Medicaid Managed Care and School Health Services: Early Lessons & Opportunities

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States have been increasingly shifting their Medicaid delivery system towards managed care with the goal of managing cost and utilization and improving quality of care. In 35 states, more than 85 percent of Medicaid-enrolled youth receive health coverage through managed care organizations (MCOs) (Kaiser Family Foundation, July 2022). To better understand the role of Medicaid managed care in school health programs, Healthy Schools Campaign (HSC) launched a project to explore how four states – California, South Carolina, Tennessee, and Washington – have or are actively working to carve school health services into Medicaid managed care.

The project sought to answer two key questions:

- What is the experience of states that have carved school health services into their Medicaid managed care delivery system or are currently working on doing so?
- How have school districts and MCOs partnered to support student health and connect school health services to Medicaid managed care?

This issue brief summarizes the project methodology, general findings across the four states, the status of managed care and local education agency (LEA) partnerships in each of the states, and recommendations for developing and enhancing the connection between school health and Medicaid managed care.

Methodology

Aurrera Health Group (Aurrera Health) worked with HSC to execute the project and disseminate findings. Aurrera Health researched state information on the intersection of school health and Medicaid managed care, which involved reviewing relevant documents including Medicaid state plans, state statute, Medicaid MCO contracts, and state Medicaid guidance. Initial research findings were used to inform semi-structured interviews (conducted between July and September 2023) with officials from state Medicaid agencies, MCOs, and LEAs to better understand the strengths and challenges involved in these relationships, requirements, and processes.

The interviews and research culminated in the development of this issue brief and individual state profiles found in Appendix A.

General Findings

Given that the majority of Medicaid-enrolled youth are members of an MCO, it is likely that an increasing number of states will continue to explore integration of school health and managed care. Therefore, it is important to learn from existing state experiences to identify opportunities and lessons that can be applied to other states.

This issue brief highlights key findings from research and interviews, including the efforts required from all stakeholders to maximize the potential of the partnership between the state Medicaid agency, MCOs, and LEAs and to increase access to school health services, improve care coordination, and obtain Medicaid payment.

Across all interviews, stakeholders expressed that relationships between LEAs and MCOs are important for increasing both students' access to care and Medicaid reimbursement for school districts. Interviewees noted that contracted relationships allow the school districts to be paid for Medicaid-eligible services they are often already providing to students. In addition, working together should ideally create a coordinated system of care for students who receive services both in schools and in other community settings.

However, comprehensive statewide efforts to integrate school health services into managed care are in the beginning stages. Findings from research and interviews revealed that states are taking different approaches to integrate school health services into Medicaid managed care and that state implementation status varies.

Tennessee is the only state that has fully carved all school health services into Medicaid managed care. South Carolina updated its guidance in July 2022 to carve behavioral health services delivered in school settings into their Medicaid managed care delivery system, but given the recency of this change, few schools seem to have established contracts with MCOs at this point. Washington allows school districts to contract with MCOs for services that are not included in an individualized education plan (IEP).[1] The majority of Washington school districts

[1] An individualized education plan (IEP) ensures that a child with an identified disability receives specialized instruction and related services. Public schools are required to implement an individualized education program under the Individuals with Disabilities Education Act (IDEA). Common IEP services offered include speech therapy, occupational therapy, and physical therapy.

that contract with MCOs do so to be reimbursed for delivering behavioral health services to students but could choose to bill for any covered service if the services provided are by qualified, licensed staff. California is still in the process of designing and implementing several initiatives that will expand the scope of school health services carved into their managed care delivery system.

