MEDICAID

IN SCHOOLS

children's defense fund texas

MEDICAID IN SCHOOLS

Our Mission

The Children's Defense Fund Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start,* a *Safe Start* and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

CDF provides a strong, effective and independent voice for *all* the children of America who cannot vote, lobby or speak for themselves. We pay particular attention to the needs of poor children, children of color and those with disabilities. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown.

CDF began in 1973 and is a private, nonprofit organization supported by individual donations, foundation, corporate and government grants.

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Inside photos: Cedric Fauntleroy; Laura James; Bruno Nnascimento; Rodnae Productions and Alison Wright Photography

TABLE OF CONTENTS

PROJECT BACKGROUND AND SUMMARY

For more than 15 years, CDF-Texas has been dedicated to increasing access to affordable health coverage for low-income children and families. Our work has focused both on direct assistance to families in obtaining health care coverage and on the policies, funding streams, and programmatic issues that affect access to health care in Texas. Through this work, we have identified the need to expand school-based efforts to connect students to health coverage as well as access to school-based health services.

Research shows that access to Medicaid has long-term benefits for children. Children who have been covered by Medicaid do better in school; miss fewer school days due to illness or injury; are more likely to finish high school and attend and graduate from college; and earn more as adults. Ensuring that eligible students are enrolled in Medicaid (or CHIP) and that their health care needs are met effectively at school, where they spend most of their day, will have far-reaching, positive benefits both for individual Texans and communities across our state.[1]

Schools are uniquely positioned to help children access Medicaid and CHIP coverage as well as the health care services they need to attend school and improve their health and well-being. Our goals with this project were to:

- Identify ways to increase school identification of student insurance status as well as school outreach and support activities to facilitate student enrollment in Medicaid or CHIP.
- Identify ways to expand Medicaid reimbursement for school-based health care services.

To accomplish this, we undertook the following activities:

- Review of state and federal policy and regulatory documentation and discussions with state agency staff to understand requirements for school districts to receive Medicaid reimbursement for health care services and outreach and enrollment facilitation activities
- A survey of school districts[2] and interviews with stakeholders (state agencies, school-related associations, billing vendors, and school district representatives) to understand:
    - How Texas schools currently leverage available Medicaid funding for provision of health care services as well as for outreach and enrollment facilitation activities.
    - Barriers and challenges that may prevent school districts from maximizing available Medicaid funding for allowable services and activities.
    - School district perceptions of unmet health-related needs among their students that could be addressed through expansion of Medicaid reimbursement for health care services allowable under federal policy.
- Review of federal and other states' policy documentation regarding revision to the "free care rule" that expanded state ability to provide Medicaid reimbursement of school-based health services
- Discussions with representatives of the School Based Health Alliance, Community Catalyst, other state Medicaid programs, and another state's school board association to understand the free care rule revision and determine how states are taking advantage of the revision to expand Medicaid reimbursement of school-based health services.

Below we present our findings from these activities, followed by recommendations for supporting schools to expand delivery of health care services as well as outreach and enrollment facilitation activities.

[1] https://ccf.georgetown.edu/2015/07/27/medicaid-50-look-long-term-benefits-childhood-medicaid/

[2] While we received assistance from the Texas Association of School Administrators to inform school districts about our survey and encourage them to complete it, we received almost no responses. Consequently, we have not included information about the survey in this report.

OVERVIEW OF MEDICAID IN SCHOOLS

Federal law provides for Medicaid payment to schools for provision of certain health and related services provided to children with disabilities under the Individuals with Disabilities Education Act (IDEA) as well as for Medicaid-related administrative services such as outreach and Medicaid enrollment activities and facilitating access to and coordination of Medicaid services. In fiscal year (FY) 2016, Medicaid spent $4.5 billion nationally on school-based health services ($3.3 billion) and administrative services ($1.2 billion).[3]

Health and Related Services Under the Individuals with Disabilities Education Act (IDEA)

IDEA (P.L. 101- 476) is a federal law intended to ensure that children with disabilities have access to a free appropriate public education. Part B of the Act[4] establishes provisions for states and local education agencies to provide "special education and related services" to enable children with disabilities to go to school and reach their education goals. Special education services are not covered by Medicaid since they are not health care services, but many related services are. As defined as 34 CFR 300.24, related services are "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education", which include:[5]

- Counseling services, including rehabilitation counseling
- Early identification and assessment of disabilities
- Medical services for diagnostic and evaluation purposes
- Occupational therapy
- Parent counseling and training
- Physical therapy
- Psychological services
- Recreation including therapeutic recreation
- School health services
- Social work services in schools
- Speech-language pathology and audiology services.

The Act requires schools to develop a written individualized education program (IEP; sometimes referred to as an individualized education plan) that documents, among other things, the special education and related services the child needs. The IEP is developed by an IEP team that consists of the parent(s), the child when appropriate, specified school representatives, and, at the discretion of the parent or school, others with knowledge or expertise regarding the child.

Medicaid Coverage of Services on the IEP. To qualify for Medicaid payment, services on the IEP must be primarily medical and not educational nature. In addition, they must be:

- Provided to a Medicaid-eligible child.
- Medically necessary and included in a Medicaid-covered category (such as physical therapy).
- Included in the State Plan or available under the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit (which requires states to provide any medically necessary health care service listed in section 1905(a) of the Social Security Act to a Medicaid-eligible child under age 21).

[3] MACPAC. Issue Brief: Medicaid in Schools. April 2018. https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf
[4] https://sites.ed.gov/idea/statute-chapter-33/subchapter-ii
[5] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf

- Provided in compliance with all federal and state Medicaid requirements, including provider qualifications, comparability of services, and amount, duration and scope provisions.[6]

States vary in their Medicaid coverage of service categories and specific service types provided by schools under IDEA but typical services include:[7]

- Physical therapy
- Occupational therapy
- Speech pathology or therapy
- Psychological counseling
- Nursing

Most states provide Medicaid payment for individual treatment services and evaluations to plan treatment. Some pay for screening, group treatment, and evaluations to develop the IEP.[8] Schools must obtain parental consent in order to provide and bill Medicaid for services.

Responsibility for Payment. IDEA requires local education agencies to provide necessary services on the IEP at no cost to the student/family. This requirement holds regardless of whether Medicaid payment is available for the services. However, if the service meets Medicaid criteria, Medicaid is responsible as the payer although Medicaid rules regarding third party liability (TPL) apply to IEP services. If coverage for the service is available through another source, such as a child's private insurance or another program, the state Medicaid program must attempt to recover the payment amount from the coverage source.

Medicaid Administrative Activities

In addition to funding direct service provision, Medicaid also provides funding to states for costs associated with program administration. This mechanism is known as Medicaid Administrative Claiming (MAC) which provides public agencies (including schools) the opportunity to submit reimbursement claims for administrative activities that support the Medicaid program. In order for the cost to be allowable and reimbursable under Medicaid, the activities must be found to be necessary for the proper and efficient administration under a Medicaid State Plan and must adhere to applicable requirements as defined in State and Federal Law. States may use Medicaid funds to reimburse schools for certain Medicaid-related administrative services related to identifying, enrolling, and providing services to Medicaid-eligible children. Examples of such services include:[9]

- Outreach to potentially-eligible children and families to educate them about availability of Medicaid and Children's Health Insurance Program (CHIP) coverage
- Assisting potentially eligible children and families to apply for Medicaid or CHIP
- Facilitating access to Medicaid services, such as providing transportation to and from school on a day a child receives a Medicaid service or providing referrals to Medicaid providers
- Coordination of Medicaid services.

Claiming Methodology. In order for states to use Medicaid funds to reimburse schools for Medicaid-related administrative activities, they must establish a claiming methodology that includes a time study that identifies the individuals performing activities, the activities being performed, and the amount of time an individual performs an activity. CMS provides guidelines for time studies as well as activity codes, which are examples of allowable administrative activities. States may customize their approach to reflect activities unique to a local environment and/

[6] Center for Medicare and Medicaid Services. Medicaid School-Based Administrative Claiming Guide. May 2003. https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf e.pdf
[7] https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf
[8] https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf
[9] https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf

or add activity codes. Any customization or additional codes must support proper and efficient administration of the Medicaid program and other requirements specified by CMS.[10]

A key underlying principle of CMS requirements for claiming methodology is that the time study and activity codes should allow for clear allocation of time spent on activities related to Medicaid and performed for Medicaid-eligibles versus on time spent on activities unrelated to Medicaid or performed for non-Medicaid eligibles. Some activities, such as coordination of care, are only reimbursed when provided to Medicaid eligibles. The time study and activity codes are used to calculate Proportional Medicaid Share (the proportion of staff time spent providing an activity to Medicaid eligibles versus non-eligibles) for these activities. Other activities are Medicaid-reimbursable regardless of student Medicaid eligibility (called 100% Medicaid Share), such as outreach to potentially eligible children and assistance with Medicaid and CHIP applications.[11]

Billing and Payment. Schools submit a list of staff participating in MAC activities along with information about their duties and associated costs (such as salaries and wages). Payment is not made on a per-activity basis, rather it is based on a proportion of costs associated with each staff member on the participation list. The proportion of costs is determined using results of the required time study. States draw down and pay schools for Medicaid administrative activity using federal Medicaid funds (federal financial participation; FFP).

Medicaid in Schools in Texas

Texas provides Medicaid payment to schools for health services through the School Health and Related Services (SHARS) program and for administrative services through the Medicaid Administrative Claiming (MAC) program.

SHARS. SHARS provides Medicaid payments to school districts for certain direct care services provided to Medicaid-eligible children age 20 and younger who:[12]

- Have a disability or chronic medical condition
- Are enrolled in a public school's special education program
- Meet IDEA eligibility requirements for special education
- Have an IEP that prescribes the needed services.

The following services are covered by SHARS:

- Audiology services
- Counseling
- Nursing services
- Occupational therapy
- Personal care services (PCS)
- Physical therapy
- Physician services
- Psychological services, including assessments
- Speech therapy
- Transportation in a school setting.

