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# CMS Issues Guidance on Medicaid and CHIP Services in School-Based Settings

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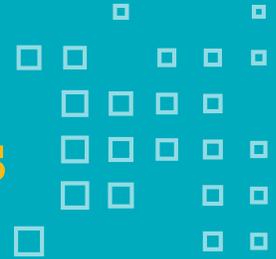
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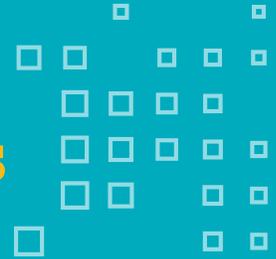
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# I. Introduction and Overview

On May 18, 2023, the Centers for Medicare & Medicaid Services (CMS), in consultation with the U.S. Department of Education (DOE), released new guidance to support **state Medicaid and Children's Health Insurance Program (CHIP) agencies (SMAs), state education agencies (SEAs),<sup>1</sup> and local education agencies (LEAs)<sup>2</sup> in working together to deliver covered Medicaid and CHIP services in school-based settings.**

These school-based services (SBS) are critical health and health-related services provided to students and their caregivers in the school setting, and can be covered by Medicaid and CHIP. This guidance, **Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming**, was accompanied by a CMS **Informational Bulletin (CIB)** summarizing the guidance for states and announcing the launch of the joint CMS and DOE **SBS Technical Assistance Center**.<sup>3</sup>

With this new guidance, **CMS highlights that schools can and should play a critical role in providing health care services to children and youth** and seeks to make it easier for them to do so. Medicaid and CHIP have a powerful role to play here, given that 42.1 million children, or over half of all children in the United States, are enrolled in Medicaid and CHIP.<sup>4</sup> The guidance focuses on:

- **New reimbursement rates and payment flexibilities**, including the option to pay higher reimbursement rates for services provided in schools.
- **New options for interim or monthly payments to schools.**
- Inclusion of **early childhood educational settings and best practices in service delivery to young children**, including mental health consultation.
- **Encouragement to states to expand the role Medicaid and CHIP can play** in financing health care services for all Medicaid- and CHIP-enrolled students, not only those students who receive special education services.
- **New flexibility for setting-specific provider types.**
- **Emphasis on the ability to cover the full cost of outreach and enrollment activities for Medicaid and CHIP**, regardless of the share of children who ultimately are found eligible for these programs.
- Ways to use CHIP Health Services Initiatives (HSIs) for SBS, including for **substance use prevention and harm reduction initiatives.**

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<sup>1</sup> Also known as state departments of education.

<sup>2</sup> LEAs are defined as "a public board of education or other public authority legally constituted within a state for either administrative control or direction of, or to perform a service function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a state, or for a combination of school districts or counties as are recognized in a state as an administrative agency for its public elementary schools or secondary schools." See 34 C.F.R. § 303.23(a) [here](#).

<sup>3</sup> The CMS guidance was required of the [Bipartisan Safer Communities Act](#).

<sup>4</sup> CMS. March 2023 Medicaid & CHIP Enrollment Data Highlights. Available [here](#).

**This brief summarizes CMS' new guidance and highlights implications of the guidance for state agencies and local partners.** The summary is tailored to meet the needs of SMAs, SEAs and LEAs to help demystify reimbursement and funding opportunities for SBS and support providers and advocates and anyone else with an interest in SBS.

Specifically, this brief provides:



Clarity about the role that Medicaid and CHIP can play in schools (see Section II).



Background and context on the role of Medicaid and CHIP financing for SBS, how services have previously been provided in schools to children and youth enrolled in Medicaid and CHIP, and how that has changed over time (see Section III).



How services must be delivered in schools in order to comply with Medicaid and CHIP rules (see Section IV).



A deep dive on the financing opportunities detailed in the CMS guidance that support SBS for children and youth enrolled in Medicaid and CHIP (see Sections V–VIII).



Appendices collecting CMS' sub-regulatory guidance, as well as a list of acronyms (see Section X).

## II. Important Role That Medicaid and CHIP Play in Schools

Schools, early childhood settings and LEAs are vital places to help support children and their families, providing children and youth with access to important health care services on-site. SBS can encompass a wide range of services, including preventive services (e.g., immunizations, screenings); behavioral health services (e.g., mental health and substance use disorder (SUD) services); physical and occupational therapy; and disease management for chronic diseases (e.g., obesity, asthma). Providing these services on-site limits disruption to caregivers' work schedules or concerns with transportation to a health care facility, increases access overall and reduces the stigma of accessing certain services, such as behavioral health services.

Schools and early childhood settings can also serve as a catalyst for children eligible for Medicaid and CHIP to access primary and preventive services, promoting health and educational equity in the school setting. Providing services to children in the school setting may yield positive downstream effects, such as increases in school attendance, reductions in health insurance churn for children and their families, and reductions in emergency room visits.<sup>5</sup> Schools can also serve a navigator role, helping children and youth obtain Medicaid and CHIP coverage, access health care services, and connect with community-based organizations and supports.

Schools already are under extraordinary pressure to fulfill a range of educational and community imperatives, making it vital that the process of using Medicaid and CHIP to finance SBS is as simple as possible. Historically, it has been complex and daunting to use Medicaid and CHIP to cover SBS for several reasons, including (1) schools and SMAs use different topic-specific jargon; (2) the funding requirements for Medicaid and CHIP and for education are complex; and (3) coverage varies by state because of the discretion SMAs have in determining what SBS are covered by Medicaid and CHIP and how they are financed. The complexities of billing systems and state financing arrangements can also make it administratively challenging for schools and LEAs to provide or contract for Medicaid and CHIP-covered SBS, often disincentivizing smaller or more rural LEAs from participating.

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<sup>5</sup> California School-Based Health Alliance. Top 10 Benefits of School-Based Health Centers. Available [here](#).

## Insights and Linkages



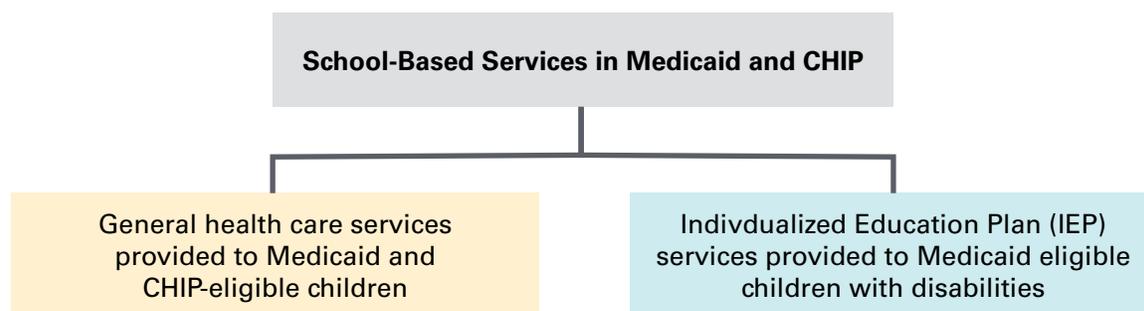
For schools that are interested in providing SBS to students or for SMAs that do not cover a broad range of SBS, knowing where to start can be daunting. Below are **ten steps for securing Medicaid and CHIP financing of SBS:**

1. The SMA and SEA (as well as LEAs, as appropriate) form a partnership.
2. The partners **decide which services to cover** and on behalf of which children, and the SMA works with CMS to discuss needs and federal authorities.
3. The partners determine **how much these services will cost**, what the approximate amount will be on behalf of children eligible for Medicaid and CHIP, and the source of any non-federal matching dollars.
4. The partners identify whether **statutory changes or state budget requests** are necessary to accomplish their goals.
5. The partners establish a **methodology for payment** of services and administrative overhead.
6. The **SEA and SMA work with LEAs and schools** to establish services, provide training and finalize memorandums of understanding (MOUs), as needed and required.
7. The SMA **submits a State Plan Amendment (SPA)** and a **“cost allocation” plan** to CMS, as necessary.
8. If possible, the SEA or other entity provides **temporary financial support** (interim payments) to schools even as the SMA is winding its way through the process to finalize what Medicaid and CHIP can pay.
9. The SMA and SEA issue **formal guidance**.
10. The partners audit **documentation** and billing on an ongoing basis to minimize audit risk.

### III. Scope of Medicaid and CHIP-Covered Services in Schools

CMS has clarified previously but emphasized in the new guidance that states can use Medicaid and CHIP funding to pay for SBS for **all Medicaid- and CHIP-enrolled children, not only those who qualify for special education**, and can pay for any service within schools that could otherwise be provided outside the schools. This section focuses on these key guidance changes and details the services covered by Medicaid and CHIP that are provided in schools and early childhood settings to all children, as well as their entitlement to the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit for individuals under 21 who are covered by Medicaid. Additionally, this section illustrates how specific school supports intersect with SBS in Medicaid and CHIP, and how CMS has sought to clarify the availability of SBS to certain populations. SBS covered by Medicaid and CHIP can fall into **either or both** of two categories, as noted in Figure 1.

