School-Based Services for Students Enrolled in Medicaid

Schools are an important setting for providing health services to children and adolescents covered by Medicaid, particularly as communities seek to address an increase in behavioral health challenges among young people.[1] Schools fill a critical role in identifying children and adolescents with behavioral health needs and connecting them with mental health and substance use disorder (SUD) treatment as well as other needed services. Children and adolescents are in school for many hours a day, for approximately half the days of the year, making schools a convenient point of access (CMS 2023a).

This issue brief focuses on Medicaid school-based services provided by personnel employed by a school or local education agency (LEA). Examples of common school-based services include physical therapy, occupational therapy, speech pathology or therapy services, psychological counseling, and nursing services. Medicaid-covered health services may also be delivered to students by contracted community providers or school-based health centers (SBHCs), which will be addressed in future MACPAC work.[2] SBHCs are typically sponsored by a local partner such as a federally qualified health center, mental health agency, or hospital, and most often provide care at a fixed location on the school campus (Soleimanpour 2022).

Until 2014, Medicaid payment for school-based services was limited to covered services identified in a student's individualized education program (IEP) or individualized family service plan (IFSP), in accordance with the Individuals with Disabilities Education Act (IDEA, P.L. 101-476). In 2014, the Centers for Medicare & Medicaid Services (CMS) clarified the policy that prohibited Medicaid payment for services provided to enrolled children if those services were available without charge to the community at large.[3] This policy change permits states to pay for medically necessary services for any Medicaid-eligible student, regardless of whether those services are identified in an IEP/IFSP or provided at no cost to other students. In states that elect this policy, schools may seek payment from Medicaid for covered services provided to Medicaid enrollees without an IEP/IFSP in addition to maintaining their obligation to provide education and related services to students with disabilities under IDEA.

This issue brief draws largely on recent federal guidance and stakeholder input to provide background information on key topics affecting school-based services for students enrolled in Medicaid.[4] It begins with an overview of school-based services and recent federal actions to reduce administrative burden and improve access to care in schools. It then describes key concepts related to the financing and payment of school-based services and discusses select factors affecting billing and claiming. The issue brief concludes by discussing considerations for further expanding access to care and Medicaid billing in schools.

Overview of School-Based Services

Medicaid covers most of the health services provided to children in schools, either under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or other state plan authority.[5] Coverage of school-based services, including categories of service (e.g., behavioral health services) and specific types of services (e.g., screening or individual treatment), varies by state (HSC 2023a, Baller and Barry 2016). States can cover a variety of behavioral health services in schools, including psychological testing and evaluation, individual and group therapy, and behavioral health crisis services.

States generally do not require LEAs to participate in the school-based Medicaid program and the extent to which LEAs bill Medicaid varies considerably by state. The percentage of LEAs that bill Medicaid for direct services

ranges from 10 percent in Wyoming to 100 percent in states such as Florida, Hawaii, Illinois, and Vermont (HSC 2023b).[6]

States typically carve school-based services out of managed care, meaning that LEAs bill the state Medicaid program directly for covered services delivered to Medicaid-eligible students (HSC 2023b).[7]

School-based services for children with an IEP/IFSP

IDEA requires public schools to provide students with disabilities with education and health care-related services, such as speech or physical therapy, that support their ability to learn. These services must be documented in a student's IEP or, for children under age three, their IFSP. An IEP describes a plan for the child's education that is tailored to a child's specific needs, and includes the educational and related services that a school will provide to help a child reach their goals (34 CFR 300.320). An IFSP is similar, but focuses on the needs of infants and toddlers and includes a plan to provide early intervention services to meet the physical, cognitive, communication, social and emotional, and adaptive developmental needs of an infant or toddler with a disability (34 CFR 303.340-330.346).

State Medicaid programs can receive federal financial participation (FFP) for school-based services required by IDEA when provided to Medicaid-eligible children as long as: (1) the services are listed in Section 1905(a) of the Social Security Act (the Act) and are medically necessary; (2) all federal and state regulations are followed; and (3) the services are included in the state plan or available under EPSDT. The service categories most commonly covered by state Medicaid special education programs are speech and language therapy, audiology services, occupational and physical therapy, and behavioral health (Baller and Barry 2016).