Services must be delivered by a provider who meets qualifications listed in the Texas Medicaid Providers Procedures Manual (TMPPM).

[10] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf
[11] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf
[12] Texas Education Agency. School Health and Related Services. (website) https://tea.texas.gov/Academics/Special_Student_Populations/Special_Education_SPED/Programs_and_Services/School_Health_and_Related_Services

In Texas, the IEP team is called the Admission, Review, and Dismissal (ARD) team. ARD meetings are the forum through which the IEP team develops and reviews the IEP.

SHARS Program Administration. SHARS is jointly administered by the Texas Education Agency (TEA) and the Texas Health and Human Services Commission (HHSC). TEA has primary responsibility for communicating with school districts and program compliance monitoring. HHSC has primary responsibility for activities related to payment and development of policy.

Table 1: Summary of TEA and HHSC Responsibilities for SHARS Program

TEA Responsibilities[13]	HHSC Responsibilities[14]
Providing policy clarifications to districts	Establishing reimbursement rates
Performing regular desk reviews and field audits	Overseeing cost reconciliation process
Monitoring compliance with documentation guidelines	Ensuring that services are delivered in a manner consistent with the Medicaid state plan and the Texas Medicaid Provider Procedures Manual
Validating submitted billing data	
Working to minimize waste, program abuse, and fraud	Developing and updating policy guidance related to the delivery of SHARS services

SHARS Billing and Payment. School districts enroll in Medicaid as a SHARS provider via the Texas Medicaid and Healthcare Partnership (TMHP) and employ or contract with appropriately qualified individuals that meet Texas Medicaid provider requirements for the services to be provided. These individuals must participate quarterly in a Random Moment Time Study (RMTS; a time study completed using sampling methodology). RMTS results are used to calculate the 'direct service percentage' of time spent serving Medicaid-eligible students and, along with other allocation ratios, to determine total allowable Medicaid costs.

Districts submit annual cost reports via a web-based system known as the State of Texas Automated Information Reporting System (STAIRS) and operate by the HHSC Rate Analysis Department through a contractor (currently Fairbanks, LLC). However, they submit interim claims quarterly based on services provided during the quarter by individuals on the participant list. HHSC uses cost reconciliation and settlement processes to ensure interim payments align with annual cost reports.

Many districts contract with a third-party entity (billing vendor) to assist with submission of claims and financial data. Billing vendors typically charge districts a percentage of submitted SHARS claims for their services. Most vendors have their own electronic system into which districts enter SHARS claims data. SHARS financial data is entered into STAIRS by either the district or the vendor but must be submitted by the district. If the district does the entry, the vendor may provide consulting services regarding what to enter and how to enter it. If the vendor does the entry, the district must review entered data to ensure and certify it is correct and finalize submission.

MAC. Texas Medicaid reimburses school districts for certain costs of providing health administrative activities related to the Medicaid program. These activities include:

- Medicaid outreach
- Facilitating Medicaid eligibility

[13] https://tea.texas.gov/Academics/Special_Student_Populations/Special_Education_SPED/Programs_and_Services/School_Health_and_Related_Services
[14] https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2018/rider42-coordination-therapy-services-provided-by-school-districts-others-dec-2018.pdf

- Scheduling or arranging Medicaid transportation
- Administrative activities related to Medicaid translation services
- Program planning, development, and interagency coordination related to medical services
- Medical and Medicaid-related training
- Referral, coordination, and monitoring of Medicaid services.

The complete list of examples of allowable MAC activities provided by HHSC is shown in Appendix C.

Some services may be reimbursed only when provided to Medicaid-eligible students while others may be provided to any student within the district, regardless of Medicaid eligibility, as well as to their families. For example, outreach to potentially Medicaid-eligible students and assistance in applying for Medicaid or CHIP as well as education provided to any student or family regarding availability of Medicaid and CHIP is allowable regardless of student Medicaid eligibility. However, activities such as scheduling or arranging Medicaid transportation or coordination of services are only allowable when provided to Medicaid-eligible students.

Billing vendors are not required to register with the state and there does not appear to be an official list, thus we were unable to verify the total number of available vendors. However, in December 2018, HHSC provided us with the names of eight billing vendors known to HHSC. Additionally, one billing vendor indicated the existence of a new vendor that was not one of the eight known to HHSC.

Services may be provided by the district's qualified SHARS providers as well as by a subset of additional provider types that HHSC allows for MAC reimbursement but not for SHARS reimbursement. These additional provider types include:[15]

- Behavioral Counselor
- Interpreter/Translator/Bilingual Specialist
- Outreach Worker
- Physician Assistant
- Pregnancy Education and Parenting Program
- Psychology - Licensed Intern
- Service Coordinator/Case Manager
- Social Worker - Licensed Bachelors of Social Work (LBSW)
- Social Worker - Licensed Masters of Social Work (LMSW)

MAC Program Administration. MAC is administere d by HHSC.

MAC Billing and Payment.[16] As with SHARS, school districts must submit a participation list of individuals providing MAC activities during a quarter. Individuals on the list are randomly selected to complete the RMTS and results are used to calculate the district's quarterly MAC claim. Claims are based on:

- Percentage of allowable time based on statewide RMTS results
- Percentage of the district's students who are Medicaid eligible
- An indirect cost rate established by the Texas Education Agency
- The quarterly costs of staff on the participant list.

[15] Based on a list provided to Children's Defense Fund in 2018 by HHSC Rate Analysis
[16] https://rad.hhs.texas.gov/sites/rad/files/documents/mac/what-is-mac.pdf

As with SHARS, many districts contract with billing vendors for assistance with MAC billing. Our discussions with billing vendors indicated that vendors that assist with MAC billing typically charge a quarterly flat rate although we identified that at least one vendor does not charge for this assistance.

Texas School District SHARS and MAC Participation and Revenue

As of the 2017-18 school year (most recent year data is available), the Texas public school system was comprised of 1,023 school districts and 177 charter operators serving about 5.4 million students at 8,766 campuses. Almost 3.2 million (58.7%) Texas public school students were categorized as economically disadvantaged and 498,320 (9.2%) were in special education.[17]

In the Central Texas area (comprised of Bastrop, Caldwell, Hayes, Travis, and Williamson counties), there are 29 independent school districts (ISDs) and consolidated school districts (CSD).[18] These 29 districts enrolled a combined 326,214 students in 2018, which is about 6% of all Texas public school students. About 42.4% (138,269) of public school students across these school districts were categorized as economically disadvantaged, which is somewhat lower than the statewide rate. About 10.3% (33,533) were in special education, which is somewhat higher than the statewide rate.

The table below shows each Central Texas non-charter public school district, the county in which it is located, and its student enrollment, percentage of economically disadvantaged students, and students in special education in 2018.

[17] Texas Education Agency. Pocket Edition 2017-18 Texas Public School Statistics. https://tea.texas.gov/sites/default/files/2017-2018_Pocket_Edition_final.pdf

[18] According to the Texas Education Agency's Snapshot 2018: School District Profiles (via 'District Detail Search' at https://rptsvr1.tea.texas.gov/perfreport/snapshot/2018/district.srch.html), there are 19 charter operators in Central Texas (three in Hays, 14 in Travis, and two in Williamson) in addition to the ISDs and CSDs identified above, but we did not include these in our analysis.

Table 2: Central Texas School Districts By County, Enrollment, and Student Body Characteristics[19]

School District	County	Student Enrollment	% Economically Disadvantaged	% Special Education
Austin ISD	Travis	81,346	53.4	10.9
Bastrop ISD	Bastrop	10,863	68.8	10.7
Coupland ISD	Williamson	165	28.5	5.5
Del Valle ISD	Travis	11,169	82.2	12.0
Dripping Springs ISD	Hays	6,430	9.0	9.9
Eanes ISD	Travis	8,055	2.6	8.4
Elgin ISD	Bastrop	4,307	75.9	9.7
Florence ISD	Williamson	1,046	52.8	10.3
Georgetown ISD	Williamson	11,508	42.4	9.9
Granger ISD	Williamson	447	62.9	11.0
Hays CSD	Hays	19,788	47.5	10.8
Hutto ISD	Williamson	7,218	38.1	12.2
Jarrell ISD	Williamson	1,698	56.0	13.3
Lago Vista ISD	Travis	1,472	24.2	7.6
Lake Travis ISD	Travis	10,382	11.6	7.5
Leander ISD	Williamson	38,936	19.1	11.0
Liberty Hill	Williamson	4,013	21.8	8.1
Lockhart ISD	Caldwell	5,901	72.4	11.4
Luling ISD	Caldwell	1,427	76.3	9.0
Manor ISD	Travis	9,061	74.4	8.7
McDade ISD	Bastrop	324	62.3	9.9
Pflugerville ISD	Travis	25,269	42.5	10.6
Prairie Lea ISD	Caldwell	199	76.4	7.0
Round Rock ISD	Williamson	48,919	25.9	9.3
San Marcos CSD	Hays	8,167	68.6	11.6
Smithville ISD	Bastrop	1,781	59.9	10.0
Taylor ISD	Williamson	3,190	63.5	10.2
Thrall ISD	Williamson	696	28.3	2.3
Wimberley ISD	Hays	2,437	25.8	8.7
TOTAL		**32,6214**		

[19] Data pulled from the Texas Education Agency's Snapshot 2018: School District Profiles. https://rptsvr1.tea.texas.gov/perfreport/snapshot/2018/index.html

The districts with the highest enrollment were Austin ISD (81,346), Round Rock ISD (49,919), Leander ISD (38,936), Pflugerville ISD (25,269), and Hays ISD (19,788). Together these five districts serve about 66% (215,258) of all Central Texas public school students. This includes about 60% of all economically disadvantaged students and 67% of students in special education across Central Texas.

The districts with the lowest enrollment were Coupland ISD (165), Prairie Lea ISD (199), McDade ISD (324), Granger ISD (447), and Thrall ISD (696). Together these five districts serve less than 1% (1831) of Central Texas public school students. This includes less than 1% (879) of economically disadvantaged students and of those in special education across Central Texas.

