HEALTHY SCHOOLS CAMPAIGN

Healthy Students, Promising Futures

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# Maximizing School Medicaid for Substance Use Prevention, Early Intervention & Treatment: 10 Actions States Can Take Now

## Contents

# Introduction

Over the past 20 years, substance use (SU) among adolescents has decreased to the lowest levels in decades. Today, fewer adolescents use substances than those who do.[1] However, certain types of substances, including alcohol and cannabis, continue to be common among adolescents:

- In 2020, 10% of 8th graders, 20% of 10th graders and 34% of 12th graders reported drinking alcohol in the prior 30 days.
- The emergence of vaping has led to an increase in nicotine and cannabis use. Although vaping rates plateaued in 2020, there is still significant concern about the risk of transition to smoking tobacco among adolescents who vape.
- 20% of adolescents reported vaping cannabis at least once, while 1.1% of 8th graders, 4.4% of 10th graders and 6.9% of 12th graders reported daily cannabis use in 2020, the highest recorded level since 1991.
- Overdose-related deaths rose three-fold from 2019 to 2021 for young people between the ages of 10 and 19, increasingly driven by synthetic opioids and most often involving other kinds of substances.[2]

**This report covers the Medicaid school-based services program**, in which school districts bill Medicaid on behalf of district employees and contract providers.

It does not address reimbursement for the delivery of health services provided by **community-based providers** or in cases where an **external provider**, such as a hospital, bills Medicaid for services delivered in a school setting. Similarly, it does not address services delivered by **school-based health centers** (SBHCs), as billing is not done by the school district on their behalf.

While there has been a decline in the use of many substances among adolescents, these public health successes have not been shared equally. Significant racial and ethnic disparities exist, with Black and Latinx adolescents, as well as adolescents from lower socioeconomic backgrounds, demonstrating smaller declines in substance use. Additionally, LGBTQ+ adolescents are more likely than their cisgender heterosexual peers to report recent substance use and problematic use practices. Inequity among adolescents experiencing overdose deaths is also highlighted by recent findings showing that American Indian and Alaska Native adolescents experienced the highest overdose rate, followed by Latinx adolescents.[3]

The systems serving young people are often not structured to provide optimal support for learning. In some cases, barriers to successful development such as poverty, discrimination and earlier trauma can reinforce inequities and amplify risks for negative outcomes.

[1] Winer JM, Yule AM, Hadland SE, Bagley SM. Addressing adolescent substance use with a public health prevention framework: the case for harm reduction. Ann Med. 2022. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/35900132
[2] Id.
[3] Id.

Schools provide an opportunity to invest in student health and wellness through a public health approach to prevention and early intervention. Yet 14 million students attend schools that have a law enforcement officer on site but lack a counselor, nurse, psychologist or social worker.[4] The vast majority of students (90%) attend public schools with staffing ratios for these positions that do not meet professional standards.[5]

More must be done to equip schools with the resources needed to support students struggling with substance use and/or mental health concerns. Research shows the need for comprehensive attention to equity and well-being, including school culture interventions that improve belonging and a true public health approach to prevention and early intervention. These and other strategies are explored further in a forthcoming (2024) companion report.

**This report focuses on one tool to help transform how schools care for students: leveraging Medicaid to increase access to — and funding for — school health services.**

It looks specifically at how Medicaid can support health services provided and paid for by school districts, and how states can shape their school Medicaid program to increase school reimbursement for substance use prevention, early intervention and treatment services. This additional and sustainable funding can create opportunities for more equitable access to healthcare and improved health and educational outcomes for all students.

# State Medicaid Coverage of Substance Use Services

The success of the school Medicaid program is inextricably linked to the state Medicaid plan. To create a Medicaid state plan that equitably and comprehensively covers substance use services, states should exercise all available flexibilities and enhancements to ensure that the plan includes the full continuum of services and that Medicaid beneficiaries have access to providers who deliver these services.

Currently, there is no uniform substance use coverage across all state Medicaid plans, which means individuals who are at risk/already experiencing symptoms of a substance use disorder (SUD) may not have access to the covered services they need. Other factors limiting access, such as healthcare workforce shortages, may be compounded by cultural and linguistic barriers as well as systemic racism. The overall result is unequal access to prevention and care — the burden of which falls on communities of color and exacerbates existing inequities.