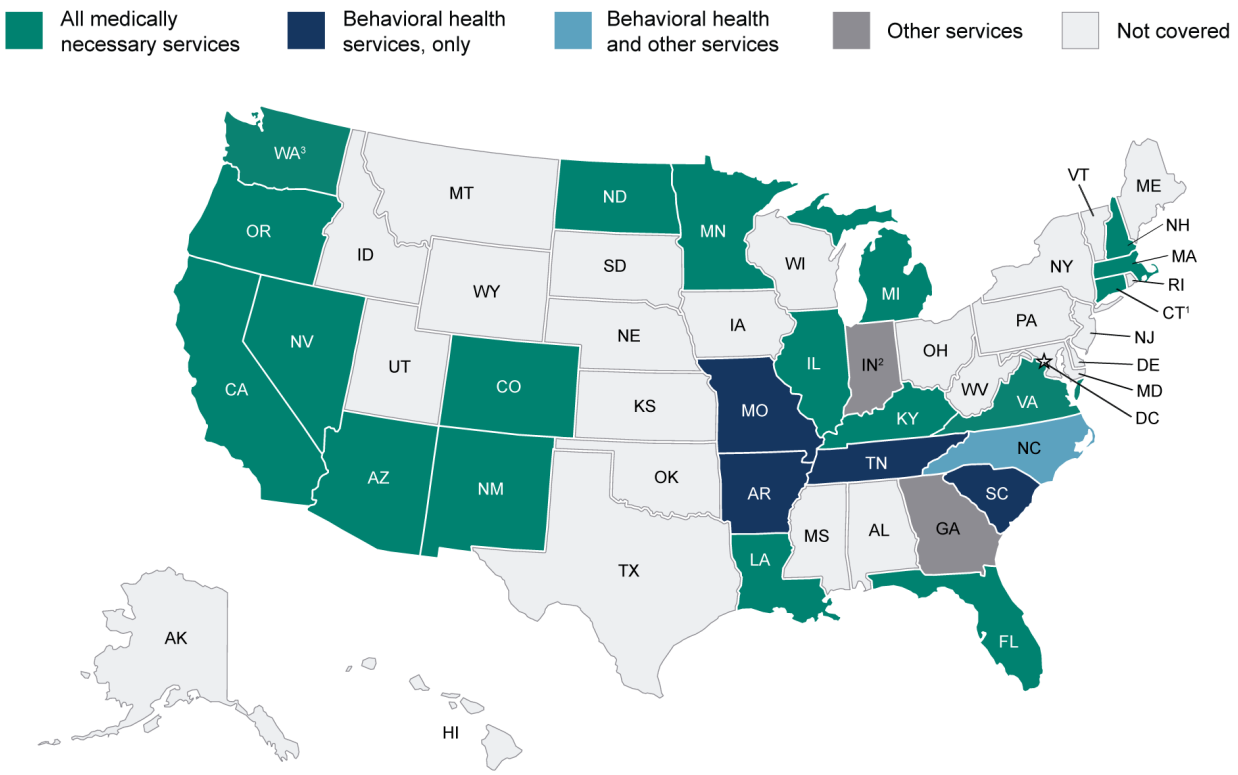
Services billed to Medicaid in schools as part of a student's IEP/IFSP cannot preclude coverage of eligible services offered to that student outside of school (34 CFR 300.154(b)(ii)). IDEA regulations also prohibit scenarios in which billing for school-based services results in families having to pay for services that would otherwise be covered by Medicaid and are required for the student outside of school (34 CFR 300.154(d)(2)(iii)(B)).

School-based services for students without an IEP/IFSP

In December 2014, CMS issued guidance to state Medicaid directors reversing the so-called "free care" rule, which prohibited states from paying for services that were available to all students without charge unless the services were part of a student's IEP/IFSP. This change makes FFP available for care provided to all Medicaid-enrolled students, not just those with an IEP/IFSP, as long as all other Medicaid requirements are met (CMS 2014).

