Structural Inefficiencies in the School-Based Medicaid Program Disadvantage Small and Rural Districts and Students

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AASA
THE SCHOOL SUPERINTENDENTS ASSOCIATION

INTRODUCTION

When children come to school with unmet health needs, they struggle to learn. However, ensuring that all children attend school ready-to-learn and have access to the school and community services necessary to meet their comprehensive health needs is a serious challenge for school leaders and a community imperative.

It is easy to point to inadequate funding as a barrier to providing children with the health-related services that they need to learn and which are mandated by law. It is easy, because it is true. Accordingly, over the past 25 years, school districts have looked to Medicaid, the same program that provides health care to millions of eligible children and families, to help mitigate the effects of constrained financial resources while facing ever-escalating demands for health services in our schools. The Medicaid program provides districts with a reimbursement stream that enables eligible children with healthcare services they may not be able to access anywhere else.

Participating in the Medicaid program is not easy for school districts and there are many obstacles to obtaining Medicaid reimbursement. Educating children and ensuring they have the supports they need in order to learn is the main focus of school districts—not managing health care billing systems—and the challenges of balancing both are intensifying. For the first time in nearly a decade, the number of uninsured children in the United States increased in 2018[1] and one out of every five children experiences a major mental or behavioral health disorder.[2] Awareness that educational equity and health care equity are intrinsically linked is becoming more commonplace, but because a significant share of states are providing much less school funding than they were a decade ago[3]

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there are fewer local education dollars allocated to addressing the health care issues of children in school.

What does this mean for school leaders? We know our primary responsibility is to make sure children are learning and growing into productive, healthy citizens, but this goal is becoming progressively more difficult as children come to school with increasingly unmet health needs. How can we achieve this objective if a child is suffering from frequent asthma attacks or hypoglycemia at school and at home and lacks access to appropriate treatment? What if a child is unable to see the chalkboard well or hear their teacher in class and the parent cannot take them for a hearing or vision screening?

In 2017, AASA issued a groundbreaking report called *Cutting Medicaid: A Prescription to Hurt the Neediest Kids* that discussed how school-based Medicaid programs can bridge a critical gap in ensuring that children are healthy enough and supported enough to learn. We issued this report at the start of a tumultuous debate on Capitol Hill about the structure of the Medicaid program and how changes to the federal financing methodology could impact the **one in three** school-aged children who rely on Medicaid to meet their basic health care needs. The debate on Capitol Hill and the data we garnered for our report allowed educators, school-health advocates, child-welfare and disability groups to inform staff, politicians and the media about the Medicaid in schools program, which had flown under the radar for the past quarter century

Protecting the viability of Medicaid funds for schools is not the only challenge. **The time has come to also improve upon the services we deliver to children in schools.** We must ensure school-based Medicaid can be an effective and sustained program for children, and that districts are provided the necessary resources to meet the growing physical and mental health care needs of children.

In December 2018, we surveyed more than 750 leaders in 41 states about their participation, or lack thereof, in the school-based Medicaid program. Our findings point to a clear need for immediate improvements to how the school-based Medicaid program is administered by the Centers for Medicaid and Medicare Services (CMS). Medicaid has an obligation to guarantee that districts currently claiming Medicaid reimbursements are not unfairly burdened by needless red tape and redundant requirements in order to obtain essential funding to support the mandated services they are providing to eligible children. Burdens that unfairly diminish the amount of reimbursement to which schools are entitled, or worse, create insurmountable barriers that freeze out small, rural and high-poverty schools from even attempting to receive reimbursement. Medicaid has the responsibility, and the opportunity, to enable school districts of all capacities to fully and equitably receive reimbursement under the Medicaid program while facilitating accountable and efficient processes for schools to follow.

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BACKGROUND ON MEDICAID BILLING IN SCHOOLS

Medicaid funding is the third largest federal funding stream school districts receive. Medicaid spending on school-based services and Medicaid-related administrative services was estimated to be $4.5 billion in fiscal year 2016,[4] which represents approximately .008% of total Medicaid spending annually.[5] While at least one state mandates that every school district participate in the Medicaid program, there is significant variation in the percentage of districts that may participate in other states. For example, in Oregon less than 50% of districts seek Medicaid reimbursement while in Michigan 100% of districts participate in the Medicaid program.