In recent years, however, legislative and regulatory policy changes — including expanded coverage requirements for substance use disorder benefits under the Affordable Care Act and the Mental Health Parity and Addiction Equity Act — have encouraged states to use

[4] Whitaker, A, Torres-Guillén, S., Morton, M., Jordan, H., Coyle, S., Mann, A., & Sun, Wei-Ling. Cops and No Counselors: How the Lack of School Mental Health Staff Is Harming Students. American Civil Liberties Union (ACLU). 2019. Retrieved from: https://www.aclu.org/report/cops-and-no-counselors
[5] Id.

Medicaid funds strategically to expand and sustain access to evidence-based substance use prevention, treatment and recovery support services.

More than 30 states have implemented waivers in their Medicaid program intended to increase access to a broad continuum of SUD treatment services, signaling a desire to strengthen access to services,[6] and at least 31 states cover "early intervention" services, which can include screening, brief intervention and referral to treatment (SBIRT).[7]

In 2023, the Center for Medicaid and CHIP Services (CMCS), part of the Centers for Medicare and Medicaid Services (CMS), published the Mental Health and Substance Use Disorder Action Plan, outlining approaches to strengthening mental health and SUD treatment in Medicaid and CHIP across all care delivery systems

The Action Plan identifies the **delivery of mental health and SUD services in schools** as instrumental to supporting access to care through non-traditional settings and notes the release of updated Medicaid reimbursement guidance (discussed in the next section) for school-based health services.

**The CMCS Mental Health and Substance Use Disorder Action Plan** includes three overarching goals with prioritized strategies that guide CMCS' actions to improve treatment and support for Medicaid and CHIP enrollees with mental health (MH) conditions and/or substance use disorders (SUDs):

**Increase Access to Prevention and Treatment by**
A. Improving coverage of MH and SUD screening and therapies and promoting parity
B. Supporting integration and coordination of MH and SUD treatment with other healthcare

**Improve Engagement in Care by**
A. Increasing treatment and support in home and community-based settings
B. Supporting access to MH and SUD services through non-traditional settings and services

**Enhance Quality of Care by**
A. Encouraging implementation of evidence-based practices
B. Improving quality measurement
C. Analyzing and publicizing data on key topics

[6] Fitzgerald, H., Williams, D. Center for Health Care Strategies. State Principles for Financing Substance Use Care Treatment and Support Services. 2023. Retrieved from: https://www.chcs.org/resource/state-principles-for-financing-substance-use-care-treatment-and-support-services
[7] KFF. State Health Facts. Medicaid Behavioral Health Services: ASAM Level 0.5 – Early Intervention. 2022. Retrieved from: https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-asam-level-0-5-early-intervention

# The School Medicaid Opportunity

Medicaid leaders at federal and state levels are motivated to expand school-based Medicaid programs to improve children's health and well-being. Addressing and preventing substance use disorders is also a priority. This is the perfect moment for a conversation on Medicaid coverage of substance use prevention services in schools.

**Comprehensive information** about the school Medicaid program can be found in Healthy Schools Campaign's "Guide to Expanding Medicaid Funded School Health Services."

Medicaid can pay for a broad array of school-based SU prevention, early intervention and treatment services provided to Medicaid-enrolled students. However, schools can only bill Medicaid if both the health service *and* the school-employed health provider (or contract provider) delivering the service are Medicaid-qualified. That's because CMS requires that school-based services and providers be included in the Medicaid statute (section 1905(a) of the Social Security Act) and covered within the state's Medicaid plan, or be available under the mandatory Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement.

States can improve the delivery of SU services by expanding the state Medicaid plan to include the broadest possible array of services that can be provided in schools and health personnel delivering those services. To support states in expanding their school Medicaid program, CMS published new federal guidance in 2023, "Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming," along with an informational bulletin that encourages state Medicaid agencies, in partnership with state education agencies (SEAs), to create a school Medicaid program that supports the delivery of SU services.

The guidance makes clear that Medicaid reimbursement is available for all Medicaid-covered physical, mental and behavioral health services — including SU services — provided by a school to Medicaid-enrolled students. Since Medicaid adheres to a medical model, there are challenges in seeking reimbursement for prevention and educational activities. But when Medicaid reimbursement is available, the funding can provide much-needed support for school health services.