In each state, there is variation across schools and regions in the extent to which LEAs and MCOs work together. Interviewees noted that a major barrier to this work is the fact that that LEAs and MCOs use different terminology and prioritize education and health care, respectively, which can sometimes lead to confusing or misaligned policies. For example, interviewees commented on how even the variation across school year, state fiscal year, and health plan year calendars can cause challenges in establishing relationships. In addition, while states may carve school health services into their Medicaid managed care delivery systems, schools still have to contract with plans and undergo credentialing in order to be reimbursed for services eligible for reimbursement. Unfortunately, many LEAs do not have the expertise or infrastructure to establish contracts with MCOs and comply with the various credentialing and claiming processes. This can be further complicated by the fact that MCOs do not necessarily operate in all geographic regions of the state, requiring LEAs to navigate multiple payors in a county.

This report elaborates on the key challenges cited by Medicaid agencies, MCOs, and LEAs around relationship building, contracting, administrative operations, and data sharing and outlines strategies that may help overcome these barriers. Recommendations included in this report are presented as options for consideration and may not be applicable to all stakeholders.

Relationship Building

Key Takeaway: State Medicaid agencies should play a strong role in bringing together partners in the health care and education sectors.

To effectively carve school health services into managed care delivery systems, it is critical that the state, MCOs, and school districts actively work together to advance partnerships, build trust, and identify best practices in service delivery. Relationship-building is a crucial component to making sure both school districts and MCOs have the information and resources needed to deliver needed health services to students. However, the relationship between an MCO and LEA can be difficult to initiate, develop, and sustain.

Without facilitation and close collaboration led by the state Medicaid agency, schools may not know what kind of services or resources MCOs can provide, and MCOs may not understand how health services are operationalized in a school setting. Having the Medicaid agency be the go-between, with the support of other state agencies when relevant, can create a more collaborative system and break down existing silos. However, research indicates that the level and extent to which state agencies facilitate this type of collaboration between MCOs and school districts varies substantially by state.

Tennessee is an example of a state where the Medicaid agency closely collaborates with MCOs and school districts, serving as a facilitator and translator between their partners in health care and education. In California, a Medicaid initiative called the Student Behavioral Health Incentive Program (SBHIP) is building foundational partnerships between MCOs and school districts throughout the state. The SBHIP offers incentive payments for MCOs to implement interventions that increase access to school-based behavioral health services, and both a county office of education and MCO interviewed for this project agreed that it has improved relationships between MCOs and the school districts in their service area.

Without direct involvement in and oversight of MCO and school district relationships, state Medicaid agencies have less insight into issues that may be happening on the ground and impacting the ability of school districts and MCOs to meaningfully partner to meet the needs of students.

Recommendations

- Given the complexities and silos between health and education systems, state Medicaid agencies and other state partners should take a lead role in fostering and facilitating strong partnerships between LEAs and MCOs. Specific steps should include:
    - Providing clear and consistent guidance to MCOs and LEAs around any initiatives related to carving school health services into managed care.
    - Providing an ongoing forum for stakeholders to come together and build relationships or address concerns, such as webinars or convenings.
    - Conducting regular outreach to MCOs and school districts, including those that are in or exploring contractual relationships, to obtain feedback and address concerns related to these partnerships.

Medicaid MCO Requirements

Key Takeaway: State Medicaid agencies allow Medicaid MCOs to set policies and procedures that contracted providers, including school districts, must navigate to draw down Medicaid reimbursement for covered services. State Medicaid agencies should work with MCOs to standardize these processes across MCOs to reduce the administrative burden on school districts.

States have flexibility in how they contract for Medicaid MCO services, including establishing criteria that MCOs must follow with contracted providers. States can also use contracts to advance health goals or innovative health care efforts. However, states vary in whether and how they require MCOs to work directly with school districts.

Not all states require MCOs to contract with school districts or include school providers in their network. Tennessee is an example of a state that not only requires MCOs to contract with school districts that are interested in billing for Medicaid services but will also require MCOs to submit an "Annual Stakeholders in Education Engagement Plan" detailing their strategies for working with partners in the education sector to receive input and advice on covered school-based services.