In 15 districts, over half the enrolled population is economically disadvantaged. These districts together serve about 68% (9399) of all economically disadvantaged Central Texas students.

Table 3: Central Texas School Districts with Over Half of Enrolled Population Economically Disadvantaged

School District	% Economically Disadvantaged
Del Valle	82%
Prairie Lea	76%
Luling	76%
Elgin	76%
Manor	74%
Lockhart	72%
Bastrop	69%
San Marcos	69%
Taylor	64%
Granger	63%
McDade	62%
Smithville	60%
Jarrell	56%
Austin	53%
Florence	53%

In 18 districts, 10% or more of the enrolled population is in special education. These districts together serve about 78% (26,080) of the Central Texas students in special education.

Table 4: Central Texas School Districts with 10+% of Students in Special Education

School District	% in Special Education
Jarrell	13%
Hutto	12%
Del Valle	12%
San Marcos	12%
Lockhart	11%
Granger	11%
Leander	11%
Austin	11%
Hays	11%
Bastrop	11%
Pflugerville	11%
Florence	10%
Taylor	10%
Smithville	10%
McDade	10%
Georgetown	10%
Dripping Springs	10%
Elgin	10%

SHARS Participation and Reimbursement.[20] For the 2016-2017 school year, 846 Texas school districts and public charter schools received a combined total of $679,155,390 in Medicaid reimbursement for SHARS. This total represents the federal portion of total allowable Medicaid costs minus a 1% administrative fee that HHSC now charges SHARS-participating districts. Dallas ISD was the top Texas district by SHARS reimbursement but had the second-largest number of students in special education. Houston ISD had the largest number of students in special education but was second highest in SHARS reimbursement. The table below shows the ten districts that received the highest amount of SHARS reimbursement for the 2016-2017 school year along with the percentage and number of their enrolled students in special education.[21]

[20] Amounts for school district SHARS revenue are taken from an Excel file provided via email to CDF-T on December 17, 2019 by the HHSC Rate Analysis Department in response to an open data request (Reference No. OR-20191204-20601).
[21] Percentage of students in special education (rounded) taken from the Texas Education Agency's Snapshot 2018: School District Profiles (https://rptsvr1.tea.texas.gov/perfreport/snapshot/2018/district.srch.html) and multiplied by total students (taken from the same source) to calculate number of students in special education (rounded).

Table 5: Texas School Districts By 2017 SHARS Reimbursement

District	2017 SHARS Reimbursement	% of Students in Special Education	Number of Students in Special Education
Dallas ISD	36,622,194	8%	12,852
Houston ISD	29,220,161	7%	15,160
Northside ISD	24,877,451	12%	12,306
Austin ISD	20,148,480	11%	8,867
Cypress-Fairbanks ISD	12,200,261	8%	9,291
Pasadena ISD	10,946,996	10%	5,343
Alief ISD	10,191,898	7%	3,374
Fort Bend ISD	10,142,754	8%	5,772
San Antonio ISD	9,685,663	10%	5,216
Fort Worth ISD	8,907,130	8%	7,141

Of the 29 Central Texas districts, 26 received SHARS reimbursement for the 2016-2017 school year, totaling $49,628,894 (federal portion of total allowable Medicaid costs minus 1% administrative fee). Austin ISD was the top Central Texas school district by SHARS reimbursement as well as by number of students in special education. The table below shows Central Texas districts by SHARS reimbursement for the 2016-2017 school year along with the percentage and number of their enrolled students in special education. [22]

[22]Percentage of students in special education (rounded) taken from the Texas Education Agency's Snapshot 2018: School District Profiles (https://rptsvr1.tea.texas.gov/perfreport/snapshot/2018/district.srch.html) and multiplied by total students (taken from the same source) to calculate number of students in special education (rounded).

Table 6: Central Texas School Districts By 2017 SHARS Reimbursement

District	2016-17 SHARS Reimbursement	% of Students in Special Education	Number of Students in Special Education
Austin ISD	20,148,480	11%	8,867
Round Rock ISD	4,848,063	9%	4,549
Leander ISD	4,578,399	11%	4,283
Pflugerville ISD	4,359,307	11%	2,679
Del Valle ISD	2,553,480	12%	1,340
Hays CISD	1,696,787	11%	2,137
Manor ISD	1,519,307	9%	788
Bastrop ISD	1,407,537	11%	1,162
Hutto ISD	1,327,672	12%	881
Georgetown ISD	1,240,104	10%	1,139
San Marcos CISD	940,789	12%	947
Dripping Springs ISD	708,540	10%	637
Taylor ISD	706,952	10%	325
Eanes ISD	676,927	8%	677
Elgin ISD	617,856	10%	418
Lake Travis ISD	546,767	8%	779
Liberty Hill ISD	413,517	8%	325
Smithville ISD	362,743	10%	178
Lockhart ISD	208,656	11%	673
Wimberley ISD	183,697	9%	212
Florence ISD	148,642	10%	108
Jarrell ISD	133,966	13%	226
Lago Vista ISD	133,099	8%	112
Thrall ISD	69,398	2%	16
Granger ISD	62,668	11%	49
Luling ISD	35,541	9%	128
Coupland ISD	0	6%	9
McDade ISD	0	10%	32
Prairie Lea ISD	0	7%	14

MAC Participation and Reimbursement.[23] In calendar year (CY) 2017, 310 Texas school districts claimed a combined total of $15,512,007 in Medicaid reimbursement for MAC activities. Both the number of participating school districts and the amount of Medicaid reimbursement are significantly lower for MAC than for SHARS.

[23] All figures for school district MAC revenue are taken from an Excel file provided via email to CDF-T on December 17, 2019 by the HHSC Rate Analysis Department in response to an open data request (Reference No. OR-20191204-20601).

We noted that 316 unique districts were listed on the data file we received from HHSC but 37 did not show any claims for at least one quarter in CY 2017. Of these 37, six showed no claims in any quarter, two showed no claims in three quarters, eight showed no claims in two quarters, and 21 showed no claims in one quarter. As shown in the table below, Medicaid reimbursement for MAC activities varied very little by quarter, with a slightly higher claims total and percentage in Q4 compared to other quarters.

Table 7: Statewide MAC Claims by Quarter, CY 2017

Q1 (Jan-Mar)	Q2 (Apr-Jun)	Q3 (Jul-Sep)	Q4 (Oct-Dec)
$3,709,880 (24% of 2017 total)	$3,451,379 (22% of 2017 total)	$3,794,691 (24% of 2017 total)	$4,556,057 (29% of 2017 total)

The table below shows the ten districts with the highest MAC claims statewide in CY 2017, along with the percentage of their students that were categorized as economically disadvantaged.[24] Dallas ISD was the top district statewide by MAC claims as well as by number of economically disadvantaged students.

Table 8: Texas School Districts By CY 2017 MAC Claims

District	CY 2017 MAC Claims	% Economically Disadvantaged	Number Economically Disadvantaged
Dallas ISD	$944,338	87%	135,881
Northside ISD	$848,650	48%	102,707
Houston ISD	$689,772	75%	79,565
Fort Worth ISD	$688,475	78%	63,206
Austin ISD	$584,717	53%	62,018
Pasadena ISD	$448,651	77%	41,762
San Antonio ISD	$339,292	91%	41,924
Cypress-Fairbanks ISD	$299,700	50%	37,479
Fort Bend ISD	$273,196	37%	18,889
Pharr-San Juan-Alamo ISF	$260,984	91%	78,123

Of the 29 school districts in Central Texas, 14 claimed a total of $1,023,665 in Medicaid reimbursement for MAC activities in CY 2017 while 15 presumably submitted no claims (these school districts were not listed in the data provided by HHSC). The table below shows Central Texas school by amount of MAC claims in CY 2017, along with the percentage of their students that were categorized as economically disadvantaged.[25] The districts that were not listed in the HHSC data are shown in gray. Austin ISD was the top Central Texas district by MAC claims as well as by number of economically disadvantaged students.

[24]Percentage of economically disadvantaged students taken from the Texas Education Agency's Snapshot 2018: School District Profiles (https://rptsvr1.tea.texas.gov/perfreport/snapshot/2018/district.srch.html) and multiplied by total students (taken from the same source) to calculate number of economically disadvantaged students.
[25]Percentage of economically disadvantaged students taken from the Texas Education Agency's Snapshot 2018: School District Profiles (https://rptsvr1.tea.texas.gov/perfreport/snapshot/2018/district.srch.html) and multiplied by total students (taken from the same source) to calculate number of economically disadvantaged students.

Table 9: Central Texas School Districts By CY 2017 MAC Claims

District	CY 2017 MAC Claims	% Economically Disadvantaged	Number Economically Disadvantaged
Austin ISD	$584,717	53.4%	43,439
Pflugerville ISD	$91,183	42.5%	10,739
Leander ISD	$77,362	19.1%	7,437
Del Valle ISD	$71,949	82.2%	9,181
Round Rock ISD	$64,528	25.9%	12,670
Hays CISD	$34,277	47.5%	9,399
Manor ISD	$28,933	74.4%	6,741
Hutto ISD	$22,524	38.1%	2,750
Smithville ISD	$12,076	59.9%	1,067
Elgin ISD	$11,392	75.9%	3,269
Lockhart ISD	$8,317	72.4%	4,272
Lake Travis ISD	$6,679	11.6%	1,204
Bastrop ISD	$6,641	68.8%	7,474
Wimberley ISD	$3,086	25.8%	629
Coupland ISD	$0	28.5%	47
Dripping Springs ISD	$0	9.0%	579
Eanes ISD	$0	2.6%	209
Florence ISD	$0	52.8%	552
Georgetown ISD	$0	42.4%	4,879
Granger ISD	$0	62.9%	281
Jarrell ISD	$0	56.0%	951
Lago Vista ISD	$0	24.2%	356
Liberty Hill ISD	$0	21.8%	875
Luling ISD	$0	76.3%	1,089
McDade ISD	$0	62.3%	202
Prairie Lea ISD	$0	76.4%	152
San Marcos ISD	$0	68.6%	5,603
Taylor ISD	$0	63.5%	2,026
Thrall ISD	$0	28.3%	197

FINDINGS FROM STAKEHOLDER OUTREACH

We completed interviews with numerous stakeholders to learn more about school district participation in SHARS and MAC and identify any barriers or challenges they encounter in implementing these programs. Stakeholders interviewed included HHSC, TEA, school districts in Central Texas as well as some districts outside Central Texas that were among the top ten districts in the state by 2017 SHARS or 2016 MAC revenue, the Texas Association of School Boards, the Texas Association of School Administrators, and billing vendors.