Both documents are designed to help states decide how best to leverage Medicaid funding to cover health services delivered in schools using new options and flexibilities for implementation.

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***Medicaid payment can be made for Medicaid-covered mental health and SUD services, including those identified in students' IEPs and Section 504 plans***
*— CMS school Medicaid guidance (pg. 24)*

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This is not a new funding opportunity; rather, the guidance offers policy options, clarification and direction on how state Medicaid agencies can leverage school Medicaid reimbursement to support schools. It provides an important foundation for ensuring all schools can take full advantage of school Medicaid financing and bring in as much funding as possible for school health services.

## Strategy: Building a Strong Medicaid State Plan for Substance Use Prevention & Early Intervention

**Center for Health Care Strategies** identified 10 strategies and principles for financing substance use care, treatment and support services. States should apply these principles to their state Medicaid plan to strengthen coverage of prevention and early intervention services, and make it possible for all individuals enrolled in Medicaid to access culturally and linguistically care.

Implementing these strategies also sets up the school Medicaid program for success. **The stronger the Medicaid state plan, the stronger the school Medicaid program.**

- Use Medicaid funds strategically to expand and sustain access to evidence-based substance use prevention, treatment and recovery support services.
- Direct flexible federal funds — to the fullest extent allowable — toward boosting infrastructure, prevention, harm reduction and recovery support services.
- Conduct an inclusive decision-making process for allocating opioid settlement funds and prioritize funds for investments in services and infrastructure needs not covered by Medicaid and other existing state/federal funding streams.
- Incentivize and sustain "no wrong door" approaches to substance use care, treatment and support services.
- Ensure patients are placed in the most appropriate level of care, including nonresidential, community-based substance use treatment and recovery support services.
- Address substance use treatment disparities for historically marginalized groups and communities.
- Advance equitable access and outcomes for substance use care, treatment and recovery support services among populations with multiple system involvement.
- Use data to drive effective, equitable care and outcomes.
- Require specialty substance use treatment providers to offer evidence-based treatments, particularly medications for opioid use disorder.
- Bolster the substance use prevention, treatment and recovery support service network for children and youth.

# How States Can Strengthen Medicaid Reimbursement for Substance Use Services

The school Medicaid program historically has been burdened with outdated federal guidance and complicated requirements, and many states limit Medicaid reimbursement to the services listed in an Individualized Education Plan (IEP) or Individual Family Service Plan (IFSP).

This can change. States can make numerous policy decisions to improve their school Medicaid program so that schools can better leverage federal funding. The example below, common to many states, shows what happens when there's coverage misalignment between the state Medicaid plan and the school Medicaid program.

## State Reimbursement Example

| Current state Medicaid plan coverage and requirements | What does this mean for school Medicaid billing? | What needs to be done to leverage Medicaid funding? |
|---|---|---|
| The state's Medicaid plan covers a wide range of substance use services, including early intervention.<br><br>However, the state's school Medicaid program covers only audiology, nursing, attendant care services, occupational therapy, physical therapy, social work services and psychological services in schools.<br><br>In addition, services must be included in a student's IEP to bill for reimbursement. | Because the state covers substance use services in its Medicaid state plan, Medicaid could reimburse for these services.<br><br>However, due to the way the state structured its school Medicaid program, reimbursement is possible only if the services fall under the limited covered benefit categories *and* are included in a student's IEP.<br><br>**Result:** The state and school districts are not able to bill for these services. Federal money is left on the table. | The state can change its school Medicaid program to:<br><br>1) Cover all medically necessary services in a school setting rather than the current, limited benefit package.*<br><br>2) Remove the IEP restriction so that school districts can bill for delivering services to all Medicaid-enrolled students.*<br><br>**Result:** School districts can bill for all substance use services in the Medicaid state plan.<br><br>**The state submits a state plan amendment (SPA) to CMS to make these changes.* |

### School Medicaid & Student Health Equity

School districts provide a wide range of mental, behavioral and physical health services using a variety of funding sources, including state and local dollars. By obtaining additional Medicaid reimbursement for services they already provide, school districts can free up funds and supplement their limited health funding.

While all school districts could benefit from additional and sustainable funds, this financing mechanism is particularly significant for schools in low-income and under-resourced communities. When these funds are fully leveraged, they can help support the workforce, workforce development and the delivery of additional services.

