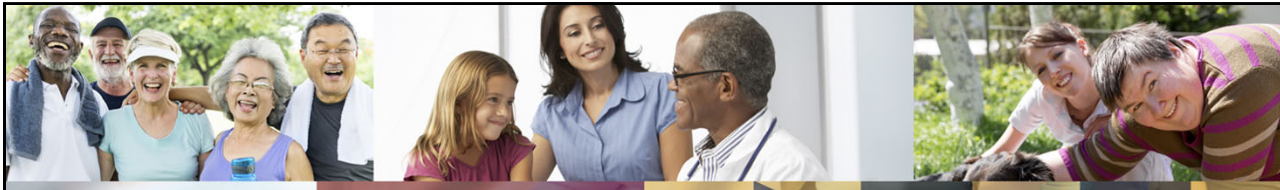

School-Based Services and Medicaid

Ryan Moran, DrPH, MHSA
Deputy Secretary, Health Care Financing and Medicaid Director

November 30, 2023

1

Agenda

- **Background**
    - Maryland Department of Health (MDH) Vision for the Behavioral Health (BH) Continuum of Care
    - School-Based Services and Medicaid
- **Anticipated Impact**
- **Considerations for Maryland**
    - Envisioned Approach
    - Next Steps
- **Partnership**

2

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Background

Role of Medicaid & Vision for the BH Continuum of Care

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3

Medicaid & Children's Health Insurance Program

- Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to over 1.7 million low-income children, including 700,000 participants under 21, pregnant women, adults, seniors, and people with disabilities in the Maryland.
  - Over 60% of these participants are between ages of 6 -18 years old
  - Source of coverage for 3 in 8 children in Maryland
- Medicaid is the largest payer for mental health services in the United States; increasingly playing a larger role in payment for substance use disorder services
- Medicaid is jointly financed with Federal and State funds. Medicaid is the payer of last resort.
  - Federal contribution is based on the state's per capita income → 65% match for Children's Health Program in Maryland, 50% match rate for non-ACA populations; 90% match for ACA populations.

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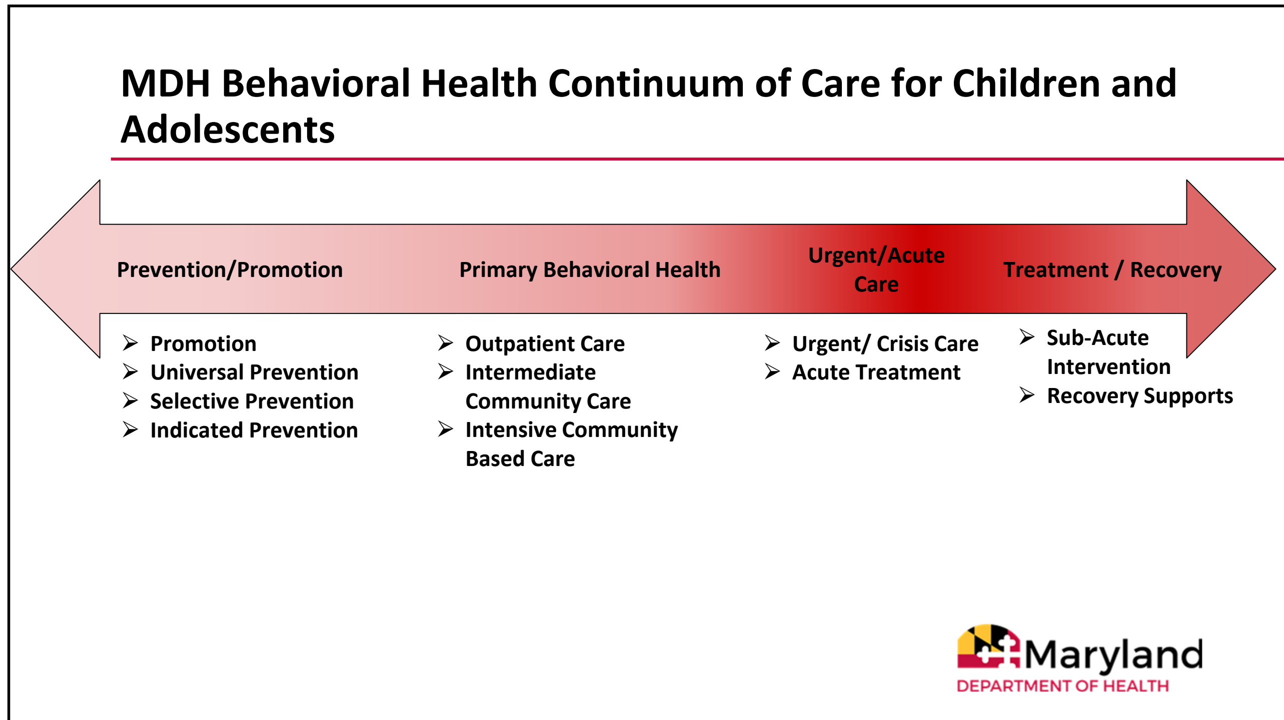

