MEDICAID AND SCHOOL MENTAL HEALTH SERVICES: FAQS

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MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

SAMHSA Substance Abuse and Mental Health Services Administration

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This publication was prepared for the Mental Health Technology Transfer Center Network under a cooperative agreement (3H79SM081774-04S1) from the Substance Abuse and Mental Health Services Administration (SAMHSA).

At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D., served as SAMHSA Assistant Secretary for Mental Health and Substance Abuse.The opinions expressed herein are the views of the Southeast MHTTC and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

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RECOMMENDED CITATION: Hu, J., Wilk, A. S., & Cummings, J. R. (2022). Medicaid and School Mental Health Services: FAQs. Southeast Mental Health Technology Transfer Center (Southeast MHTTC).

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INTRODUCTION

Medicaid and School Mental Health Services: FAQs

One in six children under the age of 18 experiences a mental health disorder.[1,2] Individuals with mental health disorders have greater risk of poor physical health (e.g., increased risks of obesity and hypertension),[3] poor academic achievement,[4,5] and diminished social role functioning (e.g., unemployment.[4]) Many mental health disorders first appear during childhood and adolescence,[6,7] and early identification and treatment can significantly reduce the severity of mental health disorders.[8,9] Yet, half of children with mental health disorders receive no treatment for these conditions.[1,2] Among the many barriers for youth to access mental health services are stigma, caregiver work and childcare responsibilities, transportation, and lack of mental health providers in the community.[10]

Schools are an essential setting for youth mental health services. Schools can facilitate access to mental health care by reducing barriers such as transportation and scheduling conflicts with caregiver work schedules. Providing mental health services in school settings is associated with increased utilization of services and a higher treatment completion rate among youth.[11-15] One study found that more than half of the children who received mental health treatment had utilized mental health services in schools.[12]

A diverse array of mental health services can be provided in schools. These include services aimed at raising awareness about mental health, identifying students with mental health needs, providing intervention, and referring students for further supports from providers in the community. The call-out box below includes more information on different types of school mental health services.

Many school mental health services can be financed through Medicaid, which is a joint federal-state program that provides health insurance coverage for many children (and adults) who meet specific criteria. This report answers some frequently asked questions about how Medicaid finances school mental health services. We also highlight examples and relevant resources for additional information.

WHAT DO WE MEAN BY "SCHOOL MENTAL HEALTH PROGRAMS AND SERVICES?"

In this report, school mental health programs and services are classified into the following three types:

- ***TIER 1***
  School-wide prevention services that aim to promote social and emotional health, such as programs to improve mental health literacy.
- ***TIER 2***
  Targeted services that aim to provide early intervention and support for students exhibiting risk factors for a mental health disorder, such as a group intervention to teach children at risk of aggressive behaviors how to cope with anger.
- ***TIER 3***
  Clinical interventions that are tailored to the needs of students who are experiencing significant distress and functional impairment, such as individual counseling for a student with anxiety.

  Click here for more information about each tier of school mental health services.

WHAT IS MEDICAID?

Medicaid and School Mental Health Services: FAQs

Medicaid is funded jointly by the federal government and individual state governments. It provides health insurance coverage and health services for children, pregnant women, individuals with a disability, and low-income individuals. States also provide insurance coverage to children in low-to-middle income families who do not qualify for Medicaid through the Children's Health Insurance Program (CHIP), another federal-state jointly funded program. As of June 2021, more than 39 million children were enrolled in Medicaid or CHIP.[16]

Medicaid is the largest insurer of children and the largest single payer of mental health services in the U.S.[17,18] It covers 48% of all children, 83% of children in low-income families, and 48% of children with special health care needs.[19] It also covers a wide range of mental health services, including inpatient stays, outpatient visits, long-term care, and prescription drugs. Medicaid accounts for 24% of total spending on mental health services in the U.S.[20] and 46% of all mental health services for school-age children (5-17 years old).[21]

Medicaid facilitates access to health care, especially for low-income children and families. Federal regulations limit the premiums and cost-sharing that Medicaid programs can charge to enrollees. Coupled with its broad coverage of health services, Medicaid allows enrollees to have insurance coverage and access needed health services with low out-of-pocket costs. Among low-income individuals, Medicaid enrollees have better access to care, a higher likelihood of using health services, better self-reported health, and a lower risk of having financial hardship due to medical bills than their uninsured counterparts.[22-24]

Each state has the flexibility to design and administer its Medicaid program within federal guidelines. Consequently, no two state Medicaid programs look the same in terms of benefits, eligibility rules, and other features. While federal law requires certain services and populations to be covered by Medicaid, states can make their Medicaid eligibility rules more generous (such as making more individuals eligible) and can expand the set of services Medicaid covers. In-depth discussions on Medicaid benefits and eligibility can be found in later sections of this report ("What services does Medicaid cover?" and "Who is eligible for Medicaid?").

NAMES OF MEDICAID PROGRAMS

Many states use call their Medicaid program by a unique name. Here are some examples:

CALIFORNIA
Medi-Cal

CONNECTICUT
HUSKY Health

WASHINGTON
Apple Health

WHEN WILL MEDICAID PAY FOR SCHOOL MENTAL HEALTH SERVICES?

Medicaid and School Mental Health Services: FAQs

Medicaid is an important funding source for school mental health services. Many school mental health services are eligible for Medicaid reimbursement if all of the following four requirements are met:

1. Medicaid covers the service.
   See "What services does Medicaid cover?"
2. The student who receives the benefit (service) is enrolled in Medicaid.
   See "Who is eligible for Medicaid?"
3. The provider who provides the service is a Medicaid-certified provider.
   See "What providers can bill Medicaid?"
4. The setting (i.e., school) is a Medicaid-accepted setting.
   See "Are schools a Medicaid-accepted settings for providing mental health services?"

We will explain these four requirements in detail in the next four sections of this report.

IN ADDITION TO MEDICAID, WHAT ARE SOME COMMON FUNDING SOURCES FOR SCHOOL MENTAL HEALTH SERVICES?

The U.S. Department of Education and the U.S. Department of Health and Human Services provide various funds and grants that can support school mental health programs. These include Every Student Succeeds Act funds and Project AWARE grants. In addition to federal funding, many states allocate state resources through specific appropriations and earmarked tax revenues. More information can be found in the following resources:

- ***EDUCATION COMMISSION OF THE STATES, 2021***
  State Funding for Student Mental Health.[25]
- ***GEORGIA DEPARTMENT OF EDUCATION, 2018***
  Whole Child Tenet: Engaged.[26]

WHAT SERVICES DOES MEDICAID COVER?

Medicaid and School Mental Health Services: FAQs

Medicaid can pay for many school mental health services and some associated administrative expenses. In general, schools can receive Medicaid reimbursement for school mental health services when the services are on the State Medicaid program's list of covered benefits. In addition to mental health services that are covered for all Medicaid-eligible individuals, this would also include services covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (described below) or the child's Individualized Education Program (IEP) under the Individuals with Disabilities Education Act (IDEA).