To comply with CMS guidance released in 2023, many states will soon consider changes to their school Medicaid program. State Medicaid agencies should use every flexibility to expand school Medicaid coverage for substance use services to improve health and education equity and outcomes.

## 10 Policy Actions for Expanding SU Services in Schools

Using the actions described below, states can eliminate barriers to reimbursement for school-based substance use services, and help school districts get reimbursed for all services — including EPSDT services — already covered in the state Medicaid plan.


*Download "Actions States Can Take to Remove Barriers to Reimbursement for Substance Use (SU) Services in School Medicaid" graphic.*

## 1. Use the "free care" policy reversal option to ensure that Medicaid can reimburse for *all* services delivered to *all* Medicaid-enrolled students.

In 2014, CMS issued a letter to state Medicaid directors affirming states have flexibility in their school-based Medicaid program to allow school districts to bill Medicaid for health services delivered to all Medicaid-enrolled students, not just those with a special education plan documented by an IEP or IFSP. The new CMS guidance strongly encourages states to use this flexibility.

Though often offered in a school setting, many behavioral and mental health prevention and early intervention services are not likely to be included as part of an IEP, which means they are ineligible for reimbursement unless the state plan covers services outside of an IEP.

HSC's policy brief "Financial Impact of Expanding School Medicaid Programs" explores the financial gains states have realized by expanding school Medicaid coverage outside the IEP.

Expanding Medicaid reimbursement for more students could mean more federal funds for states and school districts. And since most schools already deliver substance use prevention and early intervention services (and pay for them with education dollars), additional federal reimbursement can supplement education funds and help stretch resources further.

## 2. Provide guidance on the delivery and reimbursement of culturally and linguistically effective and evidence-informed substance use services.

To ensure linguistically effective and culturally appropriate delivery of substance use services, state Medicaid agencies should provide clear guidance on evidence-informed services that are/could be covered in the state Medicaid plan, along with the types of providers qualified to deliver these services. In addition, both the state Medicaid agency and the SEA should make resources and best practices available and support developing a trained, diverse workforce.

States must provide grant funding (including up-front, start-up funding), measure data and outcomes to support this work, and hold systems accountable when persistent inequities exist.

## 3. Leverage the EPSDT benefit and other statutory authorities to cover all medically necessary services delivered in a school setting, thereby allowing maximum coverage for substance use prevention and treatment services.

CMS makes it clear that states can cover a comprehensive range of medically necessary services in a school setting, including mental and behavioral health and substance use services. A 2022 CMCS Informational Bulletin notes that the obligation to provide all medically necessary care under EPSDT extends to prevention, screening, assessment and treatment for mental health and substance use disorders. The Bipartisan Safer Communities Act requires CMS to review states' compliance with the Medicaid EPSDT benefit; there could be audit and/or litigation consequences for states that fail to comply.

### What Is Medical Necessity?

Federal policy requires that Medicaid-covered services be "medically necessary." The federal statute does not define "medical necessity" but rather describes a broad standard for coverage without providing a prescriptive formula for ascertaining necessity. States can establish their own definitions of medical necessity so long as they are not more restrictive than the federal statute.

In general, states define medically necessary services as those that prevent a condition; improve health or lessen the impact of a condition; or restore health. Each state's definition of medical necessity is traced by the National Academy of State Health Policy in State Definitions of Medical Necessity under the Medicaid EPSDT Benefit.

Written documentation of medical necessity, signed by a qualified provider, is required for all school health services submitted for Medicaid reimbursement. Documentation of medical necessity can be fulfilled in several ways, such as through a doctor's order, individualized education plan (IEP), or individual health plan (IHP) that the school implements.

Some districts may keep the documentation as part of the student's record; others may use an electronic health record or billing system. Either way, the assumption is that medical necessity documentation exists for all services billed to Medicaid. For more information, view HSC's policy brief "Documenting Medical Necessity Through Plans of Care."

Still, some states take a limited approach and cover only specific services such as physical therapy and nursing services. To prioritize children's health and well-being, states should clarify that all medically necessary services are covered when delivered by schools. Using broad and encompassing language in the state plan allows coverage of the broadest possible array of services. HSC's report "School Medicaid Expansion: How (and How Many) States Have Taken Action to Increase School Health Access and Funding" identifies states that have chosen this route.

## 4. Align school Medicaid documentation requirements with CMS' minimum documentation requirements to relieve the administrative burden on school districts and providers.