Figure 1. SBS in Medicaid and CHIP



SBS in the form of any health services covered by a Medicaid or CHIP State Plan (e.g., behavioral health treatment, preventive care) can be covered for any student enrolled in Medicaid or CHIP **regardless of whether the student has an IEP or a Section 504 Plan and regardless of whether students are generally charged for such services when provided as SBS**. For decades, these services were subject to the “free care” policy, which made it unallowable to bill Medicaid for a service that another student might receive for free; this policy was rescinded in 2014. An LEA is allowed to bill Medicaid and CHIP for a service that a Medicaid- and CHIP-eligible child receives even if other students receive it for free, assuming that the services and provider types are covered under the Medicaid or CHIP State Plan.

## Medicaid-Covered SBS

**Medicaid is a federal–state partnership**, and the Medicaid State Plan is the agreement that an SMA has with CMS in order to define the conditions under which the state can draw down federal matching dollars for the state and local dollars it spends on Medicaid; it contains information on both what services will be covered and the rates paid for the services.<sup>6</sup> SMAs secure authority from CMS to provide Medicaid-covered services through their Medicaid State Plan as well as through various federal waivers, where states can request and CMS can permit states to provide additional services to expanded or limited populations.<sup>7</sup> Notably, there is no distinct Medicaid State Plan benefit called “school health services” or “school-based services”; nearly all Medicaid-covered services can be provided by or in schools, including but not limited to the following:<sup>8</sup>

- Vision and dental services
- Preventive services for children, including immunizations and other physicians’ services
- Occupational, physical and speech therapy
- Individual therapy provided by a therapist hired by the school or through a contract
- Targeted prevention programs for children at risk of developing a SUD
- Full health care services for children and their families through an adjunct school-based health center
- Navigation support in accessing Medicaid services
- Consultative services provided in early childhood classrooms
- Naloxone and naloxone training
- Health education programs

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<sup>6</sup> The federal government pays a component of all services covered by Medicaid and CHIP. The percentage depends on the state’s federal medical assistance percentage (FMAP), which can differ for Medicaid or CHIP, depending on the state. Non-federal share—including state and local dollars—can be supported through intergovernmental transfers (IGTs); additional details on this financing strategy appear in Section V.

<sup>7</sup> For additional information on federal waivers, see this Medicaid and CHIP Payment and Access Commission (MACPAC) [summary](#).

<sup>8</sup> In general, states have flexibility to determine the setting in which Medicaid and CHIP services are provided, with practical limitations on what services are available in the school setting. Some Medicaid- and CHIP-covered services are directly linked to a type of physical setting (e.g., nursing home care).

### Box 1. What Is CHIP?

The Children's Health Insurance Program (CHIP) is an optional state coverage program for uninsured children and pregnant individuals in families with incomes above Medicaid eligibility limits that are not able to access private, commercial coverage. States have flexibility in the income limits they set for CHIP eligibility and how they design their CHIP program:

- **Separate CHIP:** A state receives federal funding to provide child health assistance to uninsured, low-income children that meets the requirements of Section 2103 of the Social Security Act. Services in a Separate CHIP program may, but are not required to, match the Medicaid services package.
- **Medicaid Expansion CHIP:** A state receives federal funding to expand Medicaid eligibility to additional children. CHIP services are the same as Medicaid services in Medicaid Expansion CHIP programs.
- **Combination Separate CHIP and Medicaid Expansion CHIP:** A mix of the two noted above.

States with Separate CHIP programs must, at a minimum, cover certain CHIP services, including routine checkups, immunizations, prescriptions, dental and vision care, hospital care and emergency services. As of 2019, [behavioral health services](#) are also a covered CHIP benefit.

Many states offer SBS to children enrolled in CHIP, such as nursing care services; tobacco cessation; crisis intervention and stabilization; outpatient behavioral health services; and speech, physical and occupational therapies.

## SBS in Early Childhood Settings

The CMS guidance focuses primarily on SBS provided to school-age children in pre-kindergarten/kindergarten through high school. However, there are several early childhood programs (e.g., Head Start) that may be operated by LEAs and for which much of the guidance may be relevant. Certain early education programs are required to facilitate a child's access to health, behavioral health and preventive services. In some cases, programs provide behavioral health services through consultation, which can also be billed through Medicaid.<sup>9</sup> Additionally, these programs must promote children's health and well-being by providing medical, oral, nutritional and mental health education support services, and these services may be covered by Medicaid as well. **Like all children and youth under age 21 who are enrolled in Medicaid**, young children who are not yet old enough to attend school are entitled to EPSDT (see Box 2).

## The Individuals with Disabilities Education Act (IDEA) and the Rehabilitation Act of 1973

Under the IDEA, students with disabilities who need special education and related services have an **IEP**, which stipulates the services (educational and health care-related) a student will receive as part of the free appropriate public education they are entitled to receive under federal law (see Box 3). While **Medicaid and CHIP are generally the payer of last resort for health care services, when services are**

### Box 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

**EPSDT is an entitlement designed to ensure that Medicaid-eligible children and adolescents receive early detection and timely follow-up care.** EPSDT is a key part of Medicaid for eligible children and youth up to age 21, requiring regular preventive care and all medically necessary care needed to "correct or ameliorate" an identified condition(s) to the extent the care could be covered by a state in its Medicaid State Plan. A diagnosis is not required for treatment and services, and it does not matter whether the service or treatment is listed in the Medicaid State Plan or whether it is available for adults. EPSDT is a robust benefit standard, which makes it federally required for SMAs to cover screening and treatment services in the crucial developmental window provided by childhood, during which it is possible to reduce or fully ameliorate problems that can turn into lifelong conditions if not properly treated.

In 2022, CMS issued a **CIB** reminding SMAs of the federal requirements for EPSDT and clarifying those requirements. While EPSDT determines the benefits that must be covered for children and youth enrolled in Medicaid, it does not specify the settings in which such services must be provided. In many instances, the benefits can be provided in schools and early education settings in ways that support the child and enhance both health and educational outcomes.

EPSDT is not available for Separate CHIP programs.

<sup>9</sup> Consultation is a best practice in early childhood mental health, wherein a behavioral health professional works with the classroom teacher or other professional as opposed to conducting therapy directly with a child. Pediatric consultation is a benefit that SMAs may choose to cover. See CMS' [SHO 23-001 - Interprofessional Consultation](#).

**included in a student’s IEP, Medicaid is responsible for payment ahead of the federal IDEA funds.**<sup>10</sup> For decades, states and providers of SBS have relied on Medicaid to pay for covered IEP services received by students with disabilities.

Students with disabilities may meet the requirements for having a **504 Plan** in addition to or instead of an IEP. A 504 Plan refers to Section 504 of the Rehabilitation Act of 1973, which protects the rights of individuals in programs and activities that receive federal financial assistance. Medicaid and CHIP coverage for Section 504 services to students is identical to that for eligible students who need general health care services, meaning Medicaid and CHIP are the payer of last resort for services covered solely by a 504 Plan. LEAs may bill Medicaid and CHIP for services that students receive under Section 504 only **after** they bill any outside legally liable third parties. In circumstances where an LEA meets its Section 504 obligations to the IDEA-eligible child with a disability through an IEP, Medicaid and CHIP would be the payer of first resort for any Section 504 services included in the IEP.

### **Box 3. Free Appropriate Public Education (FAPE)**

- “**Appropriate education**” services must be designed to meet the individual education needs of students with disabilities as adequately as the needs of nondisabled students are met. The quality of education services provided to students with disabilities must be equal to the quality of services provided to nondisabled students.
- Appropriate education for students with disabilities may include education in regular classes (with or without the use of related aids and services) or special education and related services in distinct classes for some or all of the school day. However, students with disabilities must be educated with nondisabled students to the maximum extent appropriate for the educational needs of the student with a disability.
- Appropriate education includes evaluation and placement procedures that are designed to protect students against misclassification or inappropriate placement, and to support the periodic re-evaluation of students who receive special education or related services.
- The IDEA guarantees FAPE to students with disabilities (ages 3 to 21 years) under federal law, and Section 504 of the Rehabilitation Act of 1973 also guarantees FAPE to students with disabilities, regardless of the nature or severity of the individual’s disability.

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<sup>10</sup> SMAs and SEAs should consider how to address any third-party liability for SBS, including IEP services; see Section VIII for more details.

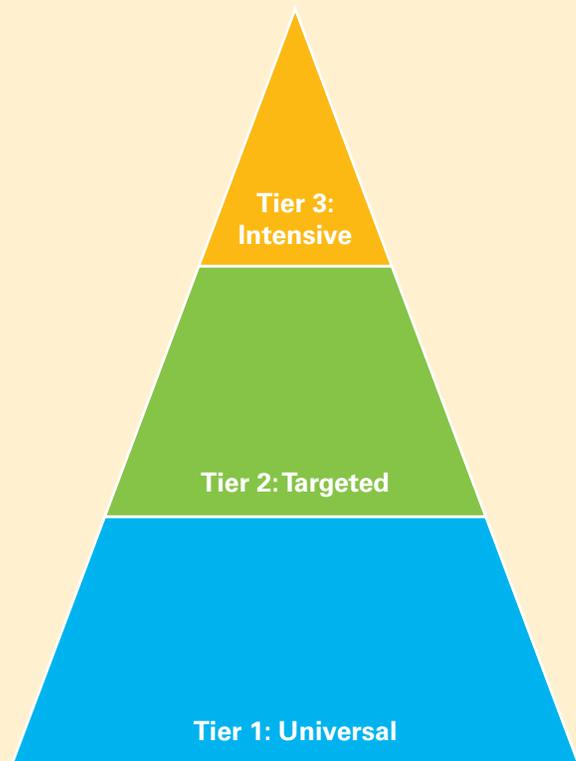
## Insights and Linkages



For SEAs and LEAs, the scope of what Medicaid and CHIP can and cannot cover can be confusing and nebulous, which can make it hard to collaborate with SMAs on Medicaid and CHIP coverage for key services. Similarly, SMAs can find it challenging to understand the language of schools, which can be a significant barrier to partnership.