MEDICAID: MANDATORY AND OPTIONAL BENEFITS

As we noted earlier, federal regulations mandate that states cover certain benefits under their Medicaid programs, and states may also include optional benefits to provide more comprehensive coverage for enrollees. Table 1 on the following page shows all mandatory benefits and key examples of optional health care benefits for youth and individuals with mental health disorders. Service categories that may include school mental health and outpatient mental health services are starred (*).

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

The EPSDT benefit is a mandatory Medicaid benefit covering a wide range of health services for Medicaid enrollees under age 21. The EPSDT benefit aims to enhance the early identification and treatment of physical and mental health problems for children and adolescents by providing access to appropriate health services.

Under EPSDT, states are required to cover all medically necessary[a] diagnostic services and treatments of all conditions discovered through an EPSDT-covered screening. Screening services commonly covered under EPSDT include: physical exams; screenings for developmental, behavioral health, vision, and hearing problems; dental exams and related services; and other diagnostic evaluations and associated treatments. Many of these treatment services are not covered as optional benefits under Medicaid in many states, but the EPSDT benefit (through Medicaid) will cover treatment services for a condition or need detected during a screening even if they are not otherwise covered by Medicaid (such as eyeglasses). We provide examples of EPSDT-covered school mental health services in this infographic. These examples include autism screening, psychosocial assessment, counseling and therapy for mental health problems.

Despite its potential to promote health among children and adolescents, the EPSDT benefit remains underutilized. In 2017, the United States Government Accountability Office found that 41% of Medicaid enrollees aged 1 to 20 did not receive any EPSDT-required screenings.[27] Common factors contributing to the underuse of the EPSDT benefit include lack of awareness of the benefit,[28] negative attitudes towards screenings among caregivers,[29] and low willingness among private clinic physicians to offer EPSDT services.[28,30] Local mental health workforce shortages can also negatively impact the use of EPSDT-covered services in schools.[31,32] More specifically, schools may be less likely to perform EPSDT-covered screenings if they believe there will not be any providers available nearby to treat students who are identified during those screenings as having health needs.

The Centers for Medicare and Medicaid Services (CMS) recognize that schools are "particularly appropriate places" to provide EPSDT-covered services, including "medical, vision, and hearing screenings; vaccinations; some dental care; and behavioral health services."[33] To this end, CMS released an informational bulletin[34] to provide guidance and resources to facilitate the use of EPSDT-covered mental health services in schools.

[a] The National Academy for State Health Policy prepared a report exploring differences and variation across states in the definition of "medical necessity" and how it is applied. The report is available here.

WHAT SERVICES DOES MEDICAID COVER?

TABLE 1. MEDICAID BENEFITS: MANDATORY BENEFITS AND EXAMPLES OF OPTIONAL BENEFITS

MANDATORY BENEFITS	EXAMPLES OF OPTIONAL BENEFITS *(Not exhaustive)*
Inpatient hospital services	Prescription drugs*
Outpatient hospital services	Optometry services
Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)*	Dental services
Physician services*	Physical therapy and Occupational therapy
Nursing facility and Home health services	Speech, hearing, and language disorder services
Rural health clinic and federally qualified health center services*	Respiratory care services
Laboratory and X-ray services	Chiropractic services
Transportation to medical care (covered administrative costs)*	Telehealth/telemedicine*
Certified Pediatric and Family Nurse Practitioner services*	Clinic services*
Freestanding Birth Center services (when licensed or otherwise recognized by the state)	Case management*
Family planning services	Inpatient psychiatric services for individuals under age 21*
Nurse-Midwife services	Services in an intermediate care facility for individuals with Intellectual Disability
Tobacco cessation counseling for pregnant women	Home and Community-Based Services*
	For more information regarding optional benefits, please see the Medicaid and MACPAC websites.

*Service categories may include school mental health and outpatient mental health services.

SOURCES:

1.Centers for Medicare and Medicaid Services, Mandatory & Optional Medicaid Benefits. Available from www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html.

2. MACPAC, Mandatory and Optional Benefits. Available from: www.macpac.gov/subtopic/mandatory-and-optional-benefits/

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a law that ensures "free appropriate public education" and "special education and related services" are available for children with disabilities.[35] A child may be identified as IDEA-eligible if the child is identified as having one or more of 13 disabilities recognized under IDEA, including multiple categories of mental health conditions. A full list is provided in the call out box on the following page. For each IDEA-eligible child, the child's school must work with parents and other community experts (such as school psychologists or other health care providers) to develop an Individualized Education Program (IEP). The IEP is tailored to the child's needs and specifies the child's academic and behavioral goals and the supports and services that the school will need to provide to achieve those goals.

WHAT SERVICES DOES MEDICAID COVER?

WHAT ARE THE 13 DISABILITY CATEGORIES RECOGNIZED BY THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT ?

- Specific learning disability (e.g., dyslexia)
- Other health impairment (e.g., ADHD)
- Autism spectrum disorder
- Emotional disturbance, including schizophrenia
- Speech or language impairment
- Visual impairment, including blindness
- Deafness
- Hearing impairment
- Deaf-blindness
- Orthopedic impairment
- Intellectual disability
- Traumatic brain injury
- Multiple disabilities

Definitions and examples of the 13 IDEA disability categories can be found at this Department of Education website.[37]

Medicaid will cover the school-based medical and behavior health services specified in a student's IEP, so long as these services meet all standard requirements for Medicaid reimbursement. Whether Medicaid will cover the same services when provided in schools for students without an IEP depends on whether the state has implemented new guidance under the Free Care Rule. We provide more information about the Free Care Rule in the section "Are schools a Medicaid-accepted setting for providing mental health services?" of this report. Additional information about IDEA and related guidance for schools, parents, and health care providers are provided in this issue brief.[36]

ADMINISTRATIVE COSTS

To assist Medicaid-enrolled children in accessing available benefits, Medicaid also reimburses the costs of necessary administrative activities. In general, Medicaid covers the following two types of administrative activities that are commonly provided by schools:[38,39]