There are several ways that schools are entitled to reimbursement from Medicaid: (1) for providing direct medical/health-related services to children who are eligible for Medicaid; (2) performing administrative activities in support of the state Medicaid plan in accordance with the state Medicaid agency's administrative reimbursement; and (3) a combination of both.

Since 1988, Medicaid has enabled school districts to bill for certain medically necessary services provided to eligible special education children who have an individualized education program (IEP) under the Individuals with Disabilities Education Act (IDEA, P.L. 101-476). While eligible services and reimbursement rates vary from state to state according to each state's CMS-approved Medicaid plan, reimbursement for these medical services is intended to recover some of the costs associated with delivering federally mandated health-related services to Medicaid-eligible students. These services can include audiology or speech-language pathology services, mental health services, physical therapy and nursing, as well as transportation and other services.

States may also provide Medicaid payments to schools for activities not mandated by federal education law, but which are requirements of the state Medicaid plan, such as Medicaid outreach and enrollment activities as well as other eligible, school-based Medicaid administrative activities. For example, a district may be reimbursed by Medicaid if they hold a meeting with school staff and parents to determine if a mental health evaluation is needed for a child, or to transport a child for a visit to health care specialist. School districts can also provide Medicaid-eligible children with a broad range of health care services such as vision and hearing screenings, and diabetes and asthma diagnosis and management through the Early Periodic Screening Diagnosis and Treatment program in Medicaid. All of these services and billing options are subject to what the state's Medicaid plan allows and services that are billable in one state may not be another. In contrast, a state can also mandate that districts participate in school-based Medicaid programs and explicitly bill Medicaid for certain services. As a result, there is considerable and intentional variation in how school-based Medicaid programs are designed in each state.

Yet, there are four specific elements that public schools in every state must meet to claim reimbursement from Medicaid. *First,* the state Medicaid plan must cover the services. *Second,* the student must be eligible for Medicaid. *Third,* the services must be provided by a Medicaid qualified professional as defined by the state Medicaid plan. *Fourth,* the services must be medically necessary.

In addition to these requirements, there are processes and requirements for billing that districts must follow even though their primary responsibility is education and not health care. For decades, Medicaid has made

schools comply with the same processes, paperwork and administrative requirements that apply to institutional and community-based health care providers even though there are some important differences between schools and other Medicaid providers. Yet, CMS has mandated districts use the same billing process as hospitals, doctors' offices and other health care entities.

For example, a speech language pathologist working with children in a school setting must complete essentially the same clinical notes required of her counterpart providing services in a hospital or community setting in order to bill Medicaid for those services. However, if she is providing Medicaid-eligible to services for students with an IEP she would also have to meet the documentation requirements for tracking and monitoring progress under IDEA. Unfortunately, in many instances there is considerable duplication between the documentation the provider must provide for Medicaid billing and the documentation that must be completed under IDEA.

Currently, providers in schools must meet paperwork requirements for Medicaid and IDEA. By simplifying the paperwork requirements through the Improving Medicaid in Schools Act (described on page 10) providers would only be responsible for meeting the requirements under IDEA.

REDUCING PAPERWORK REQUIREMENTS	Current Paperwork Required	IDEA Paperwork
Areas Covered/Assessed	✔	✔
Comments	✔	✔
CPT Code and Modifiers	✔	
Data Collection Related to IEP Goals/ Objectives	✔	✔
Date of Service	✔	✔
Duration of Service	✔	✔
Encounter Diagnosis Code	✔	
Group Size	✔	✔
IEP or IFSP Related	✔	
Location of Service	✔	
Medicaid Eligibility Number	✔	
NPI Number	✔	
Progress Notes on Service Plan and Achievement of Goals/Objectives in IEP	✔	✔
Provider Name	✔	✔
Provider Title	✔	
Resubmission Codes for Pended Claims	✔	
Service Type	✔	✔
Student Address	✔	
Student's Name	✔	✔

For district administrators trying to receive reimbursement from Medicaid for IEP services—as well as for other allowable non-special education services—the current documentation and billing requirements for Medicaid create unnecessary paperwork hurdles for districts. Medicaid's obligation to reimburse schools is completely different under IDEA than for all other health care providers. In most non-school settings, Medicaid is obligated to reimburse the provider after all other sources of public or private insurance have been billed. In other words, Medicaid is the payer of last resort and only pays after other payers have been billed. In the school setting, federal law pursuant to both the Social Security Act and IDEA, establishes a different financial obligation for Medicaid. In schools, the financial obligation of Medicaid to reimburse providers for allowable services precedes the financial obligation of the school district. In other words, Medicaid is the payer of first resort in the school setting.