In all four states reviewed as part of this project, school districts that are interested in billing for covered services through managed care must individually contract with each MCO (just like typical health care providers). In turn, each MCO has their own requirements and processes for accepting providers into their network (done through a process called provider credentialing) and establishing processes like prior authorization requirements for covered services. When these processes differ between MCOs, it can cause a significant level of administrative burden for school districts that typically do not have the infrastructure or expertise to navigate such procedures.

Eliminating prior authorization requirements is one way to reduce the administrative burden for schools that choose to work with MCOs. For example, Tennessee does not require prior authorization for most school services, which removes a layer of administrative burden for LEAs in the state.[2] In states that require prior authorization for school services, school district staff must get approval to render a range of mental health services for students, a process that

[2] TennCare does require prior authorization for Applied Behavioral Analysis (ABA) services delivered inside and outside of a school-setting.

differs depending on which MCO the student is enrolled in. Another area cited as a challenge for school providers was MCOs having different credentialling procedures, meaning one provider must undergo different processes to enroll with each MCO in their area.

To address these barriers, MCOs in Washington and Tennessee meet regularly to make sure school-based health policies and procedures are as similar as possible across plans. This did not remove every inconsistency for LEAs, but schools noted that it is helpful when MCOs do not have drastically different policies that they must interpret and follow, particularly for preauthorization of services.

Local education agencies also noted that changes in payment methodologies can serve as a barrier to contracting with MCOs. Medicaid managed care plans each pay distinct contracted rates for services, which is a departure from the line-item state appropriations or fee-for-service reimbursements LEAs are accustomed to receiving.

Interestingly, California is planning to establish a statewide school-linked fee schedule to ensure schools are reimbursed the same across private and public payors and prohibit MCOs from implementing utilization controls such as prior authorization or cost-sharing for services offered in school settings. This would significantly reduce the need for school districts to contract with each MCO or navigate different MCO policies to receive reimbursement. Issues related to Medicaid billing will be discussed further in the next section.

Finally, Medicaid MCO contracts are also an opportunity for states to rethink what services they can require MCOs to reimburse for in school settings. For example, in California, MCOs must cover care coordination between school-based health services and services delivered in other community settings.

Below are some actions state Medicaid agencies and MCOs can take to increase their collaboration with school districts by removing barriers around administrative complexity.

Recommendations

State Medicaid agencies and MCOs should take steps to support LEAs in understanding MCO processes and building effective partnerships.

State Medicaid agencies should:

- Work with MCOs and LEAs to develop a shared set of priorities before a new or updated contract is executed.
- Include LEAs and other education partners in assessments of MCO contract proposals related to school services.
- Establish a statewide fee schedule applicable to all public and private insurers to ensure consistency among payors and payment transparency.
- Revisit Medicaid managed care contracts and explore opportunities to increase or require collaboration and outreach with LEAs, such as:
    - Requiring MCOs to contract with school districts within their service area that are interested in billing for Medicaid-covered services.
    - Requiring MCOs to engage with partners in the education sector, including school districts within their service areas, and annually report on collaboration efforts.
    - Establishing standardized credentialling requirements that apply across health plans, including timelines and what school health providers should be included in MCO networks.
    - Creating a standardized MCO contract that school districts can use with each MCO in their service area.
    - Requiring MCOs to cover care coordination between school-based health and community-based services.
    - Establishing performance goals or quality incentive measures related to school health.

MCOs should:

- Work with other MCOs in the state to ensure contracting policies and procedures for school districts are as similar as possible between plans.
- Offer proactive, ongoing training and education for school districts around MCO contracting.
- Educate school districts on MCO billing and rates and how they differ from fee-for-service reimbursements.
- Work with schools to provide financial support for billing or administrative infrastructure needs.
- Explore pilot projects related to school health performance goals and quality incentives.

Impact of Medicaid MCO Billing on School Districts

Key Takeaway: Administrative burden associated with complex Medicaid documentation and claiming processes – which may differ by MCO – make it difficult for school districts to engage with managed care and get reimbursed for services they are providing. Simplified processes, streamlining across plans, increased training, and technical assistance are needed to support school districts with this issue.