As of October 2023, 25 states have amended their state plans or otherwise expanded coverage to include school-based services that are not part of an IEP/IFSP (Figure 1).[8] Most states (18) expanded coverage for all services identified as medically necessary, while the remaining states cover a more limited set of services often including behavioral health care. In many cases, the primary motivation for these expansions was to improve access to services, particularly behavioral health care, and to obtain Medicaid payment for services that were already being provided to students enrolled in Medicaid without an IEP/IFSP (Wilkinson et al. 2020).

Figure 1. Medicaid Coverage of School-Based Services Outside of an IEP/IFSP, by State, October 2023



Notes: IEP is individualized education program. IFSP is individualized family service plan. Not covered means a state does not have an approved state plan amendment to provide school-based services to Medicaid-eligible students without an IEP/IFSP, and is not otherwise covering such services. Other services refers to school nursing services in Georgia.

[1] Connecticut expanded coverage to all Medicaid-eligible students with a Section 504 plan.[9]

[2] Indiana covers nursing services identified in a student's Section 504 plan.

[3] Washington covers services outside a student's IEP/IFSP if the school district contracts with a managed care organization to provide those services.

Sources: Healthy Schools Campaign 2023a. MACPAC, 2023 analysis of state plan amendments, provider guidance, and program manuals.

Administrative services

Schools can receive Medicaid funding for qualifying administrative activities that are necessary for the proper and efficient administration of the Medicaid state plan, such as outreach, enrollment, and efforts that support the provision of Medicaid-eligible services (CMS 2023a). If the state Medicaid agency delegates the responsibility of making enrollment determinations to LEAs, schools can receive federal matching funds for outreach to eligible children and families. Schools can also draw down federal funds for activities that facilitate children's access to care, such as care coordination, referrals, and transportation (if not provided as a benefit) to and from Medicaid-eligible services, if such transportation is included in an IEP. Generally, payments for administrative actions in schools are made at the 50 percent administrative match rate, but some activities, such as translation, interpretation, and outreach, are eligible for an enhanced match rate (Barnard et al. 2023).

Recent Federal Actions

On May 18, 2023, CMS released a comprehensive guide to Medicaid services and administrative claiming in schools. Developed in consultation with U.S. Department of Education (ED), the guide was issued to improve the delivery of Medicaid and State 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). The guide clarifies existing guidance and provides new flexibilities, including those related to the random moment time study (RMTS), billing, and provider qualifications.[10] States that are not already meeting applicable federal standards and requirements discussed in the guide have until July 1, 2026, to comply. States may also amend their state plans and other relevant state policy documents to implement new optional flexibilities (CMS 2023a).

In June 2023, CMS and ED launched the school-based services technical assistance center to help states implement the flexibilities and requirements discussed in the guide and to further enhance or expand school-based services programs, as required by the BSCA. The technical assistance center will host stakeholder calls and develop additional resources, including more in-depth guidance, for state Medicaid agencies, state education agencies, LEAs, and schools (CMS 2023b). While the guide identified certain areas of focus, such as data collection, CMS is reviewing stakeholder input to determine other topics that will be addressed through the technical assistance center.

The BSCA also provided $50 million in grant funding for states to implement or expand school-based services. The grants will provide 20 states up to $2.5 million each in funding, with a minimum of 10 awards to states that have yet to expand coverage for school-based services outside an IEP/IFSP. CMS released the notice of funding opportunity in January 2024, and grant awards are anticipated in the summer of 2024 (CMS 2024).

Financing and Payment for School-Based Services

State approaches to financing the non-federal share of expenditures for school-based services have implications for how states reimburse LEAs for those services. Many states use certified public expenditures (CPEs) to finance the non-federal share, and therefore states must pay school-based services providers using a cost reimbursement methodology based on incurred costs, that must follow all relevant federal cost rules (45 CFR 75).