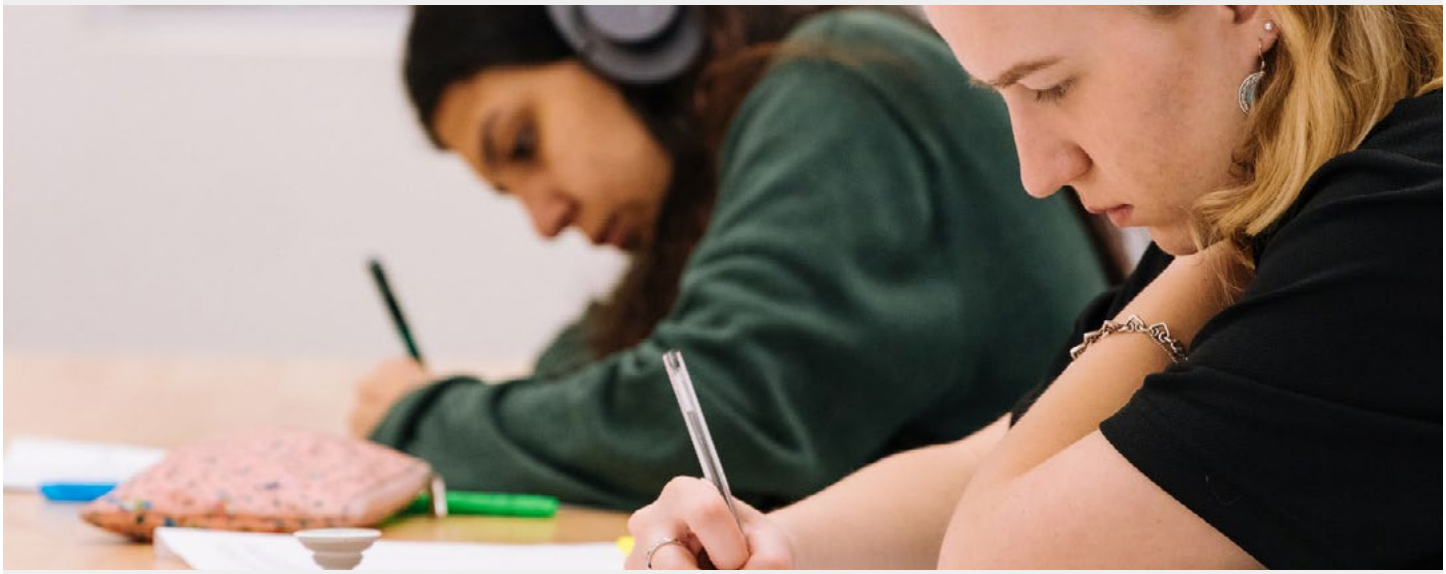
1. Administrative supports for Medicaid-reimbursable school services, including transportation, translation/interpreter services, and case management. "Medicaid-reimbursable school services" include, but are not limited to, EPSDT-covered services and school-based services that are listed in an IEP for a Medicaid-enrolled, IDEA-eligible student (as described above).
2. Outreach and enrollment services, including informing potential Medicaid-eligible students about Medicaid benefits and assisting them in completing the enrollment process.

As with most services, Medicaid coverage of administrative expenses varies across states. Some states may reimburse additional administrative activities, such as training for school staff to better assist students with accessing Medicaid-covered services, and general administration. School leaders should refer to the Medicaid School-Based Administrative Claiming Guide and their state Medicaid office for more details.

TELEHEALTH/TELEMEDICINE

Many youth have limited access to mental health services because of transportation difficulties and provider shortages. Telehealth has the potential to mitigate these barriers and facilitate access to mental health care. During the COVID-19 pandemic, many states have expanded Medicaid coverage of telehealth to ensure health services can be delivered to enrollees without interruptions. These expansions of Medicaid telehealth coverage allow Medicaid reimbursements for medically necessary services (including mental health services) provided to Medicaid enrollees via telecommunication.

WHAT SERVICES DOES MEDICAID COVER?



While schools and mental health providers may find these expansions helpful in improving access to mental health services,[40] these policies were time-sensitive and have expired in several states. A discussion of the status of Medicaid telehealth coverage expansions across states in the Southeastern U.S. is provided in this policy brief, with information current as of September 2021.

WHO IS ELIGIBLE FOR MEDICAID?

Medicaid and School Mental Health Services: FAQs

As noted earlier, Medicaid is an entitlement program that is jointly funded by federal and state governments. The federal government specifies certain criteria for eligibility, and any individual who meets those criteria (or belongs to an "eligibility group") has the right to enroll in the program. Generally, children in low-income families, children with disabilities, and children in adoption assistance or foster care services are covered by Medicaid. States may also choose to cover other optional eligibility groups. For example, as of 2019, seven of eight HHS Region IV states opted to cover "Katie Beckett children" (i.e., children under age 19 with long-term disabilities or complex medical needs who receive an institutional level of care at home) under Medicaid.[41] A complete list of Medicaid mandatory and optional eligibility groups can be found here.

To be eligible for Medicaid, the individual's household income must be below a specified income limit.[b] While federal regulations establish minimum income limits for each eligibility group, states have the flexibility to set higher income limits if they choose. As a result, these income limits can vary widely across states and eligibility groups. Typically, these income limits are specified as a percentage of the federal poverty level (FPL).

Children who do not qualify for Medicaid based on income may be eligible for the Children's Health Insurance Program (CHIP). Like Medicaid, CHIP is a health insurance program funded jointly by federal and state governments; it mainly covers uninsured children in low-to-middle income families who do not qualify for Medicaid. In most states, CHIP has higher income limits than Medicaid. However, since CHIP is not an entitlement program, eligible children may face other limits when seeking to enroll, such as enrollment caps, waiting lists, or waiting periods. For example, as of April 2021, Florida imposed a 2-month waiting period for CHIP enrollment, requiring a child to be uninsured for at least 2 months before enrolling in CHIP program.[42]

The table on the following page shows the income limits as of July 2021 for children to enroll in Medicaid or CHIP through the low-income families eligibility group among states in the Southeast region. Income thresholds are measured in relation to the federal poverty level, or FPL.

Medicaid and CHIP enrollees need to periodically recertify their eligibility to maintain coverage under the programs. This might include re-verifying income information, for example. Individuals must go through this renewal process once every 12 months. Failing to recertify eligibility can result in loss of Medicaid/CHIP coverage. Under the Affordable Care Act, many states have adopted policies to streamline Medicaid and CHIP renewal and enrollment processes, such as accepting online applications and upgrading eligibility determination systems, to reduce the risk of breaks in coverage. Please see this Kaiser Family Foundation report for an in-depth discussion of Medicaid and CHIP renewal processes across states.

WHO IS ELIGIBLE FOR MEDICAID?

TABLE 2. INCOME LIMITS FOR MEDICAID AND CHIP ELIGIBILITY AMONG STATES IN THE SOUTHEAST REGION (ELIGIBILITY GROUP: CHILDREN IN LOW INCOME FAMILIES) AS OF JULY 2021

STATE	INFANTS UNDER AGE 1	AGES 1-5	AGES 6-8	AGES 0-18
Alabama	141	141	141	312
Florida	206	206	133	210*
Georgia	205	205	133	247
Kentucky	195	195	159	213
Mississippi	210	210	133	209
North Carolina	210	210	133	211†
South Carolina	208	208	208	208‡
Tennessee	195	195	133	250

NOTE: CHIP: Children's Health Insurance Program, FPL: federal poverty level.
* Florida's CHIP program covers children age 1-18.
† North Carolina's CHIP program covers children age 6–18.
‡ South Carolina's CHIP and Medicaid programs are administered jointly as a single program (sometimes called "South Carolina Healthy Connections").
Source: MACPAC 2021. Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State, July 2021

WHAT PROVIDERS CAN BILL MEDICAID?

Medicaid and School Mental Health Services: FAQs

Most states require providers to be Medicaid-certified in order to receive Medicaid reimbursement. Generally, to become Medicaid-certified, a health care professional needs to meet the state's licensure or certification requirements[c] and complete an application. Therefore, when hiring or setting up contracts with providers, schools that plan to seek Medicaid reimbursement for school mental health services should consider whether the mental health providers are Medicaid-certified.

