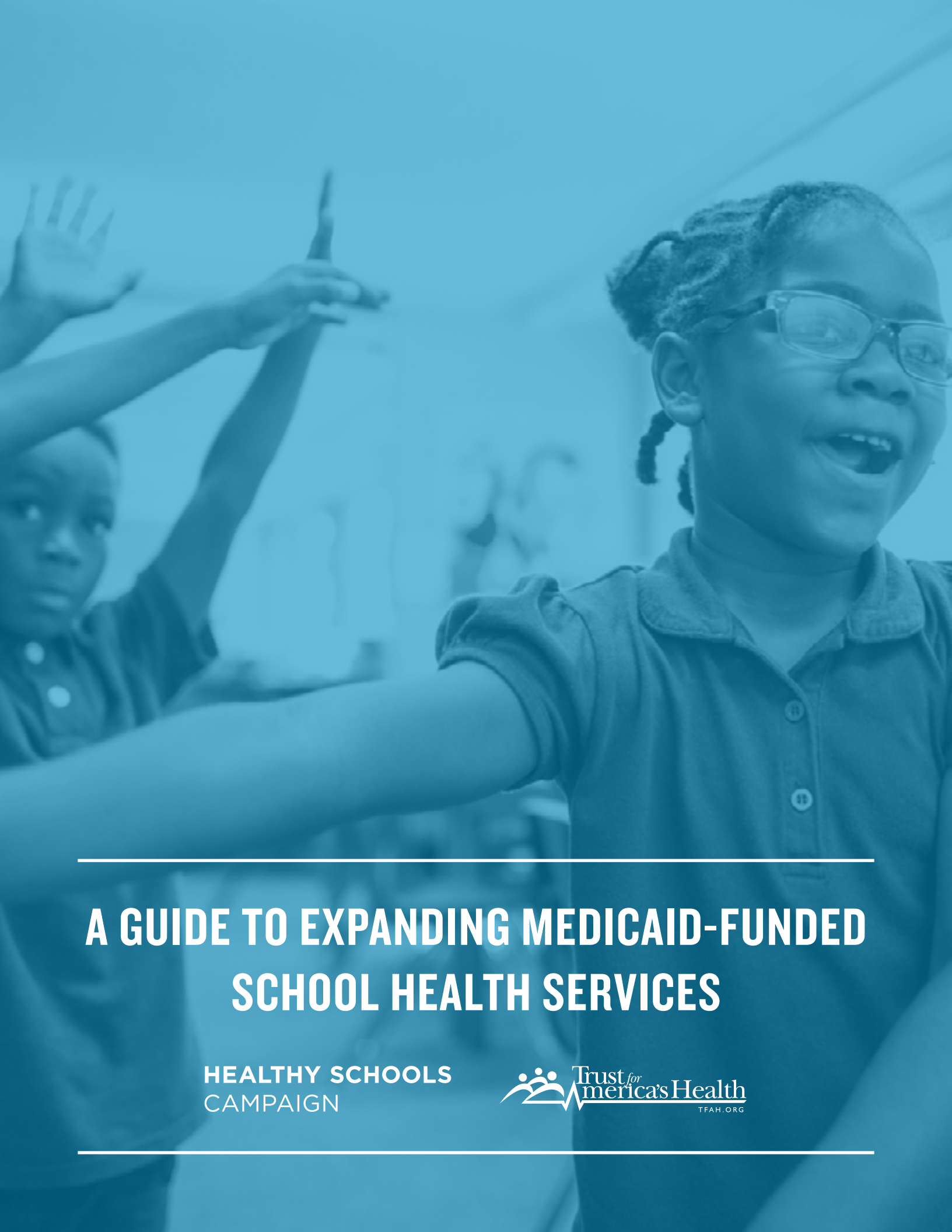

A GUIDE TO EXPANDING MEDICAID-FUNDED SCHOOL HEALTH SERVICES

HEALTHY SCHOOLS CAMPAIGN

Trust for America's Health
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DECEMBER 2019

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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.

Trust for America's Health

Trust for America's Health is a nonprofit, nonpartisan organization that promotes optimal health for every person and community and makes the prevention of illness and injury a national priority.

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A Guide to Expanding Medicaid-Funded School Health Services is designed to support people at the national, state and local levels who are working to improve student health and educational outcomes. To do this, we build on the incredible work being done across the country to expand access to and resources for school health services—and the state policies that promote these efforts.

The Healthy Students, Promising Futures Learning Collaborative informed the development of this guidance document. Trust for America's Health and Healthy Schools Campaign co-convene the Learning Collaborative with the goal of creating healthier students by increasing Medicaid services in schools and promoting safe and supportive school environments. Sixteen 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.

A special thanks to Anne De Biasi of Trust for America's Health for her contributions to this document.

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NOTES ON LANGUAGE

Throughout this document, there are references to the services students receive in schools to support their physical and behavioral health. These services are referred to as "physical and behavioral health services" or simply "health services." In each instance, the phrasing refers to the multitude of services that students need to achieve their health care outcomes.

The terms local educational agency (LEA) and school district (or district) are used interchangeably.

Frequently Used Acronyms

CMS - Centers for Medicare and Medicaid Services

CPE - Certified Public Expenditure

EPSDT - Early and Periodic Screening, Diagnostic and Treatment

FERPA - Family Educational Rights and Privacy Act

FMAP - Federal Medicaid Assistance Percentages

FQHC - Federally Qualified Health Center

HIPAA - Health Insurance Portability and Accountability Act

IDEA - Individuals with Disabilities in Education Act

IEP - Individualized Education Program

IFSP - Individualized Family Service Plan

IGT - Intergovernmental Transfer

LEA - Local Educational Agency

MCO - Managed Care Organization

RMTS - Random Moment in Time Study

SPA - State Plan Amendment

INTRODUCTION

Today, one in four children in the United States has chronic physical or mental health issues that affect their ability to succeed in the classroom, double the number just 30 years ago.

These health issues, which include anxiety, vision and hearing deficits, and lack of dental care, can have a significant impact on children's long-term health as well as their opportunities to learn. Left untreated or undermanaged, they can adversely affect children's attendance, their ability to see, hear and pay attention in the classroom, their ability and motivation to learn, their academic performance, and even their chances of graduating from high school.[1]

In addition, students in underserved communities, particularly students of color, are at increased risk of chronic health problems such as diabetes and asthma that can hinder learning. Ignoring these health inequities will undermine efforts to close the opportunity gap.

No school district is immune. Across the country, a rising trend in youth suicides, anxiety and depression underscores a desperate need for more behavioral and mental health services. State and local education agencies are struggling to respond to the needs of students and their families affected by opioids and the obesity epidemic. School safety is also driving policy conversations.

Evidence has shown that school-based health services are essential to addressing these concerns. School-based health services include physical, behavioral and mental health care that can be delivered by a range of providers, including school nurses, psychologists, and speech-language pathologists, as well as school-based health centers or through partnerships with local health organizations.

Studies show that access to school health providers improves health and academic outcomes, particularly for students with chronic health issues. A higher school-to-nurse ratio, for example, is related to better attendance. Increasing access to school health services, therefore, can help states reduce inequities in both health and education. Key opportunities exist for education, healthcare and public health sectors to work together to meet these joint goals.

Federal education policy and state education plans increasingly recognize the intersection of health and education. The Every Student Succeeds Act (ESSA),

1. Health Barriers to Learning: The Prevalence and Educational Consequences in Disadvantaged Children. The Children's Health Fund (January 2017): https://www.childrenshealthfund.org/wp-content/uploads/2017/01/Health-Barriers-to-Learning.pdf

the nation's education law, provides opportunities for schools to support student success by improving student health and wellbeing.[2] The increased focus on supporting the needs of the whole child has pushed state education agencies and school districts to look at policies that improve student health, keep children healthy and in school, and, in turn, improve their school success.

Meanwhile, health policymakers are focused on promoting value and quality—rather than volume—so that limited health care dollars deliver the maximal impact. States are working to increase access to care for children, and schools are a logical place to provide services. Nearly 80 percent of children who receive behavioral services access them at school. In a few years, states will be required to report certain child health quality measures as part of their Medicaid reporting. Providing health services in schools can help improve these metrics, but finding sustainable funding has been an ongoing struggle.

Expanding School Health Services through Medicaid

Fortunately, opportunities exist to address some of the school health services funding barriers. In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a state Medicaid director letter that clarified which services can be reimbursed by Medicaid in a school-based setting.[3] This guidance allows school districts to expand their school-based Medicaid programs to cover more students and potentially bring in additional, sustainable federal funding for states.

A Guide to Expanding Medicaid-Funded School Health Services provides background on school-based Medicaid and outlines various opportunities to advance state policy changes required to access federal funds. Across the country, states have begun to tackle different paths for increasing access to school health services through Medicaid reimbursement—and much has been learned about what it takes. There are best practices for organizing and advancing policy; for how to design the administrative processes; and how to tackle other big obstacles to improving student access to care.

By focusing on Medicaid-funded school-health services, this guide provides a unique glimpse into building a sustainable funding structure and offers concrete lessons for collaboration among agencies.

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2. State Education Policy that Supports Student Health and Wellness, Healthy Schools Campaign (August 2019): https://healthyschoolscampaign.org/wp-content/uploads/2019/08/State-Education-Policy-that-Supports-Student-Health-and-Wellness.pdf

3. Dec. 15, 2014 CMS letter on Medicaid Payment for Services Provided without Charge (Free Care): https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

Who Is This Guide For?

This guide is designed to support everyone working to expand access to school health services that are paid through Medicaid, including state and local education agency staff, state Medicaid agencies, school health providers, public health professionals, and advocates. All of these stakeholders share a common goal: improve student health and educational outcomes.

ONE

GETTING STARTED: UNDERSTANDING THE MEDICAID LANDSCAPE

Medicaid provides a significant amount of funding in almost every state for school health services. State eligibility and benefits vary based on factors and policies unique to each state.

How Does Medicaid Impact Children?

Medicaid provides health coverage to more than 65 million people, including 37 million children in low-income families.[4] It covers comprehensive and preventive physical and behavioral healthcare services.

Medicaid's signature benefit for children, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, is designed to ensure that children receive all medically necessary services. Its components include:

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified
- **Treatment:** Control, correct or reduce health problems found

For services to be considered medically necessary, they must be reasonable and necessary for the treatment of illness, injury, disease, disability or developmental condition. Medical necessity is a critical factor for determining eligibility for Medicaid-reimbursable services.

Medicaid's Role in Funding School Health Services

The cost of school health services is covered by different funding streams. Federal, state and local sources of education funding cover most of the cost, while the Medicaid reimburses a smaller portion of the total healthcare costs.