Financing the non-federal share

As with other Medicaid expenditures, states receive federal matching dollars for their expenditures on school-based services. To finance the non-federal share, states can use state appropriations or alternatives where LEAs contribute to the non-federal share through CPEs or intergovernmental transfers (IGTs).[11] In most states, LEAs contribute 100 percent of the non-federal share for Medicaid school-based services through one of the following mechanisms:

CPEs. CPEs are the most common way that LEAs contribute the non-federal share of Medicaid school-based services and related administrative service expenditures. CPE is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider such as an LEA, incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (Section 1903(w)(6) of the Act, 42 CFR 433.51). The governmental entity certifies that the funds expended are public funds used to support the full cost of providing the Medicaid-covered service or the administrative activity.[12] Based on this certification, the state can claim the federal share of these costs (MACPAC 2018).

There is no federal requirement for states using CPEs to provide any portion of federal matching funds to schools or other providers, though CMS strongly encourages them to do so (CMS 2023a). Little is known about how states direct those federal funds and the extent to which they are made available to schools.

IGTs. An IGT is a transfer of funds from a governmental entity (e.g., a county or other state agency) to the Medicaid agency before a Medicaid payment is made. When these funds are used as the non-federal share of a Medicaid expenditure, they are eligible for federal matching funds. In some states, an LEA will submit claims for services provided in schools to the Medicaid agency that will calculate the non-federal share. The locality then transfers that amount to the state so that federal matching funds can be claimed. The Medicaid agency pays the claims, with the full amount (federal and non-federal share) transferred to the LEA that provided the service (MACPAC 2018).

Payment

State Medicaid programs have considerable flexibility in how they establish Medicaid payments for school-based services, while meeting federal requirements.[13] However, states that use CPEs to finance the non-federal share for school-based services are required to pay providers of those services using a reconciled cost methodology based on incurred costs. Under this approach, which is the most commonly used payment method for school-based services, states make interim payments to providers throughout the year and reconcile those payments to incurred costs identified through a cost report. As noted above, the state can withhold a portion of the federal share from the schools.

The RMTS is a key feature of the cost reimbursement methodology in many states. It is a complicated and technical process that has been the subject of numerous audit findings by the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG).

RMTS. CMS requires states using a cost-based methodology to adopt statistically valid methodologies to allocate costs for school-based services. The RMTS is the most commonly used sampling approach for determining the amount of time that employees spend on covered health care services and allowable administrative activities. When schools conduct an RMTS, employees are randomly selected and must document all of the work that they do during one moment of a specific, randomly selected time interval. The results of the RMTS are used to calculate the total allowable direct and indirect costs associated with the provision of health care services and allowable administrative activities. LEAs can then identify the portion of those costs associated with services provided to Medicaid-enrolled children.

In its recent guidance, CMS clarifies RMTS requirements and provides some new flexibilities. Notably, CMS encourages states not to notify school personnel until the exact time of their assigned random moment, and recommends that participants complete the random moment activity documentation immediately. This will be a departure for states that currently provide advance notification and additional time to respond (HSC 2023b).[14] However, CMS will permit states to provide up to two business days of advance notification and up to two business days to respond (CMS 2023a).

Billing and Claiming for School-Based Services

LEAs that provide school-based services to Medicaid-enrolled students must comply with a number of billing and documentation requirements. Claims for FFP, including those for school-based services, must be supported by documentation that allows CMS to verify the expenditures associated with the claim. Internal and external audits also require documentation of the services performed and medical necessity, and state laws or regulations may have additional requirements beyond those stipulated in federal rules (CMS 2023a).

Medicaid payment for school-based services has been scrutinized closely, including by the OIG. OIG audits have commonly found insufficient documentation (e.g., related to service provision or an IEP), a lack of adherence to provider requirements, and insufficient state oversight of claims submitted by LEAs, among other concerns (Broome 2022).

Medical necessity

School-based providers are required to document that services meet the state's definition of medical necessity. States, or under delegated authority, managed care plans, make determinations of medical necessity. Those determinations must be made on a case-by-case basis, considering the individual student's needs and guided by information from the child's health providers. Any medical necessity criteria that a state implements must be consistent with federal rules to ensure that services are sufficient in amount, duration, and scope, and do not establish unreasonable or arbitrary barriers to accessing the required coverage (42 CFR 440.230, CMS 2022). Medical necessity can be documented in a number of ways, including in an IEP/IFSP or other individual plan of care containing the required information pursuant to state requirements (Hinshaw 2023, HSC 2022).