The graphic on the right is a rubric for considering interventions in schools and early childhood settings—the [Multi-Tiered Systems of Support \(MTSS\)](#):

- Tier 1, universal interventions, are provided to all students.
- Tier 2, targeted interventions, are provided to students with a focus on preventing risk factors or early onset concerns from progressing further.
- Tier 3, intensive interventions, are provided to students who need more significant intervention in order to succeed in their school placement. Children who receive Tier 3 services often have an IEP. If specialty services are included in an IEP and a child is eligible for Medicaid, then Medicaid can cover the services. For services provided in an IEP, Medicaid is **the payer of first resort over the federal IDEA funds** for those services. This is the traditional model of Medicaid and CHIP payment for SBS.



Medicaid and CHIP can pay for services for children in all three tiers of support. For this to happen, the SMA must (in most cases) make changes to its State Plan to ensure the services, providers and settings are covered by Medicaid and CHIP in the state, and Medicaid and CHIP financing rules must be followed.

There has been a lot of confusion about which Medicaid- and CHIP-covered services can be provided in schools, in part because what is allowed has evolved over time. However, **states can now cover any service in the school setting that is covered for Medicaid- and CHIP-eligible youth outside of schools, so long as the state and federal Medicaid and CHIP requirements are met.**<sup>11</sup> CHIP HSIs (see [Figure 2](#)) can also cover Tier 1 interventions in schools, so long as other requirements are met.

<sup>11</sup> See Section IV for more details on qualifications for school-based providers in providing SBS, including requirements on provider enrollment and claim submissions.

## IV. Delivery of SBS to Medicaid- and CHIP-Eligible Children

SBS can be delivered to children and youth in a number of ways, as appropriate for the student, provider and caregiver (as applicable). This section details how different Medicaid and CHIP delivery systems—managed care or fee-for-service (FFS)—can be leveraged to partner with early childhood settings and schools to provide SBS, as well as options to provide care in-person or via telehealth and the required qualifications for providers in the school setting. This section also describes the unique confidentiality requirements for providing SBS in order to ensure parental and minor consent is met.

### Opportunities to Promote SBS in Managed Care

Even though 80 percent of children in Medicaid are enrolled in managed care, the majority of states carve SBS out of managed care and reimburse SBS through an FFS system, meaning SMAs reimburse providers directly for services provided in schools.<sup>12</sup> For states that maintain some or all SBS within managed care, under the new guidance, CMS strongly encourages SMAs to establish and strengthen relationships between managed care plans (MCPs), LEAs and school-based providers. There are a number of options SMAs can explore to do this:<sup>13</sup>

- Include schools and early childhood settings during the MCP procurement and contracting processes.
- Require provisions in the managed care contract that MCPs establish relationships, strengthen partnerships, and coordinate care with school-based providers and school-based health centers.
- Incorporate incentive payments, withhold arrangements, and/or state-directed payments between MCPs and school-based providers via the managed care contract.

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<sup>12</sup> MACPAC. MACStats: Medicaid and CHIP Data Book: Percentage of Medicaid Enrollees in Managed Care by State and Eligibility Group, FY 2019. December 2021. Available [here](#).

<sup>13</sup> CMS. CIB: Information on School-Based Services in Medicaid: Funding, Documentation, and Expanding Services. August 2022. Available [here](#).

## Opportunities to Leverage Telehealth

SBS provided via telehealth (e.g., interactive videoconferencing, store-and-forward transmissions) are helpful in delivering health care services to children in the school setting, which may reduce student absenteeism and increase access to a type of provider not readily available in the community.<sup>14</sup> SMAs have flexibility to permit Medicaid- and CHIP-covered services to be reimbursable via telehealth, including in the school-based setting. SMAs that are interested in covering SBS should:<sup>15</sup>

- Review the range of providers and practitioners authorized to bill Medicaid and CHIP for services delivered via telehealth, including providers' licensure and credentialing requirements and similar requirements for out-of-state providers.
- Review the privacy laws for telehealth services.
- Clarify in SMA guidance to providers whether and how payments are modified based on telehealth modalities for covered services and how providers may bill for telehealth services.

**The new guidance encourages states to adopt payment parity** (i.e., paying the same for telehealth and in-person treatment); CMS will review all telehealth payment policies that do not align with payment parity.

## Updates to Qualifications for School-Based Providers

To furnish a Medicaid- or CHIP-covered service, providers must be enrolled in the state Medicaid or CHIP program. SMAs determine the criteria for licensing, credentialing and/or certification for provider types in Medicaid and CHIP.<sup>16</sup> If a given provider is of a provider type that is not eligible to enroll as a Medicaid or CHIP provider, then they must be an employee or contractor of an enrolled provider, which would then be considered the furnishing provider. For example, an LEA or early childhood setting could be an enrolled Medicaid or CHIP provider and could bill for health care services provided in the school setting by school employees. The new CMS guidance makes no changes to these requirements.

The new CMS guidance eases prior federal guidance and restrictions to **permit SMAs to establish provider qualifications for school-based providers that are different from the qualifications of non-school-based providers of the same Medicaid and CHIP services**, as long as that state's provider qualifications are not unique to Medicaid- and CHIP-covered services. The guidance also notes that schools may arrange for Medicaid-enrolled community providers to deliver services in schools. This is something some states have done, but it is not necessarily common practice; CMS clarified in the guidance that this is an acceptable practice. This is equivalent to a provider (such as a therapist) having an "office" at the school.

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<sup>14</sup> Love, H., Panchal, N., Schlitt, J., Behr, C., Soleimanpour, S. The Use of Telehealth in School-Based Health Centers. *Global Pediatric Health Journal*. October 2019. Available [here](#).

<sup>15</sup> A state may need to submit an SPA for CMS consideration only if the state is pursuing a policy of paying for telehealth-delivered services differently from services provided in person, or if the state wishes to remove any limitations on telehealth-delivered services noted in the Medicaid or CHIP State Plan.

<sup>16</sup> Some services, such as those provided by occupational therapists, speech and language pathologists and audiologists, have federal criteria for licensure.

## Requirements of Confidentiality and Parental Consent

**Confidentiality.** There are a number of laws guiding a child’s privacy (see Box 4), as well as confidentiality standards specific to Medicaid and CHIP.

**SMA**s may share members’ information with a Medicaid or CHIP provider—including schools—for the purpose of establishing eligibility, providing services, or billing for services if that provider has standards of confidentiality comparable to those of the SMA, including but not limited to the following:

- The SMA must have criteria that specify the conditions for release and use of information about Medicaid and CHIP applicants and members.
- Information access is restricted to persons or SMA representatives subject to standards of confidentiality that are comparable to those of the SMA.
- Publishing of names of Medicaid and CHIP applicants and members is prohibited.

### Box 4. Federal Privacy Laws and Requirements

- The Family Educational Rights and Privacy Act (FERPA) and the IDEA require a school district to obtain parental consent before sharing a student’s personally identifiable information with the SMA for billing and cost reimbursement.
- The Health Insurance Portability and Accountability Act (HIPAA) permits disclosures for treatment and care coordination purposes without consent, but FERPA generally does not for children under age 18. The HIPAA Privacy Rule **specifically excludes** from its coverage any records that are protected by FERPA, which includes most elementary and secondary school records.

**The key requirement for a SMA considering sharing information with an LEA is to ensure that the LEA has comparable confidentiality standards.** LEAs must meet additional federal requirements governing consent in order to share information with SMAs. SMAs can help streamline this process by creating forms and other tools on Medicaid and CHIP eligibility and coverage for LEAs and schools to share with parents and caregivers at “Back to School” nights or similar largely attended school events.<sup>17</sup>

**Parental Consent.** There are a number of laws guiding a parent or caregiver’s required consent for a child to access SBS (see Box 5). In general, health care services can be furnished only with the informed consent of the patient—or, in the case of a minor, the consent of a parent or guardian. Informed consent laws define both the types of information that must be disclosed, as well as the acceptable mechanism for providing information and securing consent. Although federal law defines parental consent requirements for certain school-based services (see Box 4), informed consent laws are primarily defined at the state level. For example, some states require written parental consent before school-based providers may provide services such as administering non-emergency medications. By contrast, for low-risk, high-value health services—such as vision and hearing testing, screening for spinal abnormalities, or vaccinations—many states require or permit schools to offer these services on an opt-out basis. Under this approach, the school provides parents with written

#### **Box 5. Federal Requirements for Consent Prior to Receiving Services**

- Currently, for children with disabilities, the IDEA requires a parent’s written consent be secured before a school district can bill Medicaid and CHIP for special education and related services identified in the student’s IEP. A DOE [proposed rule](#) announced in May 2023 would modify this rule to remove the unintentional barrier this creates for LEAs to access Medicaid and CHIP payments because there is no such rule for nondisabled beneficiaries. Currently, parents must consent twice to services, and the proposed rule change would remove the second consent, which can be confusing to parents and results in loss of available federal funds to schools (summary of proposed rule available [here](#)). Additionally:
  - With respect to evaluations for special education services, the IDEA expressly authorizes states to proceed on an opt-out basis, unless this approach would be inconsistent with state law.
  - By contrast, the IDEA requires states to obtain written parental consent before actually providing special education and related services to a child.
  - Written informed consent is also required before billing Medicaid or another public benefit program for those services, although the DOE has proposed to modify that requirement.
- Federal education funding may carry additional requirements. For example, schools receiving Student Support and Academic Enrichment grants [must](#) “obtain prior written, informed consent from the parent of each child . . . to participate in any mental-health assessment or service.”