We developed questions for each type of stakeholder (shown in Appendix B) to serve as a point of departure for discussion. Below we describe issues we identified during these discussions that present challenges for school district participation in SHARS and MAC.

SHARS Issues

Participation is Administratively Burdensome. Almost every stakeholder interviewed indicated that participating in SHARS is administratively burdensome. This includes the amount of documentation required to justify and describe the service for Medicaid billing as well as the necessity of documenting the service twice (once for the IEP, using software specific to special education services, and once for Medicaid billing). It also includes the time and documentation necessary to participate in the quarterly Random Moment Time Study, which is required for all individuals providing SHARS services for which the school district will bill Medicaid. Stakeholders indicated that the administrative burden associated with SHARS participation takes time away from direct service provision.

Obtaining Parental Consent to Bill Medicaid Can Be A Challenge. Federal regulations at 34 CFR §99.30 for the Family Educational Rights and Privacy Act (FERPA) and 34 CFR §300.622 for IDEA Part B require public agencies (which includes school districts) to obtain parental consent before they can release identifying information from the child's education records for purposes of billing a public benefits or insurance program (such as Medicaid) for the first time. Typically, districts seek parental consent at ARD meetings, through school representatives who educate and provide required notice to parents about consent requirements. Many stakeholders indicated that obtaining parental consent can be a challenge.

In some cases, schools have ***difficulty reaching the parent to obtain consent***. For example, parents may not participate in ARD meetings (which is the primary forum through which school representatives educate parents about and request consent) or may be difficult to locate or contact. A stakeholder from a Title 1 district cited issues related to high numbers of families living in poverty or near poverty that impact school ability to obtain consent (such as lack of current contact information for families that move frequently and the low priority of completing school paperwork for families operating from a place of constant crisis).

TEA reportedly limits school ability to outreach broadly to educate about and obtain consent. A stakeholder indicated that TEA prohibits sending Medicaid consent information to all students or providing it to all students evaluated for an IEP and requesting parental consent at that time. This can have the effect of reducing district ability to obtain Medicaid reimbursement for all SHARS services they provide. The school must provide services on the IEP regardless of whether they can receive reimbursement from another source but can only bill for Medicaid reimbursement after the parent has provided consent. If a child's IEP includes services that are covered by SHARS and the child is later determined to be Medicaid eligible with retroactive coverage for a period of time prior to the determination, the district may not bill for SHARS services provided prior to the date of the parent's consent.

Another challenge, which was most frequently cited, is that ***some parents refuse to give consent or rescind consent***. Stakeholders described two main reasons why parents refuse or rescind consent:

- Misunderstanding the impact of SHARS billing on the services their child receives outside of school. Some parents reportedly believe that if Medicaid reimburses the school for SHARS services for their child, other Medicaid services received outside of school (such as long term services and supports) will be reduced. Stakeholders indicated that parents may hear this information from parents and advocates as well as Medicaid providers (such as therapy or home health providers).
- Desire to avoid Medicaid billing parent's private insurance. Some stakeholders reported that parents have received notifications that Medicaid has billed their private insurance. Federal Medicaid regulations require that Medicaid be the payer of last resort (with a few exceptions) and that third parties with a legal obligation to pay for care for a Medicaid beneficiary pay claims before Medicaid pays. According to stakeholders interviewed, HHSC only began attempting to collect third party liability amounts for SHARS services about two years ago. This reportedly caused confusion and concern among parents and impacted parent willingness to provide consent.

Districts Do Not Fully Understand Documentation Requirements and What is Billable for Some Services. Many stakeholders noted a lack of district and/or staff understanding of what is billable to Medicaid. Personal care services (PCS) appear to be the primary area of confusion although transportation was also raised by more than one stakeholder. Stakeholders described inconsistencies in guidance provided by TEA and HHSC that cause confusion, such as receiving training from one agency that is contradicted by the other agency during audits (both TEA training contradicted by HHSC auditors and HHSC training contradicted by TEA auditors was noted).

Training and Assistance Does Not Adequately Support District Ability to Understand and Comply with Requirements. Stakeholders expressed multiple ways in which training and assistance provided by HHSC and TEA does not meet their needs.

Inconsistency between HHSC and TEA was most frequently cited as an issue. Several stakeholders indicated that they rely on HHSC training and guidance and either do not take trainings provided by TEA or ignore guidance provided by TEA that conflicts with HHSC training and guidance. One stakeholder noted that HHSC and TEA currently coordinate on training and guidance more than they ever have but that this has not cleared up all inconsistency.

In-person training was described as dry, rote, and the same year after year, which stakeholders indicated does not engage individuals taking the training, particularly those required to take the training regularly. Online training seems to be perceived as helpful for basic information but does not allow for obtaining information tailored to a specific district's needs. One positive comment came from a district representative who invites a SHARS representative to provide training on campus each year. This has allowed the district to ask questions and receive detailed information from the SHARS representative around areas of confusion, improving staff understanding of requirements.

We asked some stakeholders about the PCS training presentation developed by HHSC in 2018 and whether it improved their understanding. Those we asked indicated they were aware but that the presentation does not clear up all confusion. One stakeholder commented that the presentation mirrored what is in the Texas Medicaid Provider Procedures Manual (TMPPM) but that onsite TEA audit staff continued to provide conflicting guidance.

Some feedback indicated that TEA phone support for district questions has improved but that it remains difficult to connect to a live voice at TEA for questions. We also were told that it is much easier to reach HHSC via phone and that HHSC responded to messages more quickly than TEA does.

MAC Issues

Participation is Administratively Burdensome and Often Viewed as Not Worth The Effort. Stakeholders agreed that MAC participation is administratively burdensome and some districts do not participate because they do not believe the amount of reimbursement they might receive justifies the work involved in meeting participation and billing requirements. Some indicated that HHSC has made changes in recent years that have alleviated some of the burden (such as implementation of STAIRS for submitting financial information) and that some districts that opted out of participation due to administrative burden are not aware of these improvements. Still, stakeholders believe documentation and RMTS requirements remain burdensome.

Understanding of MAC Varies. Some stakeholders indicated that district staff on participation lists do not always understand what MAC is and why it is important for them to comprehensively document their MAC time during the RMTS. Some staff misunderstand the program and believe it only covers activities performed for a child receiving SHARS services.

Training Does Not Adequately Support District Ability to Understand and Comply with Requirements. Similar to input about SHARS training, some stakeholders indicated that HHSC training on MAC is rote and not engaging. We received input that the training is not sufficient to ensure understanding of the program and how it differs from SHARS. One stakeholder indicated that the HHSC training is provided in a train-the-trainer format but that HHSC doesn't provide what they need to go back and train district staff.

Districts Perform Very Few of the Types of Activities That May Be Reimbursed Under MAC. The Medicaid School-Based Administrative Claiming Guide[26] developed by CMS to provide guidance and requirements for Medicaid Administrative Claiming provides a lengthy list of examples of activities that can be reimbursed under MAC. The Texas list of examples of MAC-allowable activities (provided in Appendix C) has a few differences but closely mirrors the federal list. Stakeholder input suggests that most districts only provide a few of the activities provided as examples and that the majority of allowable activities are not being provided. To determine volume of MAC-allowable activities, we requested activity codes from HHSC but had not received them by the time this report was completed.

DISTRICT IDENTIFICATION OF STUDENT INSURANCE STATUS

A key goal of this project was to identify ways to support and expand the ability of school districts to identify Medicaid and CHIP-eligible children and connect them to eligibility determination for enrollment. As noted above and described in the list of MAC-allowable activities in Appendix C, school districts may receive Medicaid reimbursement for a variety of activities related to outreaching to potentially eligible children and their families and facilitating their enrollment in Medicaid and CHIP.

Our interviews with stakeholders indicate that some school districts do outreach and enrollment activities but that most MAC activities fall into other categories and are targeted to students receiving SHARS services rather than to the overall student body. Our interviews also suggest that it is primarily larger districts with more resources that do outreach and enrollment activities. Some

[26]https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidBudgetExpendSystem/Downloads/Schoolhealthsvcs.pdf

stakeholders discussed partnerships districts have with community organizations that perform outreach and enrollment activities on school property or at school events, which alleviates burden on the school. More than one district representative interviewed indicated interest in increasing their outreach and enrollment activities if sufficient staff were available.
One way schools can identify potentially Medicaid/CHIP-eligible students is by identifying those who are uninsured. We surveyed all the Central Texas school districts to determine whether they currently ask a question about student insurance status on any enrollment or health information forms sent to the entire student body. Of the 29 districts, only seven indicated they do so and only one (Austin ISD) described how they use this information. Austin ISD indicated that they use information about student insurance status on enrollment forms to identify campuses with high numbers of uninsured students. The district also combines this information with other data to create robust geo-mapping of the health needs of their students, which is used to target services.

PROMISING OPPORTUNITIES TO EXPAND SCHOOL-BASED HEALTH SERVICES

Our goal to expand the identification of Medicaid and CHIP-eligible children and facilitate program enrollment, discussed above, is closely related to and supports another goal of this project: to expand children's access to needed health care services during the school day. In the course of our research we identified two opportunities Texas could leverage to fund an expanded provision of Medicaid services in schools and additional outreach and enrollment facilitation activities.
We discuss each of these below, followed by an example of work already done in Texas which can serve as a foundation for expanding outreach and enrollment facilitation activities by schools.