Provider qualifications

States determine which providers of school-based services are covered and establish minimum provider qualifications. The 2023 CMS guidance granted states the flexibility to establish provider qualifications for school-based providers. States can cover services provided by school-based providers whose qualifications under state and local law may vary from those of non-school-based providers of the same services, or whose scope of practice may be limited to the school setting. For example, in addition to covering counseling services provided by state-licensed psychologists, social workers, family therapists, and professional counselors, states can also cover counseling services provided by school psychologists or school social workers who are certified to serve in schools but are not licensed by the state to provide care in non-school settings. If a school-based provider is qualified under state or local law to provide counseling to any child in school, the state cannot impose additional provider qualification requirements under state law as a condition of receiving payment for counseling provided to a Medicaid beneficiary (CMS 2023a).

Orders and referrals

Federal regulations require that school-based services are Medicaid diagnostic, preventive, and rehabilitative services recommended by "a physician or other licensed practitioner of the healing arts, within the scope of practice under state law" (42 CFR 440.130). States have flexibility to determine how to operationalize this requirement and may require schools to obtain an order or referral when providing covered services to Medicaid enrollees. Schools often employ professionals, such as school psychologists and school social workers, who have completed the state-required training and are certified to provide services in schools, but who are not licensed to practice in a clinic or other health care setting. In these instances, schools must wait for an order or referral from the child's primary care provider or other licensed provider before rendering services or risk not being able to bill Medicaid for services provided. The frequency with which schools must obtain written service orders or referrals varies by state (e.g., every six months for ongoing services). Some states also permit students to receive certain services for a specified period (e.g., 30 days) before a referral is required.

Federal law requires that Medicaid claims include the national provider identifier of any ordering, referring, or prescribing (ORP) physician or other professional (Section 1902(kk)(7) of the Act). Individual ORP providers, as well as those furnishing services, are required to be enrolled Medicaid providers even if they are employed by an LEA or other entity that is itself an enrolled provider (Section 1902(a)(78) of the Act). Becoming a Medicaid-enrolled provider requires disclosing certain sensitive personal information, such as the provider's Social Security number, and can be time intensive. If the individual who is furnishing, ordering, or referring services is of a provider type that is ineligible to enroll under the state plan, the practitioner or organization (e.g., LEA) under whose auspices they are acting is considered the furnishing provider or ORP and must be enrolled.

Parental consent and confidentiality

LEAs billing Medicaid for school-based services must comply with multiple federal rules that safeguard students' education and medical records. Medicaid regulations do not require schools or other Medicaid providers to obtain consent from the enrollee or family member before exchanging the individual's information for billing or other

purposes directly connected to the administration of the state plan. When a family member enrolls their child in Medicaid, they consent to Medicaid being billed for services (42 CFR 431.306(d), CMS 2023a).

However, IDEA and the Family Educational Rights and Privacy Act (FERPA) (20 USC § 1232g; 34 CFR Part 99) require school districts to obtain the written consent of a student's parent before disclosing personally identifiable information to a state Medicaid agency for billing purposes. IDEA regulations also require school districts to obtain a parent's written consent before billing Medicaid or CHIP for the first time to pay for services in a student's IEP/IFSP (CMS 2023a). These laws protect the privacy of education records, which are records directly related to a student and maintained by an educational agency or institution (e.g., school district) or a party acting on their behalf. On May 18, 2023, ED published a proposed rule that would remove the requirement for schools to obtain parental consent before accessing a child's public benefits or insurance (e.g., Medicaid) to pay for special education and related services under IDEA for the first time. This rule would not alter privacy protections. It is unclear when this rule will be finalized.

Schools may be subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) if they electronically bill Medicaid or other health insurance. However, in most elementary and secondary school settings, even when the school is a covered entity under HIPAA, FERPA privacy protections apply instead of the HIPAA Privacy Rule (CMS 2023a). ED and HHS have issued joint guidance to clarify the application of these laws to education records.

