Leveraging Medicaid to Enhance School-Based Mental Health Services

By Laura Conrad, M.S.W., Megan Lee, L.P.C., and Dr. Zainab Okolo, L.C.M.F.T.

March 12, 2024

Technical Assistance Collaborative
15 Court Square, 11th Floor
Boston, MA 02108

The Jed Foundation

Table of Contents

Introduction

As top health leaders have recognized, mental health is worsening at an alarming rate for young people in the United States.[1] Youth suicide rates are rising[2], and increasing numbers of young people are being diagnosed with a mental health need, particularly among ethnic minorities, low-income households, and those involved with the child welfare and juvenile justice systems.[3]

Schools are seeing the effects of increased youth behavioral health needs both directly (seven of ten public schools report that the number of students seeking mental health services has increased since 2020)[4] and through a key indicator: rising rates of absenteeism. Chronic absenteeism is known to stem from many issues, such as poverty, lack of family engagement, and increased rates of mental health needs. According to one recent report, nearly 30% of enrolled students, or 14.7 million children, were chronically absent from school in the 2021-22 academic year.[5] The researchers found that between the 2017-18 and 2021-22 school years, the greatest increases in chronic absenteeism occurred in schools with higher proportions of students experiencing poverty.

"Among schools with 75% or more of their students receiving free or reduced-price lunch (FRPL), schools with extreme chronic absence levels nearly tripled, from 25% to 69%. Among schools with 50% to 75% FRLP, it increased from 14% to 50%."[5]

Approximately 49.4 million youth were enrolled in public school in fall of 2021.[6] Yet the majority of schools are ill-equipped to address the increased needs of our young people.[7] Recent data indicates that more than 24,000 schools (25%) reported having no counselor on staff.[8]

[1] Office of the U.S. Surgeon General (2021). *Protecting youth mental health: The U.S. Surgeon General's advisory*. Office of the U.S. Surgeon General.

[2] Stone, D., Mack, K. A., & Qualters, J. (2023). Notes from the field: Recent changes in suicide rates, by race and ethnicity and age group — United States, 2021. *Morbidity and Mortality Weekly Report, 72*(6), 160–162.

[3] Office of the U.S. Surgeon General (2021). *Protecting youth mental health: The U.S. Surgeon General's advisory*. Office of the U.S. Surgeon General.

[4] Institute of Education Sciences: School Pulse Panel (retrieved February 23, 2024). Institute for Education Sciences.

[5] Attendance Works (2023, November 17). All hands on deck: Today's chronic absenteeism requires a comprehensive district response and strategy (blog post). Attendance Works.

[6] Institute for Education Sciences, National Center for Education Statistics. Table 203.40: Enrollment in public elementary and secondary schools, by level, grade, and state or jurisdiction: Fall 2021. Retrieved February 23, 2024.

[7] Institute for Education Sciences, National Center for Education Statistics (n.d.) Mental health and well-being of students and staff during the pandemic. Institute for Education Sciences.

[8] Whitaker, A., Torres-Guillén, S., Morton, M., Jordan, H., Coyle, S., Mann, A., & Sun, W. (2019). *Cops and no counselors: How the lack of school mental health staff is harming students*. American Civil Liberties Union.

This represents a significant lost opportunity, since up to 80% of young people who do receive mental health services get that care in a school setting.[9] According to a 2022 study, 48% of all schools report they do not have enough funding to provide adequate mental health services.[10]

Medicaid and the Children's Health Insurance Program (CHIP) insure more than 41 million children in the United States, providing necessary physical and behavioral health services. According to the Centers for Medicare and Medicaid Services, as of January 2024, 16 states had chosen to expand their school-based Medicaid programs, which allows them to reimburse districts for school-based mental health services provided to students covered by Medicaid.[11] However, the School Superintendent Association found that a quarter of rural districts no longer participate in the program because they lost money due to the cost burden of complying with its administrative requirements.[12] Funding is sorely needed, but so are streamlined approaches to help schools take advantage of the funding they do receive.

Schools offer an invaluable opportunity to meet young people where they are. In this paper, we make the case that in order to address the level of mental health needs experienced by today's students, our schools require comprehensive mental health programs, qualified staff, and adequate funding. We further suggest that with a more streamlined program that is less burdensome to administer, Medicaid can provide a sustainable funding source for schools to build comprehensive mental health programs that enable youth to be meaningfully engaged in school.

[9] Mental Health America (n.d.). *Addressing the youth mental health crisis: The urgent need for more education, services, and supports* (see Appendix B). Mental Health America.

[10] Institute for Education Sciences, National Center for Education Statistics (n.d.) Mental health and well-being of students and staff during the pandemic. Institute for Education Sciences.

