State Recovery Now

Policy Playbook

Promoting Health and Wellbeing: School-Based Medicaid Service Expansion

A guide to helping communities improve mental health services in schools

Executive Summary

Due to a lack of funding, most primary and secondary schools in the United States lack sufficient health services, and particularly mental health services. The impact is even more concentrated in low-income and historically underserved schools, where students are more likely to also lack access to these services at home. This exacerbates inequities in which students have access to these essential services, with far-reaching impacts on long-term health and educational attainment outcomes. The COVID-19 pandemic has worsened these existing inequities.

As state and local governments consider their options for spending American Rescue Plan (ARP) funds, they should consider investing in an expansion of school-based Medicaid programming. A state-based policy change can unlock substantial annual federal funds flowing to local education agencies to expand Medicaid services in schools, while ARP funds can be used to cover implementation and training costs.

Expanding school-based Medicaid programming can help address disparities in access to care for schools with high concentrations of low-income and historically underserved student populations, leading to long-term improvement in health and mental health outcomes. This policy change has potential to help local education agencies get closer to the recommended ratios of mental health providers to students.

Costs will vary by state, depending on the level of support the state is able to provide, but will be limited to up-front implementation and training costs. States will be able to measure the return on investment through (1) the increase in Medicaid reimbursements, and (2) the increase in health services in schools. Though not as easy to measure, states can also expect increased mental health services in schools to lead to better health outcomes among students.

Policy Overview

To overcome challenges associated with limited health services in schools — particularly in the area of mental health — state and local governments should consider allocating a portion of American Rescue Plan (ARP) funds to support the expansion of school-based Medicaid service.

As of 2014, local education agencies (LEAs) are eligible to bill Medicaid for not just services on an Individualized Education Program (which was previously the case), but for services that are simply on an authorized medical written plan of care. If states adopt this policy change, and implement it correctly, they can increase federal funds flowing to LEAs for mental health, as well as other health services, by millions of dollars annually. This would increase services available in

schools — particularly those with lower-income populations — thereby strengthening long-term health and mental health outcomes.

In order to access this funding, each individual state Medicaid agency (typically the Department of Health) must make an amendment to their statewide Medicaid plan. Once the amendment is approved by CMS, the success of the program is determined by the strength of the implementation plan, executed by the state education agency (SEA).

Policymakers can direct ARP funds to this implementation work needed to support the expansion of school-based Medicaid. The majority of this work is training and technical assistance, but can also include policy updates, technical solutions for documentation and billing, supporting work to increase the provider pipeline, and coordination efforts with the state Medicaid agency.

Initial start-up costs (e.g., training and documentation systems) can be covered with ARP funds, while ongoing costs are limited to the staffing required to run the program and provide ongoing support and training. The long-term benefit to LEAs is millions in additional federal funds — with no requirement of additional state matching funds — for health and mental health services in schools.

The key to success with this policy intervention is collaboration between the SEA and the state Medicaid agency. This may require encouragement and involvement at the Governor's level in many states.

Outcomes

Implementing this policy change, and investing ARP funds to support it, will substantially increase the amount of funding available for much-needed health and mental health services in schools. The schools and student populations that stand to benefit the most are those with the highest Medicaid populations, directing more dollars to populations historically underserved. The more low-income students a school has, the more dollars (and therefore services) they are able to provide. This intervention can help local education agencies (LEAs) get closer to the recommended ratios of one mental health provider to 250 regular education students, and one to 50 special education students — ratios that almost no LEAs currently meet due to funding constraints.

Better Medicaid services in schools will lead to better health and mental health outcomes

for students, with a particular impact on underserved students in low-income schools. Because mental health outcomes are difficult to measure and track (especially because measurable changes typically take a long time to manifest), policymakers should focus on service availability and access (i.e., staffing levels) as the main indicator of success.

Associated Costs

Costs will vary widely by state and locality, depending on the level of support the state is able to provide. Michigan, for example, chose to spend $31 million launching an expansion, while Louisiana approved expansion without spending any additional funds to support implementation.