In states that administer Medicaid programs through managed care, providers must also contract with Medicaid Managed Care plans and be in a plan's provider network to receive reimbursement from that plan. Notably, some providers may contract with select Medicaid Managed Care plans (and accept their beneficiaries as patients) but choose not to contract with other plans. Consequently, schools that plan to contract with community providers for delivering school mental health services may need to confirm that the provider is Medicaid-certified and in specific Medicaid Managed Care plans' provider networks before entering into the partnership.

During the COVID-19 pandemic, some states waived the requirement that licensed providers had to be in-state to offer services and allowed pre-licensure professionals (e.g., pre-licensure master's/doctoral level behavioral health professionals, pre-licensure clinical students in counseling, social work, marriage and family therapy, and psychology) to provide telehealth services under supervision. With these deregulations, some out-of-state licensed mental health providers and pre-licensure professionals may be eligible for Medicaid payment for telemental health services, including telemental health services for students during school hours. However, these policies were time-sensitive, and they have already expired in several states. The landscape of in-state and licensure requirements for telemental health services across states in the Southeastern U.S. is outlined in this policy brief, with information current as of September 2021.

[c] Common examples for the types of mental health professionals that may meet the licensure/certification requirements for providing school mental health services include psychiatrists, psychologists, social workers, mental health counselors, and licensed professional counselors.

ARE SCHOOLS A MEDICAID-ACCEPTED SETTING FOR PROVIDING MENTAL HEALTH SERVICES?

Medicaid and School Mental Health Services: FAQs

As described earlier, schools are an essential setting for youth to access mental health services. Most youth who have received any mental health services have accessed at least some of these services in the school setting.[12]

Historically, the "Free Care Rule" was a barrier for schools to seek Medicaid reimbursement for school mental health services. (The call-out box below has more information about the Free Care Rule.) In December 2014, the Centers for Medicare and Medicaid Services (CMS) issued new guidance concerning this rule."[43] With the goal of improving access to high-quality services for Medicaid beneficiaries and their communities, this new guidance allowed schools to bill Medicaid for Medicaid-covered services delivered to all Medicaid-enrolled students, regardless of how services for other students in the school were paid for, including students with private insurance or those with no insurance.[d]

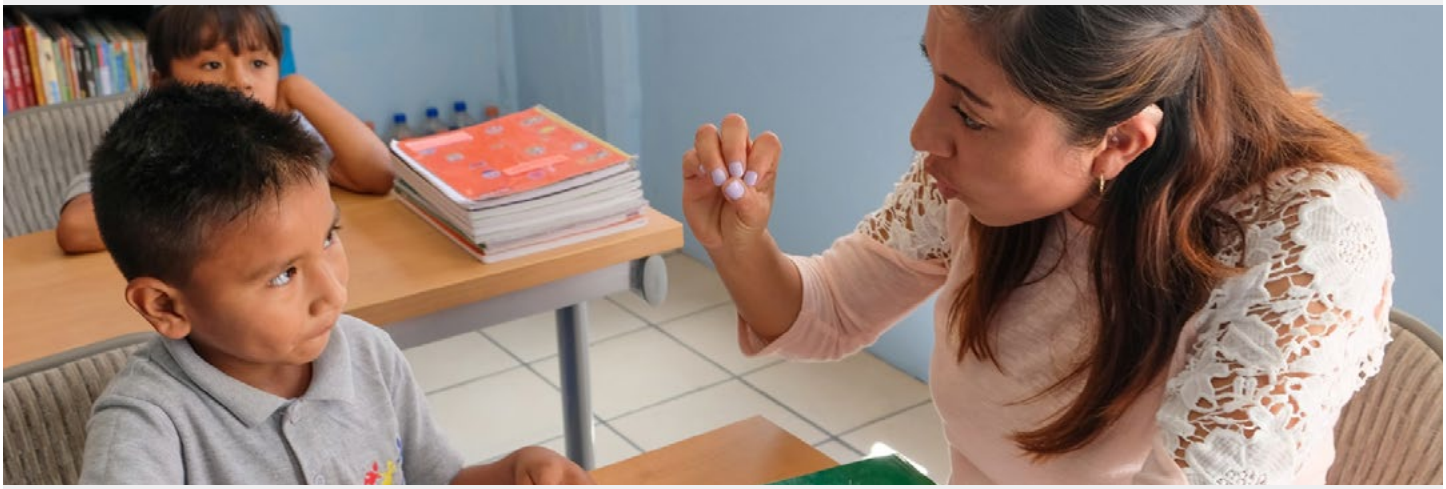
Depending on state Medicaid regulations, states can leverage the 2014 Free Care Rule guidance through different pathways. Some states have been able to allow Medicaid reimbursement for all Medicaid-enrolled students with minimal regulatory intervention, while other states have needed to make more significant regulatory and legislative changes. Specifically, many state Medicaid agencies have had to submit a state plan amendment (i.e., a formal amendment to make changes to program policies or operational approaches under a Medicaid state plan) to CMS and obtain CMS's approval before such changes could be advanced. For example, a state plan amendment was not necessary for Missouri to leverage the 2014 Free Care Rule guidance; in 2018 the state implemented regulatory reforms to allow schools to bill Medicaid for behavioral health services provided to all Medicaid-enrolled students. By contrast, a state plan amendment was required in Kentucky; consequently, the state submitted its state plan amendment to leverage the new guidance. Kentucky has allowed schools to bill Medicaid for mental health services for most Medicaid-enrolled students since CMS approved the state's state plan amendment in November 2019.

ABOUT THE "FREE CARE RULE"

Under CMS's previous guidance concerning the "Free Care Rule," it was generally not permitted for Medicaid to pay for school-based services that were available for free to at least some students. Otherwise stated, if schools provided a certain service to other students (e.g., uninsured students) at no cost, schools were not allowed to bill Medicaid for the same service when it was provided to Medicaid-enrolled students. Although exceptions were made for certain services such as services specified in an Individualized Education Plan, the Free Care Rule had limited schools' ability to seek Medicaid reimbursement for school mental health services. As a consequence of this rule, many schools with limited budgets were not able to offer services that Medicaid requires for children (e.g., screening for mental health problems) because they could not count on Medicaid to help with financing them.[44] Guidance about the Free Care Rule changed at the end of 2014.

[d] Please note that schools are still subject to Third Party Liability requirements, or "the legal obligation of third parties (e.g., other insurers or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan" when billing Medicaid for school-based services under the 2014 Free Care Rule guidance.

ARE SCHOOLS A MEDICAID-ACCEPTED SETTING FOR PROVIDING MENTAL HEALTH SERVICES?



Under a state plan amendment or other new legislation to implement the 2014 Free Care Rule guidance, some states have also expanded Medicaid-covered school-based services and/or eligible provider types allowed to bill school-based services.[e] For example, California passed state legislation and submitted a state plan amendment to CMS in 2015 to expand the scope of Medicaid-covered services to include respiratory therapy, personal care services, and orientation and mobility assessments. Additionally, California also added some provider types that are newly eligible to bill Medicaid for school-based services, including registered associate clinical social workers, personal care assistants, and licensed occupational and physical therapy assistants. CMS approved California's state plan amendment in April 2020.