<sup>17</sup> The DOE has created a model consent form that addresses the applicable requirements. Available [here](#).

information that describes the health services and explains that these services will be provided to their child unless a parent or guardian signs and returns the opt-out form by a specified date. Schools and school-based providers have observed that using an opt-out consent model significantly enhances participation rates.

**Figure 2. CHIP Health Services Initiatives Leveraged for SBS**

States can cover SBS under CHIP in various ways, with one specific mechanism being a Health Services Initiative (HSI). HSIs enable states, including states that do not have a Separate CHIP program, to leverage federal CHIP funding to develop and implement initiatives aimed at improving the health of low-income children. States have considerable flexibility with what to cover under their HSIs, and while they must target low-income children, they may provide services to a broader range of children (e.g., a school’s full student body). States can secure federal approval and funding for an HSI by submitting an amendment to the CHIP State Plan. CHIP administrative costs and HSI expenses cannot exceed 10 percent of the total amount of Title XXI funds claimed for health services by the state each quarter. Many states have room under this cap and can submit a CHIP HSI SPA to cover SBS for low-income students.

Currently, CMS has approved CHIP HSIs in 14 states to cover school-based health center screenings, support registered nurses working in schools, and purchase naloxone as well as train personnel on the use of naloxone kits to prevent overdose-related deaths. Four states—Delaware, Mississippi, Hawaii and Pennsylvania—currently have approved HSIs to support a program that offers vision services (such as screenings, eye exams and glasses) to students in low-income communities, on-site at school, and at no cost to the child or their family. [Vision To Learn](#), a non-profit provider working in these states, partners with school staff to bring mobile clinics to conduct the screenings and eye exams, with children in need of vision correction able to pick out frames and receive them about two weeks after the exam day.

## V. Requirements for Billing, Claiming and Accounting for SBS Service Provision

This section details the federal payment requirements for Medicaid- and CHIP-covered services that are provided in schools.<sup>18</sup> Schools and early childhood settings often rely on their own staff to provide health care (including behavioral health) services. These staff typically have additional duties not connected to providing Medicaid- and CHIP-covered services and serve all children in the school regardless of a child's insurance status. SMAs, SEAs and LEAs need to develop and maintain accurate ways of determining how much of a school staff person's time should be reimbursed by Medicaid versus by education funds or other non-Medicaid funds. Medicaid's role in paying for SBS has been scrutinized closely over the years, including by the U.S. Department of Health and Human Services (HHS) Office of the Inspector General, making it critical that there is clear guidance on when and how Medicaid can pay for SBS and that clear procedures are in place for maintaining and auditing records.

The new CMS guidance responds to this imperative, summarizing in detail the Medicaid payment and non-federal share requirements related to SBS reimbursement, describing how to deploy an appropriate cost allocation process for states that use cost-based reimbursement methodologies, and providing new flexibilities related to provider payment levels and interim payment methodologies. The recently announced joint CMS and DOE [SBS Technical Assistance Center](#) can help states better understand the reimbursement and payment methodologies.

### Common SBS Medicaid Payment Methodologies

SMAs have substantial flexibility in setting Medicaid payment rates for providers, including SBS providers, while meeting federal requirements that payments are consistent with efficiency, economy, quality of care and access. States must submit for CMS review and approval a change to the State Plan documenting the SBS that are covered and their related payment methodology (see Box 6). States use a number of Medicaid payment approaches for SBS, including the following:

#### **Box 6. Using Higher Rates to Expand Provider Capacity in Schools: South Carolina Example**

Through [SPA 22-0010](#), South Carolina established an alternative fee schedule for behavioral health providers that provide services in schools. Designed to increase provider capacity in the schools, the alternative fee schedule allows for payment to school-based behavioral health providers at a rate that is higher than the rate for community-based providers.

<sup>18</sup> The guidance does not address the role that Separate CHIP programs could play under various SBS financing strategies such as a cost-based reconciliation methodology; as such, this section references "Medicaid" funding and not "Medicaid and CHIP." Note, however, that Medicaid includes CHIP-financed Medicaid expansion programs for purposes of this section; further, it is possible CHIP could play a role in the SBS financing strategies discussed in this section even though this was not explicated by the guidance.

- **Fee Schedule Rates.** Some states pay for SBS using a fee schedule, where the state sets a payment rate for each service provided to a child enrolled in Medicaid. Under a fee schedule approach, school-based providers document services provided to Medicaid-enrolled students and submit claims for reimbursement to the SMA. CMS has historically limited payment rates for SBS to the “community rate,” meaning that rates for SBS could be no higher than the Medicaid fee schedule rate delivered for the same service in a non-school, or community, setting. In the new guidance, **CMS notes that in certain cases, costs to deliver SBS can be higher than costs for the same services in a community setting, and as a result it will allow SBS rates that exceed the community rate, as long as the state demonstrates that the rate is economic and efficient.**
- **Prospective Cost-Based Rate.** Other states establish a prospective, cost-based rate using data from prior year cost reports and historical utilization. States using this methodology typically establish a statewide cost-based rate for each SBS, though LEA-specific rates are also permitted.
- **Reconciled Cost Methodology.** The most common methodology for SBS reimbursement is a reconciled cost methodology, or cost settlement, where SBS providers receive an interim rate for services throughout the year and subsequently settle at the year’s end to actual costs incurred for the provision of SBS. States must use a detailed cost allocation and reporting methodology based on federal cost reporting parameters, which includes the following:
  - Interim payment methodology
  - Cost identification process to identify direct and indirect costs associated with the provision of health care services
  - Methodology to allocate costs to Medicaid
  - Cost certification statement signed by an LEA official
  - Detailed cost reconciliation and settlement process
  - Detailed cost report instructions for providers

## Non-Federal Share Financing Considerations for SBS

As with any other Medicaid expenditure, SMAs and the federal government share the cost of providing SBS, with the federal government matching a state’s expenditures at the state’s federal medical assistance percentage (FMAP). States must come up with the non-federal share of expenditures on SBS and can use state appropriations derived from taxes or other state revenue, or use alternatives where the LEAs, rather than the state, contribute the non-federal share. Options for financing the non-federal share include the following:<sup>19</sup>

- **Intergovernmental Transfers (IGTs).** These are funds transferred from a governmental entity—which could be a public hospital, a county, a city, an SEA, an LEA, or a public charter school—to the SMA before a Medicaid payment is made. Public providers must make IGTs using non-federal funds. Sometimes IGTs are placed into a “special revenue” or other specifically earmarked state fund upon being transferred.

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<sup>19</sup> For additional information on IGTs or CPEs, see this MACPAC [summary](#).

- **Certified Public Expenditures (CPEs).** These are arrangements in which a governmental entity (e.g., LEA) incurs a cost eligible for federal financial participation (FFP) under the state’s approved Medicaid State Plan or engages in an eligible Medicaid administrative activity. Unlike IGTs, CPEs are not funds transferred from the governmental entity to the SMA. Rather, the governmental entity certifies that the funds expended are public funds used to support allowable costs, and—based on this certification—the state may claim FFP for the federal share of the CPE. Medicaid payments associated with a CPE must use a reconciled cost methodology, meaning that the payments cannot exceed the certified costs of delivering services. Public charter schools, unlike private schools, are not eligible to make CPEs, as they are not considered public agencies.

**For SBS, the most common payment and non-federal share financing combination is a reconciled cost methodology with the non-federal share funded through CPEs.**

## VI. Deep Dive on the Most Common Payment Option: “Reconciled Cost Methodology”

The most common way to reimburse for SBS is through a reconciled cost methodology. At a high level, this method requires SMAs, SEAs and LEAs to determine carefully how much they spend on providing Medicaid-covered services to Medicaid-enrolled children, by going through the following steps:<sup>20</sup>

- **Determine the Cost of Providing Services to All Children.** SMAs, SEAs and LEAs use a combination of cost reports and time studies to determine how much in total was spent on staff and initiatives dedicated to services that can be covered via Medicaid (i.e., services that Medicaid will pay for), including both direct and indirect costs.
- **Determine the Share of Costs Attributable to Medicaid-Enrolled Children.** SMAs, SEAs and LEAs then need to determine the share of relevant health care costs that are **specifically attributable to Medicaid-enrolled children**, rather than those with commercial insurance or who are uninsured. Once they determine the share of students enrolled in Medicaid (often referred to as the **“Medicaid Enrollment Ratio” (MER)**), they apply it to the total of health care services that can be covered via Medicaid to calculate how much has been spent on Medicaid-enrolled children for Medicaid-covered services.
  - **CMS will require a real, point-in-time number for the MER.** Determining the number of students who are Medicaid enrolled can be a challenge for schools and LEAs, but may have other benefits, including assisting schools with establishing their student numbers for free and reduced lunch.
- **Provide Interim Payments and Reconcile to Actual Costs.** States typically provide schools with “interim” payments throughout the year to ensure schools have sufficient cash flow. At the year’s end, these payments are ultimately reconciled to the actual cost of providing Medicaid-covered services to Medicaid-enrolled children, as determined under the cost-based reimbursement methodology.

