MILLIMAN REPORT

Nevada School Health Services Policy Evaluation

Prepared for Nevada Department of Health Care Policy and Financing

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Executive Summary

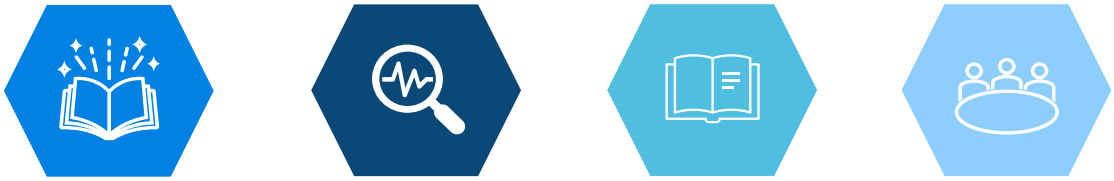
The Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), currently allows local education agencies (LEAs) and state education agencies (SEAs) to enroll as Medicaid providers, giving them the ability to access Medicaid reimbursement for health services provided to Medicaid-eligible children in school settings. For simplicity in this report, we will only reference LEAs, and not SEAs, as they are the primary school-based provider entities. Nevada's school-based Medicaid program is administered by DHHS and is locally known as the School Health Services (SHS) program.

To support this work, DHCFP has identified the following goals:

- Increase school participation in the Nevada school-based Medicaid program so that more children can access SHS
  - both encouraging more LEAs to participate and
  - expanding the service array billed through participating LEAs
- Simplify program administration for participating LEAs
- Increase revenue to the school through Medicaid reimbursement

In support of these goals, DHCFP engaged Milliman to evaluate the current SHS program and to provide policy adjustment considerations that may assist Nevada improve its SHS program. We developed this policy memo through research and stakeholder engagement. The major activities that were performed in support of this report are noted below.

SCHOOL HEALTH SERVICES POLICY EVALUATION STEPS



Review of Nevada SHS

Examined Nevada's current SHS program and policy materials

Review of CMS Guidance

Assessed and summarized recent federal guidance from the Centers for Medicare and Medicaid Services

State Comparison

Identified and reviewed four comparison state programs to identify best practices implemented by other states

Stakeholder Engagement

Facilitated two meetings with LEA stakeholders from across the state to inform our understanding of current program challenges

This report summarizes Nevada's current SHS program policies and outlines stakeholder-identified challenges as compared to available federal authorities, in order to identify pertinent areas for potential program changes. Drawing on examples from other states as well as CMS-recommended best practices, we then outline a number of potential program enhancements that Nevada may consider which may help accomplish DCHFP's goals to increase access to and participation in Nevada's SHS program.

The primary purpose of the stakeholder meetings was to understand what challenges are limiting LEA participation in the SHS program. Stakeholders noted a range of barriers to participation, which have been classified into three general categories:

- Medicaid provider licensure and credential requirements can be incompatible with the types of staff who are currently furnishing services in a school setting

- Federally required parental consent forms are difficult to obtain and limit the LEAs' ability to bill for rendered services
- Medicaid enrollment and billing rules are seen as complex and confusing, causing some LEAs not to bill for services or to bill for a lesser array of services that might be coverable

A variety of potential solutions exist that may help DHCFP to address challenges noted by stakeholders as well as promote the State's goals for the SHS program. These ideas fall across three major categories, as listed below. The identified changes are not mutually exclusive; DHCFP may consider a combination of several different approaches to best accomplish its goals.

POTENTIAL CHANGES TO NEVADA'S SCHOOL HEALTH SERVICES PROGRAM

Program Participation Changes: These approaches could be used to expand the types of providers who can participate in the program, or the children whose services are eligible to be billed under the program.

1. **Expansion of the provider types who are eligible to bill Medicaid**: Allow additional licensed providers who operate in schools, such as school counselors, to bill Medicaid for school health services.

2. **Change in collection procedures for Family Education Rights and Privacy Act (FERPA)-required consent forms**: Consider new strategies for how schools obtain signatures on FERPA consent forms to increase the percentage of Medicaid eligible students that have a signed form, allowing the school to bill Medicaid for more students for whom Medicaid-eligible services were provided.

Administrative Supports to Address Challenges with Medicaid Program Rules: These approaches could address confusion and difficulties around Medicaid enrollment and billing requirements for school health services.

3. **Technical assistance and training for LEAs**: Develop educational materials and other support activities to provide schools with clearer guidelines for participation in the SHS program**.**

4. **Change in timely filing requirements**: Update billing rules to extend the filing limit from six months to 12 months, providing schools with additional time to submit claims for services rendered.

