HEALTHY SCHOOLS CAMPAIGN

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Understanding the Financial Impact of Expanding Medicaid Funded School Health Services in Colorado

Abstract

The demand for school health services—and in particular, mental health services—is increasing across Colorado. Unfortunately it has been a challenge for schools and school districts to meet the demand. Local education agencies' (LEA) and state budgets are already stretched, and schools need new resources to increase access to these critical services. In 2020, the Centers for Medicare and Medicaid Services (CMS) approved a state plan amendment (SPA) to the Colorado Medicaid state plan that will bring new federal resources to the state and LEAs to support the delivery of school health services and help meet this need.

Colorado conducted a pilot study to better understand the financial impact of expanding its school Medicaid program and make data informed decisions about how best to move forward with their SPA. This case study details Colorado's path towards expanding its school Medicaid program and highlights key lessons learned from this work.

Background

In 2014, the Centers for Medicare and Medicaid Services (CMS), the federal agency that runs Medicaid, issued a state Medicaid directors' letter that clarified the way that Medicaid would reimburse for health services delivered in schools. Previous CMS policy prohibited reimbursement for services provided to Medicaid-enrolled students if those services were provided free of charge to all students. There were some exceptions: services could be submitted for Medicaid reimbursement if they were included in a student's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) or delivered through the Maternal and Child Health Block grant.

The letter stated that schools can seek reimbursement for covered services provided to all students enrolled in Medicaid, regardless of whether the services are provided at no cost to other students. "The goal of this new guidance," wrote CMS, "is to facilitate and improve access to quality healthcare services and improve the health of communities."

With the policy change, known as the "free care policy reversal," Medicaid can now reimburse for services provided to all Medicaid-enrolled students. While an appropriate plan of care must be in place to bill Medicaid for these services, the plan of care is not limited to an IEP or IFSP.

However, to advance this opportunity, states need to make a series of updates to policy and practice, including potentially amending their state Medicaid plan.
The Colorado Department of Education and Colorado Department of Health Care Policy and Financing made the decision to explore options to leverage the free care policy reversal and expand the school-based Medicaid program to bring additional and sustainable federal funding to the state. This funding would allow the state and LEAs to effectively target limited resources—and increase access to school health services.

Colorado's Analysis: Phases One and Two

School-based healthcare providers in Colorado participate in random moment time studies (RMTS) which has them identify the services provided on a given day—and if it is a Medicaid eligible service. RMTS is a commonly used and validated statistical analysis tool that LEAs use in their school-based Medicaid program.

A key component of the RMTS calculation is the Medicaid enrolled rate (the percentage of students in a given population enrolled in Medicaid). The Medicaid enrolled rate is often higher for students with IEPs than for students without IEPs (in Colorado, the Medicaid enrolled rate for students with IEPs was about 20 percent higher than the Medicaid enrolled rate for the overall student population).

An additional key component of the Colorado RMTS calculation is the Direct Medical Percentage, which reflects the amount of time providers spend delivering Medicaid-eligible IEP services. The amount of time school health providers spend delivering Medicaid-eligible IEP services is often significantly higher than the amount of time spent delivering non-IEP services, in part because schools are required by the Individuals with Disabilities in Education Act to provide services included in a student's IEP.

Colorado decided to conduct an analysis to better understand the financial impact and opportunities related to expanding their school Medicaid program. They developed and implemented a robust analysis that ultimately included three phases.

Phase One (2015)
For phase one of Colorado's analysis, the Colorado Department of Health Care Policy and Financing used previous time study data and cost reporting assumptions to determine if expanding the school Medicaid program to include non-IEP services would financially benefit Colorado. For the analysis, it was assumed that no additional school health providers who were not currently recognized by the state Medicaid plan would be Medicaid eligible. This means the state only ran this phase of the analysis on the providers who were already in their time study. In addition, the analysis assumed IEP and non-IEP services would be combined into the same calculation, meaning a single Medicaid enrolled rate and Direct Medical Percentage would be applied.

