School-based Health Centers and Behavioral Health Care for Students Enrolled in Medicaid

Schools are an important setting for providing health services to children and adolescents with Medicaid coverage. Schools are a convenient point of access because students attend school for many hours a day for approximately half the days of the year. Additionally, students with behavioral health disorders are often first identified as needing treatment at school (CMS 2023). Students may receive health care services by personnel employed by a school or local education agency (LEA) or by school-based health centers. Previous MACPAC work examined key topics affecting school-based services under the Individuals with Disabilities Education Act (IDEA) for students enrolled in Medicaid.[1] Examples of common school-based services include physical therapy, occupational therapy, speech pathology or therapy services, psychological counseling, and nursing services (MACPAC 2024).

School-based health centers (SBHCs) are an important source of primary care and behavioral health care (e.g., mental health care and substance use disorder services) for students (HRSA 2024).[2] The number of SBHCs has increased substantially in recent years, from 2,584 in 2016-2017 to approximately 3,900 in 2021-2022 (Soleimanpour et al. 2023). While SBHCs can serve all students regardless of insurance status, they predominately serve children and youth who are covered by Medicaid and the State Children's Health Insurance Program (CHIP) (CMS 2023, SBHA 2023).[3] Compared to schools without access to SBHCs, schools with SBHCs had a higher percentage of Black and Hispanic students (Love et al. 2019).

The number of youths reporting poor mental health outcomes has been increasing (CDC 2024). In 2023, approximately one in five adolescents experienced a major depressive episode in the past year and roughly nine percent had a substance use disorder in the past year (SAMHSA 2024). Many mental disorders begin in childhood or adolescence, and early detection and treatment, including at schools, can mitigate problems before they become disabling (Kessler et al. 2007, NIHCM 2009). Research shows there was an increased demand for behavioral health services through SBHCs after the COVID-19 pandemic, including, for example, a 12.3 percent increase in SBHC behavioral health service utilization between 2019 and 2021 (Stuenkel et al. 2023, Damian and Oo 2022, Sullivan et al. 2022). In 2022, 83 percent of SBHCs offered behavioral health services (Soleimanpour et al. 2023).

This issue brief examines how Medicaid policies support or delay access to services provided by SBHCs, with a particular focus on behavioral health. MACPAC studied five states—Arkansas, California, Michigan, Missouri, and New York— to explore the role of SBHCs in providing behavioral health services to students enrolled in Medicaid and CHIP (Appendix Table A-1).[4] Stakeholders noted that the challenges with providing behavioral health services to students are not unique to the SBHC setting, but may affect the care received. This brief provides an overview of SBHCs and discusses the sponsoring organizations for SBHCs, the different sites of service, types of behavioral health services offered, and funding. Then, it highlights some of the challenges related to providing services in SBHCs, such as coverage of behavioral health services, limited data on SBHC services, payment rates, working with managed care organizations, referrals for specialty services, consent to services, and workforce shortages.

Overview

School-based health centers are a type of health care provider located on or near school campuses to provide students comprehensive primary care and behavioral health services. SBHCs are generally subject to the same

Medicaid requirements as other health centers and primary care providers, but several qualities set them apart from those providers. The section below provides background information on key features of SBHCs, including organizational sponsorship, their locations, how they provide behavioral health, and how SBHCs are funded.

SBHC sponsors

SBHCs are typically sponsored by a local partner such as a federally qualified health center (FQHC), hospital, local health department, school system or other entities (e.g., tribal governments, mental health agencies, nonprofits) (42 USC § 1397jj). Sponsor organizations facilitate SBHC clinical and fiscal operations, such as staffing and contracting with managed care organizations (MCOs). In addition, sponsoring organizations assist SBHCs with certain administrative operations, such as billing and claiming for services, which SBHCs characterized as important in reducing the burden of these functions.

FQHCs sponsor more than half of SBHCs and this trend continues to grow. In 2021-2022, FQHCs sponsored 63 percent of SBHCs, compared to 51 percent in 2016-2017 (Soleimanpour et al. 2023). The growth in FQHC sponsorship and SBHCs overall may in part be explained by an increase in federal funding for health centers. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) increased funding to support the operation, expansion, and construction for health centers, including SBHCs (Love et al. 2019). The ACA appropriated $50 million each year for three years for SBHC development and expansion. This funding was for a one-time grant program for SBHC facilities, equipment, and related expenditures, particularly in communities that have difficulty accessing primary health and mental health care services (§ 4101(b) of the ACA).