5. **Statewide billing consortium:** Establish a centralized billing and EHR system that schools may opt to utilize rather than having to obtain their own billing mechanisms for Medicaid.

Payment Changes: These approaches could be used to enhance the funding provided to SHS providers, which may expand participation and capabilities to provide workforce to furnish SHS.

6. **Enhanced fee schedule:** Create a new fee schedule for SHS services to pay a higher rate to school-based providers, versus when the service is provided in other settings. (Note that under this approach, the state Medicaid agency must demonstrate that the higher rate is economic and efficient.)

7. **Reconciled cost methodology**: Change the methodology for payment to schools and potentially increase the amount of funding schools receive, by moving to an interim billing model using a cost-based methodology. While this new system could create administrative efficiencies for LEAs in the long run, a change in the information collected from LEAs would be required and may involve a significant increase to LEA administrative tasks in the short-term during the transition period.

There is wide variation in the timelines that would be required to implement each of these potential program changes. Some approaches, like technical assistance and training, could be implemented in the near term (e.g. 6-months to 1 year) and can be accomplished under current program authority. Others, like developing a new cost methodology for payment, would take several years to implement and may require new authorities (as detailed further in this report). All options can be considered independently, or multiple changes could be pursued concurrently.

SOLUTIONS BY LIKELY TIMEFRAME

SHORT TERM OPTIONS (6 MONTHS TO 1 YEAR)	MID TERM OPTIONS (1 TO 2 YEARS)	LONGER TERM OPTIONS (2+ YEARS)
▪ Expansion of the provider types who are eligible to bill Medicaid ▪ Technical assistance and training ▪ Change in collection procedures for FERPA-required consent forms	▪ Change in timely filing requirements ▪ Statewide billing consortium	▪ Enhanced fee schedule ▪ Reconciled cost methodology

Federal Guidance on School-Based Medicaid

INTRODUCTION

In May 2023, the Centers for Medicare & Medicaid Services, in consultation with U.S. Department of Education, released updated guidance for the delivery of school-based services, *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.*[1] The report is cited in this document and simply referred to as "CMS guidance" or "guidance" moving forward. CMS' stated goal of the updated guidance is to expand access to Medicaid funding for services that are already provided in a school-based setting, which may create an opportunity for LEAs to increase access to services in school.[2]

In May 2023, CMS published new guidance to states on ways to assist LEAs in delivering school health services and obtaining payment. That guidance can help states implement the many flexibilities allowed for delivering school-based services.

To achieve this goal, CMS has:

- Expanded the populations eligible for service in school settings,
- Expanded the services eligible for reimbursement in school settings,
- Expanded the providers eligible to participate in Medicaid, and
- Expanded the options for billing and reimbursement for school-based services.

While this guidance provides states with greater flexibility, the impact that it may have in each state and for individual LEAs will vary. Each state administers its own unique Medicaid program with different benefits, eligibility standards, provider networks, and delivery models, and thus the impact of particular flexibilities may differ.

It is important to note that regardless of this CMS guidance, state Medicaid agencies continue to have broad flexibility in determining how school health services are reimbursed. For instance, states may choose a fee-for-service or a managed care delivery model for these services. A state can individually determine the covered services, types of providers that are permitted to enroll with Medicaid, and if certain services can be covered via a telehealth modality. States may also limit certain services to be provided by certain provider types. The CMS guidance does not change any of these flexibilities but instead, it seeks to clarify these flexibilities by providing states with tools to determine which program structures may best fit their program goals and delivery system capabilities.

The federal flexibilities available to states are further discussed below.

PERMISSIBLE COVERED POPULATIONS

State Medicaid programs are highly encouraged to operate school-based service programs. While it is not mandatory for state Medicaid programs to do so, all state Medicaid programs currently operate school-based services programs. Historically, states have designed their school-based service programs to cover a limited set of services restricted to a subset of students. Originally, only services that were documented in a student's individualized education program (IEP) or individualized family service plan (IFSP) were eligible for Medicaid reimbursement in school-based services programs. These requirements were aligned with the Individuals with Disabilities Education Act (IDEA), which

[1] The Center for Medicare and Medicaid Services. (2023, May 18). *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.* https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf
[2] Id.

requires LEAs to provide students with disabilities a free appropriate education as well as early intervention, special education, and related services to eligible infants, toddlers, children, and youth.[3]

In 2014, CMS began to remove barriers to access Medicaid reimbursement for certain school health services by withdrawing the "free care" rule. The free care rule formerly prohibited schools from seeking Medicaid reimbursement for school health services, if the service was being offered free of charge to other students. With this rule no longer in effect, schools could now access Medicaid reimbursement for "free care" services provided to students enrolled in Medicaid. However, this policy reversal did not waive other Medicaid service requirements, including that all covered services must be medically necessary.