Navigating the billing and documentation processes across multiple MCOs makes it challenging for school districts to obtain reimbursement for the services they provide due to the level of paperwork required. While they offer critical health services to students, school districts often lack the resources and information needed to contract with MCOs and follow Medicaid regulations compared to a standard clinic or health care facility. A school's ability to participate in Medicaid managed care may also depend on their staffing and infrastructure, as well as the number of students enrolled in or eligible for Medicaid.

Interviews revealed that school districts are generally ill-equipped to take on all aspects of the administrative activities required for Medicaid documentation and billing with MCOs. Furthermore, some states provided little to no training and technical assistance for schools to engage with MCOs and bill appropriately. Interviews revealed one reason many school districts are not yet billing Medicaid may be due to a lack of information or dedicated MCO staff to guide them through the process. For example, one school did not have a consistent point person at the MCO they could go to for support with billing if they needed it. As a result, some school districts turn to billing vendors to help with these functions even though they often have high fees.

States are taking different approaches to address these challenges, though few have taken steps to create managed care billing processes specifically tailored for school districts. In Washington, educational service districts that function as behavioral health agencies have had success partnering with smaller school districts that do not have the capacity to become licensed and establish the proper billing and data privacy processes. In Tennessee, the Medicaid agency worked with stakeholders to extend the time schools have to file claims beyond what a traditional provider is allotted, recognizing challenges school districts were facing in meeting standard filing timelines. In addition, as California continues to plan for the rollout of their statewide fee schedule, they are considering different options to reduce the anticipated administration burden for school districts, including establishing a statewide vendor that could

support LEAs and other school health billing entities with claims matching, third-party liability, and more.

Recommendations

LEAs are working to understand the Medicaid documentation and claims submission processes required for working with MCOs. The following are steps the state Medicaid agency and MCOs can take to support LEAs and address barriers schools may encounter.

State Medicaid agencies should:

- Work with MCOs to develop a step-by-step guide on how LEAs/school districts should document services and submit Medicaid claims if they are not working with a billing vendor.
- Create tailored managed care billing processes for school districts.
- Offer resources and guidance to schools to help school districts decide whether to take on billing themselves or work with a third-party vendor.
- Offer a statewide vendor to handle certain MCO/LEA billing and administrative processes to ease the burdens on LEAs.[3]
- Conduct ongoing audits of denied claims and credentialing timeliness for school-based services to assess whether additional support is needed for school districts.
- Extend timely filing options for school districts to allow more time for claim submission.
- Have dedicated staff that can support LEAs and MCOs with questions or issues related to billing and general contracting concerns.

MCOs should:

- Identify a consistent point person to work with LEAs to provide training and technical assistance on Medicaid billing and respond to LEA questions.
- Work with other MCOs in the state to make billing and documentation procedures as similar as possible.
- Conduct proactive, ongoing outreach with education and training opportunities for school districts around Medicaid billing.
- Offer funding support to help school districts establish the appropriate billing and documentation infrastructure.

[3] If California moves forward with this, it will be important to follow how well this model is meeting its stated goals and to further assess what a similar model would mean for other states.

- Review denied claims and provide technical assistance to LEAs to enhance the claim submission process.

Data and Care Coordination

Key Takeaway: There is limited data sharing or care coordination occurring in states that have carved school health services into their managed care delivery systems. Stakeholders should work together to make sure that both MCOs and school districts have the information they need to ensure students are accessing needed health care services.

The MCO/LEA relationship presents a significant opportunity to maximize care coordination for youth to increase access to services and improve health outcomes. However, while MCOs are able to see services delivered at a school through claim submissions, they do not know which schools their enrollees attend unless the student receives a very high-level of service that authorizes them for care coordination. Being able to identify the school each enrollee attends would help MCOs work with LEAs to make sure students are receiving needed health services in a timely manner. Another reason for limited care coordination or data sharing is that school districts in states that used billing vendors had little to no interaction with MCOs.