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MDH Behavioral Health Continuum of Care for Children and Adolescents

Prevention/Promotion				Primary Behavioral Health			Urgent/Acute Care		Treatment / Recovery	
Promotion	**Universal Prevention**	**Selective Prevention**	**Indicated Prevention**	**Outpatient Care**	**Intermediate Community Care**	**Intensive Community Based Care**	**Urgent/ Crisis Care**	**Acute Treatment**	**Sub-Acute Intervention**	**Recovery Supports**
• General Outreach • Population Specific Outreach • Comms Campaigns	• ACE Awareness • Social & Emotional Learning Modules • School-Based Services (Tier 1)	• Good Behavior Game • SBIRT • Harm Reduction • Early Childhood Mental Health (MH) Consults w/ Brief Treatment	• SBIRT • Home Visiting • Mental Health First Aid • TAY • Early Childhood MH Consults w/ Brief Treatment • DHS Prevention	• Community-Based Services • Case Mgmt. • MH Client Support Services • Drug Court • Outpatient Detox • MAT • Brief Intervention - PCP • **School-Based Care**	• Youth PRP • Youth TBS • DDA Youth Community Supports Services	• Partial Hospital-ization • Intensive outpatient (IOP) • Intensive In-home Supports (EBPs) under 1915i	• 988 Hotline • Urgent Care Services • Crisis Stabilization Centers • Mobile Crisis Teams • Res Crisis • STOP • Respite	• ED • Inpatient • Inpatient Detox (ASAM 4.0, 3.7-D)	• ASAM 3.5/3.7 • Intensive in-home supports (EBPs) under 1915i • MAT	• State Care Coor. • MDRN • START • Family Peers • Adolescent Clubhouse • Recovery Schools
			• SATS (TCA) • Targeted Case Management			• ACT • MHSS / MRSS • Safe Stations		• Targeted Case Management • Res. Treatment		
			• BHIPP • EPSDT • EMR Embedded Screening • FEP							

6

Primary Behavioral Health ➡ School Services

Vision: In partnership with the Consortium on Coordinated Community Supports, implement a multi-tiered system of behavioral health supports in all public schools.

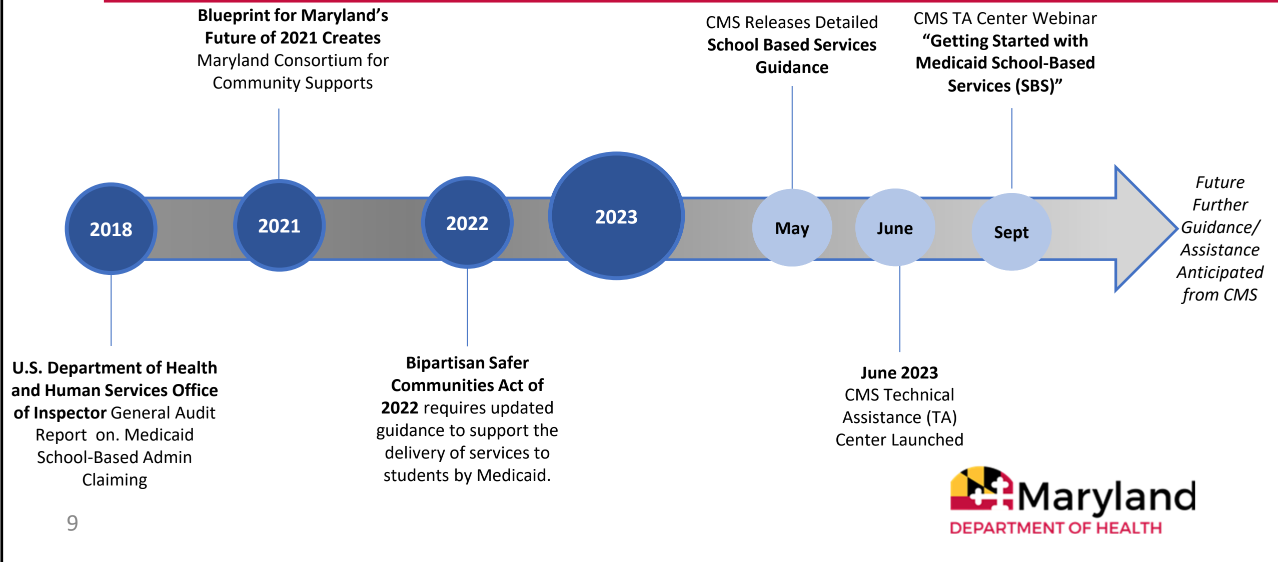
Current Activities:

- Preschool mental health consultation services in partnership with University of Maryland, Baltimore
- Partnerships with preschool programming (e.g., Lourie Center, and PACT)
- Partnership with UMB on Center for School Mental Health
- MDH School Based Health Center (SBHC) development of enhanced service standards

Opportunities: Maximize Medicaid funding to support school-based behavioral health services, including payment for non-IEP related services.

Background

School-Based Services and Medicaid



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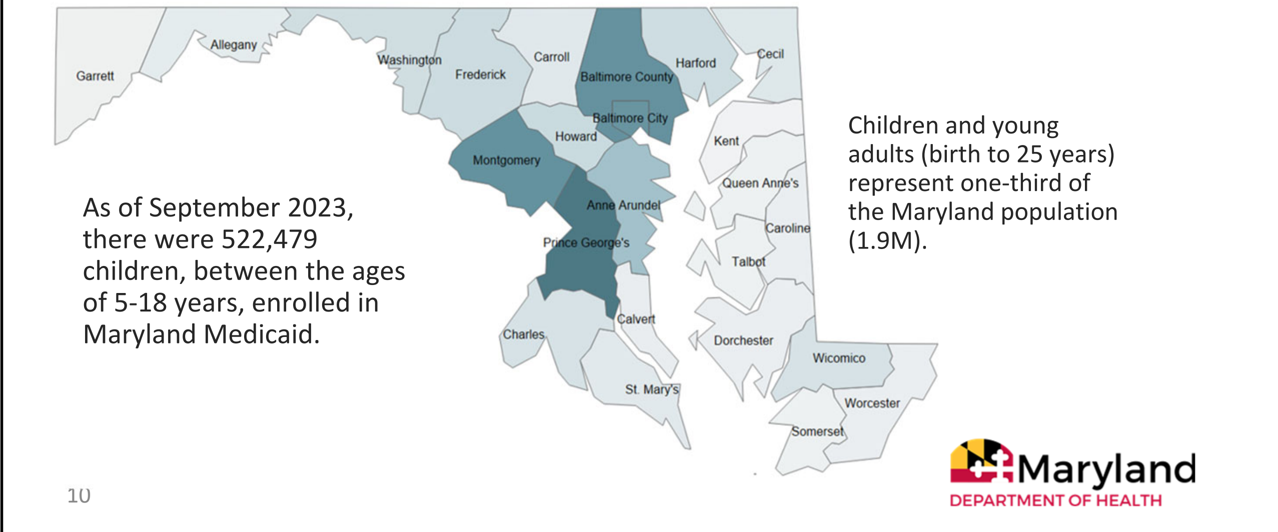

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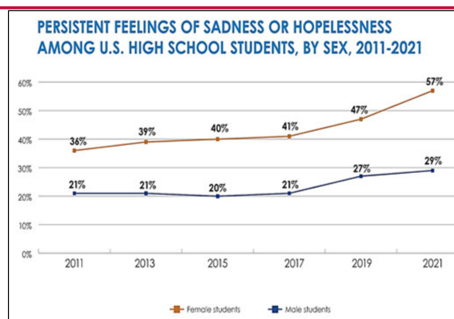
Anticipated Impact

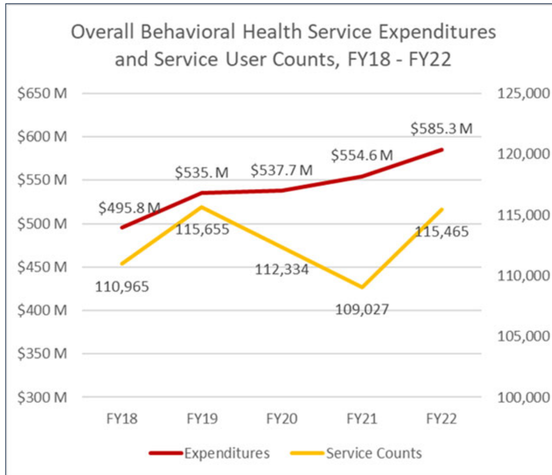
Impact - A Growing Call to Action



- More than 60% of youth with a mental illness are not identified and receiving mental health services. [1]
- High schoolers have been reporting increasing rates of "persistent feelings of sadness or hopelessness", worsened by gun violence, Covid-19 pandemic and social media [2] [see diagram above].