Following this change, school-based services may now be covered for two groups of students:

1. Medicaid-eligible children with disabilities who have an IEP or IFSP.
2. Medicaid-eligible children who need general health care services (not authorized through an IEP or IFSP). *The second category is the population most impacted by the new CMS guidance.*

The guidance clarifies that early education programs and facilities may also qualify as a school-based setting if they are operated by an LEA. Children not enrolled in a school who are eligible for Medicaid, would be entitled to certain program benefits in an early education setting. Programs such as Head Start, Early Head Start, school-based preschools, Bright Futures, and Birth to 5: Watch Me Thrive!, when operated by LEAs, are eligible to provide services and receive Medicaid funding for children not yet enrolled in a school. Several school districts in Nevada (including Clark County, Carson City, and Washoe County schools) operate their own pre-k programs which would allow for services provided to these children to also be eligible for Medicaid reimbursement.

CMS encourages states to promote the use of schools and early education programs as settings for Medicaid-covered services, as these institutions offer a unique opportunity for Medicaid to reach eligible children and provide needed services. For some students, school and early education settings may also serve as the only opportunity to obtain necessary covered services, due to a range of social determinants which may limit their overall access to care (e.g., transportation, parental availability, childcare).[4]

PERMISSIBLE COVERED SERVICES

States are allowed to cover a comprehensive range of services in school-based settings and are encouraged by CMS to draw down federal Medicaid matching funds for all medically necessary, Medicaid-covered services provided to children enrolled in Medicaid. In particular, if a state elects to expand services to all Medicaid-eligible children, the state may wish to remove any distinction that a Medicaid covered service is limited to a school setting from their state plan, manuals, and guidance documents. This guidance from CMS reinforces the ways states can build a bridge between education and health care to increase availability of, and Medicaid funding for, additional health care services such as:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
- Vision services
- Physician services
- Dental care
- Transportation
- Personal care services

[3] U.S. Department of Education. (July 2023). Free Appropriate Public Education for Students with Disabilities: Requirements Under Section 504 of The Rehabilitation Act of 1973. https://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html

[4] The Center for Medicare and Medicaid Services. (2023, May 18). *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.* https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf

- Preventative services
- Rehabilitative services
- Physical therapy, occupational therapy, and/or speech pathology/audiology
- Other licensed practitioner services
- Case management and targeted case management
- Mental health services
- Substance-use disorder (SUD) services

The inclusion of EPSDT services is an important opportunity for LEAs, as EPSDT provides a comprehensive array of preventative, diagnostic, and treatment services for Medicaid-enrolled children under age 21 and are mandatory for a state to offer. The EPSDT benefit is an expanded Medicaid benefit designed to help ensure that children and adolescents receive early detection and care so that any potential health problems are treated as early as possible. For example, vision and dental services are not always covered by state Medicaid programs but are covered under EPSDT; vision and dental may be an example of expansion of covered services for some states.

CMS also allows states to cover certain other Medicaid services in a school setting, including prevention and early intervention services for children and adolescents who may have mental health conditions or SUD, even without a formal medical diagnosis. In addition, the guidance specifies that state Medicaid agencies and schools can partner to expand the use of 988 suicide and crisis lifelines for students experiencing suicidal ideation, substance use disorder, mental health crisis, or any other kind of emotional distress. When mental health and SUD services are available in school settings, impacted youth may be more likely to be identified and to initiate treatment.[5]

Before a school may seek Medicaid reimbursement for services provided, the Medicaid state plan must be updated to detail what services can be delivered in a school-based setting. Similarly, state and federal Medicaid standards, including appropriate service delivery documentation and medical necessity, will apply to services provided in a school setting.

MEDICAID SCHOOL ENROLLMENT AND PROVISION OF SERVICES

The Local Educational Agencies may be enrolled as the Medicaid provider itself (as a Provider Type 60 with Nevada Medicaid), or it may choose to facilitate the provision of services through a contracted provider. Individual LEAs can make this determination based upon works best for their community, administration, and students.