As FQHC sponsorship of SBHCs increased, there was decline in sponsorship by other entities. In 2021-2022, 16 percent of SBHCs were sponsored by hospitals and medical centers, compared to 20 percent in 2016-2017, and 9 percent were sponsored by other sponsor types (e.g., tribal governments, mental health agencies, or non-profit organizations), compared to 17 percent in 2016-2017 (Soleimanpour et al. 2023).[5]

SBHCs are subject to regulations applicable to their sponsoring organization. For example, FQHC-sponsored SBHCs must comply with the requirements that the Health Resources and Services Administration (HRSA) mandates for all FQHCs, including Uniform Data System (UDS) reporting requirements. The UDS collects certain behavioral health data, such as number of patients receiving behavioral health services, specific mental health diagnoses, and types of therapy sessions. FQHC-sponsored SBHCs must provide primary health care services and work with the school districts to determine which other health services best meet the needs of the students (HRSA 2024).

SBHC site of service

SBHCs use different approaches, including location of clinics and varying modes of service delivery, to provide care to students. Most SBHCs, over 90 percent, use a traditional school-based approach, in which the clinic is a fixed facility on campus. In some cases, school-based clinics are not located on school grounds, but are located in a nearby facility in the community. Schools can contract with these offsite clinics and transport students to and from the clinics during school hours. Schools can also use a mobile model (e.g., an equipped vehicle is parked at or near a school) or supplement in-person services with a telehealth model. One rural state noted that the infrastructure requirements and associated costs of building and operating a fixed facility site leads them to use more mobile SBHCs. However, another state noted that they do not permit mobile SBHCs under their state SBHC grant program because these mobile clinics do not meet their state grant requirements, such as hours of availability.[6] One survey found that 2 percent of schools use a telehealth-exclusive model that linked students from a designated school location to offsite providers, and most of these models provide access to rural communities (Soleimanpour et al. 2023, Love et al. 2019).

Some states have clinics on school grounds that only provide behavioral health services. While traditional SBHCs offer physical health and other services in addition to behavioral health, school-based mental health clinics are dedicated to the provision of behavioral health services. In New York, for example, the distinction between

SBHCs and school-based mental health clinics may also result in different regulatory requirements and payment levels for the clinics.[7] New York's Medicaid base rates for SBHCs are lower than Medicaid base rates for school-based mental health clinics in the state, however rates also vary depending on the sponsoring organization and location (NYS DOH 2024, NYS OMH 2024).

SBHC behavioral health services

State policies vary with respect to the type of professionals that can provide behavioral health services in SBHCs. SBHCs can receive Medicaid payment for state plan services provided to Medicaid-enrolled children, if the health center is enrolled as a Medicaid provider. SBHCs must comply with requirements for provider enrollment, licensure and certification, and service delivery as outlined in the state's Medicaid plan (MACPAC 2018). For example, California statute stipulates that school behavioral health services must be provided by, or supervised by, a licensed mental health professional and may include assessments, crisis intervention, counseling, treatment and referrals to a continuum of services (CA 2008). About 76 percent of all SBHCs hire a licensed clinical social worker, counselor, or therapist to provide behavioral health care (Soleimanpour et al. 2023). These providers may be employed by the SBHC directly or contract with the SBHC to provide services. The most common behavioral health services offered through SBHCs were individual, group, and family counseling services (Soleimanpour et al. 2023).

Funding for SBHCs

SBHCs are funded by payments from Medicaid and other payers, in addition to support received from a combination of federal, state and other grants.[8] In 2022, 74 percent of SBHC funding came from billing and third-party revenue, although it is unclear how much comes strictly from Medicaid (Soleimanpour et al. 2023).[9] Since there is no federal provider type or place of service code for SBHCs, it is difficult to find these data in the Transformed Medicaid Statistical Information System (T-MSIS). Among the SBHCs in our study, between 20 to 90 percent of funding comes from Medicaid. In fee-for-service delivery systems, state Medicaid agencies provide SBHCs payment for services. In managed care delivery systems, SBHCs can contract with managed care organizations to be included in their provider networks (MACPAC 2018).

SBHCs also receive federal grant funding, the majority of which comes from HRSA.[10] Given the poor youth mental health outcomes highlighted by the COVID-19 pandemic, additional funding was dedicated to support the development of new SBHCs and the expansion of service offerings among existing SBHCs (Soleimanpour et al. 2023). For example, in 2022, HRSA awarded about $25 million to 125 HRSA-funded health centers to provide care at school-based sites across the United States. These SBHCs can use the funding to increase the number of students receiving mental health services, as well as community and patient outreach, health education, and translation services (HHS 2022).

