DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

***CMCS Informational Bulletin***

**Date:** May 18, 2023

**From:** Daniel Tsai, Deputy Administrator and Director

**Subject:** Information on School-Based Services in Medicaid: Policy Flexibilities and Guide on Coverage, Billing, Reimbursement, Documentation and School-Based Administrative Claiming

**Background:**

The purpose of this informational bulletin is to introduce the comprehensive guide **Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming** that the Centers for Medicare & Medicaid Services (CMS), in consultation with the U. S. Department of Education (ED), is issuing to improve the delivery of covered Medicaid and Children's Health Insurance Program (CHIP) services to enrolled students in school-based settings and to meet the requirements of Section 11003 of the Bipartisan Safer Communities Act (BSCA) (P.L. 117-159).

Medicaid and CHIP are joint State-federal programs that offer health coverage to tens of millions of Americans, including more than half of all children across the country. With this new comprehensive guide, CMS and ED strongly encourage States and schools to expand their offering of school-based services (SBS) as a way to increase crucial health care access to children enrolled in Medicaid and CHIP and meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements. Preliminary CMS data indicates that the volume and rate of primary, preventive, and mental health service use declined during the pandemic and have not yet rebounded to pre-pandemic levels.[1] Additionally, the Centers for Disease Control and Prevention reports that from 2011 to 2021, poor mental health and suicidal thoughts and behaviors increased for nearly all youth groups.[2]

SBS play an important role in the health of students. Health care services delivered in schools are an opportunity to meet children where they are and deliver services to children in a setting where they spend a majority of their time – in school. SBS can include all services covered under EPSDT, which provides a comprehensive array of preventive, diagnostic, and treatment services for eligible individuals under 21 enrolled in Medicaid. These services include, but are not limited to, preventive care, mental health and substance use disorder (SUD) services, physical and occupational therapy, and disease management.

---

[1] https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot-07312022.pdf
[2] https://www.cdc.gov/healthyyouth/data/yrbs/yrbs_data_summary_and_trends.htm

Schools can also help enhance early identification of health needs and connect students to a broad range of health care services, including mental health and SUD services, and other community-based services. Specifically, SBS providers can help promote health and educational equity and increase school attendance by:[3,4]

1. Helping eligible students enroll in the Medicaid program.
2. Connecting students' Medicaid-eligible family members with Medicaid health coverage.
3. Providing Medicaid-covered health services in schools and seeking payment for services furnished. Health services can include any covered service, including EPSDT services, at the State Medicaid agency's discretion.
4. Offering Medicaid-covered services that support at-risk Medicaid eligible students.
5. Providing Medicaid-covered services and performing Medicaid administrative activities to improving student wellness.[5]
6. Providing Medicaid-covered services that reduce emergency room visits.
7. Providing Medicaid-covered services and performing Medicaid administrative activities that promotes a healthy environment and promotes learning.

Where possible, we encourage States to ease administrative burden placed on school-based health providers to promote their participation in Medicaid and CHIP, and thereby increase access to covered services, while also maintaining fiscal and programmatic integrity of Medicaid and CHIP. Billing arrangements for SBS vary by State and locality, and operate within parameters set by the State Medicaid agency. This comprehensive guide includes a series of new flexibilities on billing, documentation, and time studies (e.g., worker logs, random moment time studies (RMTS)) to help ease the administration of SBS for local education agencies (LEAs). These flexibilities are all options for States to adopt in their State Medicaid plan. CMS urges States to adopt these flexibilities to make it easier for LEAs to bill and is available for technical assistance to help State Medicaid agencies submit a new State Plan Amendment (SPA) to implement the new flexibilities outlined in the comprehensive guide.

Schools are important providers of Medicaid direct medical services for children, as well as participants in Medicaid administrative activities for which federal matching funds are available (e.g., Medicaid outreach, enrollment, and referrals and care coordination performed as an administrative activity and not a direct medical service). This guide, following all relevant regulations and laws, provides comprehensive details regarding both SBS direct medical services

---

[3] This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites.

[4] California School Based Health Alliance. Top Ten Benefits of School-Based Health Centers, available at URL: https://www.schoolhealthcenters.org/school-based-health/awareness-month/why-sbhcs/#:~:text=School-based%20health%20centers%20%28SBHCs%29%20promote%20health%20and%20educational,Improve%20wellness%20policies%20and%20health%20programs.%20More%20items

[5] See: https://www.thecommunityguide.org/media/pdf/SDOH-School-Based-Health-Centers-508.pdf

and SBS administrative claiming. It also details policies and new flexibilities intended to ease the administrative burden associated with billing and payment for Medicaid and CHIP services, including associated Medicaid administrative activities.