The phase one results were mixed and did not show a clear increase in Medicaid reimbursement to the state. The primary reason the results were mixed was because the IEP and non-IEP services were combined into the same calculation and a single Medicaid enrolled rate and Direct Medical Percentage applied. As a result, the state decided to not move forward with expanding their school Medicaid program at that time.

Phase Two (2016)
Phase two of Colorado's financial analysis focused on conducting on-site visits with five sample districts to better understand opportunities for expanding the school Medicaid program and assess how key programmatic requirements would be met.

First, the analysis sought to identify other plans of care used to prescribe medical services. The goal of this was to better understand school districts' ability to establish medical necessity (a key requirement that must be met in order for a service to be Medicaid eligible). It was determined that while districts do utilize plans of care other than IEPs and IFSPs (e.g. behavioral health plans, 504 plans), there was uncertainty regarding whether or not these plans of care would meet the medical necessity requirement.

Phase two also collected information to better understand if there were additional, qualified school health providers delivering Medicaid eligible services that were not included in the current program. These are providers that are eligible but have not been on the time study roster because they primarily worked with non-IEP students. For example, the state was interested in looking at the services delivered by nurses and health techs. It was determined that there are very few additional, qualified providers delivering non-IEP services that are not already included in Colorado's school Medicaid program.

Colorado's Analysis: Phase Three (2018-2019)

Although Colorado had decided not to move forward with expanding their school Medicaid program after their phase one analysis, the state looked to early adopting states to find alternative models for expanding Medicaid health services that could address the issues uncovered in their initial analysis. The state found an important resource in Massachusetts. Massachusetts' SPA was approved by CMS in July 2017 and included a first-in-the-nation change that clarified how the school service claiming methodology could be applied. Specifically, under Massachusetts' expansion, separate calculations were done based on Medicaid ratios (Medicaid enrolled rate and the percentage of time providers spend delivering Medicaid eligible services) for IEP services and non-IEP services. This is especially important because, as is described above, Medicaid ratios are commonly lower for non-IEP services.

In 2018, the Colorado Department of Health Care Policy and Financing received guidance from CMS that verified this was a valid approach to structuring school Medicaid claiming methodology. Specifically, the guidance confirmed that IEP services and non-IEP services could be included as separate line items in the annual cost report. The relevant Medicaid ratios could be applied to each line item and then the total costs added together thus preserving current program reimbursement.

Committed to finding resources to expand access to school health services, Colorado decided to add a phase three, a pilot study, to their analysis to test a claiming methodology similar to Massachusetts. This would test the impact of a CMS-approved methodology.

In addition, phase three examined the impact of including service providers who deliver healthcare services in schools but who are not currently able to claim under Medicaid. This primarily included school mental health professionals such as school psychologists and school counselors. These service providers are a key part of the school behavioral health system and ensuring they can claim for services delivered is an important strategy to increase access to and resources for these services.

Phase three focused on eight diverse LEAs, picked to represent the makeup of the state. It included both large and small districts, as well as urban and rural districts. The goal was to test what expanding Medicaid in schools could mean to all types of districts—and to understand if there were disparate impacts of the policy.

In the pilot, the eight LEAs participated in a real time study. By design, LEAs were given zero day's notice and a two-day response time to have their providers fill in their RMTS paperwork that is required for submitting paperwork for reimbursement.

The LEAs were understandably concerned both about the notification timeframe and the ability of their providers to complete the paperwork. What is more, many of the providers had never participated in the state's RMTS before and very little training was provided by the state or the LEA about what to expect. Nevertheless, participation rates were ultimately very good, with 1,000 RMTS "moments" collected for each of two cost pools. The first cost pool was the traditional "free care" program, including services delivered to all students that are currently covered by the school-based Medicaid program, as well as the provider types who currently bill for services. The second cost pool was similar to the first but also included service providers who deliver health care services in schools but who are not currently able to claim under Medicaid. For both cost pools, the state used the CMS approved model of making separate calculations based on the Medicaid ratios for IEP services and non-IEP services.