Despite this major difference the current Medicaid reimbursement process for districts[6] subjects them to the same administrative hoops as other health care providers, such as determining Third Party Liability, even though under federal law it is the Medicaid agency whose liability for payment precedes that of the school district. This obligation to verify Third Party Liability means that district personnel must, in some circumstances, reach out to insurance companies and determine if they would pay for a Medicaid-covered services that districts must provide under IDEA regardless of whether they are reimbursed. The insurance companies invariably deny payment for services that districts are obligated to provide under IDEA. Since the liability of payment by Medicaid precedes that of the districts, it is an unnecessary and wasteful process to require determining third party liability of other insurers in order to process Medicaid claims.

Inconsistencies and confusion regarding HIPAA and FERPA disclosure requirements also uniquely affect providers in schools and complicate the Medicaid claiming process for services provided in schools. In order to provide the state Medicaid agency, or its Medicaid claims processing vendor, with information required for billing, districts must provide information that is protected under FERPA, even though such information may not actually be required for Medicaid reimbursement in schools. Health care providers in the schools are often concerned and confused about the sharing of protected information, yet without it, Medicaid bills cannot be processed.

The additional obligation of school districts to obtain parental consent to even share information with the Medicaid agency and to bill for services provided to their children in the school creates confusion and barriers. It raises unnecessary confusion for parents and may lead to a parent refusing to permit the school district to obtain reimbursement for the very services it is mandated to provide to their child.

A further way in which schools are disadvantaged by the current rules regarding Medicaid reimbursement is in the application of CMS guidance regarding non-IEP services provided to Medicaid eligible students (sometimes referred to as the "Free Care Rule").[7] CMS guidance regarding the Free Care Rule was issued in 2014 to allow schools to claim reimbursement for services provided to Medicaid-eligible students that were previously denied if the services were provided to all students without charge or in the absence of an IEP. A number of states are in the process of leveraging the flexibility granted by the 2014 guidance to expand the ability of districts to seek reimbursement for services they provide to Medicaid-eligible students, but to date only two have received approval to begin billing for services, that if provided in any other clinical setting, would be reimbursable.

Consequently, significant and unnecessary complexity continues to exist for districts seeking reimbursement for health care services and thousands of children are subsequently under-supported for school and learning.

DISTRICTS' REIMBURSEMENT FROM MEDICAID

In December 2018, AASA surveyed school district leaders to determine what services their districts bill for, the challenges they experience in billing Medicaid and to better understand the characteristics of schools that struggle the most to receive appropriate reimbursement.

First, AASA sought to ascertain information about the type of school districts seeking reimbursement for Medicaid-covered services and activities. We found that 80% of all school district leaders who responded to our survey indicated they have a school-based Medicaid program. When we disaggregated for locale, we found that 74% of rural school leaders surveyed indicated they bill for Medicaid as compared to 90% of suburban school leaders and 89% of urban school leaders.

The survey data confirm what has been known anecdotally for years. Critical variables in determining the participation of school districts in seeking Medicaid reimbursement, and in the cost effectiveness of their participation, include whether the district is urban, suburban or rural, large or small and the proportion of their students who are Medicaid eligible. For example, among rural school districts with greater than 50% of their students eligible for free or reduced lunches, more than 20% of rural school districts did *not* claim Medicaid reimbursement compared with only 3.5% of urban school districts not claiming Medicaid reimbursement. In comparison, only 4.7% of suburban districts with comparable poverty indicators did not claim Medicaid, higher than rural but less than urban districts. School district enrollment is another significant variable in whether school districts seek Medicaid reimbursement. According to our survey responses, around 64% of school districts seeking Medicaid reimbursement are rural, 25% suburban and just over 10% urban. Meanwhile, 84% of the school districts that do not seek Medicaid reimbursement are rural while urban districts represent less than 11% of districts that do not seek reimbursement. Among rural districts that do not seek Medicaid reimbursement, more than half, 55%, are districts whose enrollment is less than 1,000 students. Of rural districts with enrollments less than 3,000 students, 22% of them do not seek Medicaid reimbursement. Among suburban districts, only 6.5% of districts with less than 1,000 students do not seek Medicaid reimbursement and only 4% when the enrollment is less than 3,000 students.