Regardless of which entity is the “enrolled provider” (meaning the organization that is authorized to participate in Medicaid) certain requirements will apply for the “furnishing provider” (the individual who directly provides or renders the service) in order for the service to be reimbursable. Below are three scenarios that outline the furnishing provider options:

- If the individual practitioner providing the service is a provider type that is itself not eligible to enroll as a Medicaid provider, such as a school counselor or a social worker, they must be an employee or contractor of an enrolled provider; in other words, with the practitioner working on behalf of the enrolled provider, the enrolled provider would be considered the furnishing provider.
- If the individual practitioner directly providing the service is a provider type that is eligible to enroll directly in Medicaid, they would be considered the furnishing provider and must be enrolled, regardless of whether the entity employing or contracting with them is also an enrolled provider.
- If the furnishing provider is not enrolled with Medicaid, then Medicaid payment cannot be made for the service and any expenditures related to the service are not allowable.[6]

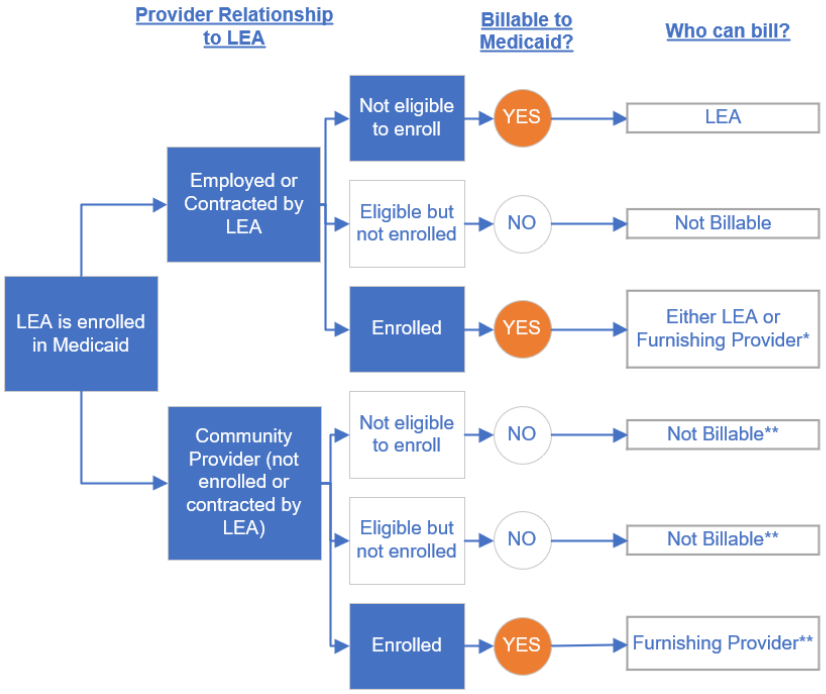
[5] Id.
[6] Id. at 26-27.

For a service to be reimbursable under Medicaid, all of the following requirements must be met:

- The service must be furnished to a Medicaid-eligible individual.
- The service must be a Medicaid covered service and must meet all specific coverage requirements applicable to the service (e.g., including prior authorization, setting requirements, service limits, etc.).
- The service must meet the state's definition of medical necessity.
- The furnishing provider must be enrolled as a participating provider in the Medicaid program, if they are a provider type that is eligible to separately enroll (i.e., with a provider agreement and a Medicaid provider identification number).