As of December 2021, five states in the Southeast region have implemented the 2014 Free Care Rule guidance. Among these states, South Carolina did not need a state plan amendment, and Florida, Georgia, Kentucky, and North Carolina have obtained CMS approval for their state plan amendments. Please refer to this Community Catalyst and Healthy Schools Campaign's living report[45] for the latest updates on states' implementation of the new Free Care Rule guidance. The Community Catalyst also provides tips for state policymakers implementing the 2014 Free Care Rule guidance in this document.[46]

[e] Community Catalyst and Healthy Schools Campaign (2021). State Efforts to Implement the Free Care Policy Reversal. Retrieved from: docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXlGX5l3s0PN2culDejXZQw/edit#bookmark=id.hdj6b6geh0am

HOW DOES MEDICAID PAY FOR SCHOOL MENTAL HEALTH SERVICES?

Medicaid and School Mental Health Services: FAQs

All organizations that deliver mental health services, whether community-based clinics or schools, are required to bill Medicaid in order to receive payment for their providers' services. This can be a significant administrative burden, and it is essential to build institutional knowledge of Medicaid billing rules, to allocate enough work time for administrative staff to complete billing tasks, and to maintain secure data systems for storing students' health records, as federal regulations require.[f]

In this section we describe the two principal systems that state Medicaid offices use to pay for services delivered by school-employed providers: a fee-for-service reimbursement system and a cost-based reimbursement[g] system. States may use different systems to reimburse services provided by community providers (as opposed to schools or school-employed providers).

FEE-FOR-SERVICE

Under a fee-for-service reimbursement system, Medicaid pays a single, fixed payment for a specific service provided, regardless of the actual cost to provide the service. The payment amount is based on pre-set lists of services and payment amounts called "fee schedules." These fee schedules are typically set by state Medicaid offices annually. To receive payment, schools or community providers partnering with schools must submit a claim to the state Medicaid office (or to the child's managed care plan if the child is enrolled in a Medicaid managed care plan) shortly after providing the service.

COST-BASED REIMBURSEMENT

Unlike fee-for-service, cost-based reimbursement systems aim to pay the actual costs of the school's services. Under a cost-based reimbursement system, schools receive a pre-set interim payment when they submit a claim and the claim is approved. Receiving payment for claims submitted in this way is like the reimbursement process under a fee-for-service system. However, schools must also collect relevant cost data about the service provided (to capture actual costs) and must submit its accumulated cost data to the state Medicaid office at the end of the quarter (or year, depending on the state). The state Medicaid office then determines the total allowable cost for all services the school has provided to Medicaid beneficiaries during that quarter (or year). In the final step of the cost-based reimbursement process, state Medicaid offices reconcile each school's interim payments against the school's total allowable cost. To reconcile these amounts, the state Medicaid office may pay an additional amount to a given school or ask the school to pay some portion back to the state Medicaid office. We provide further details about cost-based reimbursement systems in these three infographics:

- "What is Cost-Based Reimbursement?"
- "How Are Local Education Agencies (LEAs) Paid Under Cost-Based Reimbursement?"
- "Comparing Reimbursement Systems: Fee-for-Service vs. Cost-Based"

The specifics of the cost-based reimbursement process vary by state; each state sets a methodology for collecting cost data and determining the total allowable cost. Among the most commonly used methodologies are the Random Moment Time Study Method[47] (e.g., used in Georgia and Alabama[h]) and the hybrid cost settlement reimbursement methodology (e.g., used in California [i.e., the Cost and Reimbursement Comparison Schedule][48] and Minnesota[49]). Schools should apply the methodology that their state Medicaid office accepts to collect cost data and comply with the state Medicaid office's guidance on what data should be collected.

[f] Schools may bill Medicaid in some states but not others. See Section VII "Are schools a Medicaid-accepted setting for providing mental health services?"

[g] Cost-based reimbursement is also known as cost settlement, recognized cost, or reconciled cost reimbursement.

[h] The National Alliance for Medicaid in Education presents more information about the Random Moment Time Study Method in the presentation available at: www.medicaidforeducation.org/filelibrary-name/webcommittee/Topical_Call_audio/NAME%20Presentation%20RMTS_CBR_FINALv2%204-23-15.pdf

HOW DOES MEDICAID PAY FOR SCHOOL MENTAL HEALTH SERVICES?

REIMBURSING ADMINISTRATIVE SERVICES

Medicaid also pays schools for many administrative services that schools provide as part of their school-based mental health programs. Some examples of eligible administrative services include helping students complete Medicaid enrollment applications, arranging transportation for students to receive services off-site, and referring students to community providers for services. Under a fee-for-service system, schools should follow the Medicaid School-Based Administrative Claiming Guide to submit claims for administrative services. As discussed above, schools in states using cost-based reimbursement systems should follow the cost-based reimbursement process to receive reimbursement for administrative services.

WHAT IS MEDICAID MANAGED CARE?

Medicaid and School Mental Health Services: FAQs

Over the last two decades, managed care has been the primary model through which states administer Medicaid programs.[50] As of 2019, 47 states and the District of Columbia provided insurance coverage for at least some Medicaid beneficiaries through a Medicaid Managed Care program.[51] Moreover, more than 80% of Medicaid enrollees–including 88% of Medicaid-enrolled children–were covered through Medicaid Managed Care.[50,52]

Private insurance companies operate nearly all Medicaid Managed Care plans. Typically, states contract with multiple private insurers to run plans concurrently. States also review the performance of contracted plans annually. Because these privately administered plans are permitted to set their own billing rules and requirements (within state-specified guidelines), the processes through which schools and community mental health providers bill for mental health services may vary across Medicaid Managed Care plans. In this way, Medicaid Managed Care can add significant complexity and administrative burden for schools and providers relative to a traditional (state-administered) Medicaid program, even when Medicaid Managed Care and traditional Medicaid programs use the same reimbursement system (e.g., fee-for-service) to pay the provider. Medicaid Managed Care plans may also differ from one another in other important respects, including the set of providers that are in network.

Each state has considerable flexibility in designing and administering its Medicaid Managed Care programs. States can determine whether groups of Medicaid enrollees (defined by eligibility criteria) may enroll in a specific Medicaid Managed Care program voluntarily or if these groups are required to enroll in the program (i.e., "mandatory enrollment"). (The section "Who is eligible for Medicaid?" earlier in this report provides more detail on eligibility groups.) States can also determine whether a Medicaid Managed Care program is statewide or regional. For example, some states (e.g., Ohio) administer regional Medicaid Managed Care programs that may administer benefits separately to those living in rural areas and those living in urban areas.[50] Additionally, among states that administer statewide Medicaid Managed Care programs, some states (e.g., Florida) allow Medicaid Managed Care plans to serve select regions of the state under the same state-wide program. In this case, although program characteristics including services covered and eligibility groups enrolled are the same across Medicaid Managed Care plans in the state, the mix of Medicaid Managed Care plans serving each of the state's regions could be different.

In short, when states use Medicaid Managed Care, entities that bill Medicaid–including schools–must keep track of many additional details and nuances. We discuss several of these key details below.

HOW DOES MEDICAID MANAGED CARE WORK?