Phase Three Results

The pilot found that in addition to serving students with IEPs, service providers were providing a significant number of free care services to Medicaid-enrolled students. Nurses, health techs and personal care aids were delivering high rates of direct services and free care services. For example, nurses were spending 26 percent of their time providing services for students with IEPs and 18 percent of their time on services for Medicaid-enrolled students without IEP. Allowing these providers to bill for the free care services provided to students without IEPs could result in meaningful funding since they are spending a significant amount of time delivering these services. Interestingly, speech-language pathologists do not serve a high number of students outside of IEPs, and social workers and OTs were spending minimal amounts of time on free care services. It did not appear impactful to expand Medicaid billing for these providers.

In examining the second cost pool, the pilot wanted to identify how many services these providers deliver to all Medicaid-enrolled students—with and without IEP. The pilot found that master's level

school psychologists deliver a significant amount (23 percent) of services for students with IEPs, and some services for students who would be covered under the "free care" expansion (about 6 percent). Expanding Medicaid to allow for claiming and reimbursement for the school psychologist would be significant—the Medicaid-eligible services delivered by school psychologists are currently being delivered without Medicaid reimbursement at all. School counselors, program specialists (e.g., dieticians) and non-licensed social workers do not provide a significant amount of billable, direct or free care services.

Using these data, the state ran financial projections for the pilot. They looked at three different scenarios:

- Scenario #1: CO uses a SPA to lift the IEP restriction. The program bills for all existing services delivered to all Medicaid-enrolled students by existing provider types.
- Scenario #2: CO uses a SPA to lift the IEP restriction and all provider-types begin to bill for services.
- Scenario #3: CO uses a SPA to lift the IEP restriction. The program bills for all existing services delivered to all Medicaid-enrolled students by the existing provider types and school psychologists.

The financial analysis found that:

- Scenario #1: The state would receive about $8 million in new federal Medicaid funds.
- Scenario #2: The state would see an increase in federal Medicaid funds but only $123,000. This scenario also resulted in 66 percent of the LEAs incurring a net loss, including many rural districts.
- Scenario #3: The state would receive $12 million in new federal Medicaid funds.

Colorado's SPA and Next Steps

Colorado submitted their SPA to CMS in November 2019 and received approval in February 2020. The approved SPA expands the school Medicaid program to include services delivered to all Medicaid-enrolled students. The SPA has an effective date of Oct. 1, 2020. In addition, the expanded school Medicaid program will recognize applied behavior analysts, speech language pathologist assistants and school psychologists as Medicaid eligible providers.

Colorado is now in the process of implementing their expanded school Medicaid program. This work includes offering trainings and resources to support district level implementation of the expansion. A key factor in the success of the expanded program will be training school health providers who participate in the time study, including new providers to ensure they understand the changes that will occur in the coming school year. Information regarding the stakeholder trainings and other resources are available on the Colorado Department of Health Care Policy and Financing's website.

Key Questions to Ask in Your State

If your state is considering expanding school-based Medicaid through the free care policy reversal, Colorado's story highlights some key considerations for this work. The expansion is an opportunity for LEAs and the state to increase claiming and reimbursement for services already provided in schools. But as state Medicaid programs vary dramatically from state-to-state, it is important to fully understand the financial implications. With this knowledge, it is possible to design a program that allows LEAs and the state to maximize their ability to deliver school-health services. Key first steps include:

- Identify the current services that are covered in school-based Medicaid, as well as the school-based providers who deliver them.
- Learn about the current process for claiming and reimbursement. Is it RMTS or an alternate system?
- Determine if there are additional providers and services that are currently delivered in schools but are not currently reimbursed by Medicaid—but could be.
- Identify existing data that could be analyzed to determine the financial impact of expanding Medicaid to all enrolled students. If the data does not exist, consider doing a pilot like Colorado did, paying careful attention to the impact on a diverse set of LEAs.

Remember, engaging all stakeholders—including LEAs, superintendents, advocates and providers—from the beginning and working together will make the process smoother and will result in a successful policy change and implementation.