Third-party liability (TPL)

Medicaid TPL rules apply to school-based services and can create additional administrative complexity for schools. Medicaid is generally the payer of last resort, meaning that state Medicaid agencies must take steps to identify and recover payments from third parties (e.g., another health insurer or other federal or state program) that are legally liable to pay for services provided to Medicaid enrollees under the state plan (CMS 2022).

For school-based services provided outside of an IEP/IFSP, LEAs must bill any liable third parties first before billing Medicaid even though school-based services are rarely, if ever, covered by commercial insurance. If the state is aware that a Medicaid enrollee has potential third-party coverage when the claim is filed, the state must reject the claim and instruct the provider to submit it to the potential primary payer—a practice known as cost avoidance. After the potential primary payer has processed the claim, typically resulting in a denial of the claim, the LEA can submit a claim to Medicaid, which will pay if the Medicaid payment amount exceeds the amount of the primary payment (CMS 2022).

TPL requirements differ for services listed in a student's IEP/IFSP because there are instances where Medicaid pays first before federal IDEA funds (Section 1903(c) of the Act, CMS 2023a). After the state Medicaid agency makes the primary payment, it can seek to recoup that payment from any liable third party. This requirement, known as pay and chase, shifts the burden of seeking payment from liable third parties from the LEA to the state Medicaid agency.[15]

CMS guidance outlines existing options that may alleviate the administrative burden associated with TPL requirements and increase Medicaid reimbursement for schools. For example, states may exempt certain services from TPL requirements when submission of claims for those services would always result in denial. In these cases, providers can submit claims for "never covered services" to the state Medicaid agency without first seeking payment from any liable third party. States pursuing this option must maintain and update annually documentation proving that these services are never covered (CMS 2023a).

States can also seek waivers of cost avoidance which would enable them to make the primary payment before pursuing payment from any liable third party (i.e., to use pay and chase). However, no state currently has an approved waiver of cost avoidance because it is difficult to demonstrate that the pay and chase method of claims payment is more cost-effective than cost avoidance (CMS 2023a).

Considerations

The new CMS guidance appears to address several key, historical barriers to Medicaid billing and the expansion of services in schools, including those related to provider qualifications for school-based services and RMTS. It also provides new options to reduce the administrative burden associated with interim claiming.[16] Previously, CMS had not provided comprehensive guidance on school-based Medicaid since the 2003 School-Based Administrative Claiming Guide and the 1997 School-Based Services Technical Review Guide. The availability of up-to-date federal guidance, coupled with technical assistance and forthcoming federal grants, is expected to spur new efforts to expand access to care and Medicaid billing in schools.

However, states and schools are still analyzing the expansive guidance and its implications for their programs. While recent federal guidance may address certain challenges, others remain or have recently come to light. These are areas where further federal action may be needed. For example, federal officials and other national experts are concerned that Medicaid agencies and managed care organizations (MCOs) sometimes deny coverage of services outside of school because of services that students are receiving in school through an IEP/IFSP, despite IDEA rules that prohibit such scenarios (34 CFR 300.154(b)(ii)) (ASHA 2023, CCD 2023, Neas 2023). These decisions are driven by Medicaid agency and MCO determinations that the child is receiving duplicative services. Additionally, some states believe that the administrative burden associated with becoming an enrolled Medicaid provider—perceived, in some cases, as a new requirement for school-based providers—is a deterrent to Medicaid billing in schools. Schools also cite challenges with waiting for an order or referral from the child's primary care provider before rendering services in the school setting. Finally, while the guidance outlines flexibilities with respect to TPL, states may have difficulty pursuing those options. These issues may receive further consideration through the technical assistance center and other federal efforts to improve access to care and the availability of Medicaid payment for school-based services.

Endnotes

[1] The COVID-19 pandemic placed substantial stress on children and their families. In 2021, more than a third (37 percent) of high school students in the United States reported experiencing poor mental health during the pandemic, and 44 percent reported they felt sad or hopeless during the past year (CDC 2022). Rates of anxiety and depression among children and adolescents were rising even prior to the pandemic, and suicidal behaviors among high school students increased more than 40 percent in the decade before 2019 (AHRQ 2022, Lebrun-Harris et al. 2022).