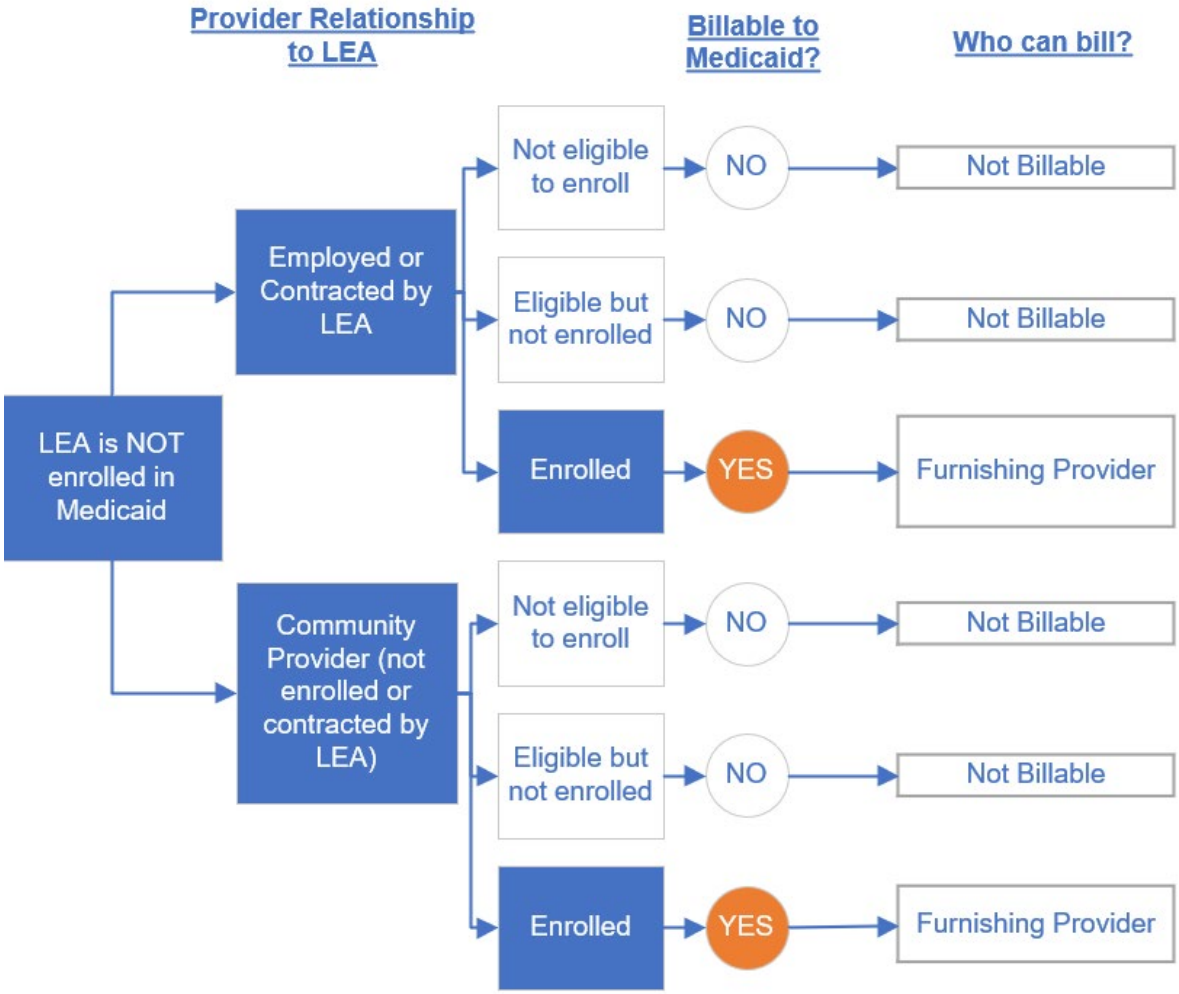
See Exhibit 1 below that outlines these rules to show which entities are eligible to receive Medicaid reimbursement, given federal provider enrollment rules.

EXHIBIT 1: FURNISHING PROVIDER OPTIONS FOR AN LEA THAT IS ENROLLED IN MEDICAID



* Services could be claimed directly by the provider or the LEA. The LEA could also pay providers a contractual rate, and the LEA would submit the claim for services.
** If the LEA performs administrative activities related to the services that are billed to Medicaid by community providers, the costs of such activities can be allowable under the Medicaid program and billed by the LEA.

EXHIBIT 2: FURNISHING PROVIDER OPTIONS FOR AN LEA THAT IS NOT ENROLLED IN MEDICAID



DELIVERY OF CARE

The CMS guidance created more flexibility around which providers states may permit to bill Medicaid for services in the school-based setting. Importantly, this flexibility now allows states to establish provider qualifications for school-based providers that differ from the qualifications of non-school-based providers of the same Medicaid services, so long as the states' provider qualifications are not unique to Medicaid-covered services.

CMS also updated previous guidance that had prevented states from including certain licensed providers as a permitted Medicaid provider, even though their services could have otherwise been covered by Medicaid. For instance, the guidance clarifies that Medicaid state plans may use certification by the federal, state or local education agency, or national accrediting bodies, as a means to include new provider types in the Medicaid state plan. If a provider is legally qualified to provide a service, that qualification could potentially also apply to Medicaid services.

Regardless of what provider furnishes the service, there are also requirements to obtain parental consent prior to treatment and submission of a claim for services provided to a student or child. Medicaid regulations do not require schools to obtain consent before exchanging personal information for billing purposes. However, the U.S. Department of Education through FERPA, requires schools to obtain written consent before billing Medicaid for any services provided. Similarly, IDEA also requires

schools to obtain consent before billing for the first time for services in a student's IEP or IFSP. While this is not a requirement or change listed in the CMS guidance, it is a federal requirement that schools, LEAs, and providers need to be aware of.

PAYMENT OPTIONS AND FLEXIBILITIES

State Medicaid agencies may select among a variety of payment methodology options for school-based services, including:

- Fee-for-service
- Payment to non-school providers
- Prospective cost-based payments
- Reconciled cost methodology

To reduce the administrative burden on schools who furnish and seek payment for school-based services, the CMS guidance introduces new flexibility for states in how they establish billing systems under these four existing payment options. All of these options are further explained below.