[11] Centers for Medicare & Medicaid Services (2023, September 28). Getting started with Medicaid school-based services (slide deck).

[12] School Superintendents Association (2019). *Structural inefficiencies in the school-based Medicaid program disadvantage small and rural districts and students*. The School Superintendents Association.

Comprehensive School-Based Mental Health

School-based mental health programs are essential in providing a supportive environment that recognizes and responds to the needs of young people. These programs should be comprehensive, inclusive, and accessible, offering a range of services interwoven throughout the school community.

A Brief History of School-Based Mental Health Programming

School-based mental health programming has its roots in the early 20th century.[13] Over the years, the approach has shifted from a focus on selective, individual treatment to comprehensive and preventive services designed to support all students.

The early 20th century saw the introduction of "child guidance" clinics. However, the clinics mostly worked mainly with children who were court-ordered to participate.[14]

In the 1960s and 1970s, the civil rights movement and the War on Poverty highlighted the need for more equitable access to mental health services. The passage of landmark legislation — the Elementary and Secondary Education Act in 1965[15], the All Handicapped Children Act in 1975[16], and the Rehabilitation Act of 1973 (section 504)[17] — provided funding for educational programs and opened doors to public education for students with disabilities, including emotional and behavioral disorders.

The 1980s and 1990s were a pivotal period for mental health services in schools. Americans became more aware of the importance of student mental health, and influential legislation was enacted, including the reauthorization of the All-Handicapped Children Act and the Individuals with Disabilities Education Act (IDEA) in 1990. However, mental health services were often limited and reactive, focusing on crisis intervention rather than prevention or early intervention. Schools primarily addressed mental health issues through special education services, lacked systemic programs for the broader student population.

[13] Flaherty, L. T., Weist, M. D., & Warner, B. S. (1996). School-based mental health services in the United States: History, current models and needs. *Community Mental Health Journal, 32*(4), 341-352.

[14] Smuts, A. (2018). *Science in the service of children, 1893-1935*. Yale University Press.

[15] U.S. Department of Education. (n.d.*). Every Student Succeeds Act (ESSA)*.

[16] U.S. Department of Education. (2024, February 16). A history of the Individuals with Disabilities Education Act.

[17] U.S. Department of Education (2023, July 21). *The civil rights of students with hidden disabilities under Section 504 of the Rehabilitation Act of 1973.* U.S. Department of Education, Office for Civil Rights.

The turn of the millennium brought a surge in more comprehensive school mental health programs. The No Child Left Behind Act of 2001 and the subsequent Every Student Succeeds Act of 2015 emphasized the role of schools in supporting the mental and emotional well-being of students.[18,19]

In recent years, approaches like Positive Behavioral Interventions and Supports and Response to Intervention have been widely adopted, integrating mental health support with academic interventions. School mental health leaders have placed a growing emphasis on evidence-based practices and the importance of early intervention and prevention. Social-emotional learning curricula are now commonly integrated into school programs.[20] The COVID-19 pandemic underscored the need for mental health support in schools and has led to an increased focus on addressing trauma and promoting resilience.

School-Based Mental Health Programming Today

Mental health programs today integrate services into the school setting, making them a part of the daily educational experience. The programs incorporate preventive, responsive, and intensive interventions. The aim is to identify and address the psychological and emotional needs of students, encourage help-seeking behavior, and improve academic performance by addressing mental health barriers to learning.

Programming typically includes:

- Direct services to students, such as counseling, crisis intervention, and behavioral coaching.
- Preventive programs, including SEL curricula, mindfulness training, and stress management workshops.
- Professional development for teachers and staff on recognizing signs of mental health issues and providing appropriate referrals.
- Family engagement that involves and educates parents and caregivers on mental health issues.
- Collaboration with community-based mental health providers for specialized services.

Successful programs establish clear outcome measures to assess the impact of interventions. Regular data collection, data analysis, and the incorporation of feedback — including from students and families — are integral components of continuous improvement. Strategies should be refined based on feedback to ensure that they meet the needs of a diverse student population, especially those from marginalized and underserved groups.

[18] Anglin, T. M. (2003). Mental health in schools. In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research*, 89-106. Springer.

[19] National Association of School Psychologists (n.d.). ESSA mental and behavioral health services for school psychologists. Retrieved March 11, 2024.

[20] Schwartz, H. L., Bongard, M., Bogan E. D., Boyle, A. E., Meyers, D.C. and Jagers, R. J. (2022). *Social and emotional learning in schools nationally and in the Collaborating Districts Initiative: Selected findings from the American Teacher Panel and American School Leader Panel surveys*. RAND Corporation.