[2] A future MACPAC publication will examine access to behavioral health services provided by SBHCs and other community providers in schools.

[3] This policy has often been referred to as the "free care" policy.

[4] MACPAC contracted with Aurrera Health Group to facilitate interviews with stakeholders in Arkansas, California, Michigan, Missouri, and New York. Interviews were conducted with state Medicaid agency officials, state education agency officials, LEA and school district representatives, and national and state-level advocates between February and early May 2023. MACPAC has since engaged with additional state and national experts, including CMS, to clarify federal requirements and flexibilities and to further examine key issues.

[5] All children under age 21 enrolled in Medicaid through the categorically needy pathway are entitled to the EPSDT benefit, which requires states to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan.

[6] In 2022, the Healthy Schools Campaign contacted state Medicaid and state education officials and gathered information via phone interviews and a written survey.

[7] In a survey of 38 states and the District of Columbia, 79 percent of states reported that school-based services are carved out of managed care (HSC 2023b).

[8] As of October 2023, 17 states amended their state plans to cover services outside of an IEP/IFSP. Washington allows LEAs to contract with managed care organizations to bill for services, including behavioral health, outside an IEP. Seven states expanded coverage through administrative or legislative action and did not require a state plan amendment (HSC 2023a).

[9] Section 504 of the Rehabilitation Act of 1973 requires schools to provide a free and appropriate education to students with disabilities through the provision of a 504 plan, which often includes modifications or services needed to access education. While children eligible for services under IDEA are also protected by Section 504, many children with a 504 plan are not eligible for IDEA (CMS 2023a). An LEA can only seek reimbursement for health services under a 504 plan if the state has expanded services outside of an IEP/IFSP.

[10] The guide builds on the CMS informational bulletin issued to states on August 18, 2022, and supersedes the 2003 School-Based Administrative Claiming Guide and the 1997 School-Based Services Technical Review Guide (CMS 2023a).

[11] Among 38 states and the District of Columbia that responded to a recent survey, 62 percent reported using CPEs and 35 percent reported using IGTs to finance the non-federal share of expenditures for school-based services (HSC 2023b).

[12] A CPE equals 100 percent of a total computable Medicaid expenditure, including the federal and non-federal share of the cost.

[13] States generally use one of three methods to pay school-based services providers: fee-for-service (FFS) rates established for serviced furnished by providers in non-school-based settings; cost-based FFS payment rates specific to schools; or the incurred cost of Medicaid services reported through cost reports, which is required in states that use CPEs to finance school-based services (CMS 2023a).

[14] For example, some states provide a three- or four-day response window.

[15] States also must use pay and chase, rather than cost avoidance, when the claim is for medical child support services or preventive pediatric services that are covered in the state plan, and in situations where the third party is a non-custodial parent under court order to provide medical support (CMS 2023a).

[16] CMS guidance describes ways that states can make interim payments without requiring schools to submit service claims. New interim rate methodologies include roster billing and a per child, per month rate. Under both approaches, interim payments would be reconciled to actual costs at the end of the year (CMS 2023a).

References

Agency for Healthcare Research and Quality (AHRQ). 2022. *2022 National Healthcare Quality and Disparities Report.* Rockville, MD: AHRQ. https://www.ahrq.gov/research/findings/nhqrdr/nhqdr22/index.html.

American Speech-Language-Hearing Association (ASHA). 2023. Comment letter on proposed rule: Assistance to states for the education of children with disabilities (August 1, 2023). https://downloads.regulations.gov/ED-2023-OSERS-0052-9581/attachment_1.pdf.

Baller, J.B., and C. L. Barry. 2016. State variation in school-based disability services financed by Medicaid. *Journal of Disability Policy Studies* 27, no. 3: 148-157.