The guidance provides a detailed review of each of these steps, summarizing the requirements related to cost principles and cost settlement and providing examples to assist states in developing approvable methodologies.

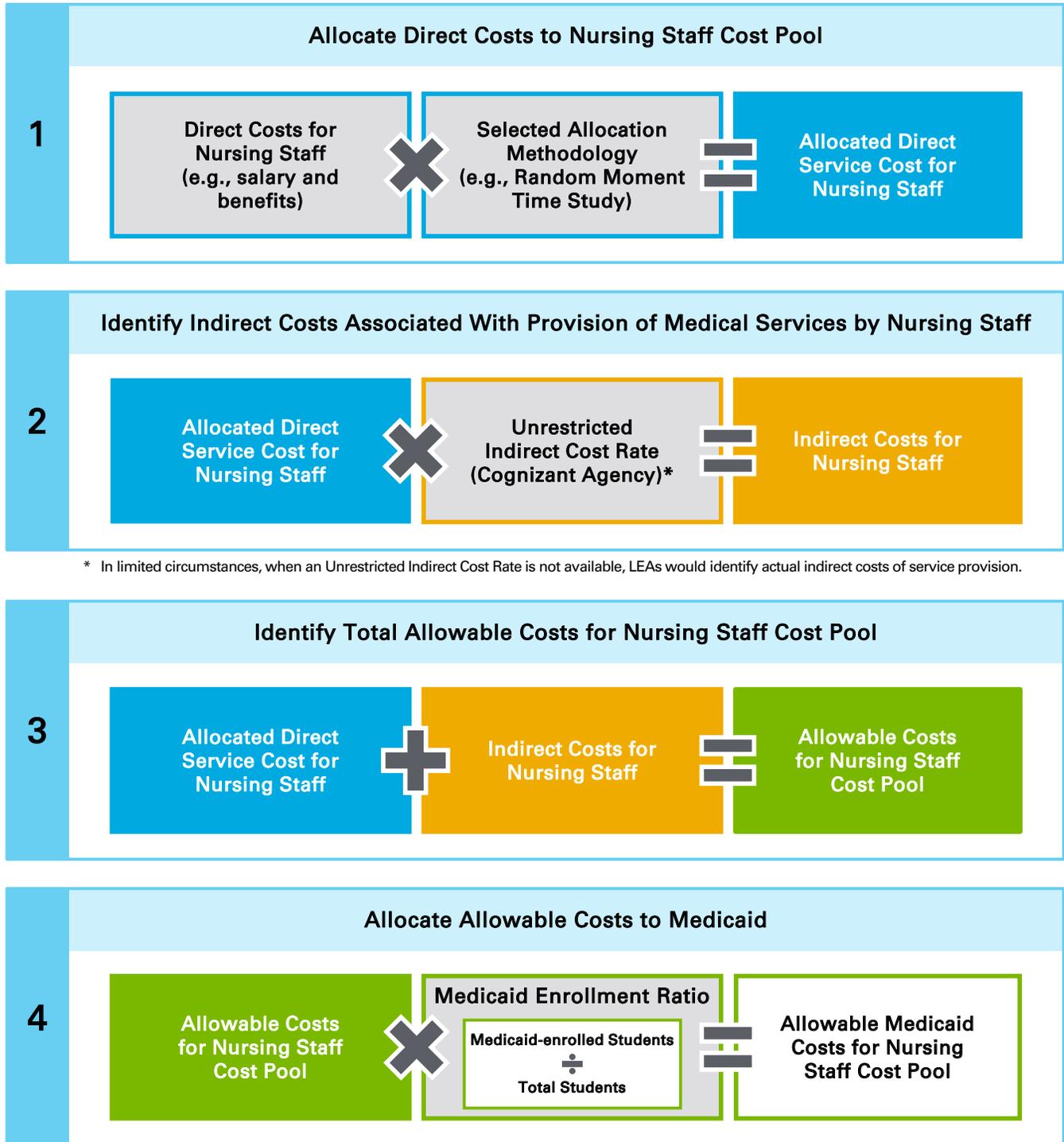
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<sup>20</sup> The guidance does not address the role that Separate CHIP programs could play under various SBS financing strategies such as a cost-based reconciliation methodology; as such, this section references “Medicaid” funding and not “Medicaid and CHIP.” Note, however, that Medicaid includes CHIP-financed Medicaid expansion programs for purposes of this section; further, it is possible that CHIP could play a role in the SBS financing strategies discussed in this section even though this was not explicated by the guidance.

## Determine the Cost of Providing Health Care Services to All Children

To determine the cost of providing health care services to all children, the reimbursed cost methodology typically starts by **establishing cost pools used to allocate direct costs**. States must establish separate cost objectives, or “cost pools,” which group together categories of SBS direct costs. Cost pools are typically established for similar categories of providers—such as therapists (e.g., mental health, physical therapy, occupational therapy, speech therapy) or specialized transportation (e.g., specially adapted buses or vehicles, relevant transport expenses—and other applicable direct costs related to SBS (e.g., facility costs, supplies). All cost pools must be mutually exclusive, meaning that no cost can appear in more than one pool. In the example in Figure 3, nursing is used for illustrative purposes; the same principles would apply to other cost pools.

Figure 3. Cost Reporting Methodology for Nursing Staff Cost Pool



After establishing cost pools, states may follow the steps below, as illustrated in Figure 3:

- 1** **Allocate direct costs to each cost pool**, which are typically the salaries and benefits of professionals delivering health care services, but can also include other costs (e.g., facility costs, supplies, equipment) directly related to the provision of health care services. For direct service costs, **states must include a detailed cost allocation and settlement methodology in the Medicaid State Plan** and collect information from SEAs and LEAs through state-developed cost reports. For cost pools that comprise provider salaries and benefits, the **most common cost allocation methodology is a random moment time study (RMTS)**, which captures the percentage of time employees in a cost pool spend on direct health care services. For example, if the nurses in a cost pool spend 80 percent of their time delivering direct health care services, then their salaries and benefits would be multiplied by 80 percent. [Figure 5](#) describes RMTS in more detail, including new flexibilities provided in the CMS guidance.
- 2** **Identify indirect costs** associated with the provision of health care services. In most cases, LEAs must use a specific indirect cost rate published by the DOE, technically referred to as the “cognizant agency unrestricted indirect cost rate (UICR).”<sup>21</sup> To identify indirect costs, LEAs multiply direct costs (from step 2) by the UICR.<sup>22</sup>
- 3** **Identify total allowable costs** by adding the direct costs (step 1) and indirect costs (step 2) together.

## Determine the Share of Costs Attributable to Medicaid-Enrolled Children

- 4** **Allocate allowable costs to Medicaid**, because LEAs deliver health care services to Medicaid-enrolled and non-Medicaid-enrolled children. As such, LEAs must identify the portion of costs associated with services provided to Medicaid-enrolled children. To do so, LEAs multiply the sum of direct and indirect costs (from step 3) by the MER. For cost pools associated with services available to all students (e.g., nursing services), the MER is the number of Medicaid-enrolled students divided by total students. For cost pools associated with services typically delivered to students with an IEP, LEAs use an IEP MER, which is the number of Medicaid-enrolled students with an IEP divided by the total number of students with an IEP.

<sup>21</sup> 45 C.F.R. §§ 75.2, 75.414.

<sup>22</sup> There are separate rules for a situation wherein an SBS provider does not have an assigned UICR, which are covered in the guidance.

## Provide Interim Payments and Reconcile to Actual Costs

States make interim payments to SEAs and LEAs throughout the year to ensure they have sufficient cash flow prior to the cost-settlement process at the year's end.<sup>23</sup> States currently use a variety of interim payment approaches, including monthly and quarterly interim rates, prospective and cost-based approaches, and/or FFS rates.

In the guidance, **CMS provides new flexibilities for interim payments designed to further minimize administrative burden**, including:

- **Roster- or cost-based monthly or quarterly interim rate billing**, where SBS providers multiply a predetermined rate for a service or set of services, such as a percentage of prior costs or FFS rates for similar services, by the number of students receiving a service on either a monthly or quarterly basis. For example, Colorado provides cost-based interim monthly payments with an annual district-specific cost reconciliation and cost settlement conducted.<sup>24</sup> Illinois received CMS approval in April 2023 for a cost-based interim payment with each participating LEA having their own fee schedule for each LEA service with an annual cost reconciliation process.<sup>25</sup>
- **Average-cost-per-service monthly interim rate**, in which states develop a per-encounter rate based on the average cost of multiple services (e.g., physical therapy, occupational therapy, speech therapy, nursing services), multiplied by the number of services delivered during the month.
- **Bundled payments**, where multiple services are reimbursed under a combined rate. CMS guidance had previously prohibited bundled payments for SBS. CMS clarifies that **bundled payments are permitted** if such payments are used only on an interim basis and ultimately are reconciled to actual costs under a cost settlement methodology.