Medicaid spending on school health services was estimated to be $3.3 billion in 2016 (with an additional $1.2 billion spent on related administrative services). 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 (about 0.5 percent in FY 2016).[5]

Since 1988, Medicaid has reimbursed states for certain medically necessary services provided in a school-based setting to children with an Individualized Education

4. Fact sheet on children's health insurance coverage, created by the Georgetown University Center for Children and Families and the American Academy of Pediatrics: https://ccf.georgetown.edu/wp-content/uploads/2017/02/United-States-Medicaid-CHIP-new-v1.pdf

5. Medicaid in Schools, Medicaid and CHIP Payment and Access Commission (April 2018): https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf

Program (IEP) and in other limited situations, providing billions of dollars of federal funding to support school health services.[6]

States are not required to participate in Medicaid, nor are they automatically eligible to receive Medicaid payment for services provided in schools. But schools are required to provide the services listed in an IEP—whether or not Medicaid funding is available. Many states and school districts (also known as local educational agencies, or LEAs) rely on federal Medicaid funding to offset the expenses of providing these medically necessary services and ease the pressure on the state education budget.

Medicaid is a federal-state partnership; states must pay a certain percentage of their state's overall Medicaid costs, known as the Federal Medicaid Assistance Percentage (FMAP). The FMAP varies from state to state[7], but the federal government reimburses, at a minimum, 50 percent of a state's spending on eligible services provided to Medicaid enrollees. This means states are responsible for up to 50 percent of the cost of care (otherwise known as the state's match). To raise their share of the match, states rely on many different funding sources, and most states require LEAs to draw from their district budget to contribute some or all of the non-federal share of school-based services.

The Centers for Medicare and Medicaid Services (CMS) reimburses states for a portion of the services that are billed, and each state passes some of the money back to schools and districts. The process for reimbursement is complicated and varies state-by-state, but one thing is clear: When a state increases the number of eligible services that are billed to Medicaid, the state gets back more money from CMS.

The converse is also true: Not billing for otherwise eligible services that are already being provided in schools means leaving federal dollars unclaimed. When that happens, state taxpayers bear the entire cost of services. This makes Medicaid a very important source of funding for school health services—and for state health and education budgets overall.

The Role of State Medicaid Plans

Benefits and eligibility levels are outlined in each state's Medicaid state plan. This agreement between a state and the federal government describes how the state administers its Medicaid program and includes clear guidelines about *who gets covered*, *what services are covered* and *who the eligible providers are*.

6. A 2014 Medicaid rule change known as the "Free Care" rule reversal opened the door to Medicaid funding for a wider range of students and services. See Chapter 6.

7. For a list of all state FMAP percentages, visit Kaiser Family Foundation: https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

In general, Medicaid will pay for covered health and behavioral health services as long as they are medically necessary; follow local, state and federal rules; are covered by the state Medicaid program; and are delivered by a Medicaid-enrolled provider. Medicaid will also pay for certain activities that are directly related to enrollment, outreach and administration of the Medicaid program.

In most states, LEAs are not required to participate in school-based Medicaid, but those that do can seek reimbursement for eligible health services delivered to Medicaid-enrolled students, thereby recouping a portion of their spending.

It's important to emphasize that states have significant flexibility in designing their state Medicaid plan within certain CMS guidelines. Information about what and who is covered is available through the state Medicaid department.

Every state issues guidance that provides significant detail on covered benefits, providers and eligibility. States with managed care arrangements for Medicaid may also have guidance for providers on how to seek reimbursement with Medicaid managed care organizations.

TWO

GETTING STARTED: UNDERSTANDING THE SCHOOL HEALTH LANDSCAPE

In order to improve school health services, it is important to know what services are already provided in your state, where there are gaps and unmet needs, and if and how they are reimbursed by Medicaid.

When trying to understand the role that Medicaid plays in school-health services, there are some preliminary questions to investigate:

1. What are the highest-priority student health needs in my school and community?

Understanding the health issues that affect students in your school, school district and community is a key step toward identifying the changes you want to make to your school Medicaid program. This can be accomplished by examining student-level data collected via health information cards, Individualized Education Program (IEP) and 504 plans for children with disabilities, and school health provider records.

In addition, aggregate-level data available at the school and community level can be helpful in better understanding the health issues in your district. For example, all nonprofit hospitals are required to complete community health needs assessments and make this information publicly available. These assessments usually draw on public health data and present a snapshot of the leading health issues affecting all populations in the community, including children.

Local community health data can be accessed by contacting your local public health agency; state health departments may also have data that would allow for comparisons across the state and between counties.

2. What health services do students have access to in schools? How are those services being provided?

Many students receive physical and behavioral health services in schools. Some services, like vision screenings and vaccination programs, are made available to the entire student population. These serve a key public health function as well as provide access to preventive care that the students may not otherwise receive. Other day-to-day health services, such as bandages and ice-packs, are widely available to the general student population.

For students with special needs, medical and behavioral health services that are listed in a student's IEP must be provided in school to help with learning preparedness. These services often include physical therapy, speech therapy, occupational therapy, and mental health counseling. These services may also be available to students without IEPs, but often schools have limited staffing and capacity to meet the needs of all students.

Most districts, or local educational agencies (LEAs), hire some combination of medical and behavioral health providers to deliver school-based services. These providers may be directly hired by the LEA or contracted through an external staffing service. They include school nurses, counselors, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists and others. The makeup and quantity of the LEA-employed workforce depends on many different factors but is often driven by the district's budget and priorities. For example, some districts have a school nurse in every school, but in many districts, a school nurse serves more than one school.

There are also healthcare delivery systems that provide services to students. For example, school-based health centers play a growing role in supporting student health. Some LEAs also partner with community-based providers to expand student access to services. Partnerships with local hospitals, universities, community health centers, public health departments or mobile clinics (such as oral health vans) provide invaluable services and expand access.

3. Can LEAs seek Medicaid reimbursement for health services provided to all Medicaid-enrolled students?

LEAs can seek Medicaid reimbursement for health and behavioral health services included in the IEPs and Individualized Family Service Plans (IFSPs) of Medicaid-enrolled students. All states except Wyoming currently seek Medicaid reimbursement for these services.[8]

Some states have expanded their school-based Medicaid programs to include services provided to Medicaid-enrolled students without IEPs or IFSPs (see Chapter 6 for more about expanding school-based health services). For more information about Medicaid eligibility in your state, contact the state Medicaid agency. The Medicaid billing specialist in your school or LEA will have information about specific billing and claiming questions.

Additional resources:

- *Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults*, a fact sheet developed by the Kaiser Family Foundation, provides a national overview of Medicaid eligibility for children.
- *State Efforts to Implement the "Free Care" Policy Reversal*, developed by Community Catalyst, Healthy Schools Campaign and Trust for America's Health, provides an

8. LEAs can also seek Medicaid reimbursement for certain services delivered through the Maternal and Child Health Block Grant. More information is available in the 1997 school Medicaid TA guidance.

overview of the states that have expanded (or that are planning to expand) their school-based Medicaid program to cover all students. If your state is not listed here, it is likely that it only bills for services included in the IEPs and IFSPs of students enrolled in Medicaid.

4. What health services does Medicaid cover in a school-based setting?

All states are required to offer comprehensive physical and behavioral health services for children, including prevention and diagnostic services, but not all of those services are covered in a school-based setting. Services Medicaid will commonly reimburse for include in-school nursing services, physical therapy and counseling. In some states, all health services are eligible for reimbursement if they are deemed medically necessary and can be delivered by a qualified school-based provider.

It is important to note that many more physical and behavioral health services may be offered in a school-based setting other than those covered by Medicaid. These services would not be eligible for Medicaid reimbursement and funding would need to come from other sources. Identifying which services are covered in the Medicaid state plan can reveal potential health gaps—and opportunities to pursue state policy to expand the menu of covered services in schools.

To find out more about Medicaid-covered services in your state, visit your state's school Medicaid program or education department website. Healthy Schools Campaign has compiled links to most state Medicaid program websites.

5. Are there restrictions on the types of providers that can be reimbursed for delivering Medicaid-eligible services?

In short, yes. The state Medicaid plan will list the types of providers eligible to bill for services delivered in school-based settings, as well as the scope of those services. Those providers, including both LEA and contract employees, might include school nurses, counselors, school psychologists, speech-language pathologists, physical therapists and occupational therapists.

But it gets a bit trickier. The state education department credentials providers who are employed by school districts and determines certification/licensure requirements for school-based health providers. The credential is specific to the school setting and generally does not allow providers to serve students in other settings.

Various state licensing boards determine requirements for providers who can treat people in community settings (e.g., clinics and hospitals). The state education department may accept this type of license to provide school-based services.

In some cases, however, the requirements for a credential issued by the state education department and a state licensing board may differ slightly. For example, the state education department might require a school psychologist to have a specialist degree, while the state psychology board might require a psychologist to have a doctorate degree. These differences can vary by state.

There's one more point to consider. The Centers for Medicare & Medicaid Services (CMS) stipulates that any provider seeking reimbursement from Medicaid be recognized as a qualified provider, as defined in the state Medicaid plan. In some cases, such as for physical therapists, CMS requires that a qualified provider meet federal licensing criteria. The state licensing requirements might be more demanding, but the federal requirement represents a minimum standard. In other cases, such as for social workers, the federal government does not set forth criteria for licensing or determining what constitutes a qualified provider, and meeting the requirements needed to be authorized under state law is sufficient.

In either case, any provider—including those who work in a school-based setting—wishing to bill services to Medicaid must meet whatever federal and state requirements apply.

To find out more about the Medicaid-covered providers in your state, visit your state's school Medicaid program website.

6. What systems are in place to support your state's school health services program?

There may be a wide range of supports and systems already in place in your state. For example, many LEAs have developed an infrastructure to help link school health services with Medicaid, including electronic case management and data collection tools. Vendors can be an important source of information and play a critical role in supporting billing and data sharing between agencies. Building on existing tools and supports can be an effective and efficient way of strengthening and expanding your state's school health services program.

THREE

GETTING STARTED: BUILDING A COALITION TO EXPAND SCHOOL-BASED HEALTH SERVICES

Many different participants are involved in developing and implementing policy on expanding school-based health services—and the policies affect an even broader circle of people.

School-based Medicaid has wide implications that affect everyone from policymakers and healthcare providers to administrators and students. Given this, it is important to be as inclusive as possible when considering policy changes. Encourage all stakeholders to make their voices heard, and give everyone the opportunity to address concerns. A broad coalition—including state and local health and education decision-makers, as well as parents, advocates and funders—is essential to expand school-based health services effectively. Together, multiple participants can build a strong school-based Medicaid coalition to support shared goals.

WHO DOES SCHOOL-BASED MEDICAID IMPACT?