- Suicide is a leading cause of death in young adults. In 2021, 13.8% of deaths of 15-24 year olds in Maryland were result of intentional self-harm (suicide). [3 4]
- 2016-2018: In children with serious emotional or behavioral difficulties:
  - 8.5% were covered solely by Medicaid
  - 3.4% were uninsured, and
  - 4% who were privately insured. [5]

Youth and Young Adult Public BH Service Use and Expenditures



Data Source: PBHS Service Claims data FY2018 - FY2021

- In FY 21, A total of 109,027 children and young adults received one or more behavioral health services within the PBHS system statewide with a total expenditure of $554.6M.
- Service use among children and young adults decreased by 5.7% between FY20 and FY21, while expenditures increased over the same period by 3.1%.
- The increase in expenditures was largely driven by increased spending on Inpatient Hospital (9.7% increase); PRP (42.0% increase); and TCM Services (113.0% increase).

Considerations for Maryland

Envisioned Approach

Envisioned Phased Implementation Strategy

Phase One

FFS reimbursement of LEAs/other provider types

Phase Two

Alternative Payment Model Implementation or Hybrid Approach

- Adopting a phased approach will allow additional planning time to develop methodology and compliance processes for alternative payment models (APMs)
- Permitting Fee-for-Service (FFS) billing in the interim will allow local education agencies (LEAs)/schools to benefit in near term prior to implementation of reimbursement for administrative costs
- Proposal is pending identification of state funding share and partnership with Maryland State Department of Education (MSDE)

Phase 1: FFS Rates Reimbursement

Key Requirements for School Based Behavioral Health Services:

- Provider must be enrolled with Medicaid
- Must be Medicaid-covered (or EPSDT*-required) service
- Third Party Liability (TPL) requirements apply, except for Individualized Education Program (IEP) services
- Auditable documentation of services must be maintained
- School-based providers no longer need to meet the same standards as community-based providers, *except:*
  - PT, OT, speech therapy and audiology services (held to federal standards)
- Telehealth is permitted

**Early and Periodic Screening, Diagnostic and Treatment*

Phase 1: FFS Reimbursement

- **Expand coverage to permit billing by school psychologists and school social workers** for services rendered to any Medicaid enrolled child (no longer limited to those with an IEP)
- **LEAs (PT 91):** Rendering providers can bill under LEA
- **Services:** Self-referred
- **Payment:** FFS Rate through Behavioral Health Administrative Services Organization (BHASO)

17

17

Phase 2: Alternative Payment Model Options

Seeking TA on potential hybrid approach to focus exclusively on use of below APMs for administrative costs and FFS reimbursement for services.

Alternative fee schedule for school-based services (e.g., higher than FFS)

- Must demonstrate that the rate is economic and efficient

Prospective Cost-Based Rates Specific to Schools

- Calculated using cost reports and utilization data from a base period that is submitted by LEAs to State Medicaid agencies to establish the rates.
- Rates can be set for a defined encounter on a statewide basis (e.g., a State Medicaid agency would set a statewide rate for a 15-minute encounter with a physical therapist), or be LEA specific.
- Actual incurred costs are not accounted for and there is no reconciliation process; therefore, not certified public expenditure (CPE) eligible

Reconciliation to the Cost of Medicaid Services Provided in Schools *(most common methodology)*

- Medicaid makes interim payments to providers throughout the year and reconciles interim payments to the proportion of costs attributable to Medicaid and identified through provider cost reports
- Eight different options for setting interim rates

18

18

Allowable Costs*

Direct Costs: Medical Services	Direct Costs: Administrative	Indirect Costs
Authority: Medicaid State Plan Allowable Costs: Salaries and benefits of qualified service providers and contracted providers who deliver covered services; medical supplies and equipment used to provide Medicaid services	Authority: Public Assistance Cost Allocation Plan Allowable Costs: Administrative activities that support the provision of medical services covered under the Medicaid or CHIP State plan such as outreach and enrollment, translation, transportation , referral and coordination of care and Medicaid- or CHIP-related training	Authority: Medicaid State Plan Two options: 1) Unrestricted indirect cost rate for the LEA or other school entity set by the cognizant agency (usually Education Department) 2) Actual indirect cost