School health providers in most states interviewed agreed it would be helpful to know about the health services students are receiving outside of school and develop closer relationships with primary care providers, pursuant to privacy laws. Ideally, MCOs could help get provider referrals needed for service authorization or help connect students to community supports if the school identifies specific health concerns – but these processes are still in development. In addition, depending on the state's Medicaid plan, time spent by the LEA on services like care coordination may not be reimbursed through Medicaid.

Data sharing between MCOs and LEAs is limited in all four states reviewed as part of this project. While reasons for this varied, some states are simply too early in their implementation of these partnerships to have a robust data collection process that would help evaluate how services are being delivered.

Recommendations

Moving forward, robust data collection and clear data sharing processes will help both LEAs and MCOs make sure children are accessing services they need.

State Medicaid agencies should:

- Require MCOs to facilitate connections between school health providers and a member's primary care provider (if they have a different one) to support the development of care plans.
- Identify school health data they would like to receive from MCOs to understand how MCO and LEA relationships are impacting access to care.
- Work with MCOs to explore data sharing opportunities with LEAs to better understand the utilization, quality, and outcomes of school health services being provided to enrollees.

MCOs should:

- Collect information on the schools their enrollees attend, if applicable. This may have to be done as part of Medicaid enrollment since the state collects information and shares it with MCOs.
- Work with LEAs to establish procedures to learn when students switch schools and/or school districts.
- Work with LEAs to understand what data school districts may like to receive from MCOs to support school health work.
- Develop processes to share data with LEAs to identify students that may need covered services.

Conclusion

Given that most Medicaid-enrolled youth are members of an MCO, it is likely that an increasing number of states will continue to explore integration of school health and managed care. Integrating school health services into Medicaid managed care and coordinating care across providers has the potential to improve the health of youth across the country, but it requires significant collaboration and training to reduce the administrative burdens on school districts. Early lessons and promising practices from four states that are carving school health services into Medicaid managed care will offer helpful information to maximize its potential to improve the physical and behavioral health of youth.

Appendix A. State Profiles

California

Currently, LEAs may contract with MCOs to provide health care services that are separate and distinct from those provided by schools through the LEA Medi-Cal Billing Option Program (LEA-BOP).[4] In addition, MCOs must cover care coordination between school-based health services (SBHS) and community-based services.

However, it appears there is variation across schools and regions in the extent to which LEAs and MCOs contract. This can be complicated by the fact that MCOs do not necessarily operate in all geographic regions of the state, requiring LEAs to navigate multiple payors in a county. Every county in California has at least two plans, but some have up to five plans. An MCO interviewee has contracts with two larger school districts, but according to the state Medicaid agency, LEAs and MCOs were largely siloed until recent state efforts described below strengthened these partnerships.

A major barrier to this work is the fact that that LEAs and MCOs use different terminology and prioritize education and health care, respectively, which can sometimes lead to confusing or misaligned policies. Many LEAs do not have the expertise or infrastructure to establish contracts with MCOs and comply with the various credentialing and claiming processes. LEAs are interested in reducing the audit and documentation burdens that Medicaid requires, and therefore are less focused on expanding contracting if they do not understand the benefits.

Additionally, schools typically do not know the kind of resources and services MCOs can offer to support schools. Proactive outreach around this has helped school districts learn about the contracting and billing processes, which can otherwise be overwhelming. Since there is a broader range of billable service options available through managed care than in the LEA-BOP program, schools can be reimbursed for services they are already providing, rather than paying for them out of the school's budget.

[4] LEA-BOP is largely based on a fee-for-service model and provides reimbursement to LEAs for health-related services provided by qualified practitioners to Medi-Cal (Medicaid) eligible students. Eligible health-related services provided by LEAs can be found on the LEA Program Overview page on the California Department of Health Care Services' website.