Some state education or Medicaid agencies provide grant funding to SBHCs, which is an integral component of SBHC operations. Grants may provide start-up funding for SBHCs or ongoing funding for program operations. For example, in 2024, Michigan and New York released state grants to expand SBHCs, with $4.46 million and $20 million in total funding, respectively (MDHHS 2024, NYS 2024). New York's grant was specifically start-up funding for licensed providers, with support from a school, to establish a school-based mental health satellite clinic.

The reporting requirements associated with grants may provide insight into SBHC activities and outcomes. For example, SBHCs in Michigan that receive funding through state Medicaid grants must follow and report on certain program requirements, including those related to provider staffing, services provided (e.g., behavioral health services are required), and when and where services were provided (MDHHS 2022). Interviewees noted that as grantees, they may be asked to report quarterly data on measures such as the number of patients seen, the reason for patient visits, top diagnoses and issues reported by students, number of visits (including number of mental health visits), and types of services provided (including behavioral health services). Grantees may also examine the quality measures related to how many students receive behavioral health screenings and risk

assessments, which are evaluated against visit data to determine whether screenings and assessments are leading to follow-up appointments.

Challenges Related to Providing Services in SBHCs, Including Behavioral health

State Medicaid and education agencies are implementing several initiatives to increase behavioral health access for students in the school-setting; however, we found that SBHCs are a small component of these efforts. Most states interviewed did not have specific initiatives related to increasing the number of SBHCs or increasing the use of behavioral health services that they provide. The initiatives primarily focused on school-based services, such as expanding coverage of services provided by school-employed personnel and building the capacity of schools to bill Medicaid for those services, following the release of recent Centers for Medicare & Medicaid Services (CMS) guidance (CMS 2023).[11]

States noted common challenges related to providing behavioral health in SBHCs, such as the coverage of certain behavioral health services and payment rates. Interviewees also noted challenges with understanding the type and amount of behavioral services provided due to the lack of place of service code for SBHCs. The other challenges cited such as referring patients to behavioral health specialists, obtaining parental consent, and behavioral health provider shortages were not unique to SBHCs.

Coverage for behavioral health services

State Medicaid agencies have flexibility to determine which behavioral health services to cover, but may not cover certain services that SBHCs commonly provide. Interviewees noted that state coverage policies can create disincentives to provide and bill for certain services, such as group therapy. For example, under one state's payment policy for FQHCs, behavioral health providers can only be reimbursed for one participant served as part of a group, even if all group participants are Medicaid-eligible. Providers in SBHCs noted they do not receive sufficient reimbursement for the amount of time they spend managing group services, including time spent completing required documentation and billing processes.

Payment

Some stakeholders noted that Medicaid payment rates do not cover the costs of services required to meet the behavioral health needs of students, especially for SBHCs that are not sponsored by FQHCs. SBHCs that are sponsored by FQHCs receive the prospective payment system rate, which can be an enhanced Medicaid payment rate.[12] Interviewees noted that Medicaid generally does not pay for non-clinical health services, such as health education and socialization support. Thus, providers who spend time outside the SBHC aiding school staff in addressing students' behavioral health needs throughout the school day (e.g., coordinating with teachers or attending school meetings), cannot bill for it.

SBHC representatives note that low Medicaid payment rates make it difficult to recruit providers who are willing to accept Medicaid patients. Some state Medicaid agencies are increasing Medicaid rates for behavioral health services, including those offered at SBHCs. Beginning January 2024, Arkansas increased Medicaid rates for individual behavioral health counseling, family counseling, and mental health diagnosis rates to 80 percent of the Medicare rate, and increased group behavioral health counseling to 100 percent of the Medicare rate (AR DHS 2023).

Data on SBHC services

Leveraging the administrative infrastructure of sponsoring organizations helps to mitigate the burden and potential challenges for SBHCs in submitting Medicaid claims. However, it also can present challenges with understanding

key SBHC metrics. For example, billing under a sponsoring organization, may obscure the number of services and the type of care provided by the SBHC. It may appear as though the sponsoring organization provided the services and not the SBHC.

It can also be difficult to differentiate services provided by SBHCs from school-based services by an LEA under IDEA requirements. State Medicaid programs allow for services delivered at any school site to be billed using the school place of service code, regardless of whether the service was delivered by a school employee, contracted provider, or SBHC. These limited administrative data make it more difficult to monitor and evaluate utilization of behavioral health services in SBHCs.