For the interim payment rate options described above, LEAs are not required to submit claims for each service to the SMA, as long as the interim payments are made and are reconciled to actual costs at the year's end. In such cases, LEAs must still document and maintain records of each delivered service. The CMS guidance also states that CMS plans to collect a streamlined set of quality metrics related to SBS and will issue additional guidance at a later date.

Ultimately, interim payments must be reconciled to actual costs. If allowable costs are higher than the interim payments, then LEAs receive an additional payment. If interim payments are higher than the allowable costs, then the state recoups the difference.

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<sup>23</sup> The end of the year is defined differently on a state-by-state basis and could be the end of the state's fiscal year, school year, or calendar year.

<sup>24</sup> Colorado Department of Health Care Policy & Financing. Colorado Medicaid State Plan (see pages 610–611). March 2022. Available [here](#).

<sup>25</sup> CMS. SPA 21-0008. Available [here](#).

## Insights and Linkages



The new CMS guidance summarizes a number of ways that schools and early childhood settings can simplify billing for SBS. There is a considerable amount of detail about how services can be billed to Medicaid by providers or LEAs and linked examples from specific states. SEAs and SMAs will need to determine on a case-by-case basis what will work best for the specific situation in their states. As noted above, the most common payment and non-federal share financing combination is a cost settlement methodology, with the non-federal share funded through CPEs. As a result, a large portion of the CMS guidance is devoted to cost settlement and CPE considerations, but that is not the only option for states.

The CMS guidance provides some information related to how a reconciled cost methodology might work in managed care delivery systems but leaves other questions unanswered. Each state that covers SBS through MCPs will need to align its own specific situation to the guidance. For example, states that require MCPs to make specific interim payments to LEAs must comply with federal managed care directed payment requirements, which permit states to direct MCP expenditures within certain federal parameters. However, the guidance also notes that payment approaches that require MCPs to “make interim payments that are then later reconciled to cost have historically presented significant challenges for states to both implement and ensure compliance with the regulatory requirements for state directed payments.” Given this, it seems unlikely that CMS would approve an interim payment and cost settlement methodology when SBS are covered through MCPs and directed payments are implicated. SMAs should have early conversations with CMS during the planning phase for SBS to ensure that what appears to work best for the state meets federal requirements and is approvable.

## VII. Administrative Claiming for SBS

Administrative claiming covers services that are not directly billable but are necessary for the running of a Medicaid program.<sup>26</sup> Allowable activities for Medicaid claiming noted in the new CMS guidance follow a set of principles that track closely with the December 1994 [State Medicaid Director Letter \(SMDL\)](#) and are summarized in this section. While the guidance does not make significant changes to administrative claiming, it does add a lot of detail about what is allowed and some useful clarifications.

Medicaid can pay schools and early childhood settings for allowable administrative activities supporting Medicaid and CHIP State Plan services if they adhere to federal requirements detailed in the guidance. Many are standard Medicaid requirements applicable to all providers, though other requirements are specific to SBS. **States must use a time study to identify and categorize Medicaid administrative activities conducted by school or district employees** (except for Medicaid eligibility and enrollment services, for which Medicaid will pay the full cost).

Administrative activities include but are not limited to the following:

- Activities to support outreach, enrollment and eligibility determinations (no time study needed)
- Translation and interpretation services
- Transportation-related activities (see Unallowable Activities below for more information)
- Referral, coordination and monitoring to support Medicaid services (distinct from care or case management)
- Program planning, policy development and interagency coordination related to Medicaid and CHIP
- Medicaid- and CHIP-related training

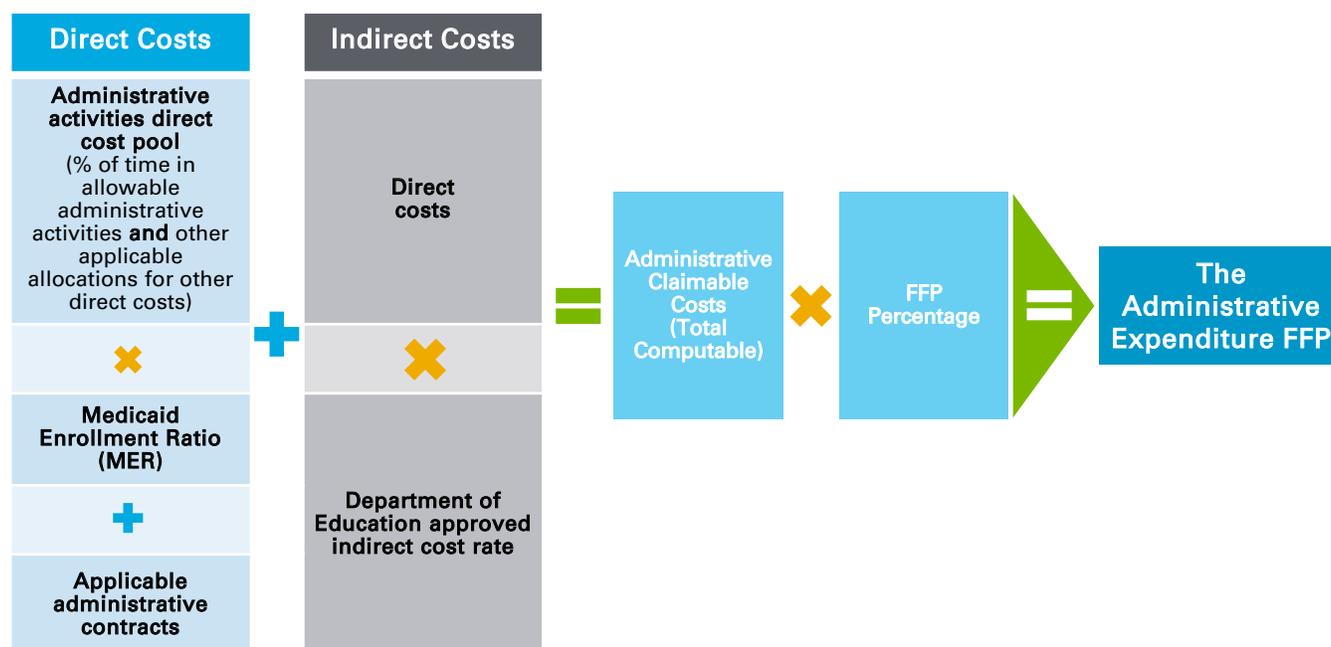
States calculate the amount of FFP they can claim per quarter for LEAs' administrative expenditures by following the formula included in Figure 4 to accurately identify and categorize Medicaid administrative activities. To calculate the administrative expenditure FFP:

1. **Calculate direct administrative costs.** Direct administrative costs are calculated by multiplying the administrative activities that the school or LEA has identified as claimable (for all students) by the MER, and then adding to that the cost of applicable administrative contracts. An RMTS may be required to establish the administrative cost pool because staff in schools spend their time on a variety of administrative activities; see [Figure 5](#) for more information about RMTS.
2. **Calculate indirect administrative costs.** Indirect administrative costs are calculated by multiplying the sum of the direct costs by the DOE-approved indirect cost rate.
3. **Determine the total amount of administrative claimable costs.** Direct administrative costs and indirect administrative costs are added together to calculate the **administrative claimable costs**. This total is then multiplied by the state's FFP percentage to calculate the **administrative expenditure FFP**.

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<sup>26</sup> The guidance does not address the role that Separate CHIP programs could play under various SBS financing strategies such as a cost-based reconciliation methodology; as such, this section references "Medicaid" funding and not "Medicaid and CHIP." Note, however, that Medicaid includes CHIP-financed Medicaid expansion programs for purposes of this section; further, it is possible that CHIP could play a role in the SBS financing strategies discussed in this section even though this was not explicated by the guidance.

Figure 4. Administrative Expenditure FFP



## Match Considerations for Administrative Claims

Administrative activities undertaken in schools are capped at the standard 50 percent administrative match rate with a few exceptions.<sup>27</sup> Translation or interpretation services may be eligible for an increased federal Medicaid and CHIP match.<sup>28</sup> Additionally, the **administrative match can be used to cover 100 percent of the costs for outreach on Medicaid and CHIP**. CMS advises SMAs to consult with it early in their development of school-based methodologies to obtain federal approval of the methodology and time study codes before the submission of amendments to the State Plan, FFP claims and Public Assistance Cost Allocation Plan (PACAP) amendments to the HHS Cost Allocation Services Division (CAS).

## Unallowable Activities for Administrative Claims

Unallowable Medicaid administrative activities include:

- Duplicative payments like those that are components or extensions of direct health care services provided by other entities.
- Duplicative payments included in managed care capitation rates.
- Activities that generally support non-Medicaid-covered services or programs.
- The federal Vaccine For Children (VFC) program’s administrative costs (as a direct or indirect cost in LEA certification).