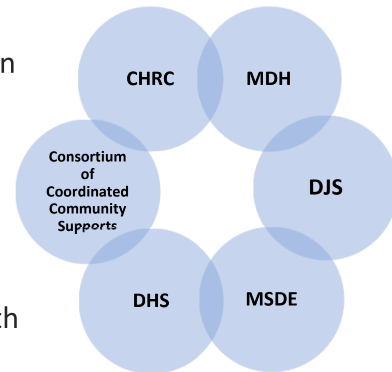
**Additional information found in the appendix.*

Considerations for Maryland

Next Steps

Call to Action

- Continued interagency coordination is necessary to ensure a continuum of care is available for all children and youth. This includes:
  - MDH
  - Community Health Resources Commission
  - Consortium of Coordinated Community Supports
  - DHS
  - DJS
  - MSDE
- Leverage and improve upon existing behavioral health infrastructure
- Ensure that Maryland is building trauma-informed systems of care



21

21

Planning Considerations

- Federal Authorities: Timing and submission of CMS authorities and CMS review of cost report templates, etc.
- State Implementation
  - Development of regulations and guidance; reimbursement and billing model, provider enrollment
  - Legal Review of Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA)/Individuals with Disabilities Education Act (IDEA) requirements
  - State funding share identification
  - Engage with technical assistance contractor
    - Cost report development
    - Time studies
    - Alternative payment model selection

22

22

Discussion

23

23

Allowable Costs; Parental Consent

Appendix

24

Direct Costs: Medical Services

- Medical Services
  - Authority: State plan describing reimbursement methodology
    - Provider cost-report templates that detail Medicaid-covered medical service-related costs
    - Must describe cost pools used and allocation of pools to Medicaid
  - Salaries/benefits of qualified service providers and contracted providers who deliver covered services; medical supplies and equipment used to provide Medicaid services.

Direct Costs: Administrative

[1] Administrative Costs

- Authority: Public Assistance Cost Allocation Plan (PACAP) addressing cost identification procedures (45 C.F.R. Part 95, Subpart E).
  - SBS Claiming Time Study Implementation Plan (a.k.a. Medicaid Administrative Claiming Plan). 45 C.F.R. § 95.517; 45 C.F.R. § 75.430(i)(5). Cost reconciliation is *not* required.
  - Interagency agreement between school district and State Medicaid agencies to conduct Medicaid administrative activities. 45 C.F.R. § 95.507(b)(6).
- Costs of administrative activities (incl. salary/benefits) that support the provision of medical services covered under the Medicaid or CHIP State plan such as outreach and enrollment, translation, transportation (when *not* provided as an optional medical service), referral and coordination of care (distinct from case management activities covered as a medical service), and Medicaid or CHIP-related training.

Slide 26

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Kristin deGrouchy -MDH-, 11/22/2023

Allowable Costs–Prospective Cost-Based Rates and Rates Reconciled to Costs

Direct Costs: Administrative (cont'd)

Not allowed:

- Direct/ indirect activities related to providing a direct medical service.
- Part or extension of a direct medical service, such as patient follow-up, patient assessment, patient education, counseling (including pharmacy counseling), or other physician extender activities.
- Any cost of general public health initiatives that are made available to all persons, *unless* the activities related to assisting Medicaid-eligible students are specifically identified.
- Non-Medicaid/CHIP outreach, facilitating eligibility determinations for non-Medicaid/CHIP public assistance programs (e.g., Temporary Assistance for Needy Families, or TANF), transportation for non-Medicaid/CHIP covered services, translation and interpretation services related to non-Medicaid/CHIP covered services, non-Medicaid/CHIP related training, or Referral, coordination, and monitoring of non-Medicaid/CHIP-covered services.

Calculating Qualifying Medical and Administrative Costs

Two-Step Process to determine qualifying costs (same for both Medical and Admin costs):

(1) Time study to allocate providers' time to all medical services (e.g., through the use of the Random Moment Time Study (RMTS) or worker log).

- Applied statewide to the cost pools that include costs of providers and others who furnished Medicaid-coverable services and/or conducted Medicaid-allowable administrative activities

(2) Use of a Medicaid Enrollment Ratios (MER) or other cost allocation methodology. MER is most common.