ARP funds can be used to cover up-front costs, which could include the following:

- **Staffing:** At a minimum, state governments will need one point person at both the state education agency (SEA) and the state Medicaid agency. If these roles do not exist, they will need to be created, at a minimum cost of $300,000. Ideally, both agencies should have a team of people supporting this program, which could cost up to $1.1 million. If a state chooses, these roles can be funded initially with ARP funds, and then on an ongoing basis by the administrative fee charged as a part of the Medicaid program. Even if the current administrative fee would not be enough to support the increase in these positions, the projected increase in Medicaid funds would result in an increase in the administrative fee, which could be applied.
- **Purchasing a documentation and/or billion solution:** States may choose to invest in purchasing a single documentation and/or billing solution for LEAs to use. This would be both an upfront cost and an ongoing one. The minimum upfront cost would be roughly $2 million, while ongoing costs could be covered by the Medicaid administrative fee. As an alternative, LEAs could be allowed to contract with private vendors to provide this type of service (which most states do). If a state chooses to proceed with private vendors at the local level, it would not need to consider this cost.
- **Development of training materials for implementation:** Implementation is key to success with this policy intervention. A state may choose to invest in the creation of training and technical assistance tools to be utilized by LEAs. If a large enough and well-qualified team exists within the SEA and the state Medicaid agency, these materials could be created in-house. If not, a state can expect to spend between $150,000 and

$300,000 on creation of materials, depending on the complexity needed.

- **Providing technical assistance to LEAs**: Ensuring that LEAs are set up for success is a critical component of implementation. Unless states have large teams at either the SEA or Medicaid agency, additional temporary staffing may be needed to help train all the LEAs on the upcoming changes. States should plan to provide at least 20 hours of individualized training to each LEA prior to the Medicaid expansion going into effect. For more states, that will require bringing on temporary contract trainers, for which pricing will vary by state.
- **Provider pipeline development:** Few states have enough qualified practitioners ready to meet the increased need LEAs will have once funding becomes available. States should consider investments to increase higher education output of school-specific qualified providers. This can be done through: loan forgiveness, reworked curriculum designs, and LEA partnerships with institutions of higher education. All planning for this work should be done in conjunction with institutions of higher education.
- **Technical expertise consulting:** States may choose to bring in temporary technical expertise consultants to support their creation and implementation of expanded school-based Medicaid services.
- **Frontloading costs:** The delay in waiting for Medicaid payments, which can be up to three years, can cause significant issues for LEAs. States may consider paying the up-front costs of additional providers for the first two years to get the program up and running. Michigan did this successfully through legislation. It is important to note that if a state chooses to do this, they must use state funds, and not federal funds (including ARP funds); Medicaid will only reimburse for health services paid for with state funds.

Assessing the Return on Investment

There are two possible measurements to assess the return on investment of expanding school-based Medicaid services:

1. The increase in Medicaid reimbursements (which can be used to fund additional health services); and
2. The increase in health services in schools.

When implemented correctly, both of these measures should see significant increases. Concrete data is not yet available from existing programs, which are still in their infancy in the 17 states that have implemented this policy,

In order to determine their possible return, state leaders can look to their current Medicaid billing, based solely on Individualized Education Programs (IEPs). Based on the ratio of IEP to non-IEP students, the mental health and nursing providers already in schools, and the current reimbursable percentages, states can project out the potential increase in funds when the pool is opened to non-IEP students. A summary of current School-Based Medicaid policy by state can be found here. Information on the 16 states that have made this policy change can be found here.

Though not as easy to measure and track, policymakers can also expect increased mental health services in schools to lead to better health and mental health outcomes among students in the long-term, particularly concentrated among lower-income students whose schools will be impacted most.

Evidence of Action

So far, 16 states have implemented this policy change, and are still in the early stages of implementation. The states that have done the best so far are the ones that have the strongest relationships between their SEA and the state Medicaid agency.

Michigan is seen as a good model for how to successfully implement this policy. The state began expanding its school-based Medicaid program in 2019, allowing school districts to seek Medicaid reimbursement for services provided to all Medicaid-enrolled students. So far, this has improved access to services for students and has underscored the role that schools can play in addressing the health and behavioral health needs of all students when they have the necessary resources.

Michigan's success is primarily due to its work to front-load funding and training resources. Strong and early collaboration with critical stakeholders, as well as ongoing communication with stakeholders and CMS, has helped speed and smooth the implementation process. Dedicated state funding was also instrumental in supporting the planning and implementation process. With support from this funding, Michigan was able to invest significant resources in early and ongoing training, helping to address providers' and stakeholders' early questions and streamline the rollout.