Specifically, this comprehensive guide:

- Clarifies how payments can be made to school-based providers under Medicaid and CHIP;
- Discusses strategies and tools to reduce administrative burden and simplify billing for LEAs, including rural and small LEAs;
- Provides best practices and examples of approved methods that State Medicaid agencies and LEAs have used to pay for Medicaid covered services;
- Gives examples of the types of providers that can participate in Medicaid and furnish covered services within school settings, and;
- Provides best practices to enroll qualified providers.

This comprehensive guide updates and supersedes previous guidance issued by CMS on school-based services, including the 1997 School-Based Services Technical Review Guide and the 2003 School-Based Administrative Claiming Guide, and explains other policies and practices that States may employ in implementing SBS.

**New Flexibilities Included in the Guide**
States are able to immediately take advantage of the following new flexibilities regarding school-based Medicaid billing, documentation, and claiming:

**Billing for States and LEAs that utilize cost-based reimbursement**

<u>Roster Billing Methodology:</u> This optional methodology allows States to compute a rate that is representative of services delivered, and the LEAs would multiply that rate, on a quarterly or monthly basis, by the number of Medicaid-enrolled students that receive a covered service within the service period. The roster billing approach presents a streamlined process compared to billing for individual claims through the Medicaid Management Information System. These quarterly/monthly payments would then be reconciled to actual costs at the end of each cost reporting year.

<u>Per Child, Per Month (PCPM) Interim Rate:</u> This optional methodology allows States to create an interim rate that can be based on the provider's previous year's actual cost. These payments could be paid out each month on a PCPM-basis or on an average cost per service basis. These monthly payments would then be reconciled to actual costs at the end of each cost reporting year.

<u>Option to Not Submit Bills for Each Service:</u> If a State chooses a roster billing or PCPM methodology, schools in the State would not be required to submit a bill for each service to Medicaid, as long as the interim rates and payments are reconciled to actual costs at the end of each year.

As LEAs, State Medicaid agencies, CMS, and ED begin to implement the billing flexibilities for Medicaid-covered services provided in schools, we are cognizant of the potential for data loss that may be associated with the flexibilities. Collection of basic data metrics (e.g., the number of children receiving SBS) is crucial for the Medicaid program in order to monitor trends in care and support performance improvement across physical and mental health services. Regardless of the delivery setting, it is important that CMS, States, and stakeholders have visibility into essential services, including EPSDT services, being provided to children and the quality of those services.

To ensure that States and CMS have information available to understand that quality care is delivered in schools to Medicaid eligible children, we intend to explore over the next year, in partnership with States and LEAs, additional methods to collect school-based data for a set of essential physical and mental health services, and particularly reporting of core data metrics. The goal is for CMS to issue national guidance to capture a consistent, simplified set of metrics while avoiding placing additional administrative burden on schools. Through collaboration in the SBS Technical Assistance Center, we will further define these reporting parameters and options for LEAs to implement billing flexibilities, while maintaining the necessary supporting documentation for States and Federal entities to assess access, quality of care, and health equity. Further guidance on this issue will be developed by CMS as part of our ongoing technical assistance.

**Billing for State and LEAs that utilize rate-based payments**

Fee Schedule Rates that Exceed the Community Rate: This flexibility allows States to pay higher fee schedule rates for services offered in schools as long as the State demonstrates that the rate is economic and efficient, as required by section 1902(a)(30)(A) of the Social Security Act (the Act).

Clarification of Restrictions on Bundled Payment Rates: CMS previously issued a 1999 State Medicaid Director's Letter (SMDL) that prohibited the use of bundled rates in school-based settings based on concerns over service documentation and financial oversight. The SMDL was issued prior to States implementing reconciled cost methodologies as the predominant method to pay for SBS. The comprehensive guide clarifies that bundled rates are permissible as interim payments when the bundled rates are reconciled to the actual cost of providing Medicaid services.

**Documentation**

Due the Family Educational Rights and Privacy Act (FERPA), States and LEAs have been unable to provide the necessary documentation to support the billing of Medicaid services and claiming of Federal financial participation (FFP). To offer States and LEAs flexibility for supporting claims of FFP, CMS and ED are offering States and LEAs the following options:

De-identified Data: This flexibility allows LEAs and school-based providers to furnish some de-identified or masked data to support Medicaid Enrollment Ratios (MERs) or other allocation statistics. Permitting this type of de-identified data can help support schools in responding to

audits, however, this does not supersede the requirement to provide the minimum documentation required for payment for Medicaid services.

Utilization of a General Allocation Ratio: Historically, most school-based providers that were reimbursed actual costs utilized an Individualized Educational Program (IEP)-based ratio to allocate costs to Medicaid at the local LEA level: **Number of Medicaid enrolled students with an IEP receiving medical services divided by number of students with an IEP receiving medical services**. This guide discusses the use of a more general ratio: **Number of Medicaid enrolled students divided by total number of students in the LEA**. This eliminates the burden of producing documentation related to non-Medicaid enrolled students with an IEP.