State Role

The California state Medicaid agency has several major initiatives underway to increase collaboration between school districts and Medicaid MCOs. State Medicaid agency representatives said their overarching goal is to create a unified delivery system for health care services, which is why they are focused on reducing the silos between MCOs and LEAs. Both the state Medicaid agency and an MCO said they want to enhance the care coordination and referral processes between LEAs, community health care settings, and primary care providers. To help with contracting, the state authorized funding for LEAs that want to establish their own administrative infrastructure to handle contracting and claiming needs.

Through the Student Behavioral Health Incentive Program (SBHIP), the state is offering incentive payments to Medi-Cal MCOs to develop targeted interventions that increase access to school-based behavioral health services. Higher incentive payments may be offered for interventions that increase reimbursement rates, serve high-risk youth populations, and/or reduce inequities. While MCOs are not required to participate, those who do are required to report on performance measures and outcome metrics related to each intervention until the project sunsets in 2024. One MCO said SBHIP has helped relationship building between plans and LEAs, which in turn has allowed MCOs to educate schools on the kinds of services and resources MCOs have that will help schools with care coordination, referral processes, and more. The interviewee did express challenges associated with this project related to changes in overall expectations and timelines. Similarly, a county office of education also said SBHIP was helpful for relationship building, which will be useful as the state moves forward with new initiatives for school-based health described below.

Contracting & Fee Schedule

New state MCO contracts effective in 2024 will require MCOs in certain counties to work with school districts to deliver of health services.[5] Under the new contracts, MCOs must execute a memorandum of understanding (MOU) with LEAs in each county within their service area for school-based services, including but not limited to Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services and behavioral health services. MCOs must also ensure that a member's primary care provider collaborates with LEAs in the development of care plans and ensures that patient care is coordinated regardless of financial responsibility.

[5] New Medi-Cal managed care contracts will apply to five health plans in 21 counties across California.

It is not clear how MCOs and LEAs will work together under the new contracts and what options will be available to reduce the anticipated administrative burden for schools. This is important since many school districts are wary of contracting due to the perceived additional work and are generally not well-versed in the managed care space. Proposed ideas from the state include establishing a statewide, centralized clearinghouse that would handle data matching, third-party liability, and claiming services. Managed care plans are available to work closely with the state on these initiatives so that MCOs are able to implement the changes.

Finally, California is also developing a statewide multi-payer school-linked fee schedule for behavioral health services with the intention of streamlining the reimbursement process.[6] This fee schedule will apply to both public and commercial insurers and ensure that schools are not receiving different rates from different payors. A county office of education noted this may negate the need for establishing MOUs with each MCO in their area, but more decisions will need to be made once the proposed fees are shared.

South Carolina

School-based Medicaid behavioral health services (referred to in South Carolina as rehabilitative behavioral health services, or RBHS) have been included in South Carolina's Medicaid managed care benefit package since 2016.[7] To increase a school district's ability to offer RBHS, a new school-based mental health initiative was launched in 2022 to improve access to school-mental health services for children across the state. As part of this initiative, South Carolina's Medicaid agency created an alternative fee schedule with enhanced rates for RBHS and updated policy guidance for LEAs and MCOs to give schools a broader set of options for delivering behavioral health services to students. These changes intend to make it easier for schools to hire their own RBHS providers. Since this guidance is only one year old, there is currently limited contracting occurring between schools and MCOs to deliver RBHS. Interviews revealed that schools may not know about their options in partnering with MCOs and instead

[6] The Children and Youth Behavioral Health Initiative is investing $4.7 billion to improve youth behavioral health through several different workstreams, including the fee schedule and SBHIP.

[7] School-based rehabilitative behavioral health services (RBHS) are medical or remedial services available to all Medicaid beneficiaries diagnosed with mental health and/or a substance use disorder (SUD). LEAs or licensed independent providers working with schools can receive payment for providing RBHS if they are a Medicaid-enrolled network provider for the MCP in which the student receiving services is enrolled.

choose to work with the Department of Mental Health or contract with independent RBHS providers who handle the billing and credentialing processes.