<sup>27</sup> Includes administrative activities to support provision of family planning services.

<sup>28</sup> CMS. SHO# 10-007 and CHIPRA# 18. Available [here](#). CMS. 2011 CIB re: Recent Developments in Medicaid. Available [here](#).

**To avoid duplicative payments, CMS encourages states to explicitly distinguish which SBS are delivered as a result of the student’s IEP from other Medicaid services provided in the school-based setting.**

**Transportation Considerations.** Transportation is worth a bit of extra clarification because confusion over the transportation benefit has resulted in audits for SMAs and SEAs in the past. Transportation can be an unallowable activity given that Medicaid generally cannot cover Medicaid-enrolled students’ transportation to school; however, Medicaid is available to transport students with documented health care needs for specialized transportation in their IEP to a Medicaid-covered service regardless of whether the Medicaid-covered service is provided on-site or by a community provider. Specialized transportation must also be provided in a vehicle that has been specially adapted to meet the needs of the student (e.g., wheelchair lifts, ramps, special harnesses). SMAs may opt to pay for specialized transportation at a fee schedule rate or as a cost per trip rate. States may also opt to pay for SBS specialized transportation using administrative claiming or using CPEs to cost allocate one-way trips to Medicaid. They can do this by creating a discrete or general cost pool (e.g., bus, vehicle drivers, mechanics) of related allowable costs that then gets stepped down to account for the Medicaid reimbursable costs of providing the service to eligible students.

## Requirement for Interagency Agreements Between School Districts and SMAs

School districts must enter into interagency agreements with the SMA to receive Medicaid funding for allowable administrative activities conducted by the school district and/or participating individual schools. States may also enter into interagency agreements with a consortium covering a collection of LEAs or school districts, but is barred from entering into agreements with private contractors. The agreement must include the services being purchased, the billing basis (e.g., time study) used by the agency providing the services, a requirement that billing depends on the actual cost incurred with limited exceptions, as well as the requirements for maintaining records, responding to audits and implementing other financial oversight procedures. **While federal approval is not required for interagency agreements, CMS encourages consultation and review with states during the development process.**

## Requirements for Cost Allocation Plans

For administrative costs, SMAs must document their methodology in a PACAP, the state’s administrative claiming agreement with CMS. The PACAP must detail the reimbursement for administrative activities for which claims will be made to the SMA by the LEAs, school districts and schools; methodologies; claiming mechanisms; interagency agreements; and other relevant information for claiming and allocating administrative costs to the SBS providers. A state may need to amend its PACAP if it seeks programmatic changes that do not comport with the time study and cost allocation methodology approved in its PACAP. The school-based administrative claiming system must be able to differentiate costs directly related to Medicaid program administration from all other costs incurred by the school, as well as other administrative expenditures directly claimed by the SMA. CAS and CMS work together to review and approve the methodologies included in the PACAP. Schools may not claim administrative costs without an approved PACAP, just as services may not be billed if they are not covered in an approved State Plan.

## Requirements for Time Studies

To guide implementation of administrative cost claiming, SMAs must submit SBS Claiming Time Study Implementation Plans (also called MAC, or Medicaid Administrative Claiming, Plans) that should include:

- Administrative and direct services that are Medicaid reimbursable (to avoid duplication of payments, states are advised to detail or diagram the current administrative activities performed by other entities and their relationship to the Medicaid activities performed in the schools, as well as Medicaid-reimbursable direct services)
- Interagency agreements between the SMA, the SEA and/or the school district or LEA providing services
- Description of cost pools
- Sources of non-federal share
- Sample design (e.g., time study, RMTS)
- Treatment of indirect costs (e.g., whether the state will claim them)
- Monitoring process for LEAs

### Insights and Linkages



While many of the requirements for administrative claiming in SBS point to the need for LEAs to complete activities, the development of administrative claiming procedures for the state is an important place for the SMA and the SEA to collaborate. The development of the PACAP in particular is ideally a responsibility that is shared by the SMA and SEA. Schools should not claim administrative costs without an approved PACAP. States should also consider including Medicaid eligibility and enrollment services in their PACAP given that Medicaid will pay the full cost for these services.

When modifying the PACAP, SMAs should have early conversations with CMS during the planning phase for SBS to ensure that what appears to work best for the state meets federal requirements and is approvable.

### Figure 5. Random Moment Time Studies (RMTS)

RMTS is a statistically valid sampling methodology that can be used by states and LEAs to allocate the portion of **direct costs associated with delivery of health care services** and **allowable administrative costs to cost pools**. When an RMTS is conducted, school employees are randomly selected and must carefully document all of the work that they do (whether allowable under Medicaid or not) during a specific, randomly selected time interval. Each activity is assigned a code that distinguishes direct service tasks from administrative activities. The results of the RMTS are then used to estimate the total time devoted to providing direct services that are covered under the Medicaid State Plan and allowable administrative activities. Then, health care and administrative service costs are allocated to Medicaid using a MER to determine what portion of those costs is associated with delivery of services to Medicaid-enrolled children. Section VII of this summary describes this process in more detail.

**New Flexibilities for RMTS.** The new flexibilities outlined in the guide are intended to mitigate administrative burden on schools and LEAs in the process of allocating costs to Medicaid. These broadened flexibilities include:

- Allowing a 5 percent error rate for SBS direct service RMTS sampling. This error rate aligns with the policy for SBS administrative RMTS sampling. Previously, the allowable error rate for SBS direct service sampling was 2 percent, which precluded the conducting of unified time studies for both SBS direct service and administrative activities.
- Decreasing the minimum “sample moments” for each time study interval from 2,401 moments to 385 moments.
- Broadening flexibility for the notification and response periods before and after time studies. While CMS encourages immediate notice to time study participants, the new flexibility allows for up to 48 hours of advance notice in some circumstances.
- Allowing states to use RMTS as a one-step Medicaid cost allocation methodology to be structured to capture moments that are associated with both the delivery of health care services and Medicaid-allowable activities (direct care and administrative). Prior CMS guidance required a two-step process wherein RMTS is used to allocate time to health care services, and then a MER was used to allocated costs to Medicaid.

**Other Methods of Identifying and Allocating Costs.** While RMTS is the typical methodology for identifying and allocating Medicaid costs, other options are permissible, so long as they:

- Are based on records that reflect actual work performed.
- Are supported by a system of internal controls that provide reasonable assurance that charges are accurate, allowable and properly allocated.
- Reflect the total activity for which the employee is compensated.
- Support the distribution of the employee’s salary or wages among specific activities.

Examples of alternatives to RMTS for accomplishing these objectives include:

- Utilization of employee worker logs or activity sheets, which are reflective of the actual work performed during a period of time.
- Use of contractual arrangements for practitioners to perform allowable activities as a means to allocate costs to Medicaid.
- “Backcasting,” wherein sample results from one time period can be used to support claims from previous time periods, under certain circumstances, such as when no better documentation is available and it can be shown that there are no significant differences between the periods in question.

States or their partners embarking on time studies for the first time should read the new CMS guidance in detail as there are examples on how other states have approached time studies. States can also seek technical assistance from CMS.

## VIII. Documentation and Billing Rules for Medicaid and CHIP Services

To be reimbursed by the SMA, there are many documentation and billing rules that LEAs and SEAs need to consider and review to ensure compliance. These rules are required regardless of whether a claims form is used and whether the payment goes through the state's Medicaid Management Information System (MMIS).

### Documentation Expectations for Medicaid and CHIP Services<sup>29</sup>

Consistent with Medicaid and CHIP documentation requirements for all service providers, SBS providers must collect and retain service-level information showing that Medicaid- and CHIP-enrolled students received the covered services for which the providers are reimbursed. Service-level documentation is critical to support the state if an audit occurs (see Box 7). In addition to complying with standardized Medicaid and CHIP documentation requirements for direct service claims, SMAs and LEAs providing direct services under the IDEA Part B may have to maintain up-to-date records of services provided in accordance with a student's IEP to support their billing documentation and allocation cost if they are using an IEP MER. SMAs and LEAs can use

#### Box 7. Medicaid Documentation

Per the [State Medicaid Manual 2500.2](#), a CMS managed manual, documentation of billed services must include at least:

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

In addition, LEAs could supplement the minimum documentation required to better support audits by including, among other things:

- Prior authorizations
- Member's health care record
- IEP
- Prescription/referral for IEP services
- Documentation of the service, including clinical notes for services provided on the date of service
- Transportation logs
- Payroll records associated with school personnel providing services
- National provider identification

<sup>29</sup> CMS acknowledges that duplicative federal SBS documentation requirements for LEAs, SEAs and SMAs were put forth by the DOE and CMS and indicated that it will work on providing additional guidance on federal department expectations regarding supporting documentation when federal audits are conducted. For example, both the DOE and CMS require documentation that includes the member's name, provider agency, person directing the service and place of service.

attendance records, prior authorization, transportation logs, provider agreements and payroll records, among other types of documentation listed by CMS, to comply with the minimum documentation requirements and support an audit defense.

Providers reimbursed using a cost-based methodology must comply with standard Medicaid and CHIP requirements that include a submission of a finalized uniform cost report, a copy of the CPE form, cost report instructions and documentation to support a MER among other requirements. The SMA is required to maintain documentation that supports its claim of FFP in accordance with federal requirements (e.g., making documentation accessible to state and federal staff for review during working hours, applying policies uniformly throughout the state).