Utilization of Time Study Moments as a One-step Allocation Methodology: Instead of a two-step process to allocate costs to Medicaid using a time study and then a MER, the comprehensive guide discusses the option for States to construct time study activity codes to capture time study moments that are both medical in nature and specifically applicable to Medicaid activities and services. These time study results can then be used to allocate cost.

**Provider Qualifications**

This flexibility allows States to establish provider qualifications for school-based providers that differ from the qualifications of non-school-based providers of the same Medicaid services, as long as States' provider qualifications are not unique to Medicaid-covered services. Prior CMS guidance made it difficult for States to rely on ED provider qualifications or to establish different provider qualifications for school-based and non-school-based providers of the same Medicaid services.

**Third Party Liability**

This flexibility eases administrative burden at schools by allowing States to suspend or terminate efforts to seek reimbursement from a liable third party if they determine that the recovery would not be cost-effective pursuant to 42 C.F.R. §433.139(f), including for Individuals with Disabilities Education Act (IDEA) or 504-plan services.

**Time Studies**

Time Study Error Rate: This flexibility allows States to increase the error rate in time study implementation plans from +/- two percent to +/- five percent. This change will allow States to conduct unified time studies with far fewer moments, which also eases administrative burden.

Time Study Notification and Response Period: This flexibility allows States to submit time study implementation plans that include up to a two-day notification window and up to a two-day response period for queried moments in their time studies for school-based providers, instead of a zero-day notification window and two-day response window.

**Implementation of the SBS Flexibilities**

CMS and ED recognize the high administrative burden for schools seeking payment for Medicaid and CHIP services. CMS and ED are supportive of school-based health programs and, where possible, encourage State Medicaid agencies to ease administrative burdens placed on school-based health providers to promote their participation in Medicaid and CHIP and thereby increase access to covered services. State Medicaid agencies should adopt policies discussed within the comprehensive guide in a manner that maintains the fiscal and programmatic integrity of the Medicaid and CHIP programs.

States seeking to take immediate action related to any of the flexibilities offered in the comprehensive guide, should submit any applicable SPAs, administrative claiming plan amendments, or amendments to time study implementation plans as soon as possible. We encourage States to review the timing requirements in 42 C.F.R. § 430.20 to ensure amendments are effective when needed. For example, a State would need to submit a SPA to CMS by September 30, 2023, in order for it to be effective as of July 1, 2023 (and must comply with existing public notice requirements and tribal consultation, as applicable).

CMS acknowledges that States may choose to direct some, but not always all, of the federal share of SBS expenditures to school-based providers. However, CMS strongly encourages States to direct all of the federal share for any SBS to school-based providers. This is essential for schools to sustain and expand SBS, especially for schools with fewer resources.

**SBS Comprehensive Guide Compliance**

In the comprehensive guide, we discuss new policies, provide policy clarifications, and reiterate existing federal requirements regarding the recognition of cost, the notification and response windows for time studies, and the standard for documenting services rendered, among other matters. If States are not already adhering to applicable federal standards and requirements as discussed in this guide, CMS expects that States submit SPAs, administrative claiming plan amendments, and/or amendments to time study implementation plans to comply as soon as possible, but no later than the start of the first quarter at least three years after the publication date of the guide. If States need assistance to submit SPAs, administrative claiming plan amendments, and/or amendments to time study implementation plans to comply with the comprehensive guide, or to take advantage of new policy flexibilities, CMS encourages States and school-based providers to use the SBS Technical Assistance Center to aid with their compliance efforts.

**Technical Assistance Center**

The BSCA also requires the Department of Health and Human Services, in collaboration with ED, to establish a technical assistance center to: (1) support State Medicaid agencies, LEAs, and school-based entities seeking to expand their capacity for providing Medicaid SBS, (2) reduce administrative burden, (3) support such entities in obtaining payment for providing Medicaid SBS, (4) ensure ongoing coordination and collaboration between ED and the Department of Health and Human Services regarding Medicaid SBS, and (5) provide guidance with regard to

utilization of various funding sources. CMS intends to establish the SBS Technical Assistance Center consistent with statutory requirements and encourages stakeholders to use the Technical Assistance Center to assist in implementing the flexibilities and requirements discussed in this SBS guide. CMS intends to share more information regarding the Technical Assistance Center soon.

As stakeholders review the comprehensive guide, there may be content areas they believe CMS should expand upon or further explore via the Technical Assistance Center. A request for proposal for a Technical Assistance Center contractor was released on April 20, 2023.

States should contact CMS to discuss the above SBS flexibilities before submission of any SPAs, administrative claiming plan amendments, and/or amendments to time study implementation plans, CMS is available to provide technical assistance to States and stakeholders to best implement, enhance, and expand their SBS programs. Questions regarding implementation of these options, compliance efforts, or thoughts about content areas CMS should further explore should be directed to CMS at: SchoolBasedServices@cms.hhs.gov.