbursement, such as using school-based staff or employing billing companies to perform the administrative functions of collecting claims and administering billing methodologies.

### **Strengthening relationships among stakeholders**

Because the carve-in required new relationships between LEAs and MCOs, and changed the role of SCDHHS and SCDE, it was essential to pay attention to how information was

disseminated, how questions were answered and how these groups communicated with one another. Some effective strategies included:

- SCDHHS took the lead in arranging and coordinating periodic joint meetings with the MCOs, SCDE and the participating LEAs during the first six months of the carve-in. These meetings provided a forum for information on the carve-in process, allowed for presentations by each MCO and afforded time for informal conversations between the LEAs and MCOs to address anticipated problems and solutions.
- SCDE leadership met with key staff from each MCO and organized joint meetings between LEAs and the MCOs. SCDE also facilitated the participation of MCOs in monthly conference calls with LEAs that served as forums for discussion of larger issues affecting all stakeholders.
- LEAs sought to build sustainable relationships with MCO administrative staff, account executives, and clinical executive leaders. This entailed learning about MCO goals, objectives, philosophies and business strategies. These efforts provided avenues for individual LEAs to address their specific pressure points with their contracted MCOs.

## **“Both Sides Now”: Key takeaways from the carve-in**

Behavioral health and RBHS services continue to grow in South Carolina as leadership from the SCDE and the Department of Mental Health have developed a joint vision for improving access to school mental health services for all students in South Carolina public schools. By the year 2022, the state intends for all schools to have at least a half-time counselor in place, employed by the Department of Mental Health, with care for MCO-enrolled students managed by MCOs.

Much was learned from moving behavioral health care services in schools to the MCOs. Transitions of this magnitude can be uncomfortable and do not always go smoothly, but comprehensive planning, strong relationships and a commitment to flexibility and joint problem-solving can create strong positive momentum.

The re-engineering of the practices of a school district requires time and buy-in from all participants. Because healthcare is not the primary focus of educational institutions, school districts need time and training to implement major changes. At the same time, MCOs must adapt to the unique challenges of working with schools by building new flexibility and support into their processes. When all stakeholders are committed to working together, the value of the relationship in improving care for students becomes evident.

# Healthy Students, Promising Futures

LEARNING COLLABORATIVE

*This case study was prepared by Healthy Schools Campaign for the [Healthy Students, Promising Futures Learning Collaborative](#), an effort that brings together 15 states teams working to improve health and education outcomes by increasing Medicaid services in school and promoting safe and supportive learning environments.*

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