Fee-for-Service

Under a fee-for-service (FFS) rate methodology, the state establishes a fee schedule for each Medicaid-covered service. At the time of this report, Nevada uses a FFS payment model for school-based services. Providers are paid based on each individual service delivered when an associated claim is submitted. Most state Medicaid agencies utilizing a FFS methodology pay school-based providers using the same Medicaid state plan payment rates paid to non-school providers. As noted previously, prior CMS guidance prohibited paying a separate rate for school-based settings if the same service was offered in the community.[7]

However, under the new CMS guidance, states can now choose to pay a higher fee schedule rate for school-based providers than other provider types, so long as the state Medicaid agency demonstrates that the rate is economic and efficient. The state Medicaid agency will be asked to document the rate calculations for these services in the school-based setting and assure that those rates are consistent with efficiency, economy, and quality of care.

Payment to Non-School Providers

For schools or LEAs that do not enroll as or employ a Medicaid-enrolled provider, the school may arrange for Medicaid-enrolled community providers to provide Medicaid-covered services to the school's students. These providers may bill for and receive payment at the Medicaid state plan payment rate for the services provided. In these situations, the school is facilitating but not furnishing the service and is therefore not responsible for billing, claiming, or documenting the services that are provided to the student or child. The school would essentially be a referral source and the community-based providers would bill Medicaid for the Medicaid-covered services they provide. The school referral would have no impact on the providers process or claiming procedures.

Prospective Cost-Based Payments

Cost-based payments are calculated using cost reports and utilization data from a designated historical period that is submitted by the LEA to the state Medicaid agency to establish specific rates for specific services. The rates are then established for each defined encounter and can either be set statewide or specific to the individual LEA. Rates for a given LEA do not have to be equal to those set for other LEAs or community providers. Cost-based payment rates may consider the salaries and benefits of qualified providers, the medical supplies and equipment needed to furnish covered services, and the overhead costs associated with each specific covered service. Prospective cost-

[7] Id.

based payments cannot use certified public expenditures in the calculation as there is no reconciliation process to account for actual costs incurred.[8]

State Medicaid agencies should monitor changes in services and cost over time to ensure rates remain economic and efficient. As the availability of services or the needs of the community change, the state may choose to update the corresponding rate to ensure that Medicaid-enrolled students and children receive the types, quantity, and intensity of services required to meet their medical needs.

Reconciled Cost Methodology

Similar to the prospective cost-based payments, state Medicaid agencies may elect to use another cost-based payment methodology called a reconciled cost methodology. Under this approach, the state reimburses school-based providers on an interim basis for the costs they incur when providing Medicaid-covered services. State Medicaid agencies make interim payments to LEAs throughout the year and then reconcile those payments based on reported incurred costs attributable to Medicaid. These costs are reported through a cost report that details which costs can and cannot be attributed to Medicaid services.

The cost reconciliation approach is the most common payment method for school-based service payments nationwide. These interim payments can help ensure that schools have adequate cash flow, while also requiring documentation to validate that medically necessary, Medicaid-covered services have been provided throughout the year.

States may establish a reconciled cost methodology in one of four ways, according to the CMS guidance:

1. **Roster billing:** Allows states to compute a rate that is representative of multiple services delivered. LEAs would multiply that rate, on a quarterly or monthly basis (to be determined by the LEA), by the number of Medicaid-enrolled students that receive a covered service within the service period.
2. **Per child, per month (PCPM):** Allows states to create an interim rate that would be 1/12th of the previous year's actual costs. This amount would be paid out each month on a PCPM basis throughout the year.
3. **Per service, per month:** Allows states to calculate an average cost per service that would be paid as an interim payment where each service rate (for a defined set of services) is based on an average calculation of expected costs per visit for several different types of services (e.g., physical therapy, occupational therapy, nursing, behavioral health, etc.) provided to all beneficiaries during the covered period.
4. **Bundled interim payments:** Allows states to develop a bundled fee schedule (i.e., a fee for a defined set of services). Previous guidance (a 1999 State Medicaid Director Letter) did not allow for the use of bundled payments, but the 2023 CMS guidance indicates bundled payments can be used on an interim basis, provided the payments are ultimately reconciled to actual cost.

If a state chooses a reconciled cost methodology, LEAs would not be required to submit a bill for each service to Medicaid, and the interim payments would be reconciled to actual costs at the end of each year. However, LEAs are still required by CMS to document and maintain records of each service delivered, regardless of whether a bill is also submitted.

Besides offering greater flexibility for payment methodologies, the CMS guidance also provides detailed instruction to states for how to handle billing, claiming, and accounting for both medical services and administrative costs.

[8] A certified public expenditure is when public funds are used to support the full cost of providing the Medicaid-covered service or the Medicaid program administrative activity. Based on this certification, the state then claims a federal match on the certified amount.