Staffing Requirements

Effective implementation of school-based mental health programs requires a multidisciplinary team,[21] which may include:

- School counselors and psychologists, who provide assessment and direct support to students.
- Social workers, who offer case management and facilitate connections to community resources.
- School nurses, who can identify health-related barriers to learning, including mental health concerns.
- Consulting psychiatrists or therapists, who provide expertise and support for more severe mental health needs.
- Peer support specialists, who provide connection through lived experience.

Ongoing professional development is crucial for all school staff to stay current on best practices and emerging trends in mental health support.

A Multi-Tiered System of Supports

The integration of a Multi-Tiered System of Supports (MTSS) is paramount in providing a continuum of mental health services. MTSS involves three tiers: universal (preventive measures for all students), targeted (additional support for at-risk students), and intensive (specialized interventions for students with severe needs).[22] This framework ensures a customized approach to mental health, addressing the varying mental health needs of students. A school or district may offer the following programming as part of its MTSS framework:

- Tier 1: SEL instruction and a positive school climate
- Tier 2: Small group counseling or skill-building sessions
- Tier 3: Individualized services

Family Engagement

Families play a critical role in the success of mental health services for young people.[23] Parents and caregivers should be informed about how schools support students' mental health and fully included in all efforts. Effective programs prioritize robust engagement of all families in the school, including regular

[21] Bohnenkamp, J. H., Patel, C., Connors, E., Orenstein, S., Ereshefsky, S., Lever, N., & Hoover, S. (2023). Evaluating strategies to promote effective, multidisciplinary team collaboration in school mental health. *Journal of Applied School Psychology, 39*(2), 130-150.

[22] American Institutes for Research (n.d.). Multi-level prevention system. American Institutes for Research, Center on Multi-Tiered System of Supports. Retrieved March 11, 2024.

[23] Lowie, J. A., Lever, N. A., Ambrose, M. G., Tager, S. B., & Hill, S. (2008). In M. D. Weist, S. W. Evans, & N. A. Lever (Eds.), *Handbook of school mental health: Advancing practice and research*, 135-148. Springer.

communication about available services and how to access them. Schools can also offer workshops and training sessions for parents and caregivers on mental health topics.

For students who struggle with mental health, family input is essential in developing and reviewing individual student support plans. Schools can also provide resources and referrals for families seeking external mental health services. No school-based mental health program is complete without family involvement. Programs should seek and incorporate feedback from families on a regular basis.

The Jed Foundation's Comprehensive Approach to Mental Health Promotion

The Comprehensive Approach to Mental Health Promotion and Suicide Prevention for High Schools from The Jed Foundation (JED) provides high schools and districts with a framework to support and improve student mental health, reduce risk for suicide, and prepare students emotionally for the transition out of high school and into young adulthood.

Programs such as JED High School and JED Boarding School support schools as they implement this approach. A central tenet involves the use of baseline evaluation and strategic planning to focus implementation efforts. A steering committee, whose members are selected to represent all key stakeholders in the school community, collaborates with JED staff to evaluate policy, programs, and resources. The committee works with a mental health specialist over the multi-year program to implement a strategic plan, evaluate progress against the baseline, and create sustainability plans for years to come.

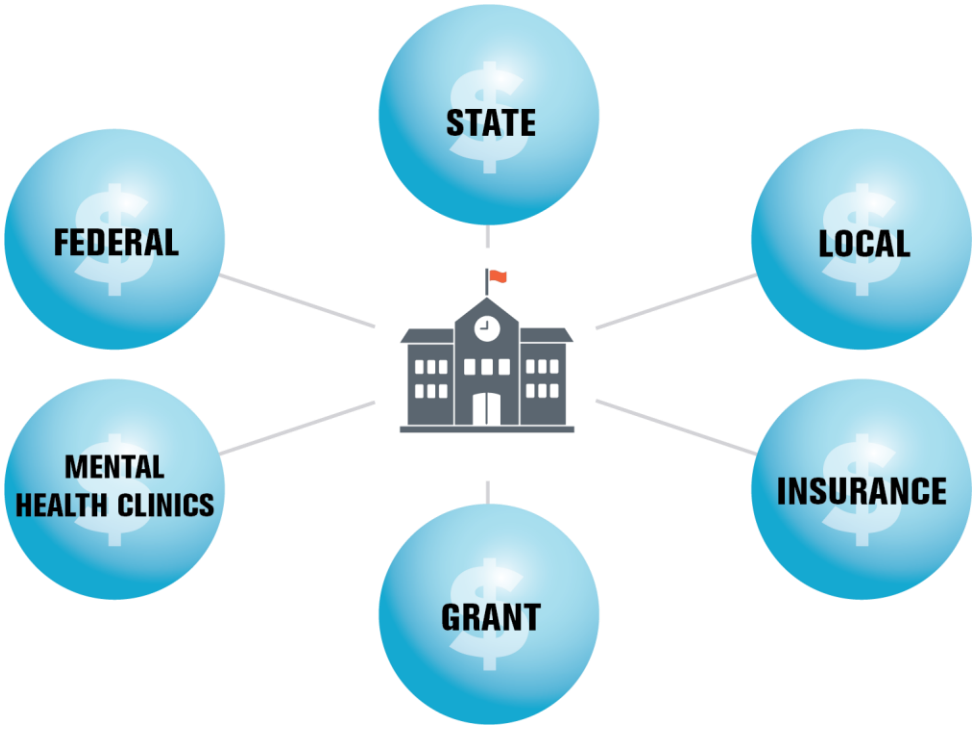
The Comprehensive Approach to Mental Health Promotion and Suicide Prevention for High Schools focuses on seven Core Domains:

- Develop life skills
- Promote social connectedness and a positive school climate
- Encourage help-seeking behavior
- Improve recognition and response to signs of distress and risk
- Ensure student access to effective mental health treatment
- Establish and follow crisis management procedures
- Promote means safety

To equitably and effectively promote student mental health and reduce suicide risk, schools take special care to learn about and plan for the needs of students whose identities or challenges may expose them to heightened psychological risk.

Sustaining School-Based Mental Health Programs using Medicaid

As the need for mental health services continues to increase, schools are meeting the demand by braiding funding from a variety of resources such as federal, state, and local programs; insurance payments; grants; and partnerships with mental health clinics. According to AASA, Medicaid pays about $4 billion a year in school-based services. While reimbursement from Medicaid is complicated and administratively burdensome, particularly for small and rural districts, Medicaid has become an essential funding source for public schools. Schools have begun to rely on this funding to support their ability to provide mental health services.



Overview of the School-Based Medicaid Program

Since 1975 with the inception of IDEA, and clarification in 1988, schools have had the opportunity to utilize Medicaid funds to pay for behavioral health services that are part of a student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). In 2014, CMS reversed what was known as the "Free Care" Rule, opening the door for states and districts to collect Medicaid reimbursement for health services for all students enrolled in Medicaid.[24] Since 2014, according to CMS, 16 states have fully or partially expanded their Medicaid school-based services (SBS) program to allow

[24] Centers for Medicare and Medicaid Services (2014). Medicaid payment for services provided without charge (free care). *State Medicaid Director Letter #14-006.*

for reimbursement for all eligible Medicaid youth, not just those with an IEP or IFSP. States have flexibility in how they design and implement their school-based Medicaid programs; each is unique. However, there are some similarities in the programs, and in how states administer them.

- States such as California, Illinois and Louisiana have fully expanded their school-based Medicaid programs, covering a broad range of mental health services, including all medically necessary services under EPSDT.
- Twenty-four states have not expanded their program, covering only IDEA/IEP services.
- Some states, such as Massachusetts cover a defined comprehensive package of physical and behavioral health services.

State Profiles of School-Based Mental Health Program Expansion

NEVADA: LANDER COUNTY SCHOOL DISTRICT

In 2019, the state of Nevada received CMS approval to cover all medically necessary EPSDT services in schools, including behavioral health and applied behavior analysis. Using grant and expanded Medicaid funding, the Lander County School District (LCSD) has been able to expand behavioral health supports.

Features of the LCSD:

- Small, rural district located in northern Nevada
- The main economy is gold and silver mining
- 41% of the students are minority
- 50% or more families live in poverty
- 39% of students are chronically absent from school

In 2015, the district started to increase SEL supports; however, the district decided to pause implementation when the community raised concerns about the role of schools in supporting youth mental health. In 2016, grant funding allowed LCSD to hire school social workers and a board-certified behavioral analyst. Then In 2021, the district was able to hire a school psychologist who worked diligently on family and community engagement and championed the importance of social emotional supports in schools. Given how rural the district is, with limited community resources, and instances in which families are not able to be reached due to working in the mines, the district worked on implementing crisis intervention, stabilization services, and safety planning. In a desire to intervene earlier, LCSD also implemented universal behavioral health screening. In 2023, LCSD began billing Medicaid for services delivered by school staff, allowing the district to sustain behavioral health staffing that was enhanced through grant funding.

MICHIGAN

Michigan is leading the way in optimizing school-based Medicaid funding to increase access to mental health supports in schools. The state is able to achieve this success through covering all medically necessary services and aligning and coordinating efforts across the state's Medicaid and Education Authorities. Together the State Medicaid Authority and State Education Authority administer the program, offering robust training and technical assistance, joint communication, and support to all of Michigan's Local Education Agencies (LEAs). Michigan uses an intermediate school district (ISD) model that allows almost all of its 587 LEAs to participate in the Medicaid program. Under this model, 56 ISDs support smaller, more rural LEAs through a less burdensome and more streamlined process. In addition, Michigan has committed more than $300 million for children's mental health over two years, increasing mental health services in schools to all students. Michigan's strategies have included:

- Collaboration and coordination between two key state agencies.
- Dedicated staff in each agency committed to optimizing Medicaid and enhancing school-based mental health services.
- LEAs recognizing and utilizing the two agencies for support and guidance on Medicaid and mental health.
- Engaging rural and small LEAs to participate in the program.