School-based Medicaid affects individuals and agencies at every level:

- Students and families eligible to receive health services
- Teachers whose students may have health needs that interfere with their attendance and learning potential
- Superintendents who may be able to access much-needed, available funds to expand health services
- School district legal departments that must work out consent agreements and contracts
- School-based and community-based service providers
- Local public health departments and behavioral health centers that can help target services to meet student health needs
- Local and state healthcare systems and provider networks
- State public health agencies that allocate funding and resources
- State education departments, including multiple programs that work on student health
- State Medicaid agencies, including eligibility and benefit departments, as well as contracting, managed care, and other programs
- State legislatures and governors who manage state budgets

Are these partners already involved in your coalition?

Building the Core

Building support at the state and local levels will help ensure the success of efforts to change a state Medicaid plan or state laws related to school health services. It is important to identify the key health and education decision-makers and to engage them from the beginning, along with agency staff who work on these issues day-to-day and people who can make decisions on behalf of their agency.

State Medicaid Agencies: Medicaid director or deputy director

Depending on the direction of the coalition's policy goals, the group may want to engage staff with expertise in issues such as benefits and coverage, managed care contracting, school-based Medicaid programs, the claiming/reimbursement process for schools, and the process of credentialing schools and school-based providers for Medicaid. It is also important to include Medicaid's legal counsel for questions on medical necessity, consent, data sharing and documentation.

State Education Agencies (SEAs): Chief state school officer or a key deputy

Additional staff to engage might include those who oversee the school-based Medicaid program, special education and efforts to advance safe and supportive school environments, and staff members who oversee school health grant programming, including the Centers for Disease Control and Prevention 1801 grants and Project AWARE grants. It is also important to include the state education agency's legal counsel for questions related to data sharing and contracting.

Local Educational Agencies (LEAs): District superintendent (or deputy), school board members, district budget director or legal counsel

Other partners might include special education directors, LEA billing specialists, school nurses, speech therapists, occupational therapists, physical therapists and other school-based providers, as well as the unions representing in-school staff.

Building Broad Support

The core group cannot do this alone. Many other partners belong at the organizing table and bring tremendous value to the process. The chart on page 21 can help you decide which stakeholders can help your group address its most pressing issues. Some possibilities include:

Additional State Agencies

It is important to identify decision-makers in state government who care about both health and education outcomes, including state legislators; the governor's office; and representatives from the various health, mental health, and alcohol and substance use agencies. These individuals can play an important role in building broad support for policy implementation and also have significant influence on state budget matters.

State public health departments can be good partners because of their depth of experience in state and local prevention, health promotion and needs assessment.

State Stakeholder Organizations

State stakeholder organizations—such as state chapters of teachers' unions, parent-teacher associations, primary care organizations and associations for school-based health centers—can play an important role in supporting state-level changes that are needed to expand and implement changes in school-based Medicaid.

State provider organizations—including state associations of school nurses, speech-language pathologists, occupational therapists and physical therapists—are essential participants as well. In addition, these organizations can play an important role in spreading the word about changes in school-based Medicaid policy and building on-the-ground support for implementation.

Local Agencies

At the local level, the mayor's office may be interested in discussing the importance of increasing access to school health services and the opportunity at hand. In addition, city council members can serve as important advocates for implementing this change, especially if the schools in the area they serve stand to benefit from increased access to school health services.

The local public health department is uniquely positioned to leverage public health data linking the top two to three health conditions from the State Health Improvement Plan (SHIP) to the delivery of Medicaid services in school settings.[9] Key allies could also include local health providers, local United Ways, and other local advocacy and social service organizations.

9. Developing a State Health Improvement Plan: Guidance and Resources, Association of State and Territorial Health Officials (June 2015): http://www.astho.org/Accreditation-and-Performance/Developing-a-State-Health-Improvement-Plan-Guidance-and-Resources/Home/

Advocates

State and local advocates bring the perspective of the community and the students and families to the table. Their involvement ensures active consumer engagement and a transparent process along the way.

National advocacy organizations are excellent sources of data, best practices and support for states. While national organizations are not likely to be a member of any state-based organizing table, engaging with one or more of these organizations can add depth and support—and a national perspective—to the work of the state team.

Health Providers and Insurers

Including health providers, local hospitals, pediatricians and managed care organizations in initial conversations can help ensure their support for this work as well as leverage the expertise and resources they bring to the table.

Funders

Many state-level funders, especially those who sit at the intersection of health and education, are well poised to support—and, in some instances, catalyze—a robust coalition in support of school-based Medicaid.

WHO SHOULD BE AT THE TABLE?

If your core policy questions include...	Make sure to include...
Financing school-based Medicaid services	· Medicaid department · State education agency · LEA and superintendent · Managed care organizations · Provider organizations
Expanding Medicaid under the CMS "free care" policy reversal	· Medicaid department staff with experience in submitting Medicaid state plan amendments (SPAs) · Medicaid staff with experience in coverage · State education department and local LEA staff who have knowledge of the various health-related services available to students served by the school · Parent/advocacy organizations
Untangling privacy or parental consent	· Legal counsel · LEA · Parent organizations · Children's advocacy organizations
The role of managed care	· Medicaid department staff who handle managed care · Representatives of managed care organizations · LEA claiming/reimbursement departments
Credentialing	· Provider organizations · Key state education agency and department of Medicaid staff who work on credentialing and licensing providers

Building a Common Language

To successfully engage partners, consider developing materials and resources that explain the program. The Indiana Department of Education, for example, has great resources available in English and Spanish that provide a good grounding in school-based Medicaid. These types of resources are particularly useful during the initial education and outreach to potential partners.

In addition, each partner comes to the organizing table with their own objectives, background knowledge and vocabulary. It's important, therefore, to clearly articulate the goals of the collaboration. To do that, each partner needs to understand specifically why each stakeholder supports the goal. Because of the differences in experiences and disciplines, it can sometimes feel like different partners are speaking an entirely different language.

For example, what healthcare stakeholders call measuring unmet need, education partners may call comprehensive needs assessment. In both cases, the purpose is the same: identify gaps where individuals are not receiving the services they need to improve their health. Same goal—different words and different processes.

Another example is that education partners will refer to specialized instructional support personnel when talking about the providers who deliver services in schools, whereas service providers are called Medicaid-enrolled providers on the Medicaid and healthcare side.

To advance a shared agenda, it is important to understand each discipline's language and priorities. It is critical to have participants who can act as interpreters, ensuring that partners understand one another.

Convening the Team: Best Practices

Regular, Effective Meetings

Regular meetings are essential to advancing a work plan and to building trust among stakeholders. Not only do meetings encourage interpersonal communication, but they are the most effective way to share information, provide updates and make shared decisions.

Experience suggests that periodic in-person meetings provide a strong foundation for advancing shared policy. Phone or video meetings also provide an opportunity for shared communication and can help bridge physical distances. Scheduled in advance, a regular meeting schedule can also serve as a deadline mechanism for individuals to complete their work.

A convener is key to making meetings work. A school-based Medicaid coalition could be convened by any stakeholder. In some cases, an external stakeholder (like a funder) may be an appropriate convener who can arrange logistics and provide financial support for regular meetings. In other cases, it may make more sense for the convener to be someone within a state agency who is tasked with advancing this work for the state.

To enhance the effectiveness of the meeting, clear goals for each meeting should be established with concrete next steps. For purposes of accountability, all deliverables should have owners and target dates attached to them.

A Shared Work Plan

A shared work plan (or action plan) may provide stability and accountability in reaching shared goals. In addition to articulating the objectives, a work plan will list the steps that each partner will take, consider possible barriers and provide a clear timeline. A work plan provides a journey map for getting from point A to point B.

Continuous Improvement and Growth

Your school Medicaid team will grow and shift over time. Asking questions of yourself and others will help you find the right partners to bring to the table and work toward making sure the coalition achieves its objectives. For example:

- **I know what my agency's goals are with school-based Medicaid.** *How do our goals align with other agencies' goals? Where do our goals overlap?*
- **My agency/organization runs programs that support student health, and we have a significant perspective to offer on how to improve programs across the state.** *What data do we have to share about how our program works? How can we collaborate with other agencies to move these goals forward?*
- **We have committed to the improvement of the school-based Medicaid program, and we have staff time to dedicate.** *What resources can we contribute to the coalition? Can we play a role as a convener? Is there a role for us to play in advancing this work?*
- **We are new to this coalition but have significant experience with school-based Medicaid.** *How can my agency bring value to the coalition? What can we take on to advance this work?*
- **We do not have support from all key agencies/parties.** *What are their priorities, and how can school Medicaid support these priorities? Who are the decision-makers, and who might have influence over them (state legislator, school district voices, other state agencies)?*

FOUR

OPPORTUNITY: CREATING A SUPPORTIVE ENVIRONMENT FOR REINVESTMENT IN SCHOOL HEALTH

States and school districts have ownership over many decisions that are critical to ensuring that the school Medicaid program supports student health and wellness.

School-based Medicaid claiming is a reimbursement program for eligible services provided to Medicaid-enrolled students. A school district provides the services, and the state Medicaid program reimburses the district for a portion of the delivery costs.

The Medicaid Match

Medicaid is a federal-state partnership; states must pay a certain percentage of their state's overall Medicaid costs, known as the federal medical assistance percentage (FMAP). The FMAP varies from state-to-state; at a minimum, the federal government reimburses a state 50 percent of its spending on eligible services provided to Medicaid enrollees. This means states are responsible for up to 50 percent of the costs of care, known as the state's "match."[10]

To raise their share of the match, states rely on different funding sources. For Medicaid services delivered in schools, many states require school districts, or local educational agencies (LEAs), to contribute to the non-federal share of school-based services. LEAs typically report their spending on school health services through certified public expenditures (CPEs), a Medicaid-approved methodology of certifying that the costs of the activities were spent from public funds, such as the school district budget.[11] This process reflects the actual costs incurred, which states capture and report using a detailed, methodology approved by the Centers for Medicare & Medicaid Services (CMS), as described in Chapter 7.

Another way that LEAs and states finance the non-federal share of school-based Medicaid is through an intergovernmental transfer (IGT). An IGT is a transfer of funds from a government entity, such as an LEA, to the Medicaid agency. In some states, LEAs submit claims for services to the state Medicaid department, which then calculates the non-federal share. The LEA then transfers that amount to the state, and the state puts in the claims to federal Medicaid. The claims then will be paid by the Medicaid agency.

10. Kaiser Family Foundation maintains information on each state's FMAP percentage and a multiplier: https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier

11. This 2012 report to Congress on Medicaid and CHIP includes information on Certified Public Expenditures: https://www.macpac.gov/wp-content/uploads/2015/01/State_Approaches_for_Financing_Medicaid_and_Update_on_Federal_Financing_of_CHIP.pdf

Understanding Reimbursement

When state Medicaid departments receive reimbursement from CMS for the services delivered in schools, they pass on all or some portion of that reimbursement to the LEAs. The amount will vary from state to state, but most state Medicaid agencies retain a percentage of the federal Medicaid reimbursement. The amount each state retains varies significantly; however, whatever money does flow back to the LEA is a sustainable source of revenue.