CMS also advises SMAs to institute best practices to alleviate the report burden felt by school-based providers, including conducting training for SBS providers on Medicaid and CHIP billing documentation and audit processes and providing adequate funding to LEAs to support the Medicaid and CHIP billing infrastructure needed.

In response to SBS providers' concerns over documentation requirements, CMS intends to collaborate with the DOE and issue additional guidance to promote flexibility for providers. CMS also suggests using strategies that SBS providers employ to comply with Medicaid and CHIP requirements and privacy requirements set by FERPA and the IDEA, including submitting deidentified or masked data or using the general MER instead of an IEP-based ratio.

## Timely Claims Filing and Other Federal Claiming Considerations

States are generally required to file claims for federal matching funds within a two-year statutory time limit or meet an exception to the requirement. The new CMS guidance notes that states should make their best effort to submit claims within the two-year time limit but may qualify for a statutory exception if claiming after the two-year limit is related to an "adjustment to prior year costs." **CMS clarifies that the date of the expenditure for purposes of the timely filing limit is the date of service, rather than the date of an interim payment.** Additionally, the CMS guidance notes that federal funds claimed related to CPE-supported interim payments should be claimed based on the FMAP in place on the date of service, rather than the date of payment. CMS clarifies that states cannot claim a federal match for direct health care or administrative SBS delivered by a contractor if the fees are based on or include contingency arrangements. Cost settlement does not need to occur within the two-year statutory time period.

## Third-Party Liability

Medicaid and CHIP are generally the payer of last resort for any health-related claim. An exception to this rule is when Medicaid and CHIP services are included in a Medicaid- and CHIP-enrolled student's IEP, which means that Medicaid and CHIP will pay in this circumstance before the federal IDEA funds for listed Medicaid- and CHIP-covered services. A student's primary insurance (if they have any) may still be responsible for services covered under an IEP. As a result, SBS providers who seek to bill Medicaid and CHIP for payment for any delivered service—even those covered under the IDEA—may be first required to bill the member's other health insurer or other responsible party, if either exist.

If the service meets one of the existing Medicaid and CHIP regulatory exceptions (e.g., medical child support, preventive pediatric care), the SMA may reimburse the SBS provider up to the maximum Medicaid and CHIP payment amount established in the Medicaid or CHIP State Plan for the service and seek recovery from a third-party payer. The CMS guidance notes several times that states may suspend or terminate efforts to seek reimbursement from a liable third party if recovery may not be cost-effective, but SMAs should guide SEAs and LEAs with regard to recovery; consultation with CMS may be required. It is possible to bill Medicaid for services that non-Medicaid eligible students receive without cost.

### Insights and Linkages



Medicaid and CHIP's documentation requirements and third-party liability provisions can be confusing for schools and early childhood centers as they start to provide SBS, especially when aiming to ensure that Medicaid and CHIP requirements have been met. SEAs often have an important role in helping LEAs and school districts ensure that SBS providers are meeting these requirements, which will help protect the schools, SEAs and SMAs from any potential negative impacts of a federal audit. To that end, SEAs should collaborate closely with SMAs in development of training for LEAs, schools, school districts and providers, ensuring that the language used is clear and the requirements are understandable and can be reasonably implemented in schools. The cost of training school staff and maintaining good records should be factored into rates and/or administrative costs.

Schools do not have to use a claim form to pay for SBS. However, the documentation requirements apply for any Medicaid service, and failure to be able to provide them may leave the SMA and schools vulnerable in an audit.

## IX. Conclusion

It is critically important for children and youth to be able to easily and safely access health care services on-site at school. CMS' new guidance is key in supporting SMAs and LEAs in partnering to expand access to SBS and reduce the administrative burden on schools in delivering SBS. With this guidance, states can move forward with ensuring that the more than 42 million children enrolled in Medicaid and CHIP nationwide can access behavioral health services, preventive care and referrals to much-needed supports between classes with limited disruption to their or their families' schedules.

## X. Appendix

### Appendix A: CMS' Sub-Regulatory Guidance Referenced in Guide

| CMS Sub-Regulatory Guidance   | Brief Overview   | Date Issued       |
|---|--|-------------------|
| <a href="#">2023 CIB: Information on School-Based Services in Medicaid: Policy Flexibilities and Guide on Coverage, Billing, Reimbursement, Documentation and School-Based Administrative Claiming</a>    | Introduces the comprehensive CMS guide summarized in this brief.   | May 18, 2023      |
| <a href="#">State Health Official Letter (SHO)# 23-001: Coverage and Payment of Interprofessional Consultation in Medicaid and CHIP</a>   | Clarifies Medicaid and CHIP policy for when a patient requests an opinion from a specialty provider (or consulting practitioner) to assist the treating practitioner, without face-to-face contact with the consulting practitioner.                                 | January 5, 2023   |
| <a href="#">2022 CIB: Leveraging Medicaid, CHIP and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth</a>   | Organizes existing guidance for SMAs on how to best deliver high-quality behavioral health services to children and youth and shares state examples.   | August 18, 2022   |
| <a href="#">2019 Joint SAMHSA and CMS Informational Bulletin: Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools</a>                                   | Provides information on how to address mental health and substance use issues in schools to states, schools and school systems, including state examples and evidence-based models in supporting students.   | July 1, 2019      |
| <a href="#">SMDL# 14-006: Medicaid Payment for Services Provided without Charge (Free Care)</a>   | Addresses Medicaid payment for services under a Medicaid State Plan that are available without charge to the Medicaid member.  | December 15, 2014 |
| <a href="#">2011 CIB: Recent Developments in Medicaid</a>   | Clarifies the increased federal funding available for translation and interpretation for children and their families.  | April 26, 2011    |
| <a href="#">SHO# 10-007 and Children's Health Insurance Program Reauthorization Act (CHIPRA) #18: Increased Federal Matching Fund for Translation and Interpretation Services Under Medicaid and CHIP</a> | Provides guidance on the increased administrative funding for translation or interpretation services provided under Medicaid and CHIP in connection with enrollment, retention and service usage of children of families with a primary language other than English. | July 1, 2010      |
| <a href="#">SMDL# 07-011: Peer Support Services</a>   | Provides guidance to states interested in covering peer support services as a Medicaid benefit.  | August 15, 2007   |
| <a href="#">1999 SMDL: Bundled Rates for SBS</a>  | Addresses Medicaid reimbursement of SBS and clarifies CMS policy on bundled rates, state claiming for health-related transportation services with IEPs under the IDEA and state claiming for school health-related administrative activities.                        | May 21, 1999      |
| <a href="#">1994 SMDL: Administrative Claiming</a>  | Details the principles states should follow for determining allowable administrative costs in order to claim Medicaid administrative expenditures.   | December 20, 1994 |

## Appendix B: Acronyms and Key Terms

| Acronym | Definition  |
|---------|---|
| CAS     | Cost Allocation Services (Division of HHS)  |
| CHIP    | Children’s Health Insurance Program   |
| CHIPRA  | Children’s Health Insurance Program Reauthorization Act                                     |
| CIB     | Centers for Medicaid and CHIP Services Informational Bulletin or CMS Informational Bulletin |
| CMCS    | Centers for Medicaid and CHIP Services  |
| CMS     | Centers for Medicare & Medicaid Services  |
| CPE     | Certified Public Expenditures   |
| DOE     | U.S. Department of Education  |
| EPSDT   | Early and Periodic Screening, Diagnostic and Treatment                                      |
| FAPE    | Free Appropriate Public Education   |
| FERPA   | Family Educational Rights and Privacy Act   |
| FFP     | Federal Financial Participation   |
| FFS     | Fee-for-Service   |
| FMAP    | Federal Medical Assistance Percentage   |
| HHS     | U.S. Department of Health and Human Services  |
| HIPAA   | Health Insurance Portability and Accountability Act   |
| HSI     | Health Service Initiative   |
| IDEA    | Individuals with Disabilities Education Act   |
| IEP     | Individualized Education Program  |
| IGT     | Intergovernmental Transfers   |
| LEA     | Local Education Authority   |
| MAC     | Medicaid Administrative Claiming (Plan)   |
| MACPAC  | Medicaid and Children’s Health Insurance Program Payment and Access Commission              |
| MCP     | Managed Care Plan   |
| MER     | Medicaid Enrollment Ratio   |
| MMIS    | Medicaid Management Information System  |
| MOU     | Memorandum of Understanding   |
| MTSS    | Multi-Tiered Systems of Support   |
| PACAP   | Public Assistance Cost Allocation Plan  |
| RMTS    | Random Moment Time Study  |
| SAMHSA  | Substance Abuse and Mental Health Services Administration                                   |
| SBS     | School-Based Services   |
| SEA     | State Education Agency  |
| SHO     | State Health Official (Letter)  |
| SMA     | State Medicaid Agency/State Children’s Health Insurance Program Agency                      |
| SMDL    | State Medicaid Director Letter  |
| SPA     | State Plan Amendment  |
| SUD     | Substance Use Disorder  |
| UICR    | Unrestricted Indirect Cost Rate   |
| VFC     | Vaccine For Children program  |

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