



FIVE

OPPORTUNITY: STREAMLINING AND IMPLEMENTING POLICIES TO FACILITATE MEDICAID REIMBURSEMENT

Implementing a successful school-based Medicaid-reimbursement program can help school districts stretch limited resources to support their school health programs.

Each state’s school Medicaid program has different rules and guidance. Understanding the policies in place in your state is critical to expanding and streamlining Medicaid reimbursement.

Direct and Administrative Services

School districts, or local educational agencies (LEAs), can bill Medicaid for direct services—eligible health services provided by Medicaid-qualified providers to Medicaid-enrolled students—if the following conditions are met¹²:

- The child receiving the service is enrolled in Medicaid.
- The services are medically necessary.
- The services are covered in the state Medicaid plan or authorized by the federal Medicaid statute.
- The LEA is authorized by the state as a qualified Medicaid provider.

These conditions previously applied only to the services listed in a child’s Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP), but now states have the option to bill for other services that meet this set of criteria.¹³

Schools can also bill for certain administrative services. These are typically either outreach and enrollment services to families and children who are eligible for but not enrolled in Medicaid, or administrative activities that support the provision of Medicaid-eligible services—including care coordination, referrals and transportation for a child to receive a Medicaid-covered service.

COMMON EXAMPLES OF DIRECT / ADMINISTRATIVE SERVICES

Direct

- Physical Therapy
- Occupational Therapy
- School Psychology

Administrative

- Counseling
- Screening services
- Nursing services

12. *Medicaid in the Schools*, American Speech-Language-Hearing Association: <https://www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit-Schools/>

13. See Chapter 6 for more on opportunities for local educational agencies to bill for eligible services not included in students’ IEPs/IFSP.

- Services for individuals with speech, hearing and language disorders
- Rehabilitative services
- Preventive care services
- Outreach and enrollment
- Care coordination
- Coordination of transportation
- Coordination of referrals

There are some exceptions. Notably, Medicaid does not cover services provided to a Medicaid-enrolled student if another program or entity is responsible for paying for those services (e.g., another health plan, or another federal or state program). This is known as third-party liability, and LEAs must seek reimbursement from other programs or entities before billing Medicaid.

THIRD-PARTY LIABILITY

Under Medicaid law and regulations, Medicaid is generally the health payer of last resort. This means that Medicaid pays for healthcare only after a beneficiary's other healthcare resources have been exhausted. In general, private insurers do not recognize school districts as healthcare providers and therefore will not provide payment for their claims. If a private insurance company denies a school district's claim, it is expected to issue a statement denying coverage. This denial should then allow payment from Medicaid for the service.

However, since most private insurers do not recognize schools as health providers, not only will they not pay for the services administered, they also might not issue the appropriate denial form. As a result, school districts are left to absorb the cost of the Medicaid-covered health services they provide to students with dual health coverage.

It is important to note that the requirement to bill third-party payers only applies to Medicaid-enrolled students who also have a third-party insurer. Approximately 8.4 percent of children enrolled in Medicaid also have private health insurance and, as a result, the issue of third-party liability does not apply to the majority of children that receive coverage through Medicaid.

While the [December 2014 state Medicaid director letter](#) also clarified that schools are not considered to be legally liable third parties, it specifically stated that schools are not exempt from the requirement to bill legally liable third-parties

prior to billing Medicaid for students with dual coverage. Additional guidance is needed from CMS regarding third-party liability requirements. However, these requirements should not serve as a barrier to billing for school health services delivered to students whose sole coverage is Medicaid.

State Medicaid agencies have taken a variety of approaches to comply with the third-party liability requirement as it relates to school-based services. It is important to understand the methodology and required documentation to satisfy the third-party liability requirement in your state. More information is available in the 2020 CMS guide on the [Coordination of Benefits and Third-Party Liability in Medicaid](#).

In practice, on any given day, school-based providers manage their caseloads, delivering the services that address their students' needs and help them learn. While attending to their day-to-day work, providers may not think about whether or not students are enrolled in Medicaid. But in order for the school district to bill Medicaid for those services, it must identify each service delivered to an eligible, Medicaid-enrolled student.

Designing and Implementing Reimbursement Policies

State Medicaid departments put in place the rules and regulations that guide the school-based billing and reimbursement process in accordance with their state plan and in partnership with the Centers for Medicare & Medicaid Services (CMS). It is the state Medicaid department, often in coordination with the state education department, that offers guidance to LEAs on direct versus administrative services and if (and when) the state uses a cost settlement methodology rather than a traditional fee-for-service approach.

Cost Settlement and Random Moment in Time Study

Cost settlement methodology generates reimbursement for services based on both claim payments for services rendered (interim payments) and a settlement of the costs associated with the provision of services. One such method is a statistically valid process called the Random Moment in Time Study (RMTS), which can provide a sampling of time spent delivering eligible services provided in schools. CMS has increasingly been interested in the use of RMTS for school-based Medicaid programs, and many states are adopting this model.