Promoting Reinvestment

The reimbursement that flows from the state to the LEA is often designated as general funding. In other words, LEAs are not required to reinvest the funding in school health services; a dollar of reimbursement for school nursing services is not necessarily a dollar reinvested in school nursing. However, additional funding for LEAs can be a significant boost for overall school budgets and helps LEAs stretch scarce local funding. In addition, this funding can incentivize LEAs to continue providing school health services and even expand access to these services.

Some states have gone farther, using legislation that encourages or requires LEAs to reinvest their reimbursement in school health services. These legislative efforts can be an important step toward increasing an LEA's commitment to school health services.

EXAMPLES OF LEGISLATION PROMOTING REINVESTMENT

In 2015, California approved legislation (SB-276) that states LEAs "must reinvest the federal reimbursement they receive under this program in health and social services for children and families, and develop and maintain a collaborative committee to assist them in decisions regarding the reinvestment of federal reimbursements."

Massachusetts has legislation (S.676) pending that would require an LEA that "obtains MassHealth reimbursement for providing direct nursing care services, administrative activities or any other medical benefits to a school-age child under this chapter, by and through its employees and agents, shall maintain the proceeds of such reimbursement to fund a program or programs of direct nursing care services and related administrative activities at any school facility or school system which it operates or over which it has direct supervision or jurisdiction."

Seizing the Opportunity

Asking questions about how school-based Medicaid works in your state will help unpack approaches to reimbursement and reinvestment. Here are some questions to consider:

- **I want to understand how billing and reimbursement work for my LEA.** *What methodology is used to determine reimbursement? If my LEA bills for services, how much money is reimbursed? What percentage of billed services stays with the state? How can the LEA or city use the revenue generated by the billing? Where does the money go—back to the school health services or to the general operating fund?*
- **I want to help my state develop a reinvestment strategy for reimbursement revenue.** *Is there interest from key stakeholders in developing a reinvestment strategy? What is my desired outcome (e.g., a legislative health services investment policy, expanded Medicaid services, etc.)? Who are champions for this initiative? What are the goals, milestones and time frame for this effort?*

FIVE

OPPORTUNITY: STREAMLINING AND IMPLEMENTING POLICIES TO FACILITATE MEDICAID REIMBURSEMENT

Implementing a successful school-based Medicaid-reimbursement program can help school districts stretch limited resources to support their school health programs.

Each state's school Medicaid program has different rules and guidance. Understanding the policies in place in your state is critical to expanding and streamlining Medicaid reimbursement.

Direct and Administrative Services

School districts, or local educational agencies (LEAs), can bill Medicaid for direct services—eligible health services provided by Medicaid-qualified providers to Medicaid-enrolled students—if the following conditions are met[12]:

- The child receiving the service is enrolled in Medicaid.
- The services are medically necessary.
- The services are covered in the state Medicaid plan or authorized by the federal Medicaid statute.
- The LEA is authorized by the state as a qualified Medicaid provider.

These conditions previously applied only to the services listed in a child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), but now states have the option to bill for other services that meet this set of criteria.[13]

Schools can also bill for certain administrative services. These are typically either outreach and enrollment services to families and children who are eligible for but not enrolled in Medicaid, or administrative activities that support the provision of Medicaid-eligible services—including care coordination, referrals and transportation for a child to receive a Medicaid-covered service.

12. Medicaid in the Schools, American Speech-Language-Hearing Association: https://www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit-Schools/

13. See Chapter 6 for more on opportunities for local educational agencies to bill for eligible services not included in students' IEPs/IFSP.

COMMON EXAMPLES OF DIRECT / ADMINISTRATIVE SERVICES

Direct

- Physical Therapy
- Occupational Therapy
- School Psychology
- Counseling
- Screening services
- Nursing services
- Services for individuals with speech, hearing and language disorders
- Rehabilitative services
- Preventive care services

Administrative

- Outreach and enrollment
- Care coordination
- Coordination of transportation
- Coordination of referrals

There are some exceptions. Notably, Medicaid does not cover services provided to a Medicaid-enrolled student if another program or entity is responsible for paying for those services (e.g., another health plan, or another federal or state program). This is known as third-party liability, and LEAs must seek reimbursement from other programs or entities before billing Medicaid.

THIRD-PARTY LIABILITY

Under Medicaid law and regulations, Medicaid is generally the health payer of last resort. This means that Medicaid pays for healthcare only after a beneficiary's other healthcare resources have been exhausted. In general, private insurers do not recognize school districts as healthcare providers and therefore will not provide payment for their claims. If a private insurance company denies a school district's claim, it is expected to issue a statement denying coverage. This denial should then allow payment from Medicaid for the service.

However, since most private insurers do not recognize schools as health providers, not only will they not pay for the services administered, they also might not issue the appropriate denial form. As a result, school districts are left to absorb the cost of the Medicaid-covered health services they provide to students with dual health coverage.

It is important to note that the requirement to bill third-party payers only applies to Medicaid-enrolled students who also have a third-party insurer. Approximately 8.4 percent of children enrolled in Medicaid also have private health insurance and, as a result, the issue of third-party liability does not apply to the majority of children that receive coverage through Medicaid.

While the December 2014 state Medicaid director letter also clarified that schools are not considered to be legally liable third parties, it specifically stated that schools are not exempt from the requirement to bill legally liable third-parties prior to billing Medicaid for students with dual coverage. Additional guidance is needed from CMS regarding third-party liability requirements. However, these requirements should not serve as a barrier to billing for school health services delivered to students whose sole coverage is Medicaid.

State Medicaid agencies have taken a variety of approaches to comply with the third-party liability requirement as it relates to school-based services. It is important to understand the methodology and required documentation to satisfy the third-party liability requirement in your state. More information is available in the 2016 CMS guide on the Coordination of Benefits and Third-Party Liability in Medicaid.

In practice, on any given day, school-based providers manage their caseloads, delivering the services that address their students' needs and help them learn. While attending to their day-to-day work, providers may not think about whether or not students are enrolled in Medicaid. But in order for the school district to bill Medicaid for those services, it must identify each service delivered to an eligible, Medicaid-enrolled student.

Designing and Implementing Reimbursement Policies

State Medicaid departments put in place the rules and regulations that guide the school-based billing and reimbursement process in accordance with their state plan and in partnership with the Centers for Medicare & Medicaid Services (CMS). It is the state Medicaid department, often in coordination with the state education department, that offers guidance to LEAs on direct versus administrative services and if (and when) the state uses a cost settlement methodology rather than a traditional fee-for-service approach.

Cost Settlement and Random Moment in Time Study

Cost settlement methodology generates reimbursement for services based on both claim payments for services rendered (interim payments) and a settlement of the costs associated with the provision of services. One such method is a statistically valid process called the Random Moment in Time Study (RMTS), which can provide a sampling of time spent delivering eligible services provided in schools. CMS has increasingly been interested in the use of RMTS for school-based Medicaid programs, and many states are adopting this model.

RMTS consists of a statewide sample of providers delivering direct and administrative services to determine the percentage of time spent delivering services or conducting outreach and administrative activities associated with the school-based Medicaid program. Providers are asked to report how they spent their time at a specific moment in a day (e.g., Tuesday, March 1, at 12 p.m.). They do that by answering a series of questions related to the nature of the activity performed at the designated moment. These questions are used to determine whether the activity was Medicaid-eligible. Providers are grouped into "pools," in which like providers are sampled together to ensure the most accurate representation of their time is reflected in the statewide sample.

Samples are drawn quarterly and are designed to reflect the entire universe of moments in time when providers in schools may be present and engaged in a Medicaid-eligible activity. All time is accounted for, including non-Medicaid allowable time, using CMS-approved codes that are designed to create buckets to describe how time is spent.

At the end of the year, the state uses the data associated with time spent, the costs provided by LEAs and a record of the interim payments already received by the LEA to calculate a final settlement amount. An additional cost settlement to correct an over- or under-payment may be necessary between the LEA and the state.

The RMTS brings some unique challenges that states and LEAs must address:

- Participation is crucial to the accuracy of the RMTS results. CMS requires a minimum of 85 percent of all moments sampled to be considered valid (i.e., completed by the appropriate staff, etc.). Failure to complete sampled moments could affect the time study results and reduce the amount of reimbursement available to those participating in the program.
- When considering a state plan amendment (SPA) that may result in CMS requesting modifications to the RMTS methodology, one of the key questions that comes up is how much notice the state will give the LEA about when their designated moment is. LEAs prefer as much lead-time as possible in order to prepare providers and staff for the increased paperwork.

- Similarly, the state will define the amount of time providers have to complete and submit their paperwork documenting what they were doing at the designated moment. Given that school-based providers spend the vast amount of their time with students, rather than in front of a computer, and that schools are closed on weekends and holidays, LEAs would like as many school days as possible in order to maximize provider participation.

Opportunities exist to streamline and implement policies that support the success of LEAs and school-based claiming. For example, designing state policy around RMTS notice and response time is a critical element. Providing training and support to LEAs and to providers is also critical. States can play a role by funding training and resources for LEAs, provider trade groups, and others. Clear state guidance and claiming manuals are also important.

Documentation of Medically Necessary Services

School providers must document the delivery of Medicaid services as part of the reimbursement process. Just as any medical or behavioral health provider might do when billing their time to a health plan, they must note what services were delivered, the duration of the services and any notes as part of the health record. But for the purposes of Medicaid, school providers must also document that the services meet the state's definition of medically necessary.

It is commonly understood that Medicaid will reimburse for services that are outlined in a student's IEP. These services are legally required to be provided to the student under the Individuals with Disabilities in Education Act (IDEA). However, services in the IEP are not automatically considered medically necessary by Medicaid, and the IEP itself may not be considered sufficient to establish medical necessity for the purposes of Medicaid reimbursement. It may be necessary, therefore, to include additional medical documentation of medical necessity according to the state's rules.

This can be confusing for providers, so clear guidance from the state on the documentation required for medical necessity, who Medicaid recognizes as qualified to establish medical necessity and the appropriate processes to collect this documentation is critical to ensure appropriate compliance.

Addressing Parental Consent

In addition to documenting medical necessity, it is important to have a process to obtain parental consent. 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) for the services provided.

High rates of parental consent are critical to making school-based Medicaid billing work for sustainable funding. The more parents who provide consent, the higher Medicaid reimbursement will be, since LEAs cannot bill Medicaid without consent to do so.

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). (See Chapter 9 for more on these laws.)

Parental consent processes—and the implications for families and school reimbursement—vary by state. It is important to carefully consider state options and engage a range of stakeholders to ensure a robust parental consent process that works for all parties. Parent education can help clarify how participating in the consent process can affect the availability of a range of healthcare services inside and outside schools.