The new federal school Medicaid guidance aims to reduce the administrative burden on school districts and school-based providers. By streamlining and identifying a school district's documentation responsibility, CMS has greatly simplified the administration of the school Medicaid program.

To receive reimbursement, school-based providers must provide documentation that a medically necessary service was delivered to a Medicaid-enrolled student. States should establish clear documentation requirements for schools that align with the CMS standard, are not overly burdensome and do not limit coverage for medically necessary care. This must be accompanied by clear guidance on how schools can document medical necessity, including for substance use prevention services.

CMS requires the following data for documentation:

- Date of service
- Name of recipient
- Medicaid identification number
- Name of provider agency and the person providing the service
- Nature, extent or units of service
- Place of service

States may have additional documentation requirements to identify the services a child receives at school. This information can be used to help coordinate care between community and school providers. With clear documentation guidelines, school districts can submit claims for payment (if required) knowing that they have the appropriate infrastructure in place and are meeting clinical practice standards.

## 5. Provide clear guidelines for covering substance use prevention services in addition to screening and treatment.

Medicaid will cover substance use prevention and early intervention services, including services provided in a school setting. As stated in the 2022 CMCS informational bulletin "Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth":

> *Prevention and early identification of health conditions is a key component of EPSDT. Early detection of mental health and substance use issues is crucial to the overall health of children and youth, and may reduce or eliminate the effects of a condition if detected and treated early. This makes routine screenings, early identification, and engagement in treatment as early as possible critical for children and youth.*

States are required to incorporate age-appropriate screenings and assessments, such as those recommended by the American Academy of Pediatrics and U.S. Preventive Services Taskforce.

Since school Medicaid programs often struggle with how to reimburse for substance use prevention, state Medicaid agencies should develop a specific policy on reimbursement for behavioral health services and substance use prevention/early intervention services, provide technical assistance and support to school districts on how to document care and seek reimbursement, and provide guidance on how payment can be accessed for linguistically effective and culturally appropriate evidence-informed services.

## 6. Cover substance use prevention and early intervention services before a diagnosis, and provide clear guidance on documentation, including how medical necessity standards apply to preventive services.

The CMCS bulletin referenced above notes that states can cover services, including prevention and early intervention services, for children and adolescents who may have mental health conditions or substance use disorders but who do not yet have a diagnosis.

The guidance also notes that "hard, fixed, or arbitrary limits on coverage (including based on lists of specific diagnoses) are not permitted."

The default policy of all states should be to permit school Medicaid programs to provide coverage even before a formal diagnosis is made. States can do this by expanding coverage to all students enrolled in Medicaid, as services delivered before a diagnosis may not be captured in an IEP. There are no federal requirements for procedure or diagnosis codes (e.g., HCPCS, CPT, CDT, ICD-10). However, most states have requirements beyond the minimum data set.

State Medicaid agencies must clearly define the circumstances under which a student can receive services in a school setting before a formal diagnosis. For example, does the student need to be deemed "at risk"? And if so, by what criteria? Providers working in school settings may have a hard time distinguishing between services that are "medically necessary" and those that are "educationally necessary" or helpful for classroom management, which providers typically do not see as eligible for billing.

For example, in Massachusetts, which expanded reimbursement to cover services outside of the IEP, behavioral health screenings are covered services, and students receiving behavioral health supports from qualified professionals don't have to be formally diagnosed with a behavioral health disorder. Rather, they can be identified as having "signs and symptoms" or other "concerns" identified through screening or any other method in which the qualified practitioner believes that the student would benefit from their skilled interventions and provides group or individual support. (Services provided by non-qualified behavioral health providers including teachers would not be reimbursable.)

Massachusetts' approach is preferable to California's, which provides specialty mental health services available without a diagnosis so long as the student is identified as "high risk," as evidenced by involvement with child welfare or scoring in the high-risk range under a trauma screening tool approved by the department (more information on California's approach is available in the same CMCS bulletin).

## Medicaid Statutory Authorities for Covering School Health Services

*These are the statutory authorities and coverage options that indicate substance use prevention services can be covered in a school-based setting if they are otherwise covered in the Medicaid state plan.*

**Early and Periodic Screening, Diagnostic, and Treatment (EPSDT):** The EPSDT benefit provides a comprehensive array of preventive, diagnostic and treatment services for most Medicaid-enrolled children under age 21. The EPSDT benefit is designed to help ensure that EPSDT-eligible children and adolescents receive early detection and care so that health problems are averted or diagnosed and treated as early as possible.