Colorado is another strong model, primarily in terms of thorough planning prior to implementation. By running cost simulations at the onset, Colorado was able to determine the best formula for their reimbursement. This helped policymakers better understand the financial impact and opportunities related to expanding their school-based Medicaid program.

Additional case studies on states that have expanded their school-based Medicaid programs can be found here.

How is this a compelling use of one-time funding that can drive long term-impact and avoid unsustainable funding?

Expanding school-based Medicaid services is an ideal use of one-time ARP funds, as a majority of the costs are one-time, up-front expenses, with an end result of an increased influx of annual federal dollars.

The long-term costs of this policy to the LEAs are limited to the staffing costs required to execute the program — some of which may be covered by the Medicaid administrative fee.

Using ARP funds for these initial set-up costs will allow states to execute this impactful policy with essentially no impact to their typical budgets.

Authority for ARP Spending: *States and local governments may spend ARP funds on policies to support public health expenditures, by, for example, funding medical expenses or behavioral healthcare. This policy initiative falls under this category of acceptable uses.*

Implementation

To ensure effective implementation, state and local policymakers should first assess whether they have the necessary systems, data, and capacity, while also engaging relevant partners early on.

Assessing Readiness

Policymakers can use the following list of questions to prepare for successful implementation:

- What school-based services does our state's Medicaid plan currently cover? This resource can help compare state-by-state.

- What is the current working relationship between the SEA and the state Medicaid agency?
- Do both the SEA and state Medicaid agency already have staff dedicated to school-based Medicaid?
- What type of providers does the SEA allow to operate in LEAs?
- What documentation systems and/or billing options are available? Will they be able to pivot to include this new expansion?
- Are there vendors in the state that are currently providing LEAs with billing support? If so, are they able to update their systems in a timely manner? If not, the cost of a new documentation system should be added to the up-front costs for the SEA (as well as any ongoing maintenance costs).
- What type and quantity of health services are LEAs in the state already providing?
- What is the current state of the provider pipeline? If resources become available to add these additional professionals to schools, will there be appropriately-trained and licensed individuals available?
- What types of culturally diverse communities does the state have, and what are the best practices for physical and mental health care in supporting them? This should be considered in creating a new Medicaid policy.

Essential Actors for Successful Implementation

In addition to core leadership commitment, policymakers will need to partner with relevant agencies, organizations, community partners, and state or local government counterparts for successful program implementation. For school-based Medicaid programming, this includes two critical stakeholders:

- State Medicaid Agency: Responsible for submitting the State Plan Amendments.
- State Education Agency: Responsible for leading the implementation and ongoing training.
- Governor: Because this policy requires two different state agencies to work together, the buy-in and direction of the Governor will increase the likelihood of success.

Engaging Stakeholders and Beneficiaries

Transparency in decision-making is essential to achieving equity in healthcare and education policies. It is essential to have a process for seeking and incorporating input from key stakeholders, in order to ensure that they feel more invested in the eventual program by having a

voice in shaping it.

Policymakers should partner and coordinate with all relevant stakeholders to ensure buy-in, including: major state philanthropic investors; the state board of education; education professionals; institutions of higher education with social work, counseling, and education programs; nonprofit organizations; and advocacy organizations.

For a full list of essential stakeholders and recommendations for how to engage each, see the "Stakeholder Engagement Table" in the Appendix.

Risk Mitigation

What could go wrong? How can we mitigate the biggest risks?

- **Lack of coordination between the state Medicaid agency and the state education agency.** The Medicaid agency must be the one to submit the SPA and handle the CMS requirements. However, the implementation will live within the SEA, which requires their involvement in the SPA. Having this work led by or championed by the Governor's office can help mitigate any inter-agency issues. The heads of both agencies must also be bought into the strategy to ensure its effectiveness.
- **Poor training of LEAs.** The funding methodology used by most states (RMTS) requires collective action for individual schools to benefit. If LEAs across the state are not simultaneously well-trained in how to use this system, it could result in significantly decreased reimbursement for all schools. Sufficient training should help mitigate this risk.
- **Limited professionals available to fill positions.** In many states, there are currently not enough mental health professionals trained in school-based care. Once funding is increased and additional positions are available, concerted work must be done to build up the pipeline of professionals, in order to ensure enough qualified professionals are available to fill positions.