VARIABLES TO SEEKING MEDICAID REIMBURSEMENT:

Cost effectiveness of their participation

Urban or rural district

Large or small district

% of Medicaid-eligible students

Second, we wanted to understand what services districts billed Medicaid for and if there are meaningful trends or differences in the reimbursement they seek. Fifty-seven percent (57%) of survey respondents bill for direct medical services, while less than half that number, 23%, claim for the Medicaid administrative activities they perform. Just one-third (33%), of districts bill for both direct services and administrative claiming. As we disaggregated the results, we found that suburban and urban districts are 65% more likely to bill for direct services, compared to 52% of rural districts, as well as seek reimbursement for Medicaid administrative activities (27% and 28%, respectively, compared to 21% rural). Unsurprisingly, suburban and urban districts are also more likely to bill for both direct services and administrative claiming (41% of suburban districts and 45% of urban districts compared to 28% of rural districts).

We then surveyed respondents to indicate whether district participation in the Medicaid program provided two specific benefits for children. The first is whether Medicaid funding enables respondents to have someone at the district or school-level who could address student health needs, such as a school nurse. The second is whether Medicaid reimbursement enables them to expand health-related services for children.

Twenty-two percent (22%) of respondents said that they were able to use Medicaid funding to have someone like a school nurse present in their school buildings. Urban districts were more likely to indicate that Medicaid funding was used for this purpose than suburban and rural districts. There were no discernable trends in terms of student enrollment and the use of funds for a school nurse. Districts with higher rates of poverty were more

likely to use Medicaid funding to hire someone who could address student health needs.

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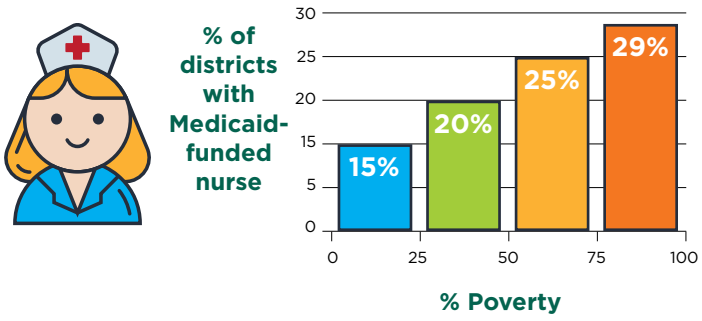
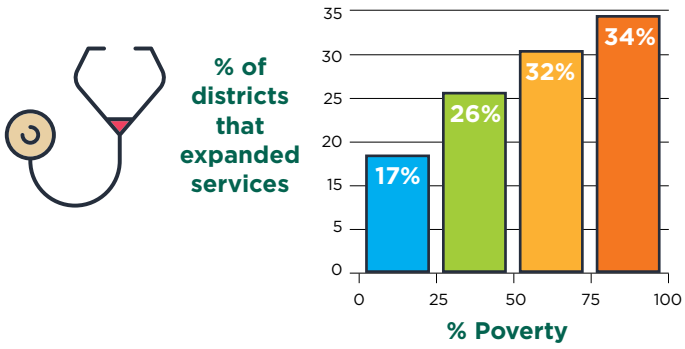


Twenty-eight percent (28%) of district leaders affirmed that Medicaid reimbursement enables them to expand health-related services to children. When disaggregating the data by locale, we found 26% of rural leaders agreed with this statement, compared to 29% of suburban district leaders and 34% of those in urban districts. As with the presence of school nurses, there was a trend in terms of the presence of poverty and the expansion of health-related services for children.

POVERTY RATES IMPACT EXPANSION OF HEALTH-RELATED SERVICES



MANAGING THE MEDICAID BILLING SYSTEM

CMS has not updated its guidance for districts to claim Medicaid reimbursement since it issued its administrative claiming guide in 2003.[8] Its technical advisory guide for school districts that bill for direct services was last updated in 1997.[9] A quick glance at either guide will overwhelm the average provider working in a school setting. A school district leader interested in knowing what is involved in billing will likely feel similarly confounded, which is why many districts employ third-party billing services that can help manage the billing and compliance procedures required by Medicaid. Of the school leaders AASA surveyed, 30% indicate their district outsources their Medicaid paperwork to a third party-biller. Rural districts and urban districts were slightly less likely to outsource the paperwork than suburban districts. One reason could be that urban districts have the resources to create a billing unit dedicated to Medicaid claiming in-house. Rural districts may only bill for one or two providers or services and, therefore, can also try to manage the billing themselves. The scope of billing for a suburban district may be considerably higher, but using limited resources to hire specialized individuals to solely manage it at the central office level may not be justified.