**Preventive Services Benefit:** Preventive services are generally defined as services recommended by a physician or other licensed practitioner of the healing arts, within the scope of authorized practice under state law, to prevent disease, disability, and other health conditions or their progression; prolong life; and promote physical and mental health and efficiency. Preventive services include immunizations, well-child care, clinical and behavioral interventions to manage chronic disease and reduce associated risks, and counseling to support healthy living and self-management of chronic disease.

**Rehabilitative Services Benefit:** Rehabilitative services are generally defined as "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." This benefit category is often used to authorize mental health and substance use services. The state will need to describe the rehabilitative services it seeks to cover and list the practitioners who will furnish the services, along with their qualifications. For example, a state may seek to cover individual and group counseling, or peer support services for children in schools with mental health conditions or substance use disorders.

**Other Licensed Practitioner Services Benefit:** States have flexibility in covering services provided by licensed practitioners as defined by state law. Other licensed practitioner services are "any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under state law." Under the Medicaid state plan, states may elect to cover services furnished by state-licensed practitioners, including in school settings. For example, this benefit could be used to cover the services of a licensed clinical social worker to furnish counseling, a licensed psychologist to administer psychological tests, a licensed nurse to administer medications, or a nurse practitioner to perform physical exams.

**Case Management and Targeted Case Management Benefit:** States can choose to furnish case management services to assist Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services. A state may elect to cover case management under the Medicaid state plan. Case management services could help coordinate services a beneficiary receives across both school and community settings.

## 7. Cover services for a certain period before a plan of care is required.

Many state Medicaid agencies require students to have a plan of care (POC) before a service is considered eligible for reimbursement in a school. These plans, which must be signed by a qualified Medicaid provider, are used as documentation (and often to document medical necessity). The plan of care may be an IEP/IFSP, or it may be a separate document created specifically to substantiate a diagnosis or demonstrated need.

However, students who need prevention and some early intervention services, as well as crisis intervention services, may not yet have a plan of care. As long as a practitioner is within the scope of practice and practice standards, it is appropriate (and desirable) for Medicaid to reimburse schools for the time that qualified providers spend on these services.

State policy determines if the care provided in school for prevention or unplanned services is eligible for Medicaid reimbursement. Some points to consider:

- In states that cover only services included in an IEP/IFSP, prevention and/or unplanned services would not be covered — even if the service is needed for a student with an IEP/ISFP.

**Aurrera Health Group's research**, "Medicaid Coverage of School-Based Crisis Services: Analysis and Recommendations Based on a Review of Eleven States," provides specific examples of how states cover unplanned and crisis services through school Medicaid.

- In states that have expanded their school Medicaid program to cover selective services outside of an IEP, the time a qualified provider spends on a prevention/unplanned service is reimbursable if the service itself is covered.

- In states that have expanded their school Medicaid program to cover all medically necessary services, the time a qualified provider spends on an unplanned service should be covered by Medicaid, assuming the service is classified as medically necessary.

Because the vast majority of states require that Medicaid-reimbursable school health services be provided under an IEP, IFSP or other written POC, state guidance should make clear that unplanned behavioral or physical health interventions needed to address an acute need are eligible for reimbursement.

Michigan, for example, requires the development of a formal POC only if a student continues needing services more than 30 days after the initial service. Michigan's policy states, "[w]hen ongoing services are provided in the absence of a POC due to the urgency of the student's medical needs, the expectation is that a POC will be developed within 30 calendar days from the first date that services are provided for a specific condition."

This is a very reasonable requirement; it appropriately supports the establishment of a POC for students who need ongoing services, while recognizing that coverage should be provided for services to students with only immediate or short-term needs.

Arkansas has a more demanding coverage policy for crisis intervention services. For behavioral health crisis services to be billable, the provider must develop a crisis plan or revise an existing plan, and a mental health diagnosis must be completed within seven days. In practice, this can be a challenge for providers to coordinate, and additional time may be needed.

## 8. Include providers who specialize in school-based substance use prevention in the list of qualified Medicaid providers.