MASSACHUSETTS: A MODEL FOR COLLECTING PARENTAL CONSENT

As part of the state's school-based Medicaid expansion, Massachusetts revamped its parental consent process, requiring all parents to submit new forms.

The state released extensive guidance to LEAs on how and why to collect parental consent forms—which are key to seeking sustainable Medicaid reimbursement—and identified several best practices:

- LEAs may use the new consent form at IEP or other health plan meetings. During the meeting, the LEA can ask if parents/guardians are willing to complete the form naming all children in the family.
- LEAs may include the new consent form with other required information sent home with students pursuant to Title I, information about free and/or reduced lunch applications or other similar communication.
- LEAs may include the form in annual "back to school" packets for families that are understood to have MassHealth (Medicaid), including any family that participates in the free lunch program.
- LEAs may use Medicaid Eligibility Matching response file information made available to school districts to identify students who are enrolled in MassHealth.
- LEAs may use the Provider Online Service Center (POSC) individual eligibility

inquiry function to determine if a student is enrolled in MassHealth prior to obtaining parental consent.

The Massachusetts Department of Education website features the full parental consent guidance and FAQs that provide excellent information (the administrative advisory is also posted). Translated versions of the parental consent form are available in Spanish, Haitian Creole, Chinese and Portuguese.

Where to Go for More Information

Today, there are school districts in every state (except Wyoming) that bill Medicaid for eligible services included in the IEPs of students enrolled in Medicaid. These districts provide important lessons and best practices—as well as ways to address barriers—for other LEAs.

For more information on the LEAs in your state that bill for Medicaid, contact your state Medicaid agency or education department. Information may also be available on state websites. The California Department of Healthcare Services, for example, lists all the participating LEAs, and the Indiana Department of Education provides similar information.

Your state's existing school Medicaid program infrastructure, including training, guidance and billing systems, provides an important foundation for expansion. There are specialists employed by LEAs who understand the intricacies of developing and implementing billing and reimbursement processes. It is not necessary to know every detail or understand every decision. What is important is a foundational understanding of how it works and how claiming for school-based services can lead to increased access to and funding for school health services.

Important opportunities exist at the state and LEA levels to clarify the claiming requirements for billing Medicaid, for educating LEAs and providers, and for making improvements that streamline the documentation and claiming process. State policy and guidance documents are critical for supporting this work.

CMS provides guidance to states through two guides: a technical assistance guide that provides an overview of Medicaid and school health and an administrative claiming guide that provides support to states on the school-based administrative claiming program. However, these guides were published in 1997 and 2003, respectively. While they remain the core federal guidance on claiming, stakeholders continue to underscore the importance of publishing an updated guide that reflects the current Medicaid environment.

ROLE OF VENDORS IN ADMINISTERING SCHOOL-BASED MEDICAID

In order to participate in billing and claiming for school-based Medicaid, many states and school districts rely on vendors. This is a common practice in the healthcare industry: Many hospitals, clinics and providers use outside vendors to process their medical claims and reimbursements.

Vendors perform the administrative functions of collecting claims and administering billing methodologies and do the actual billing and reimbursement with the state Medicaid department. They offer valuable solutions to the complex functions of school-based Medicaid.

However, vendors can be expensive. Some districts find that using vendors helps them maximize reimbursement, and the investment yields greater reimbursement. Other school districts find that they are able to perform the same functions more efficiently with school-employed staff.

It is important to evaluate both options against the impact on costs and reimbursement. Decision factors may include the size of the district, the proportion of Medicaid-enrolled students, the volume of services provided, and the complexity of the state's billing and reimbursement systems.

Seizing the Opportunity

The case for expanding Medicaid billing by LEAs is an easy one: The more services that the LEAs bill for, the higher the reimbursement. This can help LEAs stretch limited resources to support school-based health programs. But putting the pieces together to streamline billing is a complicated process and requires clear state guidance for LEAs, provider education and training, and the implementation of billing systems. Above all, it takes making a clear and compelling case that expanding reimbursement will help increase access to health services.

States and LEAs will both play a key role in developing and implementing the policies and procedures. It is important to talk to a range of stakeholders about their experiences. Here are some perspectives and questions to consider:

- **I know that expanding Medicaid reimbursement will help LEAs stretch scarce resources for school health services.** *How can I make that case to stakeholders? Is there already a group of stakeholders talking about this—and is it the same people who are considering expanding the state's school Medicaid program? For LEAs that have implemented successful reimbursement programs, what messages did they find most useful?*

- **In addition to documenting unmet student need, I want to compile data about how LEAs could use additional resources from reimbursement.** *Is there data available about how much revenue LEAs receive from school-based Medicaid reimbursement?*
- **I want to understand what services LEAs are already billing for in the state.** *What services are billable by my state? Are they direct or administrative services for the purposes of claiming?*
- **I want to understand more about the nuts and bolts of what it means to administer the billing and reimbursement process in an LEA.** *Who in my LEA works on billing and reimbursement?*
- **I'm at the state level and want to support LEAs.** *What are the key obstacles facing LEAs in their claiming? Is it lack of resources? The need for more funding for provider education and compliance? Are the state claiming processes too complicated and, if so, would additional guidance or training help?*
- **I know a lot of LEAs in our state don't bill Medicaid. I want to make it easier for them.** *What resources are available for training LEAs and providers in my state? Who at the state level (in the state education department or Medicaid) works with LEAs?*
- **My state is considering changes to school-based Medicaid, but CMS is saying we need to make changes to our methodology.** *What is our current methodology, and how might it change? What are the notice and response times that CMS is asking for, and are they realistic?*
- **I keep hearing that medical necessity documentation is a challenge.** *What are the policy requirements for documentation to establish medical necessity—and what are the state policy levers that impact those decisions? What policies does my state have regarding who is eligible to establish medical necessity?*

SIX

OPPORTUNITY: EXPANDING SCHOOL-BASED MEDICAID PROGRAMS THOUGH THE "FREE CARE" RULE

Many states are in the process of (or are considering) expanding school-based Medicaid programs to include all Medicaid-enrolled students—and to add additional covered services and provider types. This presents a tremendous opportunity to expand access to and resources for school health services.

The History of the "Free Care" Rule

In 2014, the Centers for Medicare and Medicaid Services (CMS) issued a letter to state Medicaid directors that clarified which services can be reimbursed by Medicaid in a school-based setting.[14] This guidance allows school districts to expand their school-based Medicaid programs to cover more students and potentially bring in additional, sustainable federal funding for states.

Known as the "free care" policy reversal, the letter clarified CMS policy that prohibited reimbursement for services provided to Medicaid-enrolled students if those services were provided free of charge to all students. There were some exceptions: Services could be submitted for Medicaid reimbursement if they were included in a student's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) or delivered through the Maternal and Child Health Block grant.

The CMS letter clarifies that schools can seek reimbursement for covered services provided to all students enrolled in Medicaid—not just those with IEPs and IFSPs. It states that the "goal of this new guidance is to facilitate and improve access to quality healthcare services and improve the health of communities."

Some states have used this policy to expand their school-based Medicaid programs, with more following suit. It presents an important opportunity for states to: 1) support school districts, or local educational agencies (LEAs), in drawing down additional Medicaid funding for school health services; and 2) increase access to school health services.

This policy has also opened the door to broader conversations about what school-based Medicaid programs could look like. Many states are considering how to get Medicaid to recognize the role of additional providers who are delivering services in schools—and to increase the types of school-based physical and behavioral health services that are reimbursed by Medicaid.

States now must make policy decisions about what their school-based Medicaid program will include. Will LEAs be allowed to bill for services delivered to all Medicaid-enrolled students, or just for services included in IEPs or IFSPs? Will more states expand the types of covered services—or the list of providers qualified to seek reimbursement for school-based services?

14. Dec. 15, 2014 CMS letter on Medicaid Payment for Services Provided without Charge (Free Care): https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

Expanding billing for more students—as well as expanding the types of services and providers being reimbursed—could mean more federal revenue to the state and more reimbursement to districts. And since most schools already deliver some of these services (and pay for them with education dollars), bringing in federal reimbursement can replace scarce education money and help stretch resources further.

As a result, this can help ensure ongoing investment in and support for the delivery of school health services to students enrolled in Medicaid. And it could also ultimately help schools expand the staffing needed to provide physical and behavioral health services to students.

BILLING MEDICAID

What does an expanded school-based Medicaid program mean for the process of billing Medicaid? For the most part, states will continue to bill using the same CMS-approved structures as before. In states that use a fee-for-service model, LEAs will continue to bill on a fee-for-service basis. In states that use a cost-settlement model, LEAs will continue to use the random moment in time sampling methodology to apply their costs. But in each environment, more students will be included. There will need to be more LEA and provider training to ensure services are billed correctly.

Federal funds can be used to supplement education funds to increase provider capacity, add additional services, or plug budget holes to keep school health services strong. The "free care" policy reversal helps increase health equity across schools by targeting reimbursement to schools that have higher percentages of Medicaid-enrolled students.

Moving forward with a plan to expand school-based Medicaid takes time and coordination. But there are potentially huge benefits. Some states will need to pursue a formal state plan amendment (SPA) with CMS, while other states may be able to make the change at the state level. This will depend on the existing language in each state's Medicaid plan.

Many state Medicaid plans codified the pre-2014 CMS policy by explicitly stating that school districts may only seek Medicaid reimbursement for health services delivered

under a student's IEP.[15] In order to bill for covered health services delivered to all students enrolled in Medicaid, those states will need to submit a SPA to expand that definition and to make changes to the types of eligible services and providers.

It is also important to note that a small number of states codified the restrictive policy in state law as well as in their state Medicaid plan. For example, Florida and Maryland have state laws that limit LEAs to billing only for school health services included in a student's IEP. While state law can present a barrier to the implementation of the revised CMS policy, it can also serve as an important tool for catalyzing action.

WHAT IS A STATE PLAN AMENDMENT (SPA)?

The Medicaid state plan is the formal, written agreement between the state Medicaid program and CMS that outlines the operational and policy decisions that determine who is eligible for Medicaid, what services and providers are covered, and how payments are set.

The state plan can be amended as needed to reflect changes in state policy and federal law and regulation. Changes or updates to the state plan are made through a state plan amendment (SPA). States can choose to submit SPAs on a variety of different policies, and CMS must formally approve the SPA before it can be implemented.

The Medicaid and CHIP Payment and Access Commission (MACPAC) has excellent information about Medicaid state plans and the SPA process.

States that do not need to pursue a SPA are able to leverage the "free care" policy reversal to expand their school-based Medicaid programs without engaging CMS. In those cases, state policy and program decisions would determine the LEA's opportunity to begin billing for additional populations.