As part of this guidance, CMS offers new instructions for Random Moment Time Studies (RMTS), which may help reduce the time and effort required for this process. RMTS is a statistically valid study that is used to allocate the amount of time LEAs spend on Medicaid reimbursable activities – this is used to identify the amount of Medicaid allowable costs that will be reconciled against the interim payments. The updated guidance eases this process in several ways, including reducing the number of times these studies must be completed by staff and increasing the acceptable error rate from two percent to five percent. These changes build upon a 2022 CMS Bulletin that created greater flexibility around time study notification and response requirements, as well. The CMS guidance also clarifies other RMTS requirements, such as when an RMTS must be administered during summer months and the timelines for prior notification and responding to a moment.

EFFECTIVENESS AND IMPLEMENTATION

If States are not already adhering to applicable federal standards and requirements as discussed in the CMS guidance, CMS established a deadline for adherence as no later than the first quarter, three years after the date of publication of the guidance (e.g., compliance as of July 1, 2026). CMS recommends that states submit compliant state plan amendments (SPAs), administrative claiming plan amendments, and amendments to time study implementation plans as soon as possible.

CMS strongly encourages states to promote the use of school-based settings to provide Medicaid enrolled students with Medicaid-covered services. CMS has established a School-Based Services Technical Assistance Center to aid states with their compliance efforts.[9] In addition, CMS also recently opened up a funding opportunity through a school-based services grant under the Bipartisan Safer Communities Act (BSCA), of which Nevada was just announced as one of 18 states awarded.[10] Nevada's grant is for $2.5 million over 3 years and supports the implementation, enhancement, and expansion of the use of school-based services through Medicaid and CHIP starting on July 1, 2024.

Nevada's application for this grant outlines several plans for use of these grant funds, including opportunities for:

- Building a School Health Access Resource Center
- Streamlining Medicaid policies for SHS
- Creating new innovative payment models for SHS to reduce administrative burdens
- Pilot a new EHR and billing vendor system for LEAs to utilize a centralized billing consortium to process documentation and claims

[9] CMS is available to provide technical assistance to States to best implement their programs. Questions regarding implementation can be sent to CMS at: SchoolBasedServices@cms.hhs.gov
[10] *Medicaid and school based services* (2024, June 25). *Medicaid*. https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/medicaid-and-school-based-services/index.html

Nevada's School Health Services Program

HISTORY OF SCHOOL HEALTH SERVICES IN NEVADA

In 2009, Nevada received federal approval to allow Medicaid payment for covered services when furnished in a school setting by a Medicaid participating provider.[11] The initial list of covered school health services in Nevada included only those services identified in a student's Individualized Treatment Plan, which is a component of the IEP. Nevada then expanded School Health Services in 2019 by submitting a SPA to CMS, that added coverage of Early Periodic Screening, Diagnostic, and Treatment services provided in school-based settings.[12] In 2023, Nevada updated its program once again to align with additional federal policies by continuing to expand eligible services and treatment modalities, including:

School Health Services under Nevada Medicaid are provided through a Local Education Agency. The full range of Medicaid covered services can be provided to any Medicaid-enrolled child. The SHS program is carved out of managed care, allowing LEAs to submit claims directly to the state for payment.

- Telehealth
- Behavioral health services
- Katie Beckett policy[13]
- Medical Team Conference process related to Applied Behavioral Health (ABA) diagnosis[14]

A high-level summary of Nevada's current school health services program is provided below.

TABLE 1: NEVADA'S SCHOOL HEALTH SERVICES SYSTEM

School Health Delivery System	Covered Populations	Categories of Covered Services	Payment Methodology
Fee For Service (carved out from managed care)	All Medicaid enrolled youth age 3-21	▪ Services identified in IEP/IFSP or an Individualized Health and Support Plan (IHSP) ▪ EPSDT Services	Services paid per a fee schedule

Following is a detailed explanation of each of the above program features.

[11] Medicaid Services Transmittal Letter. (2010). https://dhcfp.nv.gov/uploadedfiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C2800/MSM_2800_10_10_21.pdf

[12] Sisolak, S., Bierman, S., Division of Health Care Financing and Policy, Patton, J., Gladys Cook, & Lindesmith, J. (n.d.). Public Workshop: Proposed State Plan Amendment (SPA) to expand School Based Child Health Services (SBCHS). In *Division of Health Care Financing and Policy*. https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Public/AdminSupport/SBCHS_Presentation_04_23_19.pdf

[13] Katie Beckett policy refers the eligibility category that waives the parental income and resources for a disabled child under 19 years of ago who would be eligible for Medicaid if he/she were in a medical institution and who is receiving, while living at home, medical care that would normally be provided in a medical institution. Katie Beckett Eligibility Option. (n.d.). https://dhcfp.nv.gov/Pgms/LTSS/LTSSKatieBeckett/