RMTS consists of a statewide sample of providers delivering direct and administrative services to determine the percentage of time spent delivering services or conducting outreach and administrative activities associated with the school-based Medicaid

program. Providers are asked to report how they spent their time at a specific moment in a day (e.g., Tuesday, March 1, at 12 p.m.). They do that by answering a series of questions related to the nature of the activity performed at the designated moment. These questions are used to determine whether the activity was Medicaid-eligible. Providers are grouped into “pools,” in which like providers are sampled together to ensure the most accurate representation of their time is reflected in the statewide sample.

Samples are drawn quarterly and are designed to reflect the entire universe of moments in time when providers in schools may be present and engaged in a Medicaid-eligible activity. All time is accounted for, including non-Medicaid allowable time, using CMS-approved codes that are designed to create buckets to describe how time is spent.

At the end of the year, the state uses the data associated with time spent, the costs provided by LEAs and a record of the interim payments already received by the LEA to calculate a final settlement amount. An additional cost settlement to correct an over- or under-payment may be necessary between the LEA and the state.

The RMTS brings some unique challenges that states and LEAs must address:

- Participation is crucial to the accuracy of the RMTS results. CMS requires a minimum of 85 percent of all moments sampled to be considered valid (i.e., completed by the appropriate staff, etc.). Failure to complete sampled moments could affect the time study results and reduce the amount of reimbursement available to those participating in the program.
- When considering a state plan amendment (SPA) that may result in CMS requesting modifications to the RMTS methodology, one of the key questions that comes up is how much notice the state will give the LEA about when their designated moment is. LEAs prefer as much lead-time as possible in order to prepare providers and staff for the increased paperwork.
- Similarly, the state will define the amount of time providers have to complete and submit their paperwork documenting what they were doing at the designated moment. Given that school-based providers spend the vast amount of their time with students, rather than in front of a computer, and that schools are closed on weekends and holidays, LEAs would like as many school days as possible in order to maximize provider participation.

Opportunities exist to streamline and implement policies that support the success of LEAs and school-based claiming. For example, designing state policy around RMTS notice and response time is a critical element. Providing training and support to LEAs and to providers is also critical. States can play a role by funding training and resources

for LEAs, provider trade groups, and others. Clear state guidance and claiming manuals are also important.

ADAPTING MEDICAID BILLING DURING COVID-19

When school buildings closed in 2020 and health services started being delivered remotely, two issues quickly emerged. First, since the RMTS process requires a large pool of data to be statistically significant, schools worried they would not have enough “moments” in their samples. Second, it was not clear for which services school-based health professionals and administrators could bill.

Could services provided by telehealth be considered as “moments”? Could schools get an administrative match for new services like COVID surveillance? CMS responded to these concerns with concrete policy fixes. These were documented in school waivers and in FAQs from CMS to state Medicaid agencies and included the following clarifications:

- States would be allowed to waive certain cost settlement requirements and, for Q3 2020, to use Q2 data as the baseline.
- The waivers permitted states to use their Q2 2020 data from before the pandemic began for as long as the public health emergency continues in order to ensure consistency.
- CMS clarified that administrative staff still working during the pandemic may use their moments for the RMTS.
- CMS clarified that administrative staff not working as a result of the pandemic may mark their time as paid or unpaid.

States were encouraged to add language to their RMTS manuals and/or school guidance on Medicaid claiming, clarifying that the RMTS would not be conducted in case of a state of emergency that causes extended statewide school closures and impacts statistical validity. Instead, the average of the RMTS results from all previous statistically valid quarters during the same fiscal year should be applied to the quarter(s) occurring during the emergency. Multiple states updated their manuals to reflect this language.

For more information about how school health services were impacted by COVID-19, view [Providing Health Services During School Closures](#).

Documentation of Medically Necessary Services

School providers must document the delivery of Medicaid services as part of the reimbursement process. Just as any medical or behavioral health provider might do when billing their time to a health plan, they must note what services were delivered, the duration of the services and any notes as part of the health record. But for the purposes of Medicaid, school providers must also document that the services meet the state's definition of medically necessary.

It is commonly understood that Medicaid will reimburse for services that are outlined in a student's IEP. These services are legally required to be provided to the student under the Individuals with Disabilities in Education Act (IDEA). However, services in the IEP are not automatically considered medically necessary by Medicaid, and the IEP itself may not be considered sufficient to establish medical necessity for the purposes of Medicaid reimbursement. It may be necessary, therefore, to include additional medical documentation of medical necessity according to the state's rules.