Every state has its own process for moving a SPA forward, but it's worth noting that state Medicaid departments change state plans regularly—and Medicaid officials can advise on the formal process for pursuing a SPA. In general, a state submits paperwork to CMS requesting the policy change and then works with CMS to iron out the details, with other stakeholders joining in as needed. While there are time clocks on how quickly the SPA process should move, CMS can start and stop the clock.

15. Medicaid's "Free Care Policy:" Results from Review of State Medicaid Plans, National Health Law Program (2016): https://healthyschoolscampaign.org/wp-content/uploads/2017/07/MedicaidFreePolicyCare.revd_.10.20.pdf

As of December 2019, 10 states—Connecticut, Kentucky, Louisiana, Massachusetts, Michigan, Missouri, Nevada, New Hampshire, North Carolina and South Carolina—have successfully expanded their school-based Medicaid programs, with many more in the queue. Though each took a slightly different approach, they all leveraged the opportunity to expand access to covered services and providers. Here's how five of those states accomplished this.

Louisiana

In 2015, CMS approved a change to the Louisiana state plan to remove the IEP requirement and to allow school districts to bill for school-based nursing services delivered to all Medicaid-enrolled students. Louisiana's SPA was fairly narrow in that it was a limited expansion for school-based nursing. It did not add additional providers or services to the school-based Medicaid program.

Unofficial estimates from the state suggest that school-based Medicaid revenue has, over three years, dramatically increased as a direct result of this policy change, as has the number of school nurses statewide.

Massachusetts

In 2016, CMS approved a change to the Massachusetts state plan to allow school districts to bill for all Medicaid-enrolled students and to allow billing for additional services and providers types. The state then spent time on building the necessary infrastructure for implementation. This expanded Medicaid program change went into effect in the 2019-2020 school year (billing is not retroactive back to 2016).

Massachusetts did have to apply for a SPA to make these changes to its school Medicaid program. Notably, CMS approved a new methodology that allowed the state to settle costs for IEP and non-IEP services separately. Under the expansion, separate calculations will be done based on a provider's time spent delivering either IEP or non-IEP services, as well as Medicaid eligibility rates for IEP services and non-IEP services. This important development helped the state ensure appropriate reimbursement for each set of students.

Massachusetts also provides an example of a state that used its SPA to expand the types of services and providers covered by the school-based Medicaid program. The SPA makes clear that coverage applies to all medically necessary services covered by MassHealth (the state's Medicaid program) and provided in a school-based setting to Medicaid-enrolled students. It also stipulates that the LEA may seek reimbursement for those services. Additional details are available in this brief prepared by Community Catalyst, Healthy Schools Campaign and the National Health Law Program.

Michigan

In July 2019, CMS approved Michigan's SPA to allow districts to bill for school-based services provided to both IEP and non-IEP students. Michigan's approach greatly simplified the SPA for by covering all medically necessary services included in Medicaid's comprehensive Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit.

The SPA also enhances and clarifies the list of qualified providers in the Medicaid state plan who can claim for services provided to Medicaid-enrolled students. The newly added providers include nurse practitioners, physician assistants, clinical nurse specialists, marriage and family therapists, behavior analysts and assistant behavior analysts, school social workers and school psychologists.

North Carolina

In January 2019, CMS approved a change to the North Carolina state plan, allowing school districts to bill for nursing, counseling, occupational therapy, speech language therapy and physical therapy services for all Medicaid-enrolled students. The school-based Medicaid program also now allows billing for vision screening and clarifies the definition of hearing services. The state did need a SPA to make the policy change to expand billing for all Medicaid-enrolled students and to expand services and provider types.

In many ways, the North Carolina SPA is similar to the Massachusetts SPA. One key difference is that North Carolina does not cover all medically necessary services provided in schools in the same way that Massachusetts does. North Carolina's school-based Medicaid program is limited to the specific services outlined in the plan. Additional details are available in this analysis prepared by Community Catalyst.

South Carolina

In 2016, South Carolina started permitting districts to bill for eligible services delivered to all Medicaid-enrolled students. There were no restrictions in South Carolina's state Medicaid plan that precluded it from taking full advantage of CMS policy. As a result, the state did not need to submit a SPA, nor did it need approval from CMS.

A particular focus for expansion has been nursing services provided by the school districts and behavioral health provided in collaboration with the state's Department of Mental Health.

Seizing the Opportunity

There is now a significant amount of activity around school-based Medicaid. Many states are considering expanding the program to include billing for all Medicaid-enrolled students—and to add additional services and provider types to the list of covered benefits and services. A significant number of states have expressed interest in expanding their programs to increase access to behavioral health services to address unmet mental health needs.

As a result, many states already have—or are planning to—submit SPAs. Community Catalyst, Healthy Schools Campaign and Trust for America's Health regularly update a state activity brief pertaining to school-based Medicaid expansion: bit.ly/freecareupdate.

Now is the time to engage in the conversation. Some issues and questions to consider include:

- **My state is pursuing opportunities to expand school-based Medicaid, and I want to be at the table.** *Who is convening the stakeholders in my state?*
- **I see students whose needs aren't being met in school or in the community.** *How can my LEA expand school-based health services? Can we leverage CMS policy to increase the types of services and providers that are reimbursed by Medicaid?*
- **It looks like my state is interested in submitting a SPA.** *What are the details? Which students does it affect? Does the SPA expand school-based Medicaid to cover additional providers or services?*
- **I want to increase mental and behavioral health services in schools.** *Does CMS policy present an opportunity to increase funding for my state to expand access to these services?*
- **I really want to get engaged but have no idea how to participate.** *Who is working on expanding school-based Medicaid in my state? Is my LEA's Medicaid coordinator involved? What about children's advocacy groups?*

Does your state...	Read more about...
Need a SPA to expand services?	LA, MA, MI, NC, NV
Seem prepared to expand without a SPA?	SC
Want to expand reimbursement to a single provider type (e.g., school nurse)?	LA
Want to expand reimbursement for a range of providers?	MI
Want to expand reimbursement for all medically necessary services provided to Medicaid-enrolled students?	MA, MI, NV
Want to understand the impact of the methodology used to separate billing for students with IEPs and students without IEPs?	MA, MI, NC
Interested in expanding reimbursement for a specific set of services?	NC
Interested in expanding reimbursement for behavioral or mental health services?	MI
Need to make legislative changes to clarify what can be covered by Medicaid in schools?	FL

SEVEN

OPPORTUNITY: WORKING WITH MEDICAID MANAGED CARE ORGANIZATIONS

Understanding the role of Medicaid managed care organizations (MCOs) and thinking about how to strengthen partnerships between schools and MCOs can be a winning strategy for states, school districts and the MCOs themselves.

Medicaid managed care organizations (MCOs) are private health insurance companies that work with Medicaid to provide health insurance, contract with providers, and handle billing and reimbursement. In many ways, MCOs are comparable to employer-based health plans: They have a defined benefit package and in-network providers, and they pay providers for the services delivered to their members.

Almost all children enrolled in Medicaid have some type of managed care[16], and over two-thirds are enrolled in comprehensive managed care. All Medicaid MCOs must cover comprehensive care and are required to keep costs affordable by limiting out-of-pocket spending.

Each MCO has a state contract to provide a specific bundle of services and manage care for its members. The contract lists the different services that must be provided, along with the types of providers who may participate in the plan's network. The MCO is paid a monthly fee by the state for each member who is enrolled—this is known as a capitated payment or capitation rate.

In most states, school-based Medicaid services are not the responsibility of the MCO; this is commonly known as being "carved out." Instead, school districts, or local educational agencies (LEAs), directly bill the state Medicaid department for the services they provide, and the Medicaid department provides the reimbursement, as described in Chapter 2.

If school-based Medicaid services are included in the MCO contract ("carved in"), the MCO's 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. In areas where there are several MCOs operating, LEAs might need to contract with several different plans to get reimbursement for all their students.

Information about which and how many MCOs serve students in a geographic region is available through state Medicaid departments. Kaiser Family Foundation maintains helpful charts showing the number of children enrolled in comprehensive Medicaid MCOs and the MCOs operating in each state.

Partners To Achieve Quality

It is likely that your LEA already has a relationship with some MCOs in its area, even if school-based health services are not carved into the state's MCO contract. Many MCOs

16. Types of Managed Care Arrangements, Medicaid and CHIP Payment and Access Commission: https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/

work with schools on back-to-school health insurance enrollment events, and on health fairs and vaccination efforts. These partnerships are not the same as a contractual relationship in school-based Medicaid, but having or developing a relationship with the MCOs is a good first step toward a strong partnership.

Taking the time to get to know the MCO helps both sides understand the role that Medicaid plays in supporting student health in general—and student health in schools. This is especially important when considering the challenges both MCOs and schools face when school-based Medicaid services are carved into the MCO model. Provider network arrangements, credentialing criteria and program requirements, including prior authorization of services, can vary between MCOs. Often the MCO policies governing these areas can take time to untangle.

An important element of a school/MCO partnership is understanding how school-based health services can help MCOs achieve the federal and state-specific quality metrics they are required to meet for their Medicaid populations, including many child-specific measures.

Common pediatric quality metrics that states require include child vaccination rates and well-child visits. In addition, there is a growing focus on improving outcomes on social determinants of health—and states are increasingly requiring plans to address such issues as food insecurity, unstable housing and exposure to violence. Some states are also considering requiring MCOs to improve quality metrics on measures such as reducing rates of chronic absenteeism.

Schools can help MCOs improve their pediatric quality outcomes in multiple ways. If MCOs need to reach children on specific measures, schools can provide access to students and their families, eliminating barriers for families in accessing the services. As partners, schools and MCOs can work together to address the needs of the community. But schools can't provide these additional services without resources, and MCOs will need to think carefully about how best to provide sustainable support to schools in order to achieve their annual metrics.

Over the next five years, the importance of quality metrics will become more transparent. Beginning in 2024, states will be required to publicly report Child Core Set measures, a standardized set of pediatric quality measures required for all states in the Medicaid program. The Child Core Set measures are already updated annually, but state reporting is voluntary.

As states look to 2024, they will increasingly rely on MCOs to deliver services necessary to improve quality. Now is the time to build meaningful relationships between schools and MCOs to achieve the quality metrics—and the goal of improved child health.

For more information about the Child Core Set, including the current measures, visit the CMS page on Children's Healthcare Quality Measures.