Regardless of whether a school district employs a third-party billing service, district leaders agree the billing requirements for Medicaid are onerous. When asked to classify the paperwork required for Medicaid billing, **43% of rural and suburban districts described it as extremely difficult or difficult to complete. Thirty-seven percent (37%) of urban districts consider the paperwork difficult or extremely difficult to complete.**

REASONS WHY DISTRICTS DO NOT BILL MEDICAID

In light of the above-mentioned findings, AASA sought to understand how Medicaid's complex administrative and paperwork requirements may prevent districts from participating in the Medicaid program. A quarter of rural districts indicated they no longer participate in the program because they lost money due to the cost of complying with the paperwork and administrative requirements. In contrast, 31% of suburban districts indicated they lost money due to the associated paperwork and compliance requirements. Affluent districts were also more likely to indicate that they lost money when they participated in the program, hence they stopped billing Medicaid. A quarter of rural districts also indicated they stopped participating because they could not afford to outsource billing to a third-party vendor and this was also true for 35% of suburban districts that stopped participating.[10]

A quarter of rural districts indicated they no longer participate in the program because they lost money due to the cost of complying with Medicaid paperwork.

Another reason that districts indicated they could no longer participate in the Medicaid program was a lack of qualified Medicaid providers in their area. Thirteen percent (13%) of rural districts indicated they stopped participating because they could not find people who were considered by their state to be qualified Medicaid providers to provide Medicaid-reimbursable services to children. There was also a correlation in finding qualified Medicaid providers and the district's rate of poverty—

the poorer the district, the more likely it was that it struggled to find providers. Districts with less than 25% poverty indicated no issue in finding qualified Medicaid providers, however almost a quarter of districts with 75% or more students in poverty reported issues in finding qualified providers.

When asked what had deterred non-participating districts from participating in the Medicaid program, 37% of rural districts indicated that the costs of complying with the paperwork and administrative requirements of the program was the reason they did not attempt to bill Medicaid. Twenty-three percent (23%) of suburban district leaders said the paperwork requirements dissuaded them from participating.

The clear inference from these responses is that size matters. There is a high proportion of small districts that do not seek Medicaid reimbursement despite their level of need, suggesting that the complexities and costs of claiming Medicaid reimbursement limit the ability of those rural and smaller suburban districts to access the resources they need to serve their students. The current transactional billing system for Medicaid creates unanticipated inequities by enabling larger and/or urban districts to receive more Medicaid funds than smaller districts despite comparable levels of Medicaid eligibility and need, mainly due to their economies of scale.

THE CURRENT MEDICAID BILLING SYSTEM LIMITS THE PARTICIPATION OF THE NEEDIEST SCHOOL SYSTEMS

While the "need" for Medicaid reimbursement is comparable in high-poverty communities regardless of locale, the level of participation in school-based Medicaid programs is significantly lower among rural districts. The findings below demonstrate that small and rural school districts face unparalleled obstacles in participating in the Medicaid program.

Eighty-four percent of the school districts we surveyed that do not seek Medicaid reimbursement are rural and among rural districts that do not seek Medicaid reimbursement, more than half, 55%, are districts whose enrollment is less than 1,000 students.

Of rural districts with enrollments less than 3,000 students, 22% of them do not seek Medicaid reimbursement.