There are three major types of Medicaid Managed Care programs: (1) comprehensive managed care organizations (MCOs), (2) primary care case management (PCCM), and (3) limited benefit plans. Generally, states administer benefits for a given population (such as children with a long-term disability) through either comprehensive MCOs or PCCM. Most states also administer limited benefit plans that cover additional benefits to complement their comprehensive MCOs or PCCM programs. We describe each type of program below, including a discussion of how behavioral health services may be treated within each type of plan.

Comprehensive managed care organizations (MCOs):

Comprehensive MCOs are the most common type of Medicaid Managed Care program.[50,53] Under this arrangement, state Medicaid offices contract with Medicaid Managed Care plans to cover and manage health services for Medicaid enrollees. These plans receive capitation payments (i.e., pre-determined, fixed payments that are paid in advance to MCOs for each beneficiary they have enrolled) from state Medicaid offices on a per-enrollee-per-month basis. MCOs are responsible for coordinating care for enrollees and paying providers for services delivered to enrollees. In 2019, comprehensive MCOs

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WHAT SERVICES DO COMPREHENSIVE MANAGED CARE ORGANIZATIONS COVER?

In order for an MCO to be considered comprehensive, it must typically meet one of two standards. The MCO must cover inpatient hospital services in addition to one or more of the service types below, or the MCO must cover any three or more of the service types below.[51] Benefits related to school mental health and outpatient mental health care are starred (*).

- Early and periodic screening, diagnostic, and treatment (EPSDT) services*
- Family planning services
- Federally qualified health center services*
- Home health services
- Lab and X-ray services
- Nursing facility services
- Outpatient hospital services*
- Physician services*
- Rural health clinic services*

covered nearly 70% of all Medicaid enrollees, including about 75% of Medicaid-enrolled children.[54,55] We describe the services covered by comprehensive MCOs in the call-out box on this page. States that administer comprehensive MCOs may choose to exclude certain services from this type of program—that is, the state may "carve out" select benefits and cover particular services through a different arrangement such as traditional Medicaid or a limited-benefit Medicaid Managed Care plan. (This type of plan is described in more detail below.)

With respect to behavioral health services, states may choose to carve out some or all of the following services from their comprehensive MCOs: specialty outpatient mental health services, inpatient mental health services, and substance use disorder services. In 2019, ten states reported carving out specialty outpatient mental health services from the state's primary comprehensive MCO program.[56] For example, in 2019, Michigan and Pennsylvania both carved out behavioral health services from comprehensive MCOs and administered these benefits through separate behavioral health managed care organizations (i.e., a type of limited-benefit plan).[56] Notably, even if states do not carve out behavioral health services at the program level, individual comprehensive MCOs may still administer behavioral health benefits under a subcontract with a behavioral health managed care organization or another managed care plan.[57]

Primary Care Case Management (PCCM)

Under Primary Care Case Management, every enrollee must choose a primary care provider who receives a monthly fee for managing and coordinating the enrollee's health services. In some cases, enrollees are assigned to a primary care provider. This arrangement is distinct from comprehensive MCO programs, in which Medicaid Managed Care plans—rather than providers—are typically responsible for coordinating enrollees' health services. The monthly fee, often called a "case management fee," is structured to pay primary care providers for assisting enrollees with identifying appropriate specialty providers and preventing unnecessary use of health care services. State Medicaid offices can determine

which types of primary care providers are eligible to serve as Primary Care Case Management providers and receive case management fees. Generally, pediatricians, general practitioners, internal medicine physicians, and family medicine physicians are eligible. Under the PCCM model, specialists continue to receive reimbursement directly from the state Medicaid office, as in traditional Medicaid programs. As of 2019, 13 states administered Primary Care Case Management Medicaid Managed Care programs, covering about 7% of total Medicaid enrollees, including 11% of Medicaid-enrolled children.[54,55]

Limited-benefit plans

Many states contract with Medicaid Managed Care plans to cover select health services under limited-benefit plans. Limited-benefit plans typically are used to complement comprehensive MCOs. As discussed above, some states have carved out behavioral health services from their comprehensive MCOs, choosing instead to cover these services through separate managed care organizations called behavioral health managed care organizations, a common type of limited-benefit plan. Other common limited-benefit plan types include dental care plans, long-term care plans (i.e., managed long-term services and supports), and non-emergency medical transportation plans.

In states where these types of services are carved out from comprehensive MCO benefits, Medicaid enrollees commonly enroll both in the comprehensive MCO and in one or more limited-benefit plans.[56] As of 2019, 44% of Medicaid enrollees, including 54% of Medicaid-enrolled children, were covered by one or more limited-benefit plans.[54] Among all Medicaid enrollees, 12% were enrolled in a behavioral health managed care organization.[55]

HOW DOES MEDICAID MANAGED CARE CONTROL COSTS?

It is a commonly stated goal of Medicaid Managed Care to "manage cost, utilization, and quality."[58] To achieve this goal, Medicaid Managed Care plans often use cost containment tools. Common cost containment tools include prior authorization, preferred drug lists, and selective contracting with providers.[59] We describe each below.

Prior authorization is a process where patients or providers are required to get advance approval from the insurance plan to use a certain service or medication. In order to be eligible for reimbursement, prior authorization must be obtained before the service or medication is used.

Preferred drug lists are lists of medications that do not require prior authorization. They typically include less expensive generic medications or a specific medication within a drug class, where the plan has negotiated a better price for that medication.[60] This encourages providers to prescribe those medications over the alternatives. An insurance plan may require enrollees to pay a higher copayment and/or to obtain prior authorization for medications that are not listed on the plan's preferred drug list, or they may not cover these other medications at all.

Selective contracting with providers is a process by which an insurance plan reaches a contractual agreement with certain providers to form the plan's provider network, typically because they are providing services at a lower cost. The insurance plan covers services provided by these "in-network providers." Enrollees are responsible for higher costs if they receive services from a provider that is not in the plan's provider network.

Medicaid Managed Care plans use these tools to reduce utilization and spending, particularly concerning high-cost services (such as specialty mental health services) and for high-cost enrollees (such as enrollees with a disability).[61,62] Consequently, when schools provide care for children enrolled in Medicaid

WHAT IS MEDICAID MANAGED CARE?

Managed Care plans, the schools should maintain regular communication with the plans to stay informed about prior authorization rules as well as any changes to preferred drug lists or providers' network membership.

HOW MANY MEDICAID MANAGED CARE PROGRAMS AND PLANS DOES EACH STATE HAVE?

Most states administer more than one Medicaid Managed Care program at the same time. This may include one Medicaid Managed Care program for most children and separate programs to administer benefits for enrollees with more complex health care needs, such as children with a disability or children in foster care and adoption assistance services. For example, as of 2020, Georgia administered four different Medicaid Managed Care programs; one of these programs ("Georgia Families 360") covered children in foster care and adoption assistance services, and other programs covered other populations.[50] States may also administer benefits for some populations through Medicaid Managed Care and for other populations directly (i.e., through state-administered Medicaid).