Recent Changes

On June 25, 2022, President Biden signed into law the Bipartisan Safer Communities Act, which required CMS to provide additional guidance to states on Medicaid school-based services. The new guidance was supposed to:

- Increase access to Medicaid-funded, school-based health services, including mental health services;
- Reduce administrative burden;
- Support federal compliance with billing and payment; and
- Set up a technical assistance center to support the administration of school-based Medicaid.

In compliance with this legislation, CMS issued a comprehensive guide on Medicaid SBS in May 2023. The guide is meant to clarify and simplify different aspects of the program, and thereby to encourage states to expand SBS beyond IEP services. In the summer of 2023, CMS also launched the Medicaid and School Based Services Technical Assistance Center. Many advocates and states applauded the federal government for issuing the guide and moving forward with the Center. While the guide and the Technical Assistance Center are a step in the right direction to expanding funding, there are still many questions and hurdles states and districts must overcome to improve access to mental health services in schools.

Barriers to Utilizing School-Based Medicaid

Over time, many states and LEAs have learned more about the Medicaid program, thus increasing opportunities for reimbursement. However, barriers remain that lead many states to choose not to expand their Medicaid SBS programs, and some LEAs to choose to not participate at all. Even with the recent CMS guidance there are still several issues that continue to plague the program and that will take time to resolve.

Administrative Burden

The amount of administrative oversight that schools must manage to utilize Medicaid is enormous. Medicaid requires educational facilities to understand insurance processes, including the Random Moment in Time Study, documentation of sessions, billing requirements, verification of Medicaid eligibility, claiming, and other processes. Documentation requirements come as added responsibilities to staff with already high caseloads, including behavioral health staff who would rather spend their time with students than on documentation. Many behavioral health staff are required to provide IEP documentation in addition to Medicaid documentation, creating further workload challenges. Schools are expected to understand the complexities of FERPA, HIPAA, IDEA, IEPs, Medicaid, and other insurers, while their primary role is to educate youth. Larger districts such as those of Chicago and Los Angeles have dedicated Medicaid/insurance specialists to manage the program, but the burden leaves many small and rural districts unwilling to utilize Medicaid funding. A survey by the School Superintendents Association found that 20% of rural districts do not claim for Medicaid services.[25] Many districts lack the infrastructure to document appropriately and do not have any form of an electronic health record, with behavioral health staff instead recording information using pen and paper. Additionally, the new requirements listed in the recent CMS guidance related to transportation documentation have raised considerable concerns. Multiple states and schools have stated "the juice wasn't worth the squeeze" and that they potentially would discontinue seeking reimbursement for transportation.

Billing and Reimbursement

Even with the 2023 CMS guidance, billing and reimbursement methodologies remain complicated. Many state agencies lack dedicated staffing resources that would enable them to decipher the particulars of school-based Medicaid. School districts often have limited staffing resources and lack the knowledge to navigate insurance processes; this applies both to large urban districts and small, rural districts. However, such challenges are even more evident in small and rural schools (43% of rural and suburban districts describe paperwork as extremely difficult or difficult to complete).[26] Schools have had to hire third party vendors to help them navigate and manage this process. Given the risk associated with school-based

[25] School Superintendents Association (2019). *Structural inefficiencies in the school-based Medicaid program disadvantage small and rural districts and students*. The School Superintendents Association.

[26] School Superintendents Association (2019). *Structural inefficiencies in the school-based Medicaid program disadvantage small and rural districts and students*. The School Superintendents Association.

Medicaid due to Medicaid requirements and fraud concerns (as seen in recent incidents in New Jersey and New York), it is not surprising that states and districts are hesitant to expand and utilize the program.