This can be confusing for providers, so clear guidance from the state on the documentation required for medical necessity, who Medicaid recognizes as qualified to establish medical necessity and the appropriate processes to collect this documentation is critical to ensure appropriate compliance. Massachusetts recently revised many of its provider manuals and other documents to clearly describe this process. For example, the MassHealth School-Based Medicaid Program's [Top 5 Things Providers Need to Know For the 2020-2021 School Year](#) includes clear language about medical necessity, service documents, diagnosis and more.

Addressing Parental Consent

In addition to documenting medical necessity, it is important to have a process to obtain parental consent. Parental consent (or student consent, if the student is age 18 or older) not only confers permission to provide diagnostic and treatment services within the school, but it is also required to bill the student's health insurance plan (including Medicaid) for the services provided. Therefore, **high rates of parental consent are critical to making school-based Medicaid billing work for sustainable funding.** The more parents who provide consent, the higher Medicaid reimbursement will be, since LEAs cannot bill Medicaid without consent to do so.

Parental consent also facilitates the sharing of information between healthcare providers and education agencies under state and federal privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). (See Chapter 9 for more on these laws.)

Parental consent processes—and the implications for families and school reimbursement—vary by state. It is important to carefully consider state options and engage a range of stakeholders to ensure a robust parental consent process that works for all parties. Parent education can help clarify how participating in the consent process can affect the availability of a range of healthcare services inside and outside schools.

PARENTAL CONSENT TO BILL MEDICAID FOR NON-IEP SERVICES IN CALIFORNIA

In 2005, the U.S. Department of Education instituted a requirement for written parental consent in order for districts to access Medicaid reimbursement and draw down eligible funds to address the needs of their special education population. [Rule: 34 CFR 300.154\(d\)\(2\)\(iv\)](#) requires school district officials to obtain signed parental consent before accessing Medicaid payments for the first time and annually thereafter.

The Office of Special Education and Rehabilitative Services (OSERS) issued a [letter to all State Directors of Special Education](#) in 2013 revising, but maintaining, requirements for districts to access reimbursement from the Centers for Medicare and Medicaid Services (CMS). (The process of obtaining a signed parental consent form prior to releasing health-related service information to a state’s Medicaid agency is not required by CMS.)

However, this requirement is specific to school health services delivered under IDEA. States that have expanded their school Medicaid programs to include all medically necessary services can make the decision to not require parental consent to bill for non-IEP school health services. California has taken this approach; the state’s Medicaid billing guidance for LEAs indicates the following:

“LEAs do not have to obtain parental consent to bill Medi-Cal before providing non-IEP/IFSP services to Medi-Cal eligible students, since this consent is provided during the Medi-Cal application process. However, students with services covered under IDEA (under an IEP/IFSP) do require parental consent, since IDEA created a statutory requirement to obtain parental permission before billing a Medicaid program (34 CFR 300.154).”

It is ultimately up to each state to decide how it wants to handle parental consent to bill Medicaid for non-IEP services.

The process for *obtaining* written parental consent was an issue during the COVID-19 pandemic when there were limited options for in-person meetings between parents and schools. The U.S. Department of Education issued a [Q&A](#)

document explaining that schools may obtain parental consent electronically for special education services and for Medicaid claiming during the pandemic.

This was a critical development, as parental consent is required before a school can deliver the service. This document did not impose additional requirements beyond those included in applicable law and regulations, but it did make clear that public agencies may accept an electronic or digital signature to indicate parental consent. This change may be desirable beyond the pandemic and facilitate greater parent participation.

BEST PRACTICES FOR COLLECTING PARENTAL CONSENT: MASSACHUSETTS CASE STUDY

As part of the state’s school-based Medicaid expansion, Massachusetts revamped its parental consent process, requiring all parents to submit new forms.

The state released extensive guidance to LEAs on how and why to collect parental consent forms—which are key to seeking sustainable Medicaid reimbursement—and identified several best practices:

- LEAs may use the new consent form at IEP or other health plan meetings. During the meeting, the LEA can ask if parents/guardians are willing to complete the form naming all children in the family.
- LEAs may include the new consent form with other required information sent home with students pursuant to Title I, information about free and/or reduced lunch applications or other similar communication.
- LEAs may include the form in annual “back to school” packets for families that are understood to have MassHealth (Medicaid), including any family that participates in the free lunch program.
- LEAs may use Medicaid Eligibility Matching response file information made available to school districts to identify students who are enrolled in MassHealth.
- LEAs may use the Provider Online Service Center (POSC) individual eligibility inquiry function to determine if a student is enrolled in MassHealth prior to obtaining parental consent.

The [Massachusetts Department of Education website](#) features the full parental consent guidance and FAQs that provide excellent information (the [administrative advisory](#) is also posted). Translated versions of the parental consent form are available in Spanish, Haitian Creole, Chinese and Portuguese.