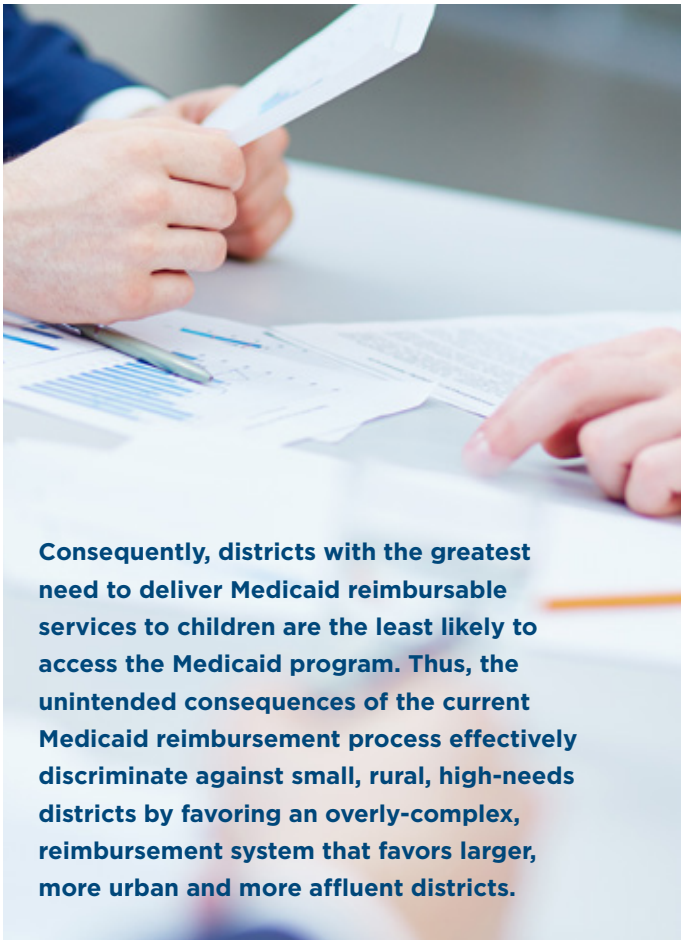
More than 20% of rural school districts did not claim Medicaid reimbursement despite having more than 50% of their students eligible for free or reduced lunches, compared with only 3.5% of urban school districts not claiming Medicaid reimbursement with similar levels of poverty.

Thirty-seven percent of rural districts indicated that the costs of complying with the paperwork and administrative requirements of the program were why they did not attempt to bill Medicaid.

A quarter of rural districts indicated they no longer participate in the program because they lost money due to the cost of complying with the paperwork and administrative requirements.

The inability of rural, small and high-poverty districts to participate in the Medicaid programs means they must rely more heavily on local funding to provide healthcare and special education services for their students. However, because these districts receive fewer local, state and federal dollars they are less able to dip into local coffers to meet the health needs of children which means they are disproportionately and severely limited in how they fund necessary special education and healthcare services.

The inability to fund healthcare and special education programs adequately through local dollars coupled with the inability to seek Medicaid reimbursement for the provision of these services means that children in these districts receive fewer healthcare services. Despite having high numbers of Medicaid-eligible children, the low administrative capacity of these districts limit their ability to access a reimbursement stream that could assist them in ensuring a host of Medicaid services are provided to these students in school. Consequently, districts with the greatest need to deliver Medicaid reimbursable services to children are the least likely to access the Medicaid program. Thus, the unintended consequences of the current Medicaid reimbursement process effectively discriminate against small, rural, high-needs districts by favoring an overly-complex, reimbursement system that favors larger, more urban and more affluent districts.



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REDUCING THE ADMINISTRATIVE COMPLEXITY OF MEDICAID WOULD MAKE A DIFFERENCE FOR SMALL, RURAL HIGH-NEEDS DISTRICTS

When asked whether their district would benefit from receiving Medicaid reimbursement for health services delivered as part of an IEP or for other health services provided, 44% of rural districts said they would seek Medicaid reimbursement if the administrative requirements were substantially decreased. Thirty-seven percent (37%) of suburban districts indicated they would participate if the paperwork and administrative requirements were substantially decreased and 40% of urban districts also agreed.

There were also noticeable trends in terms of district size and a reduction in administrative requirements. Nearly 60% of districts with less than 1,000 students said they would be more willing to administer a school-based Medicaid program if the paperwork requirements were reduced.

WHO WOULD SEEK MEDICAID REIMBURSEMENT IF THE ADMINISTRATIVE REQUIREMENTS WERE SUBSTANTIALLY DECREASED?

44% of rural districts

37% of suburban districts

40% of urban districts

WHO WOULD BE MORE WILLING TO ADMINISTER A SCHOOL-BASED MEDICAID PROGRAM IF THE PAPERWORK REQUIREMENTS WERE REDUCED?

Districts with less than 1,0000 students

Districts with 1,001–2,500

Districts with 2501–5,000

Districts with 5,000–10,000

Twenty percent (20%) of rural districts indicated they would bill Medicaid if it was less expensive to outsource their billing obligations. This was also true for 16% of suburban districts. High poverty districts were more likely to participate if it was more affordable to bill a third-party vendor or provider. Almost a quarter

of districts with 75% or more children in poverty said they would participate if they could inexpensively bill using a third-party vendor compared with 16% of district leaders with less than 25% of children in poverty. An affordable third-party biller would also incentivize greater participation by districts enrolling less than 1,000 students, of which 59% said they would consider participating if it was less costly to contract with a third-party.