The state Medicaid plan defines the types of providers, subject to state scope-of-practice laws, able to receive Medicaid reimbursement for services delivered in a school-based setting. At the same time, school districts hire a wide range of providers who are licensed and/or credentialed to deliver services in schools through their state and/or through the state department of education.

A problem experienced by school districts is that those two lists don't always match. Highly trained and credentialed service providers employed by school districts and working in schools may not be recognized under a state's Medicaid plan, which means they are not eligible to bill Medicaid for services provided, even if the services themselves are covered by Medicaid. (Learn more about misalignment in HSC's report, "State Medicaid & Education Standards for School Health Personnel: A 50-State Review of School Reimbursement Challenges.")

Federal school Medicaid guidance provides flexibility and additional support for states to align their education and Medicaid provider types, and CMS encourages states to recognize an array of providers, including those working in the school setting, who can maximize access to needed behavioral health services.

To draw down as much federal Medicaid funding as possible to support substance use prevention and treatment services, state Medicaid plans should cover the broadest possible array of provider types to deliver services in schools. This way, when services are delivered by the provider, Medicaid can reimburse the school district for that service.

The first step is to compare the list of substance use providers working in the school setting against the state's list of Medicaid-qualified providers covered in the state Medicaid plan and identify any misalignment. The state Medicaid agency should update the state plan to include the full list of licensed and/or credentialed providers employed by school districts. Then the school Medicaid program will provide reimbursement for the substance use services being delivered and increase overall reimbursement to the school district.

## 9. Support school districts in strengthening or establishing a Medicaid administrative claiming program.

A school Medicaid administrative claiming (MAC) program allows schools to receive reimbursement for certain activities that support the effective administration of the Medicaid program. This can include time school staff spend on family outreach and Medicaid enrollment, application assistance, care and benefits coordination, and training on Medicaid billing and translation services.

Services covered under MAC are not direct healthcare services, but they have an undeniably positive effect on student health and improving outcomes. Keeping kids and families enrolled in Medicaid makes healthcare more affordable and helps improve access to care. Particularly as states and families face post-COVID Medicaid redeterminations (sometimes called the Medicaid unwinding), students and their families may experience confusion or instability in their coverage.

Providing care and benefit coordination, including with primary care providers and families, helps students access the services they need. Translation services, including to family members, remove barriers to linguistically appropriate care. Investing in strengthening or establishing a MAC program can mean more funding to schools for these services.

### 10. Establish that state Medicaid agencies require school districts to reinvest Medicaid reimbursement into a broader substance use prevention package.

Increased Medicaid reimbursement can significantly boost overall school budgets and help school districts stretch local funding for student health. This is particularly important as school districts look for sustainable funding sources for school health services. In addition, this funding can incentivize school districts to continue providing and even expand access to these services.

In some states, reimbursement funds can be classified as general funding that can supplement district budgets. Other states either encourage or require schools to invest in school health services.

California, for example, approved legislation (SB-276) in 2015 requiring school districts to "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." Almost 20 years earlier, Colorado passed legislation (SB-101) authorizing school districts to use Medicaid funds to provide health services for all children based on a local needs assessment and plan.

State policy should require that Medicaid reimbursement be reinvested in student health services — and administered with flexibility so that districts can identify effective interventions and promising practices to advance equitable outcomes for students.

# Challenges of Covering Substance Use Prevention and Early Intervention

Together, the 10 policy actions outlined in this report create a state policy ecosystem that maximizes federal reimbursement for school health services while adhering to a medicalized model of delivering substance use prevention and care. Yet even with all the levers pulled, there are shortcomings.

First, Medicaid typically covers evidence-based clinical interventions; while non-clinical interventions may be just as effective in practice, identifying reimbursement pathways and building the resources and evidence needed to cover these services poses challenges.

There also are reimbursement challenges concerning non-traditional medical providers. While there are opportunities to expand the types of qualified providers under the Medicaid state plan, teachers, principals and other educators, as well as other school staff who provide day-to-day student support, are not considered "qualified Medicaid providers" for the direct services billing program.

Finally, services must benefit a specific Medicaid-enrolled student (or group of specific students). This eliminates the opportunity to use Medicaid funds for school programs that are seen as "health education" or "wellness" — even when provided by a licensed professional.