Where to Go for More Information

Today, there are school districts in every state that bill Medicaid for eligible services included in the IEPs of students enrolled in Medicaid. These districts provide important lessons and best practices—as well as ways to address barriers—for other LEAs.

For more information on the LEAs in your state that bill for Medicaid, contact your state Medicaid agency or education department. Information may also be available on state websites. The California Department of Healthcare Services, for example, lists [all the participating LEAs](#), and the Indiana Department of Education [provides similar information](#).

Your state’s existing school Medicaid program infrastructure, including training, guidance and billing systems, provides an important foundation for expansion. There are specialists employed by LEAs who understand the intricacies of developing and implementing billing and reimbursement processes. It is not necessary to know every detail or understand every decision. What is important is a foundational understanding of how it works and how claiming for school-based services can lead to increased access to and funding for school health services.

ROLE OF VENDORS IN ADMINISTERING SCHOOL-BASED MEDICAID

In order to participate in billing and claiming for school-based Medicaid, many states and school districts rely on vendors. This is a common practice in the healthcare industry: Many hospitals, clinics and providers use outside vendors to process their medical claims and reimbursements.

Vendors perform the administrative functions of collecting claims and administering billing methodologies and do the actual billing and reimbursement with the state Medicaid department. They offer valuable solutions to the complex functions of school-based Medicaid.

However, vendors can be expensive. Some districts find that using vendors helps them maximize reimbursement, and the investment yields greater reimbursement. Other school districts find that they are able to perform the same functions more efficiently with school-employed staff.

It is important to evaluate both options against the impact on costs and reimbursement. Decision factors may include the size of the district, the proportion of Medicaid-enrolled students, the volume of services provided, and the complexity of the state's billing and reimbursement systems.

Important opportunities exist at the state and LEA levels to clarify the claiming requirements for billing Medicaid, for educating LEAs and providers, and for making improvements that streamline the documentation and claiming process. State policy and guidance documents are critical for supporting this work.

CMS provides guidance to states through two guides: [a technical assistance guide](#) that provides an overview of Medicaid and school health and [an administrative claiming guide](#) that provides support to states on the school-based administrative claiming program. However, these guides were published in 1997 and 2003, respectively. While they remain the core guidance on claiming, stakeholders continue to underscore the importance of publishing an updated guide that reflects the current Medicaid environment. Healthy Schools Campaign and AASA: The School Superintendents Association [submitted a letter](#) to CMS in 2021 requesting updated guidance documents. Fifty national organizations signed on to the letter in support of this issue.

Seizing the Opportunity

The case for expanding Medicaid billing by LEAs is an easy one: The more services that the LEAs bill for, the higher the reimbursement. This can help LEAs stretch limited resources to support school-based health programs. But putting the pieces together to streamline billing is a complicated process and requires clear state guidance for LEAs, provider education and training, and the implementation of billing systems. Above all, it takes making a clear and compelling case that expanding reimbursement will help increase access to health services.

States and LEAs will both play a key role in developing and implementing the policies and procedures. It is important to talk to a range of stakeholders about their experiences. Here are some perspectives and questions to consider:

- **I know that expanding Medicaid reimbursement will help LEAs stretch scarce resources for school health services.** *How can I make that case to stakeholders? Is there already a group of stakeholders talking about this—and is it the same people who are considering expanding the state’s school Medicaid program? For LEAs that have implemented successful reimbursement programs, what messages did they find most useful?*
- **In addition to documenting unmet student need, I want to compile data about how LEAs could use additional resources from reimbursement.** *Is there data available about how much revenue LEAs receive from school-based Medicaid reimbursement?*
- **I want to understand what services LEAs are already billing for in the state.** *What services are billable by my state? Are they direct or administrative services for the purposes of claiming?*
- **I want to understand more about the nuts and bolts of what it means to administer the billing and reimbursement process in an LEA.** *Who in my LEA works on billing and reimbursement?*
- **I want to reach students who may be eligible for health insurance who aren’t already covered.** *What outreach and enrollment services could a school deliver for which there would be an administrative match?*
- **I’m at the state level and want to support LEAs.** *What are the key obstacles facing LEAs in their claiming? Is it a lack of resources? The need for more funding for provider education and compliance? Are the state claiming processes too complicated and, if so, would additional guidance or training help?*

- **I know a lot of LEAs in our state don't bill Medicaid. I want to make it easier for them.** *What resources are available for training LEAs and providers in my state? Who at the state level (in the state education department or Medicaid) works with LEAs?*
- **My state is considering changes to school-based Medicaid, but CMS is saying we need to make changes to our methodology.** *What is our current methodology, and how might it change? What are the notice and response times that CMS is asking for, and are they realistic?*
- **I keep hearing that medical necessity documentation is a challenge.** *What are the policy requirements for documentation to establish medical necessity—and what are the state policy levers that impact those decisions? What policies does my state have regarding who is eligible to establish medical necessity?*