However, reducing paperwork alone would not alleviate all the concerns for districts. Finding qualified staff remains a challenge, and rural districts are three times more likely than suburban districts to indicate their participation is contingent on finding personnel who are considered qualified Medicaid providers. This was also true for district leaders in small school systems, 74% who said they would consider participating in the Medicaid program if they could find qualified providers.

Some district leaders simply have no interest in entangling themselves with another state and federal agency, along with the oversight and compliance associated with the Medicaid program. Eight percent (8%) of rural districts said they have no desire to bill Medicaid at all, regardless of how much easier reimbursement would become, and this was true for 11% of suburban districts as well.

NEXT STEPS

At a time when we have an uptick in children who lack health insurance coverage[11] and a surge in children coming to school with unaddressed mental health needs, there is an urgency to improve the reimbursement stream for school-based Medicaid programs so schools can deliver more services to more students. For example, research has shown that less than half of children and adolescents with a mental disorder receive the treatment they need and of those who do receive assistance, the vast majority (70% to 80%) receive mental health services in schools.[12] School-based Medicaid programs serve as a lifeline to children who may struggle to access critical health care services outside of their school. While a school's primary responsibility is to provide students with a high-quality education, we know children cannot learn to their fullest potential with unmet health needs. Streamlining the Medicaid billing system for districts will enable school personnel to deliver health services more effectively and efficiently in the place where children spend most of their days. Increased access to health care services through Medicaid improves health care and educational outcomes for students. Moreover, providing health and wellness services for students in poverty and health services that benefit students with disabilities ultimately enables more children to become employable and attend higher education.

So, what can Congress and the Trump administration do to reform the Medicaid billing process to reduce administrative expenses and direct cost savings toward providing direct health care services for children?

Streamlining the Medicaid billing system for districts will enable school personnel to deliver health services more effectively and efficiently in the place where children spend most of their days.

Our survey makes clear that paperwork is hampering efforts by districts to provide health care services to Medicaid-eligible children. As the health care needs of children are intensifying and school personnel face escalating demands to provide those services, it is time to transform the billing process for Medicaid reimbursement for schools.

Specifically, education and health care advocates must work with leaders in Congress and the administration to reduce the administrative burdens on districts that do bill or want to bill Medicaid. By reducing the barriers to entry and the overhead costs of billing software, billing staff and third-party billers, while freeing up financial and staff resources, schools can more readily participate in the Medicaid program and school personnel can dedicate more time to providing direct health-related services to children in school.

To that end, AASA calls on Congress to pass the *Improving Medicaid in Schools Act.* The *Improving Medicaid in Schools Act* would do seven things:

1. Simplify the Medicaid billing process for schools to ensure fewer dollars are spent on administrative expenses.
2. Permit states the flexibility to use a uniform, cost-based reimbursement methodology for school districts that would lower barriers to participation in Medicaid and guarantee that all school districts are reimbursed based on their needs and not on arcane administrative procedures that create inequities among school districts.
3. Confirm accountability for how Medicaid dollars flow to school districts by following well established CMS cost reporting methods that adhere to Medicaid cost principles and ensuring Medicaid funds are used appropriately.
4. Encourage improvements in care coordination and outcomes by incentivizing school districts to partner with Managed Care Organizations (MCOs) to improve delivery of health care for children and advance social determinants of health.
5. Reduce the burden on state Medicaid agencies and insurance companies to manage and respond to a high volume of Medicaid transactions from school districts.
6. Reduce confusion about disclosure of records by district personnel who currently struggle to abide by both FERPA and HIPAA obligations, thereby ensuring greater protection of student records and health care information.
7. Enable school districts to leverage an existing billing process to consolidate and streamline Medicaid claiming for both administrative activities and direct services.

The *Improving Medicaid in Schools Act* offers states the flexibility to shift away from a transactional billing model and implement a cost-based reimbursement model for school districts. This has the potential to benefit students and families, district personnel and administrators, states and other health care partners to ensure more efficient delivery of health care services to children in schools in the following ways.