Seizing the Opportunity

Partnerships with MCOs present a tremendous opportunity to advance student health services. What's more, it's a win-win situation. LEAs can put in place structures to bill for school health services, and MCOs can help students get the services they need and meet their quality metrics. If you are interested in pursuing partnerships with MCOs, consider the following situations and questions:

- **I want to make the case that schools can play a big role in helping MCOs meet their quality metrics.** *What quality metrics are MCOs in my state responsible for meeting, and which of those can schools play a role in?*
- **I want to demonstrate to MCOs that schools are an important provider for improving child and adolescent health.** *What data can I use to show that the LEAs in my state are already providing a significant number of health and behavioral health services in schools?*
- **I had a conversation with MCO or health plan leadership, and it is clear they don't understand the role that schools play in student health.** *How can I make the case for partnerships that reflect the LEA's unique situation?*
- **I see the potential here, but I really don't know where to start.** *What LEAs in my state have a relationship with MCOs? Where are MCOs already partnering with schools, and in what capacity?*
- **I want to encourage formal, contractual relationships between LEAs and MCOs.** *Are there any existing partnerships in my state? What type of formal contract or memorandum of understanding is there, and is it replicable?*
- **I understand that a good first step is to engage the right person at the MCO.** *Who at the MCO—or at the state health plan association—is the point person for student health or for local partnerships?*

EIGHT

OPPORTUNITY: UNTANGLING HIPAA & FERPA

Communication among all members of the care team is critical to making sure students get the health services they need—but it can be challenging to share healthcare and education data while navigating federal and state privacy rules.

Understanding Federal Law

The Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule are the key federal laws that protect the privacy of education records and healthcare information and limit how that information can be shared. It is important to note that in addition to federal laws, there are also state laws that impact data sharing, some of which may include more specific or more stringent data privacy and confidentiality rules.

FERPA applies to all elementary, secondary and post-secondary schools that receive funding from the U.S. Department of Education. It covers the "education record" and any personally identifiable information that could be used to identify a student. This includes student health records, such as immunization records, maintained by the school or school nurse. The information cannot be disclosed under FERPA without written consent from a parent or student age 18 or older, except in certain emergency situations.

A school may disclose "directory information"—such as a student's name, date of birth and grade level—without consent. If a school-based health program is funded, administered or operated by the school, the health records are considered "education records" and are covered by FERPA. This would include providers hired by the school district with grant funds, possibly from a foundation or government agency.

HIPAA applies to most healthcare providers and covers information relating to an individual's past, present or future physical or mental condition. The broad range of providers subject to HIPAA includes physicians, clinical social workers, and mental health practitioners, as well as hospitals and clinics.

Like FERPA, HIPAA also requires written consent from parents or students age 18 or older for disclosure of information, with some exceptions. If a school-based health program is funded, administered or operated by an external, non-education agency or healthcare system (e.g., a school-based health center), then HIPAA applies.

FERPA and HIPAA can never apply to the same information at the same time, because health information that is held in education records is specifically excluded under HIPAA.

Resources to Help Untangle HIPAA and FERPA

Understanding whether your school health program is covered by HIPAA or FERPA is important because: 1) it puts in place different paperwork and reporting requirements for sharing student health data with others on the care team; 2) means different things in terms of parental or student consent to share information; and 3) requires different protocols for sharing and transmitting information.

DATA SHARING IN D.C.: A CASE STUDY

An innovative data-sharing agreement in Washington, D.C., is helping health and education leaders identify student health needs—and make sure those needs are met. The agreement has improved coordination and delivery of services among the city's schools, the public health department and the Medicaid agency.

Each agency holds critical student health data and has an important incentive to ensure that students receive health services:

- D.C. Public Schools has an institutional requirement to collect health information, including oral health information, for each enrolled student; the forms collected help schools plan for the medical needs of students. D.C. Public Schools also holds student enrollment data.
- The Department of Health requires that all students complete school health forms and have required immunizations to enroll in school, which means each student must go to their primary care provider for a well-child visit and dentist for a dental exam within the year.
- The Department of Health Care Finance (the District's Medicaid agency) is required to document that the city's Medicaid-enrolled students receive appropriate healthcare services; it also has data showing what services were paid for and to what managed care organization the student is assigned.

When pieced together, the data identify the schools with high Medicaid populations, with high unmet need, and where students are not receiving annual well-child or dental visits. Together, the agencies developed a Memorandum of Agreement (MOA) that allows them to share data in a way that helps them target outreach and resources to schools and students with the greatest unmet needs.

–From Sharing Data to Meet Student Health Needs in Washington, D.C., published by Healthy Schools Campaign

Untangling HIPAA and FERPA is critically important to building an effective school-based health system—but it can be extremely technical. It is important to include representatives from the state education agency, state Medicaid agency and an LEA's legal counsel when figuring out what needs to happen for parental consent, or when building out new data-sharing arrangements. Including counsel from the beginning will help identify the legal complexities—and provide real solutions.

The distinction between HIPAA and FERPA is described in detail in two primers developed by the National Center for Youth Law: *HIPAA or FERPA? A Primer on School Health Information Sharing in California* and *HIPAA or FERPA? A Primer on Sharing School Health Information in Indiana*. They can be a helpful resource even for agencies not in those two states.

The Association of State and Territorial Health Officials (ASTHO) created a fact sheet, *Comparison of FERPA and HIPAA Privacy Rule for Accessing Student Health Data*, which offers additional information.

Seizing the Opportunity

Navigating privacy and confidentiality laws will require patience and dedication—and the early involvement of appropriate legal counsel. But these problems are solvable, and solutions can be developed in tandem with other state and local policy changes.

In addition, LEAs that are already billing Medicaid for services included in IEPs will have a solid foundation on which to improve data-sharing agreements. School-based Medicaid programs can expand and build on top of existing infrastructure—and offer a great opportunity to improve data sharing.

Here are some issues and questions to consider concerning data-sharing opportunities:

- **I know that LEAs in my state have addressed data sharing already.** *How did they do so, and what are the best practices already in place?*
- **My state has complicated HIPAA and FERPA interactions.** *What are the rules unique to my state? What are the key considerations that will need to be addressed in my state to ensure appropriate compliance?*
- **I'm worried about how data sharing works in practice.** *What does this mean for the various different parties, including parents and healthcare providers? How has this been addressed in practice?*
- **I want to expand school-based Medicaid.** *Should I have legal counsel join our coalition from the beginning in order to address these issues up-front?*

NINE

OPPORTUNITY: BUILDING PARTNERSHIPS TO EXPAND ACCESS TO SCHOOL HEALTH SERVICES

Partnerships can play an essential role in addressing student health needs and expanding access to student health services. Identifying and engaging potential partners in your state and community is key to ensuring access to care for vulnerable students.

Increasingly, healthcare providers recognize the role that schools can—and do—provide in meeting student health needs. As such, there are emerging opportunities to expand access to health services in school-based settings, including partnerships with a variety of different healthcare stakeholders. These types of partnerships already exist in communities across the country and hold great potential for bringing additional healthcare resources into schools and expanding the workforce to serve students.

This chapter provides an overview of the different kinds of service providers that might be willing to partner with schools and school districts to improve student health. It also looks at a few emerging delivery options—meaning formal agreements with an external healthcare provider, such as a hospital or a nurse who is not employed by the district or the school, in which the provider agrees to deliver services to students in a school-based or linked setting (a site near the school campus).

Many local educational agencies (LEAs) will expand their school-based health services program through a combination of partnerships, school-based providers and other models. In this way, they can help as many students as possible receive the services they need.

The partnership models are distinct from the expansion of school-based Medicaid programs through implementation of the "free care" policy reversal; however, Medicaid may play a role in reimbursing the providers for services delivered. In these partnerships, the school and the LEA are not employing or contracting with the provider to pay for services. Instead, the provider seeks reimbursement through its regular methods.

For example, hospitals and federally qualified health centers (FQHCs) already bill Medicaid for services delivered by their providers, and that process would be extended to cover services delivered to students enrolled in Medicaid. By entering into these partnerships, schools can expand access to needed services without having to use scarce district resources to do so—and without taking on any of the administrative and paperwork burdens.

It may be necessary to have a formal memorandum of understanding (MOU) between the school or LEA and the external partner that includes a clear definition of the roles and responsibilities of all parties. This will ensure that students are receiving services from qualified health providers and that their health data remains protected. The MOU may also clarify any financial implications (such as whether the external provider will bill Medicaid for the services provided)—and what that means for schools and families.

State agencies can play a role in fostering partnerships between healthcare providers and school districts and schools. This can be done by: developing state-level guidance

that helps communities address data sharing or contracting with managed care organizations; conducting statewide assessments that provide communities with the data needed to inform partnerships; and approving policies that create a supportive school health environment.

State agency leaders also can be the catalyst for building an improved system of care. Agencies can partner directly with school districts and offer a new vision for how schools can improve physical and behavioral health. Mental health and alcohol and substance use services may be provided through collaborations between state agencies and school districts.

Building a partnership between a school or LEA and a healthcare provider takes time. It involves the development of a shared understanding of the scope of services and clear guidelines around data-sharing, parental consent and documentation. While the logistics can feel overwhelming, the process can start with a phone call between interested parties. Once there is an interest in working together, and institutional commitment, the right people can be brought together to formalize the arrangements.

Partnerships with Healthcare Providers

Partnerships with external healthcare providers usually take place at the school or district level. The healthcare entity may approach the school, or the school or district can be proactive in reaching out to the healthcare entity. Many of these external health partners may already be engaged in school health, making it possible to tap into existing efforts.

The chart below features examples of the types of healthcare providers and organizations that may partner with schools and LEAs. Every community offers different opportunities and resources. An independent assessment of each community's healthcare system may uncover many different willing partners. Local public health agencies and community-based organizations can also play a role in identifying willing community providers and other local programs that could partner with schools.

Potential Partner	Value of Establishing a Partnership
Hospitals and health systems	Hospitals and health systems are working to identify and implement new strategies that increase access to comprehensive and coordinated care for the populations they serve. Schools can play a key role in meeting the needs of the children that the hospitals serve. Hospitals may have a medical director, community benefits department or an outreach director who can explain more about potential partnerships.
Healthcare practitioners and large medical practices	A wide range of healthcare providers can support student health. Community-based providers, including pediatricians, nurse practitioners and counselors, may want to expand their reach outside the office walls and into the communities where their patients and families live. Often, individual providers will help shape partnerships with schools; other times, large medical practices will have a community outreach manager.
Federally qualified health centers (FQHCs)	FQHCs are community-based health centers that provide a wide range of primary care services in underserved areas. Their services are provided on a sliding-scale based on ability to pay. The vast majority of health center patients are enrolled in Medicaid. Because of their deep community roots, and because they may serve as the primary care provider of many Medicaid-enrolled students, FQHCs can be an excellent partner for an LEA interested in expanding access to school-based services. Individual FQHCs will have medical and dental directors, as well as community outreach staff, who can discuss potential partnerships. Also, community health centers are represented across the state by the state Primary Care Association (PCA), which can be an important resource. Many school-based health centers are also FQHCs.