Expanding Provision of Medicaid Services in Schools: Free Care Rule Reversal

In 1997, CMS published guidance[27] regarding Medicaid reimbursement to schools for provision of Medicaid-covered services to students. This guidance, which was incorporated into other federal Medicaid guidance documents on school health and administrative claiming, introduced the "free care rule" which prohibited schools from seeking Medicaid reimbursement for health services provided to Medicaid beneficiaries if the services were available to Medicaid-ineligible students without charge or pursuit of third party liability for the cost of the services. The guidance included an exception for services provided under an IEP.

In 2004, Oklahoma challenged the free care rule to the Department of Health and Human Services Departmental Appeals Board (DAB). The DAB determined that the free care rule was "not an interpretation of any provision of the [Social Security] Act nor indeed of any regulation implementing a provision of the Act"[28], effectively rescinding the rule. However, CMS did not immediately alert states of this change or revise guidance on billing for school health services in alignment with the DAB ruling.

In 2014, the American Federation of Teachers, National Education Association, the Healthy Schools Campaign, Trust for America's Health, the School-Based Health Alliance, the National Association of School Nurses, and the Childhood Asthma Leadership Coalition asked the Departments of Education and Health and Human Services to clarify the free care rule reversal.[29] While the

[27] CMS. Medicaid and School Health: A Technical Assistance Guide. August 1997. https://www.medicaid.gov/medicaid/finance/downloads/school_based_user_guide.pdf
[28] Department of Health and Human Services Departmental Appeals Board. Docket No. A-03-79 Decision No. 1924. June 14, 2004. https://www.hhs.gov/sites/default/files/static/dab/decisions/board-decisions/2004/dab1924.htm
[29] https://www.aft.org/linking-childrens-health-education/access/free-care-rule

Department of Education did not issue a clarification to schools, CMS issued a letter to state Medicaid Directors withdrawing the free care rule guidance and clarifying that:

"…Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, Federal Financial Participation (FFP) is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met." [30]

Since 2014, several states have taken steps to expand Medicaid reimbursement for school health services in light of the free care rule reversal. Some states must seek CMS approval of a state plan amendment (SPA) to do so as the free care rule is incorporated directly or indirectly into their state plans, while some may not need a SPA but require legislative and/or regulatory changes to free care rule-related restrictions in their statutes and/or regulations.[31]

Below we summarize how other states have responded to the free care rule reversal and how Texas could take advantage of this opportunity to expand Medicaid reimbursement for school health services.

States That Have Expanded Medicaid in Schools. Community Catalyst, Trust for America's Health, and Healthy Schools Campaign have developed and periodically update a briefing document (state activity brief) on the actions states have taken to expand Medicaid reimbursement to schools.[32] As of December 2019, the state activity brief shows:

- Eight states have received approval for a SPA to reverse the free care rule.
- Two states have submitted a SPA and are awaiting CMS approval.
- Two states are considering a SPA.
- Two states have expanded Medicaid reimbursement for school health services and did not need a SPA to do so.
- Four states have passed legislation to expand Medicaid reimbursement for school health services and two are pursuing legislation to do so, although for three of these states the legislation is unrelated to free care rule reversal.

The table below presents summaries of state activity related to free care rule reversal taken from the December 2019 update of the state activity brief.

[30] CMS SMD# 14-006, Medicaid Payment for Services Provided without Charge (Free Care). December 15, 2014. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf
[31] National Health Law Program. Medicaid's "Free Care Policy:" Results from Review of State Medicaid Plans. October 20, 2016. https://healthyschoolscampaign.org/wp-content/uploads/2017/07/MedicaidFreePolicyCare.revd_.10.20.pdf
[32] Community Catalyst, Trust for America's Health, Health Schools Campaign. State Efforts to Implement the Free Care Policy Reversal. Last updated December 2019. https://docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXlGX5l3s0PN2cuIDejX-ZQw/edit

Table 10: Status of State Efforts to Implement Free Care Rule Reversal[33]

State	Status
CA	Passed state legislation and submitted SPA to CMS to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students and add additional services.
CO	Testing financial impact of expanding Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.
FL	SPA approved to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.
GA	SPA submitted to expand reimbursement for school nursing services delivered to all Medicaid-enrolled students.
KY	Considering a SPA to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.
LA	SPA approved to expand reimbursement for school nursing services to all Medicaid-enrolled students.
MA	SPA approved to expand reimbursement to all Medicaid-enrolled students and expand the scope of covered school services. State legislation pending that addresses reinvestment of school-based Medicaid revenue.
MI	SPA submitted to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.
MO	State policy adopted that expands Medicaid reimbursement to include behavioral health services delivered to all Medicaid-enrolled students.
NC	SPA approved to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students and expand the scope of covered services.
NH	Legislation passed in 2017 to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students. State has yet to publish final rules needed to implement this expansion.
NV	Considering a SPA to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.
SC	Expanded Medicaid reimbursement to include services delivered to all Medicaid-enrolled students (no SPA needed).
UT	Passed legislation to expand Medicaid reimbursement to include services delivered to all Medicaid-enrolled students.

We contacted several of these states to obtain more detailed information on their efforts. We received information from the following states.

- **Georgia**. The SPA would allow schools to receive Medicaid reimbursement for nursing services provided outside of an IEP but the state is considering other services that could be covered such as medication administration. The state is working with a consultant (including looking at other states' processes) to develop a process for Local Education Agencies to direct bill Medicaid for services, including how to meet requirements that Medicaid claims include a diagnosis code approved by a physician.

[33] Community Catalyst, Trust for America's Health, Health Schools Campaign. State Efforts to Implement the Free Care Policy Reversal. Last updated December 2019. https://docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXlGX5l3s0PN2cuIDejXZQw/edit

- **Missouri**. In 2018, the state expanded Medicaid reimbursement for behavioral health services provided in schools to all children, not just those with an IEP. Schools bill the fee-for-service system for services provided under and IEP, and the state's contracted Medicaid managed care organizations for services provided outside of an IEP. (See call out box below for more information on the expansion process in Missouri.)
- **Nevada**. The state received approval for its SPA in October 2019. It is in the process of drafting policy to implement the change, which is expected to be released for public comment in December 2019 and published as final in late March 2020 (with ability for schools to bill under the new policy retroactive t expanded the documentation options schools can use as a basis for providing Medicaid reimbursable services beyond the IEP to include an Individual Family Service Plan (IFSP), a section 504 Accommodation Plan, an Individual Health Plan (IHP), and a Behavior Intervention Plan (BIP). Vision and hearing screening were also added as reimbursable services.
- **South Carolina**. The state provides Medicaid reimbursement for:
  - Rehabilitative Therapy Services provided under IEP, IFSP, or an EPSDT examination that identifies the need for the services.
  - Orientation and Mobility Services provided under an IEP or IFSP.
  - Medically necessary Rehabilitative Behavioral Health Services provided to any Medicaid-eligible student with a confirmed psychiatric diagnosis from the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (excluding irreversible dementias, intellectual disabilities or related disabilities, and developmental disorders unless they co-occur with a serious behavioral health disorder that meets the current edition DSM criteria).

Expanding Medicaid Reimbursement for School-Based Behavioral Health Services in Missouri

Missouri's expansion of behavioral health (BH) services in schools was the result of an intensive, collaborative stakeholder process initiated and led by the Missouri School Board Association (MSBA) in response to the significant unmet student need for BH services identified in 2016 by MSBA's School-Based Health Center Task Force.

The Task Force was initially comprised of a diverse group of school districts from across the state. It was expanded to include leadership and policy staff from the state's health and human service agencies as well as community providers. Task Force participants met for a full day each quarter for over two years to explore options and barriers to increase school-based services and identify ways to align their efforts toward a common goal of improving access to BH services in schools. MSBA partnered with the School-Based Health Alliance, a non-profit organization that provides national advocacy for school-based health care, to educate participants about options for providing school-based BH services.

As a result of these efforts, the state amended the SMP and adopted a policy allowing community BH providers to provide BH services in schools when the school determines it is appropriate and expanding Medicaid reimbursement to schools for BH services provided to Medicaid-enrolled children without an IEP. MSBA convened another stakeholder workgroup to develop detailed guidance and resources to help schools understand the new policy and how to implement it. This guidance (along with a summary of MSBA's efforts) is available on MSBA's website at https://www.mosba.org/behavioral-health.

Texas Opportunity to Expand Medicaid Reimbursement for School Health Services. In 2016, the National Health Law Program (NHeLP) obtained the State Medicaid Plans (SMPs) and other Medicaid documents of 43 states and the District of Columbia to identify those with provisions that directly or indirectly prohibit reimbursement of schools for services provided free of charge to Medicaid beneficiaries and others.

NHeLP's multi-state review included Texas. NHeLP determined that Texas' SMP incorporates provisions related to reimbursement of schools for EPSDT services but that these provisions likely do not constitute a direct barrier to Medicaid coverage of other services. NHeLP noted that the SMP includes:

> *"Many references to school health services being covered, without reference to IDEA, but description of reimbursement methodology indicates that Medicaid pays only for children with IEPs. Not a barrier itself, but indicates policy that is a barrier."*

HHSC staff provided us with the most recent (2006) CMS-approved language in the SMP that addresses Medicaid reimbursement for school health services. We validated NHeLP's conclusion that the SMP restricts Medicaid reimbursement under the SHARS program to specified EPSDT services provided to Medicaid beneficiaries with an IEP:

- The methodology described in the section (17.A.6) for determining the Medicaid portion of the total net cost of providing ESPDT services includes the use of IEPs in the calculation: "The results of the previous step [addition of net direct and indirect costs to determine total net cost] are multiplied by the ratio to the total number of students with IEPs receiving medical services and eligible for Medicaid to the total number of students with IEPs receiving medical services."
- Similarly, the methodology described in the section (17.B.3) for determining the Medicaid portion of the total direct costs for covered transportation services includes the use of IEPs in the calculation: "Adjusted direct costs from item 2 above [total direct costs for covered transportation services less any federal payments for those costs] are then allocated to Medicaid by applying the ratio of one-way trips provided pursuant to an IEP to Medicaid beneficiaries over total one-way specialized transportation trips."