States can establish their own coding practices to allow identification of SBHC services. Seven state Medicaid agencies designate SBHCs as its own provider type through a unique Medicaid identification number. In these states, Medicaid agencies are able to identify and differentiate services provided at an SBHC versus their sponsoring organization or other school-based providers (SBHA 2023).[13]

Managed care

Depending on the state, services provided by SBHCs can be carved into or out of managed care delivery systems.[14] In states where SBHCs are included in MCO provider networks, administrative barriers can hamper prompt payment for services or lead to denial of services. For example, interviewees noted that there are variations in MCO administrative requirements related to provider credentialing and claims approvals. In particular, SBHCs that do not operate under a sponsoring organization cited these administrative burdens as especially challenging to navigate. Another challenge is that MCOs can have difficulty distinguishing between claims provided through school district employees and those provided through SBHCs, leading to inappropriate claim denials for SBHC services. One stakeholder noted that in their state, school-based services are carved out of managed care and SBHC services are carved into managed care, but an MCO may automatically deny a claim labeled “school” without determining first that it came from an SBHC.

Some states have implemented strategies to reduce administrative burdens for SBHCs and their sponsoring organizations. CMS guidance on school-based services, released in May 2023, clarifies that state Medicaid agencies can use their managed care contracts to require MCOs to coordinate with or establish relationships with SBHCs (CMS 2023). In Michigan, SBHCs that participate in the state grant program are considered designated MCO providers and do not require prior authorization to provide for covered services. In addition, MCOs must pay SBHCs for services provided even if the SBHC is not enrolled in the MCO network. However, the state encourages MCOs to include SBHCs in their provider networks (MDHHS 2021). California is rolling out a new multi-payer fee schedule, which requires all MCOs to pay school-linked providers, including those at SBHCs, for behavioral health services provided to students, regardless of whether the provider is in the MCO network (CA DHCS 2024).

Referrals for specialty services

SBHCs experience many of the same challenges other primary care providers face when referring patients to specialty behavioral health services. For example, a lack of providers in the community who accept Medicaid or waitlists for behavioral health services can impede SBHCs ability to ensure that students receive the services they need. However, interviewees indicated that SBHCs that are sponsored by FQHCs or hospitals that are part of a larger health system may experience greater ease in finding specialty providers. In addition, like many providers, SBHCs often have limited staff and resources available to search for other community providers willing to serve their patients. When referring students to a community provider or social service program, SBHC staff do not always know whether patients ultimately receive these services. Some of these challenges are reduced when the SBHC serves as the student’s primary care provider or medical home because the SBHC knows whether students received services.

Consent

Interviewees noted that it can be challenging to obtain parental consent for services in a timely manner and to keep parents and caregivers engaged throughout a student's treatment, including to support coordination of referrals. States may require parental consent before particular SBHC services can be provided to students, unless the student is over the age of 18 or the state allows minors to consent. Along with state law, SBHCs may be subject to parental consent requirements outlined in their contract or memorandum of understanding with school districts.

Some states allow minors to consent to receive certain services, including behavioral health care, without the involvement of a parent or guardian, which can help support access to behavioral health services through SBHC. For example, Michigan allows minors aged 14 and older to consent to receive behavioral health services without parental involvement (MI § 330.1707, § 333.6121). While not specific to SBHCs, interviewees noted that MCOs have challenges ensuring that confidential services provided to students are not disclosed to their parents or guardians through explanation of benefit mailings to the family home.

Workforce

While not unique to SBHCs, interviewees noted that behavioral health workforce shortages are a significant challenge. A limited workforce can impede the ability of an SBHC to offer behavioral health care services that meet the needs of the students. Some Medicaid agency officials noted that they have expanded, or are considering expanding, the allowable types of providers who can deliver behavioral health services through their Medicaid programs, including at SBHCs. For example, some of the states interviewed are allowing master's level clinicians to provide care in FQHC-sponsored SBHCs. Other states are expanding the types of providers who are eligible for loan forgiveness as an incentive for more individuals to enter the behavioral health workforce. For example, one interviewee noted a state loan forgiveness program for licensed providers, including licensed social workers and mental health counselors, who practice in the school-based mental health clinics.

Conclusion

SBHCs offer primary and behavioral health services to students in a convenient setting where children and adolescents spend a significant amount of time. SBHCs may also serve as a student's medical home and connect students to other resources and health care providers in their community. However, our understanding of utilization of SBHC services is hampered by data limitations that prevent differentiating those services from services provided by a sponsoring organization or providers of other services in school settings.