- MER allocates costs to Medicaid using a ratio of the relevant Medicaid-enrolled population (e.g., ratio of students with an IEP who are Medicaid beneficiaries to all students with an IEP (which should all be verifiable in an audit), or ratio of students who are Medicaid beneficiaries to the entire student population).
- Must be updated on a regular basis.
- Both the number of Medicaid-enrolled students and the number of total students used to calculate the MER must be identified for the same time period.

Administrative Claiming: Detailed Formula

Direct Costs

Administrative activities direct cost pool (includes personnel and other direct costs)
x *(multiplied by)*
- a) The percentage of time in allowable administrative activities (i.e., results of the time study)
  and
- b) other applicable allocation statistic for other direct costs

x *(multiplied by)*
The Medicaid Enrollment Ratio, where applicable (i.e., n/a for outreach/enrollment)
\+ *(plus)*
The costs of any applicable administrative contracts

\+ *(plus)*

Indirect Costs

Direct costs (or a proportional share of the allocated cost pool and allowable other costs)
x *(multiplied by)*
The Department of Education approved indirect cost rate
= *(equals)*
Administrative Claimable Costs (Total Computable)
x *(multiplied by)*
The FFP(s) Percentage
= *(equals)*
The Administrative Expenditure FFP

Allowable Costs–Prospective Cost-Based Rates and Rates Reconciled to Costs

Indirect Costs

- Authority: SPA
- Determining qualifying costs:
  - Cannot duplicate any direct costs
  - Two options:
    - (1) Usually uses the **unrestricted indirect cost rate (UICR)** for the LEA or other school entity set by the cognizant agency (usually Education Department) per 45 C.F.R. Appendix IV to part 75 (C)(2). Cognizant agency is typically the Education Department. That rate is then multiplied by the direct costs that relate to the provision of medical services. The product of the direct cost multiplied by the cognizant agency indirect cost rate is the total allowable indirect cost
    - (2) **Actual Indirect Cost**

Allowable Costs–Prospective Cost-Based Rates and Rates Reconciled to Costs

Other Framework

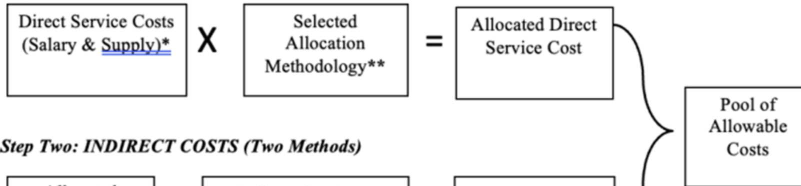
- Must be necessary for "proper and efficient" administration of Medicaid (45 CFR 75.403)
- Cost pools must be established
  - Mutually exclusive and homogenous
  - Separate pools for medical and admin services
  - E.g., Salaries/benefits for specific direct medical costs, equipment and supplies to support specific activities, etc.
- Revenue Offsets
  - *All* revenues received by schools that cover SBS activities must be recognized and considered
  - Such funds are subtracted from allowable costs

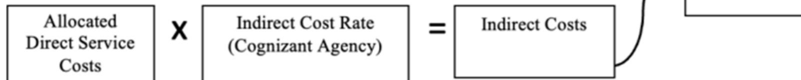
31

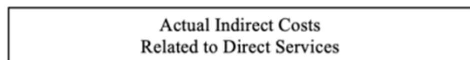
31

Calculating Total Allowable Costs

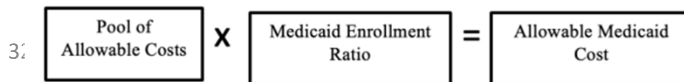
Step One: DIRECT COSTS







Step Three: Allocating Allowable Costs to Medicaid



32

Confidentiality & Parental Consent

- The State will need to develop guidance in consultation with its attorneys regarding interaction of FERPA, HIPAA, IDEA, and the delivery of school services to Medicaid participants. These laws also impact data sharing between agencies, MCOs, etc.
- Most recent FERPA/HIPAA Guidance is here.
- Development of relevant forms and boilerplate language for use by schools to ensure statewide uniformity may also be advisable.
- One recurring item raised by SBS providers is the challenge schools face with furnishing documentation to support the rendering of Medicaid services, while also ensuring compliance with privacy provisions under IDEA and FERPA.
    - De-identified or Masked Data: To meet the documentation requirements applicable to Medicaid and to be prepared for audit, school-based providers can furnish de-identified or masked data, which has been redacted or conceals PII.
    - To the extent possible, and to aid in relieving school-based providers of administrative burden, State Medicaid agencies that do not allow providers to use de-identified data to support payment for services should consider amending their policies to do so.