We discussed the free care rule reversal with HHSC staff. We learned that HHSC considered the federal policy change when CMS sent revised guidance to states in 2014 and that one school district approached HHSC to discuss its interest in expanding Medicaid reimbursement to include services beyond those provided under an IEP. However, HHSC concluded that legislative direction was needed to make any SMP change that would have a fiscal impact. To the knowledge of staff to whom we talked, HHSC has not undertaken additional consideration of any policy changes to reflect the free care rule reversal since that time.

Our interviews with Texas school district representatives found that almost all were unaware of the free care rule reversal and the opportunity for reimbursement expansion. However, all indicated at least some level of interest in providing additional health services if Medicaid reimbursement were made available. Almost every district representative we interviewed indicated that mental health is a top unmet health need in their district and interest in providing or expanding mental health services if Medicaid reimbursement were available. Other unmet health needs district representatives noted and expressed interest in pursuing if Medicaid reimbursement were available include nursing, medication administration, and immunizations.

Additionally, many district representatives indicated the need to expand Medicaid reimbursement for services provided under a 504 plan. House Bill 706 (86th Legislature), which went into effect on September 1, 2019, expands SHARS to include audiology services provided under a 504 plan. An HHSC representative indicated to us in January 2020 that HHSC is still in the process of determining whether a SPA is required to implement this change.

CHIP Health Services Initiatives

In the course of our research into best practices in school-based services to CHIP and Medicaid eligible students we also learned about a flexible funding opportunity that Texas is not currently utilizing: CHIP Health Services Initiatives.

A CHIP Health Services Initiative (HSI) is a program or project designed to improve the health of low-income children under age 19 who are eligible for Medicaid or CHIP, although a state's HSI may benefit all children within a state regardless of income. States can use HSIs to cover the costs of direct services or to support public health priorities, such school-based health services and supports, outreach and enrollment to children potentially eligible for CHIP or Medicaid, immunization services, the operation of poison control centers, or intensive lead screening promotion and lead abatement. HSIs provide states flexibility and a chance to experiment. Since states are not required to execute HSIs on a statewide basis, they can target communities or populations that might reap particular benefits from the HSI, or they can pilot new ideas and approaches to delivering quality healthcare. States can fund multiple projects with a wide range of purposes. As of February 2019, 24 states had 71 HSIs approved in their CHIP state plans.[34]

Federal rules define HSIs as activities that protect the public health, protect the health of individuals, improve or promote a state's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children, including targeted low-income children and other low-income children (42 CFR 457.10).

States seeking to implement HSIs must submit a state plan amendment describing the populations served and how the HSI will improve children's health, as well as an updated CHIP program budget. States must also provide assurances that they will not supplant or match CHIP federal funds with other federal funds (CMS 2017a). The Centers for Medicare & Medicaid Services (CMS) works closely with states to define and refine HSIs prior to the formal submission of state plan amendments, which facilitates the review process.

Funding HSIs. Under CHIP, states can use up to 10% of the amount they spend on health coverage for program administration and other non-coverage activities. States must prioritize administrative funding for necessary programmatic expenditures, including eligibility determinations and renewals, contract negotiations, performance measurement, and other activities to meet regulatory requirements. However, they also can use a portion of administrative funds for outreach activities to identify and enroll eligible children in the program and for the implementation of an approved HSI.

The federal matching rates for CHIP-funded activities are advantageous to states. For Texas, the CHIP matching rate for FY2020 is 84%. It appears that the state has significant room under the 10% cap to draw down funding to support HSIs. An analysis of CMS expenditure data by the Center for the Study of Social Policy and Manatt shows that Texas could draw down more than $103 million in federal match with state expenditures of less than $20 million,[35] resulting in more than $120 million available to support HSIs.

Use of HSIs in Other States. While states use HSIs for a wide variety of purposes, a number of programs are focused on school-based initiatives. Below we provide examples of how other states are using HSIs to provide services in schools. Supplementary information on HSIs is provided in Appendix D.

[34] https://www.macpac.gov/wp-content/uploads/2019/07/CHIP-Health-Services-Initiatives.pdf
[35] https://cssp.org/wp-content/uploads/2019/06/Medicaid-Blueprint.pdf

Florida: School-based Health Services and Supports. This HSI targets schools with high rates of teen birth, substance abuse, and other high-risk behaviors and schools with high numbers of medically underserved students. Services include:

- Nursing assessments
- Individualized health care plan development
- In-school care management for chronic and acute health conditions
- Medication administration
- Vision, hearing, scoliosis, and development screenings
- Interventions and classes to promote student health; reduce high-risk behaviors and their consequences (e.g., substance abuse, unintentional and intentional injuries, and sexually transmitted diseases); prevent pregnancy; and, provide support services to promote return to school after giving birth.

Idaho: Healthy Schools Program. This HSI targets low-income pre-kindergarten through 12th grade students in 16 school districts. It provides financial support to a state program that funds the salary expenses of registered nurses working in schools to help increase the nurse to student ratio. By increasing the ratio, the state hopes to increase provision of services such as preventive services for low-income children in school settings.

Massachusetts: The Essential School Health Services Program. This program provides funding to eligible school districts to provide school-age children access to a school health service program that includes nursing assessment/health education; medication management; and screenings with respect to posture, height and weight, hearing, oral health, and vision.

Missouri: Health-Related Services. This HSI supports Local Public Health Agencies (LPHAs) in providing health-related services in schools and pre-schools including health education, screenings, maintenance of health records, basic nursing services and referrals as needed to other health care providers. These services are distinct and different from the services provided in schools as part of special education services authorized under the Individuals with Disabilities Education Act.

Example of Expanding Outreach and Enrollment Activities: All Healthy Children Initiative

From April 2013 through July 2016, the Children's Defense Fund of Texas (CDF) and the School Superintendents Association (AASA) conducted the All Healthy Children initiative to explore how schools could implement best practices in child health outreach and enrollment. The initiative, funded by Atlantic Philanthropies, supported three Texas school districts (Alief, Houston, and Edinburg) and seven California school districts to enroll uninsured children in the Medicaid, CHIP, or other health coverage and promote the important role of health coverage and good health in student educational performance.

The goals of the initiative were to:

1. Increase the capacity of school districts to systematically incorporate sustainable child health outreach and enrollment activities into routine school district operations.
2. Identify uninsured children in the targeted districts and link them to health insurance coverage during the 2014-2015 and 2015-2016 school years.

Outcomes. The initiative successfully:

- Increased school district capacity to incorporate children's health outreach and enrollment into routine school district operations
- Enrolled more than 6,400 children in health insurance over the three years.

- Created permanent systemic change by integrating enrollment models in schools that reach students with health coverage; and
- Targeted dissemination of project findings to networks of CDF and AASA to encourage schools and school districts across the country to institutionalize these issues.

Development of the Insure All Children Toolkit. The culminating activity of the initiative was the creation of a toolkit to help other school districts connect their uninsured students with health coverage. The Happy, Healthy, Ready to Learn: Insure All Children! toolkit offers school districts, school and community leaders, child advocates, and parents a clear set of steps, useful tools, tips, and lessons-learned from school districts and communities that have worked to ensure that classrooms and neighborhoods are filled with healthy, educated, well-rounded, productive, contributing members of society.

The toolkit, which is available as both a downloadable PDF as well as an interactive website (http://www.insureallchildren.org), has five sections that break down the major steps necessary to establish and implement a systematic process for outreach and enrollment facilitation: Build Your Team, Identify Uninsured Children, Reach Out, Enroll Children by Engaging Partners, and Sustain for the Future. Each section outlines specific tasks for school district administrators and staff to successfully implement the step, detailing why the step is important, who are the key players in planning and implementing it, and how to accomplish the task.

A critical first step for schools interested in doing more to ensure uninsured students are connected to affordable health coverage options is to identify them. Schools participating in the Insure All Children agreed to 1) add a question about insurance status on all enrollment forms; and 2) develop a process to reach out to families with uninsured children and (EDIT)/or refer them partner organizations (like CDF) for enrollment assistance.

Below is an example of the type of questions that schools included on enrollment and registration forms for students (asking these questions in other languages is encouraged).

Does your child have health insurance?
☐ Yes ☐ No ☐ I don't know

If you checked "No," your child may be eligible for low-cost health insurance through Medicaid or the Child Health Insurance Program (CHIP).

☐ Please check this box to get more information or assistance in obtaining health insurance for your child(ren).
☐ Check this box if you would like assistant with renewing your child's health insurance.

I give (*School District/Community Health Enrollment Partners*) consent to contact me with more information.

Parent/Guardian Signature: _____ Phone:_____ Date: _____

RECOMMENDATIONS

Many schools in Texas receive Medicaid dollars for providing direct health care services that enable Medicaid-enrolled students to access a free and appropriate public education. However, the requirements schools must abide by to receive those dollars can be complicated to understand and follow and Texas is not taking full advantage of new federal policy that expanded allowable Medicaid reimbursement for school-based health services. In addition, many schools are not maximizing their use of available Medicaid funds for outreach and enrollment activities that would connect more uninsured students to sources of health care coverage. Lastly, Texas has yet to take advantage of the program flexibility and generous matching rate available under the CHIP Health Services Initiative.

What follows are a set of recommendations that can improve and expand how the Medicaid and CHIP programs can be better utilized to provide health care services to students and all Texas children.