Potential Partner	Value of Establishing a Partnership
Community mental health centers	As states pursue opportunities to increase access to student behavioral health services, community-level mental health centers will play a key role. They can provide an accurate assessment of the opportunities for expanding access in schools, address workforce shortages in the area of mental health providers, and provide clinical services through joint partnerships.
State and local public health agencies	State public health agencies are an excellent source of state data and state needs assessments. They can provide support in convening and implementing, and in aligning state policy with the State Health Improvement Plan. Local public health agencies can help school districts by helping to assess unmet healthcare needs in the student population; by filling in gaps in services and programs; and by helping to foster important connections between the local healthcare community. Schools and LEAs would benefit from strong and ongoing partnerships with public health agencies in a number of key areas.
Academic institutions / universities	Local academic institutions and universities can be excellent partners for schools. In addition to deep community roots, academic institutions with medical or professional services programs have a built-in healthcare workforce that needs professional practice. With direct supervision, students in medical or professional services programs may be able to deliver services in schools.
Community-based organizations	Community-based organizations can provide medical services and supports. Some CBOs work with community health workers, including promotoras (female community health workers in Spanish-speaking communities) who can provide services in schools. Other CBOs may be able to provide linkages to other external services, like helping families navigate health insurance or options for obtaining eyeglasses.

Other Partnerships to Increase Access to School Health Services

Schools and LEAs have been able to expand access to school-health services by utilizing a range of partnerships that focus on the delivery of services, meaning an external provider either provides or facilitates the services.

These types of partnerships rely on several different funding streams. Medicaid will reimburse for the services provided to Medicaid-enrolled students. Schools and LEAs would only be responsible for the costs associated with the time and activities of the district-employed providers.

The start-up costs associated with some of these delivery models can be very low (simply a matter of the school providing free space) or high (if including investments in physical spaces and technology). This type of investment has been successfully funded by grants and donations in many communities.

Potential Model	How it Works
School-based health centers	School-based health centers (SBHCs) are based in schools and provide students and their families with a full range of age-appropriate healthcare services, typically including primary care. School-based health centers provide a much more comprehensive set of services than are typically offered by schools and can serve as a student's primary care provider and medical home. SBHCs draw their funding from a variety of sources, but Medicaid does reimburse SBHC on a per-patient rate for services delivered to Medicaid-enrolled students. While not every LEA has SBHCs, those that do value the contribution they make to the student and community health. Learn more about school-based health centers from the Health Resources & Services Administration and the School-Based Health Alliance.

Potential Model	How it Works
Mobile Van	Mobile vans have been successfully used to expand access to certain health services for students, including oral health and vision services. Mobile vans work in partnership with the schools but are usually externally funded. If the mobile van serves a Medicaid-enrolled student, it may be able to bill for that service. The billing and reimbursement is handled by the organization or operator of the mobile van, not by the school or LEA. Operators of mobile vans can be private providers, universities or community health centers.
Telehealth	Through the use of specialized technology, telehealth virtually links the student in the school-based setting with an external provider who can offer diagnosis and treatment. Telehealth programs are used in schools to treat acute illnesses (e.g., ear infection, sore throat) and to provide a limited amount of chronic care management for conditions such as asthma and ADHD. Telehealth can also be used for certain behavioral health and therapy services (e.g., speech-language therapy, physical therapy). In many cases, services are provided to the student by the nurse (or an aide) in the school setting and by a local provider at the other end of the line. The provider assesses the student and provides the needed medical advice. The nurse and the provider coordinate care and follow-up. Telehealth services require complicated funding streams, often braiding together several funding sources. Depending on the state, both the school and the telehealth provider may be able to bill for their time. In many cases, Medicaid does reimburse for visits: Schools get reimbursed for their time with a facility fee, and the external provider is paid for delivering the services. 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. Specialized equipment is needed—some schools and LEAs have received donated equipment from local healthcare providers or local telecommunications companies.

TEN

HOW TO EVALUATE PROGRESS

As states across the country move forward with making major changes to their school-based Medicaid programs, it's essential to evaluate the impact of these changes on both health and academic outcomes.

Evaluating school-based Medicaid programs is key to ensuring program sustainability and informing program development and delivery. More states are considering or are already in the process of expanding their school Medicaid programs to support innovative models for delivering school-based health services. Working with your team to develop assessment frameworks—including program objectives, outcome measures, evaluation questions and methods, and a timeline for measuring impact—can help you track and communicate the success of your work to state leaders and advocates.

1. Establish program objectives and action items.
The objectives of your efforts to expand access to school health services will serve as the foundation for evaluation. What are the changes you want to make to your school Medicaid program? What impact do you hope those changes will have?

Here are some examples of objectives and related action steps:

Objective	Action	Sample Measures
Expand access to school mental health services to address student mental health needs.	· Submit and obtain approval for a state Medicaid plan amendment to implement the CMS "free care" policy reversal. · Ensure school mental health providers (school psychologists, social workers, counselors) can bill Medicaid for reimbursement.	· Number of mental health visits · Percentage of students with mental health diagnoses that accessed mental health services · Depression, anxiety and suicide rates
Improve care coordination between healthcare providers and school districts.	· Establish MOUs between managed care organizations and school districts. · Release state guidance on HIPAA and FERPA and data sharing.	· Percentage of students with a care coordinator · Percentage of students connected to appropriate follow-up care

Objective	Action	Sample Measures
Increase Medicaid revenue generated by the state's school Medicaid program.	· Submit and obtain approval for a state Medicaid plan amendment to implement the CMS "free care" policy reversal. · Update guidance on billing and reimbursement. · Develop and implement training on school-based billing, including administrative billing.	· Total Medicaid revenue generated by the school Medicaid program

2. Develop policy and program evaluation questions.
Changes in state policies and programs related to health and education can be used to demonstrate the success of your efforts—and asking the right questions can help you to identify new opportunities as well as areas of progress. While questions should be based on your specific objectives, here are some questions to consider:

- Did the state submit a state plan amendment (SPA) to: implement the CMS "free care" policy reversal; expand the list of Medicaid-eligible school health providers; or expand the list of Medicaid-eligible services?
- Did the state issue new or revised guidance—such as a school-based reimbursement guide, telehealth guidance, or data-sharing guidance—to support states in expanding access to school health services through Medicaid?
- Was there a change in revenue generated from the school Medicaid program?
- How is the revenue generated by the school Medicaid program being used?
- Did the state establish a formal committee or charge an existing department or agency with advancing this work?
- Did the state leverage non-Medicaid funding, such as federal grant funds or local education funding, to support this work?

3. Identify the impact on key state health measures.
Health and education accountability metrics may shift due to increased access to school health services. Some questions to track impact include:

- Was there an impact on Medicaid accountability metrics? (Consider tracking the impact on measures from Core Set of Children's Healthcare Quality Measures for Medicaid and CHIP relevant to school health.)
- Was there an impact on education accountability metrics, such as chronic absenteeism?
- Was there a change in revenue generated from the school Medicaid program?
- How is the revenue generated by the school Medicaid program being used?
- Was there a change in the number of school health providers (school nurses, psychologists, counselors, social workers, etc.) employed across the state?

4. Identify the impact on school districts and schools.
Increased access to school health services will affect school districts and schools. Some questions to track impact include:

- What were the leading health conditions affecting students in the district prior to the change? Did the changes in policies and programs support addressing those health needs?
- Was there a change in the school district's chronic absenteeism rate? Was there a change in math and/or reading scores?
- Was there a change in revenue generated from the school Medicaid program?
- How is the revenue generated by the school Medicaid program being used?
- Was there a change in the number of school health providers (school nurses, psychologists, counselors, social workers, etc.) employed by the district?
- Was there a change in the number of health services being delivered in the school district?

5. Engage decision-makers and build cross-sector collaboration.
Efforts to expand school-based Medicaid will involve key decision-makers and cross-sector collaboration. Some questions to track engagement efforts include:

- Who have you engaged in regular conversations with about this work?
- Who on your team can move this work forward?

- Is there demonstrated support for this work from your state education agency or state Medicaid agency?
- Have the leaders of this work agreed on the goals and a work plan for achieving them?
- Has state leadership demonstrated a public commitment to this work (e.g., has anyone contacted school districts, conducted a media interview or discussed this as part of the state's strategic plan)?

6. Identify potential data sources.

Identifying and tracking data to answer these questions and move your work forward can be challenging. Not all of the necessary information is publicly accessible or presented in a way that allows you to monitor changes over time.

To start, consider who might have the data you need to better understand student health needs in your state. At the state level, this could be individuals in the state education agency or state Medicaid agency in charge of managing the school Medicaid program. It could also include staff in those agencies coordinating the state's special education programming or leading broader efforts to create safe and supportive school environments.

The state public health department can also play an important role in helping to identify data sources and facilitate connections to key contacts in other agencies. In addition, each state's school nurse consultant may have some of this information and/or be able to facilitate connections to individuals who do. The National Association of State School Nurse Consultants can direct you to the school nurse consultant in your state.

At the school district level, individuals with access to key information could include the district billing lead, special education coordinator or school nursing coordinator. District health provider partners, including school-based health centers, hospitals or local health departments, can also support the collection of data. For example, local nonprofit hospitals can share data from their community health needs assessments. Finally, managed care organizations serving the students in your district can provide helpful data.

While a great deal of information is available from public databases and reports and through building relationships with state and district employees and partners, it is also important to consider the submission of a Freedom of Information Act (FOIA) request, if needed.

7. Establish a timeline.
Establishing a timeline is important for gathering baseline data and ensuring regular data collection. It's also important for monitoring progress and evaluating the impact of your efforts.

To get an accurate and clear picture of the work you are leading, start the evaluation progress at the beginning of your initiative. If you've already begun, start now—even if you start late, you can still gather information that could prove useful to the initiative's success.

CONCLUSION

The delivery of school-based health services—including physical, behavioral and mental healthcare—is critical to support the health and academic outcomes of students, including the nation's most vulnerable children. We are confident that expanding Medicaid-funded school health services is a key strategy to reduce disparities and improve outcomes for all.

Fortunately, there are multiple avenues to advance this work. The Centers for Medicare and Medicaid Services' 2014 letter clarifying that school districts can seek reimbursement for covered services for Medicaid-enrolled students, even if those services are provided to all students, offers a tremendous opportunity. CMS has given the go-ahead to expand billing for more students—and the opportunity exists to expand the types of services and providers eligible for reimbursement.

The end result could mean more federal revenue to the state and more reimbursement to districts, which could help ensure ongoing investment in and support for the delivery of school health services. It could also ultimately help schools expand the staffing needed to provide physical and behavioral health services to students.

We encourage the opportunities this policy shift invites, including building partnerships with managed care organizations to support the delivery of school health services; creating a policy environment that is supportive of school districts utilizing Medicaid funding to support student health and wellness; and supporting partnerships with community-based providers and other partners to address unmet student health needs.

We commend you for taking on this work in your state and encourage you to contact us with any questions.

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