To better address substance use among youth and increase equitable access to care, school Medicaid programs must shift to comprehensive prevention and early intervention. The federal Medicaid guidance released in 2023 hopefully will spur creative thinking and address some of these structural challenges.

For example, can a broader range of health education services be reimbursed as administrative claiming activities, if not as direct services? Services such as universal health education and prevention, and appropriate intervention strategies during child development, are about long-term health and the prevention of future health issues. CMS should provide additional insight and options in this area.

# Additional Investments to Improve Equity in School-Based Medicaid

As the CMCS Mental Health and Substance Use Disorder Action Plan makes clear, enhancing the school-based Medicaid program is just one strategy available to state Medicaid agencies to improve student access to substance use services.

State Medicaid agencies can advance the complementary strategies below to ensure that more (and more equitable) substance use services are available in schools:

- Make certain the services covered in schools are high quality, evidence-informed and culturally and linguistically effective. These services should be integrated into the overall state Medicaid plan to ensure equitable access and outcomes are covered in the school setting as part of the benefits package.

- Partner with education and other stakeholders to offer training to school staff and health providers to counter substance use stigma, mistrust and historical biases. While such efforts are not a stipulation of the Medicaid program, state Medicaid agencies can develop partnerships to promote greater training and education that wrap around other key program areas, including documentation requirements and provider qualifications.

- Strengthen partnerships with SEAs, licensing divisions and other agencies to regularly review and assess qualified providers and identify linguistically effective and culturally appropriate substance use providers and services.

- Review school Medicaid program monitoring and data collection. Without making it overly burdensome for school-based providers, state Medicaid agencies can implement improved monitoring and quality metrics to better assess school services and data to ensure equitable outcomes.

- Ensure that best practices and efforts are integrated into school-based healthcare settings while exploring ways to integrate substance use services into general healthcare.

- Establish community advisory boards or other structures to allow young people and their families to inform and co-create solutions that span both school and community.

CMS can play a supportive role by providing additional technical assistance to states on designing substance use prevention and early intervention services and on assessing equitable access to these services. While CMS' support is emphasized in federal guidance, states may be hesitant to make changes without clear permission.

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# Additional Resources

## Federal Guidance

- Overview of Medicaid and School-Based Services – Centers for Medicare and Medicaid Services (CMS)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement – CMS
- Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming – CMS; also see this informational bulletin introducing the Guide.
- Mental Health and Substance Use Disorder Action Plan – Centers for Medicaid & CHIP Services (CMCS)
- Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth – CMS/CMCS informational bulletin
- Joint Information Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools – CMS/Substance Abuse and Mental Health Services Administration (SAMHSA)
- Letter to state Medicaid directors – CMS clarifies that federal policy allows states flexibility to cover health services outside of a student's IEP or IFSP

## Partner Resources

- Medicaid Is Key to Building a System of Comprehensive Substance Use Care for Low-Income People – Center for Budget and Policy Priorities
- State Principles for Financing Substance Use Care Treatment and Support Services – Center for Health Care Strategies
- State Definitions of Medical Necessity under the Medicaid EPSDT Benefit – National Academy for State Health Policy
- Advocates' Guide to the Change In The Medicaid Free Care Rule – Community Catalyst

## Healthy Schools Campaign Publications

- A Guide to Expanding Medicaid-Funded School Health Services
- School Medicaid Expansion: How (and How Many) States Have Taken Action to Increase School Health Access and Funding
- Financial Impact of Expanding School Medicaid Programs
- School Medicaid: Documenting Medical Necessity Through Plans of Care
- Medicaid Coverage of Crisis Intervention Services in a School Setting
- Medicaid Coverage of School-Based Crisis Services: Analysis and Recommendations Based on a Review of Eleven States – with Aurrera Health Group
- State Medicaid & Education Standards for School Health Personnel: A 50-State Review of School Reimbursement Challenges – with Aurrera Health Group
- Tapping into Federal COVID-19 Relief Funding & Medicaid to Support Schools and the Wellbeing of Students – with Council of Chief State School Officers and National Center for School Mental Health

## Healthy Schools Campaign

Healthy Schools Campaign (HSC) engages stakeholders and advocates for policy changes at local, state and national levels 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. HSC's Healthy Students, Promising Futures initiative supports states and school districts in expanding access to Medicaid-funded school health services. To learn more, visit healthyschoolscampaign.org and healthystudentspromisingfutures.org.