Consent

Consent-related challenges are widely seen as a barrier to receiving services. IDEA and FERPA require parents' consent for services before they can be delivered and billed. The new CMS guidance and proposed regulations reflect an attempt to streamline some of the challenges, but feedback from stakeholders expressed ongoing confusion about the interplay of HIPAA, FERPA, and parental consent. As reported by the School Superintendents Association in January 2023, "Parents/guardians do not understand what the form is for, and they are hesitant to sign because of their financial situation(s) becoming public/known to federal officials."[27] Minor consent laws vary across the nation and create challenges for LEAs, for example, when they are administering universal behavioral health screening and the screening suggests that a student requires ongoing support — but due to not having consent, the school is unable to offer services beyond the screening.[28]

Workforce

There are widespread shortages of community-based behavioral health providers[29] and school-based behavioral health professionals.[30] Nationwide, schools struggle to fill behavioral health positions, which are more specialized than similar roles in community-based organizations. School-based behavioral health staff often perform duties outside their scope of practice such as bus or lunch duty, classroom management, and IEP documentation. According to the National Center for Education Statistics, 70% of public schools say more students are seeking mental health services, but 87% of those schools say they can't provide such services to all of the students in need.[31] In a recent survey, 13% of rural districts reported they stopped participating in the Medicaid program because they could not find people considered qualified by their state to provide Medicaid-reimbursable services to youth.[32] Another hurdle such providers must overcome to seek reimbursement from Medicaid is having a National Provider Identifier number. This requirement is standard practice in health care settings, but not in schools, thus creating barriers to seeking reimbursement.

---

[27] School Superintendents Association (2023). *Obtaining parental consent to bill Medicaid: An unnecessary, time-consuming and emotionally fraught process for districts and parents*. The School Superintendents Association.

[28] Sharko, M., Jameson, R., Ancker, J. S., Krams, L., Webber, E. C., & Rosenbloom, T. (2022). State-by-state variability in adolescent privacy laws. *Pediatrics, 149*(6).

[29] Counts, N. (2023, May 18). Understanding the U.S. behavioral health workforce shortage. The Commonwealth Fund.

[30] Prothero, A., & Riser-Kositsky, M. (2022, March 1). School counselors and psychologists remain scarce even as needs rise. From *Education Week* Special Report *Student and Staff Mental Health: Emerging from COVID's Crisis*.

[31] Institute for Education Sciences, National Center for Education Statistics (2022, May 31). Roughly half of public schools report that they can effectively provide mental health services to all students in need [press release].

[32] School Superintendents Association (2019). *Structural inefficiencies in the school-based Medicaid program disadvantage small and rural districts and students*. The School Superintendents Association.

At the Heart of It: Opportunities to Strengthen Youth Mental Health

States and districts have a unique opportunity to expand their school-based mental health programming and repair inequities in service access and delivery. Here are some specific areas of focus for efforts to strengthen Medicaid SBS.

★ Address the ongoing needs of small and rural districts.

Students in rural areas often struggle to access community-based services and supports, and many don't have access to comprehensive behavioral health services through their schools.[33] Districts with strong programming, such as Nevada's Lander County School District (profiled above) serve as stand-ins for a local community hospital and outpatient clinic, as those resources are themselves limited and often far away. Students are more likely to show up to school every day, and to feel supported, when they receive enhanced behavioral health services. Small and rural districts need targeted funding and technical assistance resources to support staffing and other challenges that are unique to them. Developing ISD type models, such as in Michigan (profiled above), allows rural and smaller districts to meaningfully participate in the Medicaid SBS program.

★ Develop a Medicaid Innovation Accelerator Program focused on school-based Medicaid.

State Medicaid and Education Authorities (SMAs and SEAs) are looking for guidance and clarification on Medicaid SBS. Previously, CMS used Innovation Accelerator Programs (IAPs) to support states in developing areas such as payment strategies and enhancing behavioral health. Given the changes outlined in the CMS guidance and the ongoing need within states to expand Medicaid SBS, an IAP-like model would serve as a perfect opportunity to elevate and strengthen Medicaid SBS. An opportunity like this would allow for more federal and state-level collaboration as well as peer-to-peer learning.

★ Find creative solutions to the behavioral health workforce shortage.

A bright spot in the CMS guidance is the new opportunity for states to offer flexibility in school behavioral health staff licensure requirements. SMAs and SEAs now have the ability to license behavioral health professionals to work in schools (as is the case in Colorado) rather than depending entirely on licensing by a state medical board. This added leeway allows states to increase the types of eligible mental health providers, such as school psychologists, school social workers, and licensed mental health counselors. The state can determine which type of professional can deliver each part of the school-based services benefit, consistent with the State Plan Amendment (SPA). This change could have a major impact by increasing Medicaid revenue for schools and improving students' access to services. With more Medicaid funding, states, districts, and schools have the ability to increase the ratio of mental health staff to students, thus reducing workloads, improving quality and comprehensiveness of care, and — hopefully — boosting staff retention and satisfaction.

[33] Gale, J., Janis, J., Coburn, A., & Rochford, H. (2019). Behavioral health in rural America: Challenges and opportunities. Rural Policy Research Institute.

★ Develop the role of peers within school-based settings.