The information below reflects interview findings from the state Medicaid agency and a school district that was an early adopter of RBHS. We were unable to secure an interview with an MCO in South Carolina to learn more about their efforts to work with school districts.

State Role

Based on the interviews with the Medicaid Agency and LEAs, the Medicaid agency primarily reviews network adequacy standards. MCOs establish rates, credentialing, and utilization management processes without significant involvement from the state. Issues from school districts that rise to the state level around claims and rates are typically redirected to the MCO.

LEAs are still learning about the options for delivering and paying for school-based services. More awareness and information sharing could help schools evaluate their options between hiring their own providers to deliver RBHS and/or contracting with outside entities. Processes between the LEA and MCOs could also be improved by creating consistent contacts and MCOs who can support school districts through any issues that arise.

Medicaid Billing

LEAs face a high level of administrative burden when contracting with MCOs to be reimbursed for school health services. There are five health plans with different processes for credentialing, prior authorization approvals, and billing, which makes it challenging for schools to obtain reimbursement for the services they provide due to the level of paperwork required. For example, some MCOs still require prior authorization materials via fax and can take up to a year to complete provider credentialing processes.

More education may be needed to support school districts in establishing Medicaid billing programs. Some LEAs use a billing vendor, though they often need to follow up with vendors to correct errors in documentation and billing. Interviews also revealed that clinicians prefer when students have fee-for-service Medicaid, which is easier for families to understand and for providers to bill.

Tennessee

All Medicaid-covered services, including school-based health services, are included in the state's managed care program. The state has always allowed schools to bill Medicaid for school-based behavioral health services regardless of whether the services were included in the student's IEP or individualized family service plan (IFSP). In 2021, the state expanded coverage to allow schools to bill for all medically necessary, covered services included in an individualized health plan (IHP).

More awareness of the benefits of MCO contracting may be useful for LEAs in Tennessee. Interviews found that some school districts began working with Medicaid MCOs not because the school district leadership required it, but rather because it was championed by the school nursing staff. These nurse champions then assumed a leadership role in their Medicaid managed care relationships.

State Role

The Tennessee Medicaid agency (TennCare) facilitates relationships between MCOs and schools throughout the state, serving as a translator between the two entities. For example, one challenge that LEAs, MCOs, and TennCare worked together to resolve was the requirement that claims must be filed within a certain time limit (timely filing). Schools were largely not able to adhere to the time limits, due to challenges in obtaining the physician's order in a timely manner, leading to denied claims. Working with relevant stakeholders, the state extended timely filing requirements for LEAs from 120 to 365 days.

TennCare oversees certain processes, such as tracking claim payments and denied payments and auditing the credentialing process, to help give MCOs and LEAs the support they need. TennCare noted that relationships between LEAs, MCOs, and the state are intended to reduce the administrative burden schools face in working with Medicaid. However, interviews showed school districts may benefit from a thorough guide from the state or MCOs on how to set up Medicaid billing infrastructure within the school to reduce their reliance on a billing vendor.

Contracting and Credentialing

Tennessee Medicaid MCOs work closely together to simplify LEA requirements by ensuring there is as much consistency in policies as possible. They also work closely with TennCare and engage with schools that do not have established contracting. Like all other states, Tennessee

does not have one statewide Medicaid managed care contract template or centralized credentialing, so LEAs must contract with each MCO individually.

To build these relationships, TennCare amended their contracts with MCOs to require them to not only contract with any LEA seeking to contract with the MCOs for medically necessary, covered school-based services but also to nudge them towards building more partnerships with schools. MCOs are now required to submit an annual stakeholder engagement plan that details the strategies they will use to engage stakeholders in the education space to receive advice or input on all aspects of medically necessary, covered school-based services.

Additionally, credentialing was cited as an issue during stakeholder interviews. The state has credentialing requirements for all provider types, but there are no unique requirements for providers employed by school districts. TennCare said it takes significantly longer for LEAs to get credentialed compared to other providers, potentially due to unfamiliarity LEAs have with the process and a lack of relationships with MCOs. TennCare is working with MCOs and billing vendors to put a process in place when more communication is needed from the health plan.