Supporting and Expanding Health Services Provided by School Districts

- Convene a working group of state agency staff and school-district health personnel to review the current administrative requirements and processes in both the SHARS and MAC programs to identify and implement ways to streamline the programs and improve training for school district staff.
- Create a "User Guide" for the MAC program to provide examples of the full range of services that can be supported with models for schools to adopt.
- Create better educational and outreach materials for parents about the benefits of services under the SHARS program.
- Provide clearer reassurances that parental consent to bill Medicaid for those services will not negatively affect other Medicaid benefits and clarify how Medicaid billing interacts with private insurance.
- Rescind the TEA policy that prohibits broader outreach to parents about consent for Medicaid billing for IEP required services.
- Align and clarify conflicting information from TEA and HHSC about the full range of services that schools can bill under the SHARS program.
- File a State Plan Amendment (SPA) to take full advantage of new flexibility to expand health and mental health services to all Medicaid-eligible students due to federal reversal of the Free Care Rule.
- Expand allowable Medicaid reimbursement for school nursing, medication administration, and immunizations.
- File a State Plan Amendment to implement one or more HSI projects, with at least one focused on school-based health and mental health services and/or focused on specific regions or demographic groups.

Increasing School District Activity to Identify and Enroll Potential Medicaid/ CHIP-Eligible students

- Improve current MAC processes to specifically emphasize that funding can be used to identify uninsured students and connect them to affordable health coverage.
- Expand school-based outreach and enrollment activities (e.g. adding an insurance status question to all enrollment forms, develop a process for collecting the data and referring – or directly assisting - parents with uninsured children in accessing affordable coverage – see toolkit for schools at www.insureallchildren.org).
- Utilize CHIP administrative funds to support school-based outreach and enrollment activities.


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APPENDIX A:
SCHOOL DISTRICTS INTERVIEWED

Central Texas Districts

We reached out to the majority of the Central Texas districts. Some did not return phone calls and emails. Of those we reached, two declined to participate, and several requested that we send questions via email but did not send a response. We were able to complete interviews (either in person or via phone) with the following districts:

- Austin ISD
- Bastrop ISD
- Elgin ISD
- Florence ISD
- Hays ISD
- Lake Travis ISD
- Taylor ISD (represents a co-operative that incorporates Coupland, Granger, and Thrall ISDs
- Thrall ISD

We surveyed all Central Texas districts to determine whether they currently ask a question about student health insurance status on any enrollment or health information forms they require for all students.

Districts Outside Central Texas

We reached out to nine districts outside Central Texas that were among the top 10 districts statewide for either 2017 SHARS or 2016 MAC revenue. Two did not return phone calls and two requested that we send questions via email but did not send a response. We were able to complete phone interviews with the following districts:

- Alief ISD
- Dallas ISD
- Garland ISD
- Pharr-San Juan-Alamo ISD
- San Antonio ISD

APPENDIX B:
STAKEHOLDER QUESTIONS

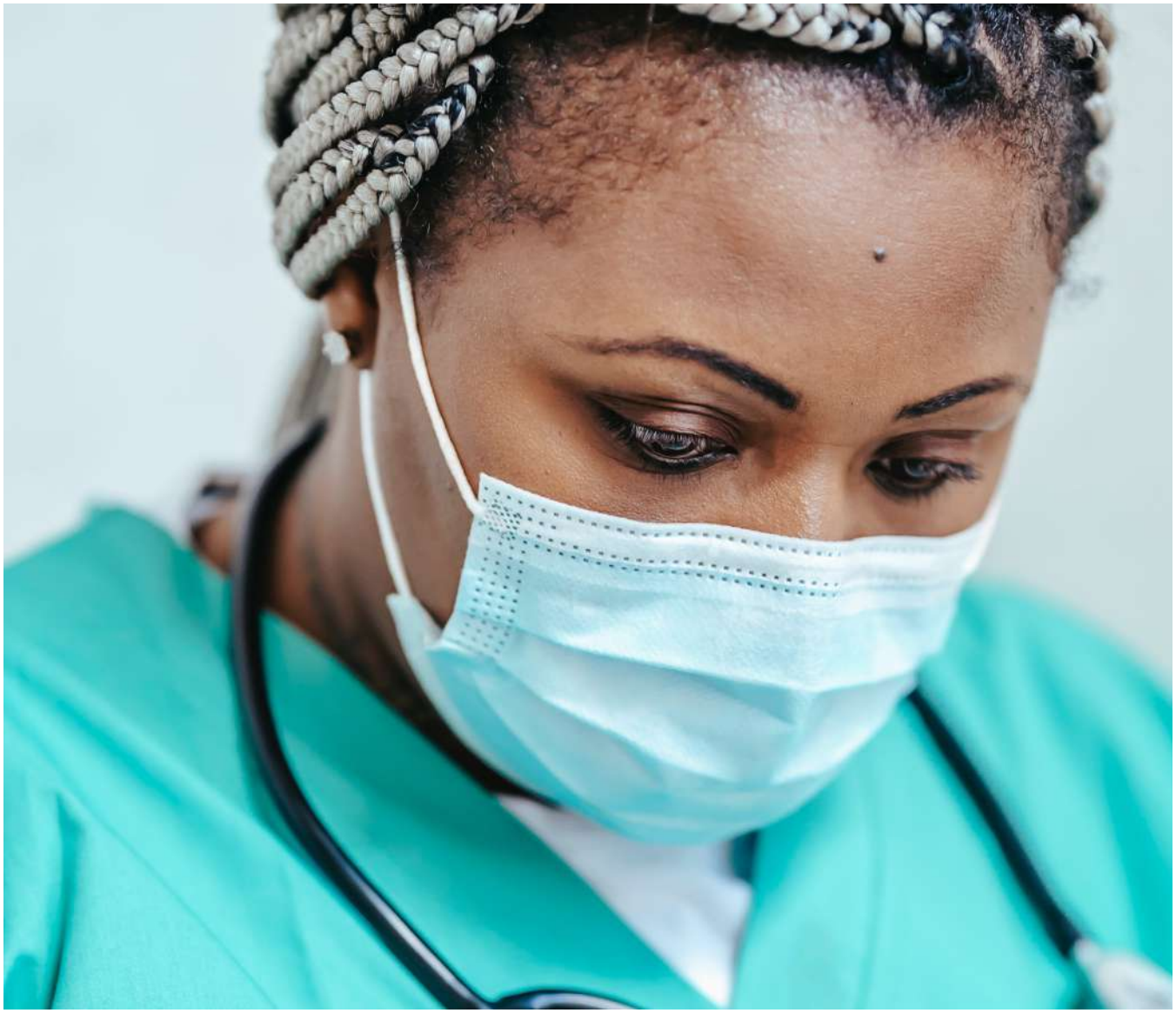
School District Questions	
SHARS	1. Do you know what percentage of your students have an IEP that includes Medicaid-covered services? Of those, what percentage do you bill Medicaid for? 2. What issues, if any, do you experience in providing Medicaid services to students with an IEP? What types of changes, if any, would make it easier for you to provide services and bill the SHARS program (such as policies, training, etc.)? 3. How big an issue is it to obtain parental consent needed for SHARS billing? What are the barriers? What strategies do you use to obtain consent? What strategies been the most helpful? 4. Do you contract with any local health/mental health entities (such as FQHCs/CMHCs) or Medicaid MCOs to provide or coordinate services?
MAC	1. Does your district participate in MAC now? Has/how has your participation in MAC changed over time? 2. What barriers, if any, are there to getting MAC reimbursement? Are the rules, policies, etc. clear? Do they make it easy to participate? If not, what should be changed to make it easier? 3. What types of staff are on your MAC participation list? 4. What MAC-reimbursable activities does the district engage in? How much of your MAC activity involves referring students to Medicaid eligibility? How much is more related to coordinating Medicaid services, and what types of coordination do you do?
OTHER	1. In your opinion, what are the top unmet health-related needs in your district for all students, not just those with an IEP? 2. In 2014, federal regulation changed so that states can reimburse schools for Medicaid services provided to students outside of an IEP. In some states, making this change requires a Medicaid State Plan amendment and/or changes to state regulation. Some states have made such changes and now permit schools to be reimbursed for some Medicaid services provided to students without an IEP. If Texas reimbursed for health services provided outside of an IEP, what services would your ISD consider providing?

Billing Vendor Questions	
VENDOR LANDSCAPE AND PROCESSES	1. HHSC sent us a list of 8 vendors – Houston ISD, Intel Med Electronic Management, Lone Star Education Billing Services, Medicaid Claim Solutions, MSB, TASB, T&G, and TSBS. To your knowledge, are there others? Are you familiar with Intel Med (we were unable to find a website or contact information)? 2. Do you know which vendors have the largest market share statewide? Dominate the market in certain geographic locations? Serve only certain types of districts (such as in a single geographic area, only urban districts, only rural districts, etc.)? 3. How do vendors charge for their services? (For example, flat fee based on enrollment, percentage of submitted claims?) Does this differ for SHARS and MAC? 4. Do all vendors offer client districts an electronic system for entering claims? Do districts directly enter data into the vendor system or upload from their own system? Does this differ for SHARS/MAC? 5. What administrative or other challenges, if any, currently exist that impede vendor ability to adequately support school districts in billing SHARS/MAC?
SHARS	1. Are districts maximizing their ability to provide SHARS services under current regulations/procedures? If not, what are the barriers? 2. What current regulations/procedures, if any, impede district ability to serve as many SHARS-eligible children as possible? 3. Are your client districts fully aware of the 2014 changes to the "Free Care Rule" that allowed for a broader set of services billable to Medicaid?
MAC	1. In your experience, what types of staff constitute the largest volume of district billing for MAC? 2. Are you aware of any common types of activities districts bill MAC for? Any that are not common but one or more districts bill for? 3. Are districts maximizing their ability to perform MAC activities under current regulations/procedures? If not, what are the barriers? 4. Are there differences in the types of districts or campuses that are using MAC versus those that do not (such as urban versus rural, certain parts of the state, district or school administrator interest in the program, etc.)? 5. What current regulations/procedures, if any, impede district ability to use MAC to identify and assist Medicaid-eligible and potentially Medicaid-eligible children to obtain coverage and access needed health care services?