Endnotes

[1] The Individuals with Disabilities Education Act (IDEA) requires public schools to provide all children with disabilities with a free and appropriate public education (P.L. 101-476). States may seek payment from Medicaid for medically necessary services for any Medicaid-eligible student, regardless of whether those services are identified in an individualized education plan, in addition to maintaining their obligation to provide education and related services to students with disabilities.

[2] SBHC services are distinct from school-based services. SBHCs provide a variety of health services beyond the first aid treatment provided by a school nurse; they can provide preventive services (e.g., immunizations), oral health care, routine screenings, or acute care services (e.g., treatment for asthma) (HRSA 2022).

[3] As of October 2024, about 38 million children and adolescents are enrolled in Medicaid or CHIP, representing about 47 percent of total Medicaid and CHIP program enrollment (CMS 2024).

[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, representatives of state school-based health alliance chapters, school-based health centers, sponsoring entities, as well as the national School-Based Health Alliance between February and May 2024.

[5] School districts and local health departments are less common sponsorship organizations and have remained at similar sponsorship levels from 2017 to 2022.

[6] SBHCs may also rely on state grant funding for start-up operations, to expand operations, or cover non-reimbursable Medicaid services. These state grant programs may be administered by the state Medicaid agency, the state education agency, or both agencies.

[7] New York's SBHCs are referred to as Article 28 clinics and the school-based mental health clinics are referred to as Article 31 clinics.

[8] These other sources of funding come from local governments, private foundations, or school system funding (Soleimanpour et al. 2023).

[9] This data comes from a voluntary survey conducted by the School-Based Health Alliance (SBHA) in 2022. The final sample included responses from approximately 40 percent of SBHCs known to SBHA.

[10] Federal grant funding also comes from Title X Public Health Service Act, Section 330 Public Health Service Act, Title V Social Security Act, the Substance Abuse and Mental Health Services Administration, and the U.S. Department of Education (Soleimanpour et al. 2023).

[11] 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 (CMS 2023).

[12] Medicaid payment rules for FQHCs differ from those for other provider types because federal law has established a prospective payment system prescribing how FQHCs are to be paid for each encounter or visit. FQHCs are often eligible to receive enhanced Medicaid reimbursement rates (MACPAC 2017).

[13] Delaware, Illinois, Louisiana, Maine, New Mexico, North Carolina, and West Virginia designate SBHCs as a specific provider type. SBHCs in Illinois, Louisiana, New Mexico, and North Carolina are credentialed through the state and receive a unique Medicaid ID (SBHA 2023).

[14] In the interviewed states, SBHCs were carved into managed care. New York is in the process of carving their SBHCs into managed care and plans to maintain fee-for-service rates for SBHCs for several years to ease the transition (NYS DOH 2025).

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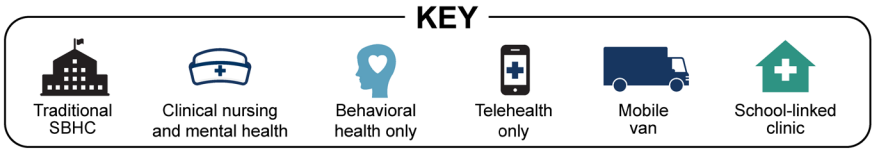
APPENDIX A

TABLE A-1. School-based Health Centers (SBHCs) Overview Across Study States, 2024

State	# of SBHCs	SBHC site of service	Sponsoring organization
AR	68		75% FQHCs 25% Medical centers
CA	377		52% FQHCs 27% School districts 21% Hospitals or health departments
MI	300		33% FQHCs 33% Local health departments 33% Hospitals
MO	675		36% FQHCs 26% Non-profit organizations 17% Hospitals 11% Community and mental health clinics 9% Local health departments 1% Other organizations
NY	1452		Article 28 57% Medical centers 43% Hospitals Article 31 100% Community and mental health clinics



Notes: Totals may not sum to 100 percent due to rounding. Traditional SBHCs are a fixed facility clinic on a school campus that provide primary and behavioral health services. Clinical nursing and mental health sites pair a full-time registered nurse with a mental health provider to provide a range of health services. Behavioral health only sites are clinics that only provide behavioral health services, including mental health and substance use disorder treatments. Telehealth only are programs that only provide services via telehealth. Mobile vans are clinics that offer health services in a van and can travel to several schools. School-linked clinics are health centers that are off-campus and have formal operating agreements with schools to provide services to students during the school day. FQHCs are federally qualified health centers.

Source: Aurrera Health analysis of information from state Medicaid agency, state departments of health, state departments of education, and state's school-based health alliance in Arkansas, California, Michigan, Missouri, and New York, as of June 2024.