Within the behavioral health system peers have become a valued asset. Across the behavioral and physical health industry, many are looking to the peer workforce to fill some of the need and alleviate pressure created by the current workforce crisis. Many SMAs have the authority to offer peer support as a covered service. Given this fact, and the opportunity for states to cover all medically necessary services through the Medicaid SBS program, states and schools should be working to add the role of peers within schools to support student mental health. According to Mental Health America, "Youth involved in peer support programs and leadership roles can help create systems of services that better meet young people's needs in the ways that matter to them."[34] Peers can play a vital role in promoting recovery and wellness, building trust and camaraderie, providing group-based supports, and making community-based connections.

★ Create meaningful, public facing, transparent data.

Understanding the impact of school-based behavioral health programs will help address gaps and barriers for districts and states and can drive future programming. State-level collaboration is essential for successful outcome tracking, as this collaboration can allow state agencies to collect and publish standardized, statewide data. Key areas for outcome and utilization tracking include:

- Attendance
- Academic performance
- Student/parent/teacher engagement
- Functional/symptom improvement
- Number of EPSDT services
- Number of providers participating
- Dollars spent
- Number of students served
- Reimbursement rates
- Demographic data, such as race and language

Data visibility is important to demonstrate the outcomes and performance of SBS programs and for other states and districts to learn from. Arkansas , Hawaii and Ohio have user-friendly public-facing dashboards that publish district-level annual Medicaid data.

Ohio is leading the way in publishing both district-level and individual school data. A partnership between the Ohio Department of Medicaid and the Ohio Department of Education provides the Ohio Healthy Students Profiles as a data resource for needs assessments and planning. The profiles describe health care interactions, health conditions, and educational indicators for Medicaid-participating students. Other states, too, should work across agencies and utilize existing resources to create public-facing dashboards that highlight Medicaid and educational data.

[34] Davis, K., Chilla, S., & Do, Nghia (2022). *Youth and young adult peer support: Expanding community-driven mental health resources*. Mental Health America.

FIGURE 1: STATEWIDE PROFILE, 2021-2022 SCHOOL YEAR

HEALTH AND EDUCATION MEASURES FOR MEDICAID-PARTICIPATING STUDENTS

Measure Type	Measure	K-12 Count	K-12 Rate	Grades K-5	Grades 6-8	Grades 9-12
	Medicaid-Participating Students	682,712	–	**321,182**	159,632	201,898
Interaction	Comprehensive Well-Child Checkup	280,430	**41.1%**	**42.2%**	43.2%	37.6%
Interaction	Primary Care Physician (PCP) Visit	481,926	**70.6%**	**70.9%**	70.2%	70.4%
Interaction	PCP Visit *within 2 years*	567,002	**83.1%**	**83.6%**	82.6%	82.5%
Interaction	Dental Care Visit	288,506	**42.3%**	**46.3%**	41.4%	36.4%
Interaction	Dental Care Visit *within 2 years*	380,755	**55.8%**	**59.7%**	54.6%	50.5%
Interaction	Trip to Emergency Room	212,293	**31.1%**	**30.1%**	28.9%	34.5%
Interaction	Overnight Stay at Hospital	11,691	**1.7%**	**0.9%**	1.6%	3.1%
Condition	Asthma	26,533	**3.9%**	**4.4%**	3.7%	3.2%
Condition	Diabetes	4,003	**0.6%**	**0.3%**	0.6%	1.0%
Condition	Any Behavioral Health Condition	183,477	**26.9%**	**22.7%**	29.7%	31.2%
Condition	Serious Emotional Disturbance	64,016	**9.4%**	**6.6%**	10.5%	13.0%
Condition	Autism	10,862	**1.6%**	**1.8%**	1.4%	1.4%
Condition	Depression (Any Type)	34,555	**5.1%**	**1.0%**	6.3%	10.6%
Condition	Major Depression	20,309	**3.0%**	**0.4%**	3.6%	6.6%
Condition	Anxiety	58,022	**8.5%**	**4.9%**	9.8%	13.2%
Condition	Attention-Deficit/Hyperactivity Disorder	77,200	**11.3%**	**12.1%**	12.7%	8.9%
Condition	Substance Use Disorder	4,364	**0.6%**	**<0.1%**	0.4%	1.8%
Education	Demonstrating Kindergarten Readiness	11,796	**22.9%**			
Education	Proficient in English Language Arts	159,209	**44.1%**			
Education	Proficient in Mathematics	136,749	**33.7%**			
Education	Graduating On-Time (2021 cohort)	46,694	**76.6%**			
Education	Chronically Absent	279,020	**43.7%**			
Education	Disciplinary Incidents (per 100 students)	230,332	**35.9**			
Staff	School Counselors (per 1000 students)	4,184	**2.5**			
Staff	School Nurses	2,121	**1.3**			
Staff	School Psychologists	2,029	**1.2**			
Staff	School Social Workers	699	**0.4**			

Source: Ohio Department of Education and Workforce

★ Enhance state collaboration.