Medicaid Billing

The state and MCOs both remarked on the importance of providing education to LEAs on billing, audits, and other aspects of the contracting process. These partnerships allow schools to bill for the services they are providing, which reinforced comments made by both school districts mentioning the increased Medicaid reimbursement they receive through managed care. According to the LEAs, this money goes back into the school system and is used for school health services or to bolster the school nurse workforce.

Some LEAs in Tennessee work with a billing vendor and have little to no direct contact with MCOs, and therefore data sharing and care coordination between the MCO and LEA did not appear to be occurring at this stage. To address this, TennCare is working to strengthen relationships between MCOs and LEAs to ensure that the needs of students and staff are being met.

A lack of coordination between the plans and the schools interviewed left one LEA wanting more information on how to set up an in-house Medicaid billing program. This process – which includes acquiring a National Provider Identifier (NPI), working with a licensed practitioner, and handling the billing and reimbursement – is a huge challenge for schools. LEAs were not aware of any training available from the state to set up their own programs but said a step-by-step

guide from the state or MCOs would be helpful. However, TennCare is engaged in a pilot program to assist one LEA in the state through the steps of becoming a Medicaid provider, paying special attention to where challenges in this process exist. Learnings from this pilot will likely inform future technical assistance and training for additional LEAs across the state.

Washington

Washington school districts and educational service districts (ESDs) can receive Medicaid reimbursement for the physical and behavioral health services they provide to eligible students.[8] While the Washington Medicaid agency (Washington State Health Care Authority, or HCA), reimburses schools for IEP services using a fee-for-service model, MCOs may contract with schools to provide services outside of what is included in an IEP.

To provide outpatient behavioral health services (including substance use disorder services), LEAs are first required to obtain licensure through the Washington State Department of Health as a behavioral health agency. In order to receive Medicaid reimbursement from the MCOs for these outpatient behavioral health services, LEAs must also register as a Medicaid provider with HCA and enter into contracts with the Medicaid MCOs. This option is more realistic for ESDs and as of May 2023, five out of the nine ESDs and one school district were licensed behavioral health agencies and contracted with the Medicaid MCOs.

State Role

The state Medicaid agency works closely with the State Department of Education to assist school districts and ESDs on Medicaid billing, including managed care contracting. In 2022, the HCA released a School-based Behavioral Health Services and Billing toolkit for school districts and ESDs that includes information on managed care contracting, as well as other Medicaid reimbursement options through the state. Interviews suggest the state provides limited oversight over LEA/MCO contracts but will step in if an issue arises that needs to be addressed.

Ideally, education stakeholders said it would be helpful for the state to convene a steering committee or workgroup with relevant stakeholders so that the education and health care sectors can come together to create shared goals around these efforts. HCA is currently

[8] Washington is divided into nine ESDs, which serve as liaisons between state education partners and local schools and district offices. The nine ESDs oversee 295 school districts and support various administrative functions and educational services for local districts.

engaged in a chartered workgroup, titled “Medicaid in Schools: Recommendations for Centers for Medicare and Medicaid Services (CMS) Compliance and Expansion,” which is working with ESDs and other stakeholders to make recommendations.

Contracting and Medicaid Billing

Overall, interviews with LEAs revealed a positive working relationship with MCOs, though the process to establish these relationships can be difficult. Like other states, the Medicaid agency and LEAs commented on the different languages used by schools and MCOs and how their expectations towards student health differ. It is difficult to fit schools into a medical model, so it takes significant education to train school health providers on what services they can bill for and how long they can provide a service based on state guidelines and MCO rates. Credentialing was cited as another challenge because of the significant amount of time it takes to get a provider enrolled with a health plan given each plans’ different policies. A final challenge raised during interviews is the prospect of changing a school’s funding formula, since they are most comfortable with line-item funding directly from the state.