Within a given Medicaid Managed Care program, there may be many different Medicaid Managed Care plans contracted to administer benefits. For example, in Georgia's largest Medicaid Managed Care program ("Georgia Families") four different plans administered benefits in 2020: Amerigroup Community Care, CareSource of Georgia, Peach State Health Plan, and WellCare of Georgia.[50]

The table on the following page provides an overview of the largest Medicaid Managed Care programs for children across states in the Southeast U.S. as of 2020, including information on the name of the program, the type of Medicaid Managed Care program, the categories of children eligible for enrollment (i.e., not exempt from the program), and whether eligible individuals in these groups are required to enroll in the program ("mandatory enrollment") or have the option of enrolling in either the Managed Care program or remaining in the traditional, state-administered Medicaid program ("voluntary enrollment"). Additional details for each Medicaid Managed Care program can be found in Medicaid Managed Care Enrollment Reports published by the Centers for Medicare and Medicaid Services.

WHAT IS MEDICAID MANAGED CARE?

TABLE 3. CHARACTERISTICS OF THE LARGEST MEDICAID MANAGED CARE PROGRAMS ACROSS STATES IN THE SOUTHEAST REGION, 2020

STATE	LARGEST MEDICAID MANAGED CARE PROGRAM NAME	PROGRAM TYPE	MANDATORY (M) OR VOLUNTARY (V) ENROLLMENT		
			DISABLED CHILDREN	NON-DISABLED CHILDREN	FOSTER CARE/ ADOPTION ASSIS-TANCE CHILDREN
AL	Alabama Coordinated Health Networks	PCCM	M	M	M
FL	Managed Medical Assistance Program	Comprehensive MCO	M	M	M
GA	Georgia Families	Comprehensive MCO	N/A	M	EXEMPT
KY	Kentucky Managed Care	Comprehensive MCO	M	M	M
MS	Mississippi Coordinated Access Network Program (MississippiCAN)	Comprehensive MCO	V	M	V
NC	Community Care of North Carolina	PCCM	V	M	V
SC	South Carolina Managed Care	Comprehensive MCO	M	M	V
TN	TennCare II	Comprehensive MCO + MLTSS	M	M	V

SOURCE: CMS, 2022. 2020 Medicaid Managed Care Enrollment Report. Notes: Georgia Families does not include disabled children. All of the largest Medicaid Managed Care programs in the states in the Southeast region are statewide. However, Florida allows Medicaid Managed Care plans to serve Medicaid beneficiaries in select regions under the Managed Medical Assistance Program. M=Mandatory, V=Voluntary. PCCM=Primary Care Case Management. MCO=Managed Care Organization. N/A=Not Applicable. MLTSS= Managed Long-Term Services and Supports.

WHAT ARE THE MAJOR TYPES OF MEDICAID REFORMS?

Medicaid and School Mental Health Services: FAQs

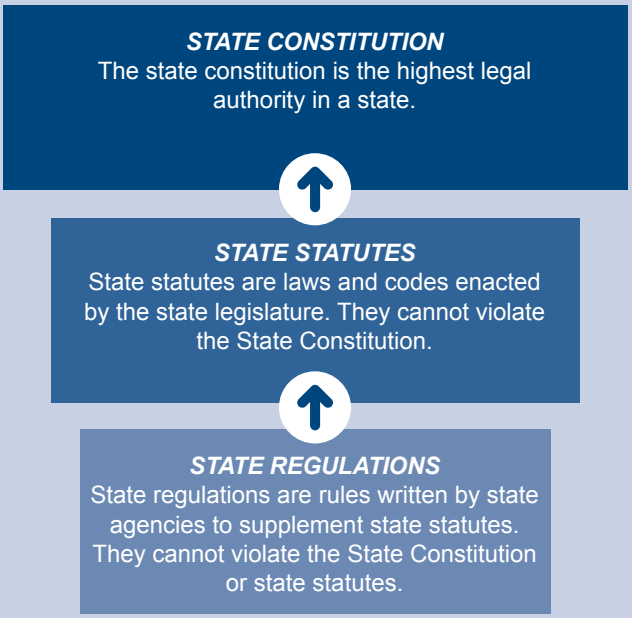
As we've noted throughout this report, every state's Medicaid program has their own requirements for reimbursing school mental health services. State and local leaders in school mental health may consider working with state Medicaid leadership to modify these requirements to improve Medicaid financing for school mental health services. Such modifications could include expanding terms of coverage, changing reimbursement processes, and adjusting fee schedules (i.e., what the state will pay for each service).

In general, state policymakers can reform their Medicaid program by: (1) passing legislation and making regulatory changes within the state, or (2) obtaining approval from the federal government for State Plan Amendments or Medicaid waivers. In some cases, a combination of these strategies may be needed to implement a given reform.

WITHIN-STATE REFORMS: LEGISLATION AND REGULATORY CHANGES

States specify their Medicaid program's covered services and eligible populations in legal statutes, which are laws passed by a legislature. State Medicaid statutes also grant state Medicaid offices the authority to create administrative regulations and rules. Figure 1 gives an overview of state law and regulations and their hierarchy of authority.

FIGURE 1. STATE LEGAL FRAMEWORK AND HIERARCHY OF AUTHORITY



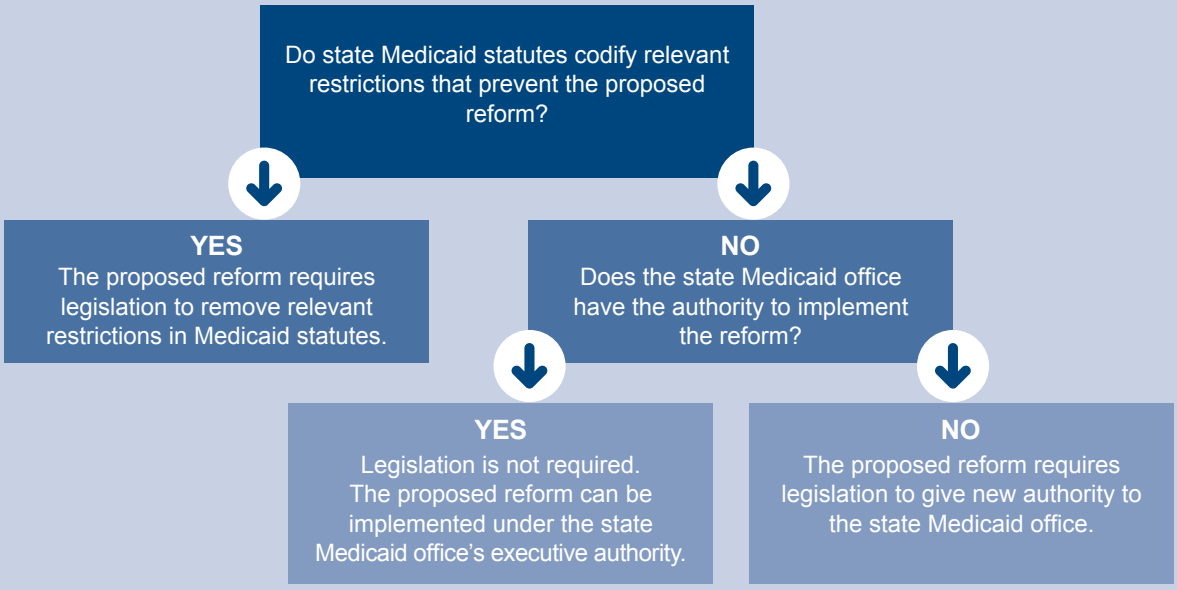
WHAT ARE THE MAJOR TYPES OF MEDICAID REFORMS?