Data and Learning Strategy

Baseline Systems: Necessary inputs to implement the policy effectively

As state and local education agencies prepare to implement an expansion of school-based Medicaid, they should first assess current ratios of mental health professionals to students in schools. The recommended ratios — which few schools are currently meeting — are 1:250 for regular education students, and 1:50 for special education students. Gathering data around where local schools fall will help SEAs and LEAs set goals and measure progress toward reaching the desired ratio.

Measuring Progress: How can progress toward the desired outcomes be measured — both to assess progress and inform improvement along the way?

To measure progress of the overall school-based Medicaid expansion program, state and local policymakers can track performance metrics across the following categories:

- Federal Medicaid dollars flowing to schools each year
- Reimbursable percentage by RMTS pool
- Number of school-based providers by profession
- Number of services delivered
- Ratio for mental health providers to students

Additional Resources

Case Studies: State Success
Healthy Schools Campaign

Playbook Authors

Sarah Broome
sarahebroome@gmail.com

Appendix

Stakeholder Engagement Table

Stakeholder	Requested Contribution
Governor	• Support for any legislative changes that are needed to enact the plan – particularly needed if the state requires legislation to enact the free care policy • Support for supporting schools on the financial cost
Commissioner of Administration (or whichever state entity develops the state budget)	• Support for supporting schools on the financial cost • Support in navigating any state policy red-tape or procedural barriers that arise.
Education leadership in state House and Senate	• Support for any legislative changes that are needed to enact the plan – particularly needed if the state requires legislation to enact the free care policy • Support for supporting schools on the financial cost
Key players in state House and Senate	• Support for any legislative changes that are needed to enact the plan – particularly needed if the state requires legislation to enact the free care policy • Support for supporting schools on the financial cost
State Medicaid Agency Leadership	• Commitment to the plan from a department level and allocation of resources as needed – most particularly staffing support on Medicaid-related issues • Support for the SPA
Medicaid Division Leadership	• Commitment to the plan from a department level and allocation of resources as needed • Ensure schools are easily and quickly added as Medicaid providers • Oversight of the SPA
Medicaid/LEA auditor/liaison	• Commitment to the plan from a department level and allocation of resources as needed • Creation of the SPA • Collaboration with the project leader to ensure the policy makes the most sense for schools

Major state philanthropic investors and foundations	• Initial philanthropic investment in expanding mental health access to help train and incentivize schools
State Board of Education	• Support for any policy changes that must be enacted to make the plan work • Visible and active support for the goal to help encourage schools to utilize mental health
State association of school superintendents	• Assistance in connecting with district leaders across the state to get buy-in on the plan • Offering support both content and technical for district leaders who want to implement this in their schools
State teachers unions	• Support for the plan at the teacher level and to prevent potential panic that this may cost teacher jobs • Representation for what type of mental health supports teachers feel they most need in schools
State charter school association	• For states with a large charter school presence, support for the technical differences in this process that may exist by state
University social work program leaders	• Commitment to increase the number of students specializing in school social work • Commitment to teaching and researching culturally relevant practices for school social work
University professional counselor program leaders	• Commitment to increase the number of students specializing in school level professional counseling • Commitment to teaching and researching culturally relevant practices for school professional counseling
University teacher preparation and school leader preparation programs	• Commitment to including at least one class on mental health in schools in teacher preparation • Commitment to including a significant amount of credits on mental health in schools in school leader certification programs
Non-profit groups currently working in Medicaid access in schools (consider looking	• Commitment to work together with the best practices and resources they may have already established to increase mental health access in schools

at members of NAME in each state)	• Make clear the desire for a partnership to work for the best interest of kids; some entities who have already been doing this work may be slightly uncomfortable with a changing dynamic, but their knowledge and skill sets are invaluable and should be treated as such.
Individual schools currently doing exceptional work on mental health	• The best resource in any state is going to be the schools who are already doing this work well. Invest in studying and replicating their practices. • As systems are designed, their real world experiences of state-specific issues in particular will be invaluable and they should be included at every step.
Potentially opposed advocacy groups	• Each state has their own ecosystem of educational advocacy groups. Some are more involved and vocal than others. It is suggested that pre-work be done to bring the most vocal groups on board before moving forward in an attempt to both craft the best possible plan and limit potential surprises down the line.