TEA Questions	
	How do TEA and HHSC work together to coordinate program oversight?
SHARS	1. Are districts maximizing their ability to provide SHARS services under current regulations/procedures? If not, what are the barriers? 2. What current regulations/procedures, if any, impede district ability to serve as many SHARS-eligible children as possible? 3. Are you aware of any changes to SHARS policy that have been considered at TEA or HHSC based on 2014 changes to the "Free Care Rule" that allowed for a broader set of services billable to Medicaid?
MAC	Does TEA do anything to encourage/support schools to use MAC to identify and support Medicaid (or CHIP) eligible students to enroll so that districts can access SHARS for those who need/are using those services?

HHSC Questions	
SHARS	1. How do most districts use SHARS? Which services constitute the largest volume of district billing for SHARS? 2. What creative/innovative uses of SHARS are you aware of? 3. Are districts maximizing their ability to provide SHARS services under current regulations/procedures? If not, what are the barriers? 4. What current regulations/procedures impede district ability to serve as many SHARS-eligible children as possible? 5. According to the participation report on HHSC's website, there are six districts that participate in MAC but not SHARS. Why do you think these districts don't participate in SHARS?
MAC	1. How do most districts use MAC? Which services constitute the largest volume of district billing for MAC? 2. What creative/innovative uses of MAC are you aware of? 3. Are districts maximizing their ability to provide MAC services under current regulations/procedures? If not, what are the barriers? 4. What current regulations/procedures impede district ability to provide MAC services to Medicaid-eligible and potentially Medicaid-eligible children? 5. According to the participation report on HHSC's website, about two-thirds of school districts participate in SHARS but do not participate in MAC. Why do you think these districts don't participate in MAC?

BILLING VENDORS	1. How many vendors in Texas support school districts in SHARS and/or MAC billing? 2. Is any registration or certification required? For example, do you have to register with TMHP to submit billing on behalf of districts? If so – is there a master list of all registered/certified vendors? 3. Which billing vendors have the largest market share? 4. Do different billing vendors serve specific types of districts (large v small, urban v rural, etc.)? 5. How do billing vendors charge for their services? (For example, flat fee based on enrollment, percentage of submitted claims?) 6. What is the overall annual gross revenue of billing vendors statewide (as a total dollar amount, percentage of SHARS/MAC expenditures, etc.)?



APPENDIX C:
EXAMPLES OF ALLOWABLE ACTIVITIES UNDER TEXAS MAC PROGRAM[36]

Medicaid Outreach

- Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening) including services provided through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.
- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. Note: This does not include when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school developed outreach materials should have prior approval of the Medicaid agency.
- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available through the Medicaid program.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
- Encouraging families to access medical/dental/mental health services provided by the Medicaid program.

Facilitating Medicaid Eligibility

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.

[36] https://rad.hhs.texas.gov/sites/rad/files/documents/mac/ex-mac-activ.pdf

- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

Medicaid Transportation

This does not include the provision of the actual transportation service or the direct costs of the transportation (bus fare, taxi fare, etc.), but rather the administrative activities involved in providing transportation.

- Scheduling or arranging transportation to Medicaid covered services. (Arranging for a taxi to take a student to the doctor; scheduling Medicaid Transportation to take a student to the doctor.)

Medicaid Translation

Translation may be allowable as an administrative activity, but only if it not included and paid for as part of a medical assistance service.

- Assisting a client/student/family to obtain translation services for the purpose of accessing Medicaid services.
- Arranging for or providing translation services that assist the individual to access and understand necessary care or treatment.
- Accompanying a child/family to the physician's office to translate from Spanish to English medically related information between the MD and the individual.
- Serving as a translator on how to access Medicaid services. This includes alternative languages, Braille, sign languages, and translation due to illiteracy.

Program Planning, Development, and Interagency Coordination Related to Medical Services

- Identifying gaps or duplication of medical/dental/mental services to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
- Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to increase provider participation and improve provider relations.
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
- Defining the relationship of each agency's Medicaid services to one another.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.

- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
- Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

Medical/Medicaid Related Training

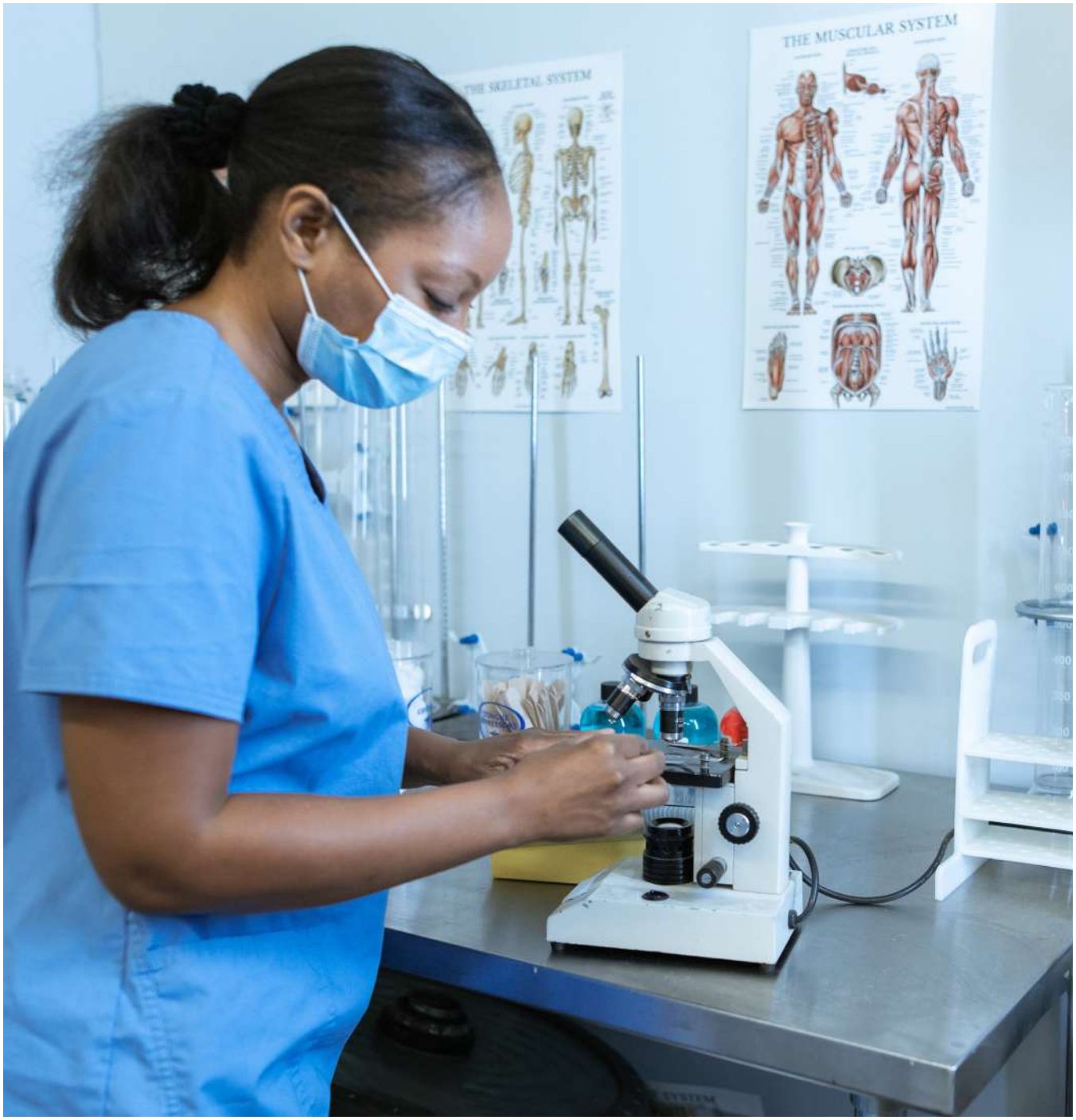
- Coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer clients/students for services.
- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.
- Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child-find programs.)
- Participating in training for outreach and eligibility assistance.
- Attending training specifically related to the provision of direct care client services.
- Training and/or supervising staff in the performance of delegated nursing tasks (for example, a Registered Nurse training staff to perform tube feeding, medication administration or other delegated nursing task).
- Training and/or supervising staff in the performance of personal care services.

Referral, Coordination, and Monitoring of Medicaid Services

Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) are not included under MAC. Note that targeted case management, if provided or covered as a medical service under Medicaid is not included under MAC.

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review a student's needs for health related services covered by Medicaid.
- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.

- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the child's related medical/dental/mental health services and plans.
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.



APPENDIX D:
SUPPLEMENTARY INFORMATION ON CHIP HEALTH SERVICES INITIATIVES

For additional reading and information on CHIP HSIs, we recommend the following resources.

CMS. Frequently Asked Questions (FAQ): Health Services Initiative. January 12, 2017.[37]

Kaiser Family Foundation. Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings From a 50-State Survey. March 2019.[38]

National Academy for State Health Policy. *Oklahoma Uses an Innovative Funding Opportunity to Promote Healthy Child Development through the Reach Out and Read Program*.[39]

Medicaid and CHIP Payment and Access Commission. *CHIP Health Services Initiatives: What They Are and How States Use Them*. July 2019.[40]

Center for the Study of Social Policy, Pediatrics Supporting Parents, and Manatt Health. Fostering Social and Emotional Health Through Pediatric Primary Care: A Blueprint for Leveraging Medicaid and CHIP to Finance Change. June 2019.[41]

[37] https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf
[38] https://ccf.georgetown.edu/wp-content/uploads/2019/03/Report-Medicaid-and-CHIP-Eligibility-Enrollment-Renewal-and-Cost-Sharing-Policies-as-of-January-2019.pdf
[39] https://nashp.org/oklahoma-promotes-healthy-child-development-through-increased-well-child-visits-and-screenings-using-innovative-funding
[40] https://www.macpac.gov/publication/chip-health-services-initiatives-what-they-are-and-how-states-use-them
[41] https://cssp.org/wp-content/uploads/2019/06/Medicaid-Blueprint.pdf

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