Barnard, Z., C. Clemons, J. Guyer, et al. 2023. *CMS Issues Guidance on Medicaid and CHIP Services in School-Based Settings.* New York, NY: Manatt Health. https://www.manatt.com/Manatt/media/Documents/Articles/CMS-SBHC-Guidance_2023-08_b.pdf.

Broome, S. 2022. *Office of the Inspector General School-Based Medicaid Reports: A Consolidated Review.* Chicago, IL: HSC. https://healthystudentspromisingfutures.org/wp-content/uploads/2022/03/OIG-Report-Final.pdf.

Centers for Disease Control and Prevention (CDC). 2022. New CDC data illuminate youth mental health threats during the COVID-19 pandemic. March 31, 2022, press release. Atlanta, GA: CDC. https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2024. CMS Announces $50 Million in Grants to Deliver Critical School-Based Health Services to Children. January 24, 2024, press release. Baltimore, MD: CMS. https://www.cms.gov/newsroom/press-releases/cms-announces-50-million-grants-deliver-critical-school-based-health-services-children.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023a. *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.* Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023b. Technical Assistance Center (TAC). Baltimore, MD: CMS. https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/medicaid-and-school-based-services/technical-assistance-center-tac/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2022. Center for Medicaid and CHIP Services informational bulletin on “Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services.” August 18, 2022. Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2022-08/sbscib08182022_2.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Letter from Cindy Mann to state Medicaid directors regarding "Medicaid payment for services provided without charge (free care)”. December 15, 2014. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

Consortium for Constituents with Disabilities (CCD). 2023. Comment letter on proposed rule: Assistance to states for the education of children with disabilities (August 1, 2023). https://downloads.regulations.gov/ED-2023-OSERS-0052-9580/attachment_1.pdf.

Healthy Schools Campaign (HSC). 2023a. School Medicaid expansion: How (and how many) states have taken action to increase school health access and funding. Chicago, IL: HSC. https://healthyschoolscampaign.org/dev/wp-content/uploads/2023/10/Status-of-School-Medicaid-Expansion_-How-and-How-Many-States-Have-Taken-Action-to-Increase-School-Health-Access-and-Funding.pdf.

Healthy Schools Campaign (HSC). 2023b. Healthy Students, Promising Futures: School Medicaid Survey. Chicago, IL: HSC. https://healthystudentspromisingfutures.org/wp-content/uploads/2023/06/School-Medicaid-Survey.pdf.

Healthy Schools Campaign (HSC). 2022. School Medicaid: Documenting medical necessity through plans of care. Chicago, IL: HSC. https://healthystudentspromisingfutures.org/wp-content/uploads/2022/05/Plans-of-Care-Policy-Brief.pdf.

Hinshaw, K. 2023. Expanding school-based health services in Illinois. Presentation at the National Academy for State Health Policy annual conference, August 15, 2023, Boston, MA.

Lebrun-Harris, L., R. Ghandour, M. Kogan, et al. 2022. Five-year trends in US Children’s Health and Well-Being, 2016-2020. *Journal of American Medical Association Pediatrics*. March 14, e-publication. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2789946?guestAccessKey=41fde697-e79f-411c-bed3-

743faeb63055&utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_content=tfl&utm_term=031422

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. *Medicaid in Schools*. Washington DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf.

Neas, K. 2023. Update from the U.S. Department of Education Office of Special Education and Rehabilitative Services. Presentation before the National Alliance for Medicaid in Education, October 25, 2023, Dallas, TX. https://macpacgov.box.com/s/btcm88jjv4f74ywp5p7mkog4fp7stfuk.

Soleimanpour, S., K. Cushing, A. Goddard, et al. 2022. *2020-2021 National Survey of School-Based Health Centers: The Impact of the COVID-19 Pandemic*. Washington, DC: School-Based Health Alliance. https://sbh4all.org/wp-content/uploads/2023/04/National-Survey-2021-Summary-Report-Final.pdf.

Wilkinson, A., A. Gabriel, B. Stratford, et al. 2020. *Early Evidence of Medicaid's Important Role in School-based Health Services*. Rockville, MD: Child Trends. https://www.childtrends.org/publications/early-evidence-medicaid-role-school-based-heath-services.