First, the *Improving Medicaid in Schools Act* would open the door for collaboration between Managed Care Organizations (MCOs) and districts. In our survey, many rural and small districts indicated they could not participate in the Medicaid program due to a lack of providers. Additionally, the current capitated payment methods for MCOs and transactional billing requirements for schools are incompatible and create barriers to collaboration between them. Other constraints, such as credentialing and licensure of providers, complicate collaboration as well. The *Improving Medicaid in Schools Act* would provide states with the flexibility to do away with transactional billing for school-based Medicaid reimbursement and facilitate collaboration between MCOs and school districts that would benefit both, and bring improved and more efficient health-related services to school children. School districts could leverage providers that are employed by MCOs. MCOs would be able to deploy providers into school districts, thus alleviating some of the shortage of providers in schools. It would also encourage improvements in care coordination and determinants of health outcomes by incentivizing school districts and MCOs to partner with each other.

Second, by giving states the flexibility to use a uniform, cost-based reimbursement methodology, the *Improving Medicaid in Schools Act* would more equitably facilitate participation in Medicaid by school districts large and small, rural and urban, and ensure that federal funds are applied to health-related services where they are most needed instead of based on the sophistication of billing procedures. Leveraging an existing billing process to consolidate and streamline Medicaid claiming for both administrative activities and direct services would also lead to efficiencies for the third of districts that bill for both direct services and administrative claims. By using the existing cost-based methodology for claiming administrative reimbursement for direct services, districts can reduce the complexity of paperwork even if they continue to only bill for direct services. The administrative claiming process, which follows well-established CMS cost-reporting methods that adhere to Medicaid cost principles, is far simpler than the methodology required for billing for direct services. Furthermore, one system for both administrative and direct-service claiming is easier to train personnel to understand and administer than two separate systems with very different accountability and cost-reconciliation processes. For smaller districts that do not currently bill, this would reduce the risk of participating since it would mean they only need to invest once in training providers or administrative staff on how to bill Medicaid. It would also make the school-based Medicaid program more equitable by lowering the barriers to participating and enable more rural districts to claim the Medicaid reimbursement they need to serve their students.

Third, by reducing the paperwork burden for personnel school districts are more likely to attract and retain qualified Medicaid providers who will work in a school setting. According to the National Coalition on Personnel Shortages in Special Education and Related Services, excessive paperwork is a leading cause of shortages of specialized instructional support personnel in schools. Specialized instructional support personnel such as school psychologists, speech-language pathologists, occupational and physical therapists and

school nurses, are frequently able to bill Medicaid for the services they provide to special education and general education students in schools. Unfortunately, schools have to compete with hospitals and clinics for a limited pool of these Medicaid providers, which is why it is essential that the paperwork and administrative burdens for these professionals in a school-based setting mirror what these personnel would experience in a clinical setting. By ensuring these qualified providers can spend less time on paperwork and more time delivering healthcare services to children schools are much more likely to attract and retain these much-needed professionals.

While not at the heart of our concerns, there is certainly a benefit to streamlining the school-based Medicaid system for states. By consolidating the processing of Medicaid reimbursement to an efficient, quarterly cost-reporting process, states would see a significant reduction in reducing the volume of transactions they need to process. Further, it would eliminate the administrative burden on state Medicaid agencies of duplicative processing and resubmission of claims, and reducing or eliminating other unnecessary transactions.

Finally, the *Improving Medicaid in Schools Act* option would reduce confusion among school personnel and qualified Medicaid providers about what records can be disclosed under student privacy requirements. Processing billing transactions requires that school districts comply with HIPAA in transmitting personally identifiable health information to other state agencies, using HIPAA-certified billing vendors and software systems, and safeguarding the storage of and access to confidential health information. At the same time, districts are obligated to comply with FERPA requirements to protect personally identifiable information, which complicates meeting the compliance of both mandates.

Transforming Medicaid billing in schools to eliminate transactional billing would mitigate these issues and streamline the process of obtaining reimbursement without jeopardizing confidential student information. A further advantage to the transformation away from transactional billing is the corresponding reduction in erroneous or over/under payments that result from FERPA and HIPAA disclosure conflicts, billing errors and denial of parental consent.

CONCLUSION

Now is the time to harmonize and simplify the Medicaid reimbursement process in schools to be more cost effective and to ensure districts can participate regardless of their enrollment level, poverty rate or location. We cannot wait any longer to improve the delivery of health care services to children in school. That requires reimagining what Medicaid billing in schools can be and how other community-based health care partners can assist school districts in providing health care services.

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