The U.S. Department of Health and Human Services and the U.S. Department of Education have signaled to governors the need for SMAs and SEAs to work collaboratively on expanding services to youth.[35] IDEA requires states to establish an interagency agreement between the SEA and the SMA. States should review those agreements to ensure they meet the needs of today's Medicaid SBS programs, and that they support collaboration. Stakeholders resoundingly talk about the need for collaboration within and between federal, state, and local agencies. Interagency agreements should formalize a collaborative relationship between state agencies, LEAs, managed care organizations,

[35] U.S. Department of Health & Human Services (2024, January 24). Letter to Governors announcing Notice of Funding Opportunity, State Grants for the Implementation, Enhancement, and Expansion of Medicaid and CHIP School-Based Services.

and school boards. The agreements should include data-sharing language, establish clear responsibility for interagency coordination, and be publicly available. New Mexico has a standard contract agreement that includes the LEA, SMA, and SEA. Michigan is an example of a functional collaboration between the SMA and SEA, modeling a collaborative partnership, which has had a positive impact on school districts.

Through collaboration, the SEA and SMA should serve as leaders in supporting the expansion of school-based behavioral health programs in their states. The SMA is responsible for setting reimbursement methods and updating the state plan amendment and should communicate the changes and resulting protocols to the districts, which can be a collaborative effort with the SEA. Training on administrative claiming, provider requirements, and documentation can also be coordinated between SEAs and SMAs. States could remove administrative burden from LEAs by creating a list of approved vendors that are able to offer billing, claiming, and documentation services. LEAs are often contracting to third party vendors for these tasks, and many LEAS do not have the knowledge to recognize the skills needed to manage a Medicaid SBS program.

★ Dedicate state staff to champion this work.

In order to have a robust school-based Medicaid program, states must support committed positions at the SEA and SMA, working in collaboration with another.

★ Leverage the Medicaid and School Based Services Technical Assistance Center.

The CMS Technical Assistance Center can play an important role in helping states and districts plan for, implement, and enhance their school-based Medicaid programs. SEAs, SMAs, and LEAs have called for clarification in the guidance, and for CMS to model functional collaboration with other federal offices, like the Department of Education. Convening states and districts frequently to review topical areas or implementation challenges, hosting learning collaboratives, and highlighting successes are all activities that could fall under the role of the Center. Just as important as technical support, interviewees also expressed a desire for the Center to continue issuing grants to support rural and small districts and innovation at any level in the expansion of school-based behavioral health programs.

★ Strengthen the use of telehealth.

The ability for states to deliver services via telehealth brings opportunities in access, comprehensive care planning, and family engagement, particularly in rural districts. Only 17% of schools offered telehealth services for mental health during the 2021 school year.[36] Schools with limited provider capacity and vast geographic diversity can connect providers to students via telehealth when travel is limited. Parent and family meetings can be more accessible via telehealth and students can access a greater array of services. Districts and states have an opportunity to proactively identify workflows and policies for the use of telehealth to maximize the potential and reduce risks associated with employing technology in school-based settings. Planners should take into account considerations such as supervision of students while telehealth sessions are underway, backup for connectivity

[36] Kimball, A., Lofton, D. Y., & Mehta, P. S. (2023). *2023 school mental health state legislative guide*. Inseparable Action.

issues, interstate laws for the various professionals involved, appropriateness of use, and specific SPA provisions that might need to be updated.

★ Support the implementation of electronic health records.

Throughout the U.S., many districts are still capturing behavioral health information in archaic ways, using paper and pen. One of the biggest barriers to participating in the Medicaid SBS program is the lack of proper documentation and system integration of student data, e.g., Medicaid enrollment data, IEP information, physical health data, and behavioral health data. Federal and state agencies can facilitate needed upgrades by providing infrastructure to support electronic health records (EHRs). Through EHRs, districts will be better able to claim for Medicaid SBS and track outcome and measurement data. In 2009, the federal government committed over $27 billion to support and promote the implementation of EHRs in physical health systems. In 2022, Colorado issued $26 million in ARPA grant funding to enhance EHRs. Since schools are required to follow similar insurance rules to those that govern health systems, they should be included in infrastructure funding streams and should receive technical support to integrate data.

Schools have the opportunity to help young people, both academically and in their overall wellness, at this historically challenging moment. Providing mental health supports in schools can provide a key access point to such services, improving equity through increased days in school, higher graduation rates, and greater wellbeing for youth. Medicaid is an avenue to the funding that can allow schools to add staff with the appropriate skills and realize this vision.