There are two principal reasons why passing legislation might be necessary to enact a Medicaid reform. First, if the state's Medicaid statutes prohibit enacting the reform or meaningfully restrict how the reform could be implemented, legislation may be needed to remove those restrictions. And second, if the state Medicaid office does not have the authority to implement the reform, legislation may be needed to give that authority to the office. Figure 2 at the bottom of this page illustrates how to determine whether passing legislation is required to enact a given Medicaid reform.

For example, before 2015, California's Medicaid statutes prohibited local education agencies from seeking Medicaid reimbursement for targeted case management provided to children who did not have an Individualized Education Plan, or IEP. To reform this reimbursement process, California passed legislation to remove the restriction and expand the authority of local education agencies.[63] With the passage of this legislation, Medi-Cal (California's Medicaid program) was able to modify its rules and allow reimbursement for school-based targeted case management, regardless of whether the child had an Individualized Education Plan.

Implementing a given reform may not require passing legislation if state Medicaid statutes and regulations already authorize state Medicaid offices to modify the relevant administrative processes and policies by executive decision. In many states, Medicaid offices have the authority to allocate the state's Medicaid budget, set new fee schedules for covered services, amend Medicaid Managed Care contracts, and select the Medicaid Managed Care plans that will administer Medicaid benefits.

FIGURE 2. DOES REFORMING THE STATE MEDICAID PROGRAM REQUIRE PASSING LEGISLATION?



WHAT ARE THE MAJOR TYPES OF MEDICAID REFORMS?

INTERACTIONS WITH THE FEDERAL GOVERNMENT: STATE PLAN AMENDMENTS AND MEDICAID WAIVERS

Some Medicaid reforms require interactions between the state and the federal government to secure federal Medicaid matching funds for financing the reforms. These interactions usually include obtaining approval for a State Plan Amendment and/or a Medicaid waiver from the Centers for Medicare and Medicaid Services (CMS).

As explained earlier in this report, Medicaid is funded jointly by the federal government and the states. In keeping with that structure, a Medicaid state plan is an agreement between a state and the federal government describing how that state administers its Medicaid program.[64] This document must specify the single state agency with the authority to administer the state's Medicaid program, the standards for determining eligibility, the scope of services covered, the processes for reimbursing providers, and other administrative and operational details.[64] The call-out box on the right describes what sections are included in a Medicaid state plan. CMS must approve each state's plan, to ensure that its Medicaid program abides by federal regulations. This approval certifies that the state can seek federal Medicaid matching funds for its Medicaid program.

EACH STATE'S MEDICAID STATE PLAN IS ORGANIZED INTO SEVEN SECTIONS:

- Single State Agency Organization
- Coverage and Eligibility
- Services: General Provisions
- General Program Administration
- Personnel Administration
- Financial Administration
- General Provisions

Please see this MACPAC webpage for more information.[1]

A State Plan Amendment–sometimes called a SPA (typically pronounced "spa," like a jacuzzi)–is a formal amendment to one or more provisions specified in a Medicaid state plan. Generally, state Medicaid leaders must submit a State Plan Amendment to CMS and receive CMS approval before the state can change: 1) rules for determining Medicaid eligibility, 2) service coverage, or 3) reimbursement rules. For example, in 2017, CMS approved a Massachusetts State Plan Amendment to expand the scope of services for which schools can seek Medicaid reimbursement. In this case, the amendment allowed schools to bill Medicaid for many services that were not previously eligible for Medicaid reimbursement when provided in a school setting (e.g., physician services, respiratory services, optometry services).[65,66] This MACPAC webpage has more details on the process of submitting and obtaining approval for State Plan Amendments.[64] In addition, this CMS repository includes information on approved Medicaid State Plan Amendments.[67]

WHAT ARE THE MAJOR TYPES OF MEDICAID REFORMS?

A Medicaid waiver is written approval from CMS that allows states to differ from the federal rules for the Medicaid program.[68] Medicaid waivers allow states to have more flexibility in exploring innovative program designs by waiving some federal requirements. Examples of approved Medicaid waivers include mandating Medicaid Managed Care enrollment for certain Medicaid eligibility groups (called "Section 1915(b) waivers") and expanding Medicaid eligibility rules to cover more uninsured people with behavioral health needs (called "Section 1115 waivers"). CMS's website describes different types of Medicaid waivers[69] in more detail and explains how to obtain guidance on how to apply for Section 1915 waivers[70] and Section 1115 waivers.[71]

MEDICAID REFORM EXAMPLES: IMPLEMENTATION OF CMS'S REVISED GUIDANCE ON THE "FREE CARE RULE" (2014)

As described above, the process of implementing Medicaid reforms can vary across states, depending on current statutes and regulations. For the same Medicaid reform, some states might only require state legislation, some states might only require a SPA or a Medicaid waiver, and some states might require both legislation and a SPA or Medicaid waiver. Notably, for states that require both legislation and a SPA, the necessary order of these events may also vary: state legislation might be required before submitting a SPA, or legislation might be passed after a SPA has been approved.

To illustrate this variation, we describe the distinct processes used in Florida, Massachusetts, and South Carolina to enable Medicaid reimbursement for school-based services in response to CMS's revised guidance concerning the "Free Care Rule" (2014).[43] (Please refer to the section "Can schools bill Medicaid for mental health services?" earlier in this report, for further discussion on the 2014 Free Care Rule guidance.)

Florida

At the time of the release of CMS's revised guidance in 2014, Florida's Medicaid statute and state plan had codified restrictions on reimbursing school-based services provided to students without an Individualized Education Plan. Consequently, a State Plan Amendment (submitted in 2016) was required to change the plan, and new legislation was required to remove the codified restrictions.[45] CMS approved Florida's State Plan Amendment in 2017.[72] After the State Plan Amendment was approved, Florida passed legislation to remove restrictions in the statute on reimbursement for school-based services to implement the 2014 Free Care Rule guidance. This legislation took effect in July 2020.[73]

Massachusetts

Because the Massachusetts Medicaid statute did not include relevant restrictions on reimbursing school-based services, legislation was not required to implement CMS' revised guidance.[45] However, a State Plan Amendment was required to remove a restriction in the state plan. The Massachusetts Medicaid office submitted a State Plan Amendment to CMS in 2016 and received approval in 2017.[65]

South Carolina

As of 2014, South Carolina's Medicaid plan and statute contained no language that would restrict the implementation of CMS' revised guidance concerning the Free Care Rule. Consequently, South Carolina did not require legislation or a State Plan Amendment to allow Medicaid reimbursement for school-based services.[45]

SOUTHEAST MHTTC RESOURCES

Medicaid and School Mental Health Services: FAQs

This report is available for download on the Southeast MHTTC website. Through this website, we provide many additional school mental health resources, including resources about the financing of school mental health services. To receive updates about events and resources available through the Southeast MHTTC, please sign up for our e-mail listserv here, and follow us on Twitter @SE_MHTTC.

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