[14] *Medicaid Services Manual*. (2023, November 28). https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C2800/MSM_2800_23_11_29.pdf

DELIVERY SYSTEM FOR MEDICAID SCHOOL HEALTH SERVICES

The Nevada public education system is comprised of 17 school districts, organized by county, as well as a number of charter schools.[15] While a majority of children in Nevada Medicaid are covered under managed care, all school health services for Medicaid enrollees, regardless of managed care, are paid for under fee-for-service (carved out of managed care) and are not get billed to MCOs.[16]

Currently, ten school districts are enrolled in the SHS program (of which, eight are currently billing).[17] Charter schools can also bill for SHS services under the State Public Charter School Authority (which is a state-wide government agency), a school district, or a college that is accredited in Nevada. The State Public Charter School Authority operates as the LEA for all charter schools across the state.[18] Charter schools do not operate as independent LEAs and therefore cannot bill directly for school-based services.

Below is a full list of the Nevada public school districts and those that are currently billing Medicaid through the SHS program.

TABLE 2: NEVADA SCHOOL DISTRICTS CURRENTLY BILLING MEDICAID

COUNTY DISTRICTS BILLING FOR SHS	COUNTY DISTRICTS NOT BILLING FOR SHS*
Carson City	Douglas
Churchill	Esmeralda
Clark	Lander*
Elko	Lincoln
Humboldt	Perishing*
Lyon	Storey
Nye	White
Washoe	

**Lander and Perishing County School Districts are enrolled, but not currently billing*

The Division of Health Care Financing and Policy Nevada Medicaid Services Manual (MSM) Chapter 2800, outlines the program policy and coverage for school health services under Nevada Medicaid.[19] The MSM includes a brief policy background, covered services, non-covered services, service limitations, provider responsibilities, authorization process, provider qualifications, and other related information. However, the manual does not provide specific billing codes pertinent to covered SHS services.

COVERED POPULATIONS THAT MAY RECEIVE SCHOOL HEALTH SERVICES

Nevada has expanded eligibility for SHS, providing SHS coverage for all Medicaid enrolled students. This is broader than many states, including the comparator states reviewed for this memo, the majority of whom continue to limit school health services to individuals with an IEP or IFSP. As of October 2023, twenty-two (22) states (including Nevada) have expanded school-health service to allow at least some services to be available to all Medicaid enrolled children.[20] Some states allow

[15] While a majority of children in Nevada Medicaid are covered under managed care, all school health services for Medicaid enrollees, regardless of managed care, are rendered under FFS (carved out of managed care) and do not get billed to MCOs.
[16] Nevada Medicaid Office. (2021, February). Nevada Medicaid & Nevada Check Up (NCU). https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/CPT/FINAL-NMO-1114E_SHS_Brochure_02-21.pdf
[17] Lander and Perishing County School Districts are enrolled, but not currently billing
[18] Chapter 388A-Charter Schools. (n.d.). Nevada Legislature. https://www.leg.state.nv.us/nrs/NRS-388A.html
[19] Under MSM Chapter 2800, DHCFP supports the policy to deliver health services to Medicaid eligible students when they are primarily medical and not educational in nature.

[20] *School Medicaid expansion: How (and how many) states have taken action to increase school health access and funding.* (2023, October 17). Healthy Students, Promising Futures. https://healthystudentspromisingfutures.org/wp-

Medicaid eligible students to access a limited set of services, such as behavioral health services, while other states allow for a full range of services to be available through SHS to all Medicaid eligible students.[21]

COVERED SCHOOL HEALTH SERVICES[22]

Nevada MSM Chapter 2800 provides that "for an LEA to receive reimbursement for services through the Medicaid SHS Program, each Medicaid eligible student must have a Plan of Care (POC) that documents the medical necessity of the service to be provided and/or preventive services that are coverable under EPSDT." Once listed in the POC, Medicaid coverage of screening and diagnostic services under EPSDT are guided by the periodicity schedule recommended by the American Academy of Pediatrics and documented on the Bright Futures website. Guidelines are updated periodically and EPSDT benefits are updated to align with those updates.[23]

The MSM defines school health services as "medically necessary diagnostic, evaluative, and direct medical services to detect, correct, or improve any physical or mental diagnosis that meets the medical needs of Medicaid eligible students. The services are provided by an LEA to meet the health needs of a student. The services are 1) directed at early detection of a physical or mental health impairment, or 2) the reduction of a physical or mental impairment and restoration of the child to their best possible functioning level."

Nevada SHS covered services include:

- Screening, diagnostic, and treatment services
- Physician services
- Mental health and alcohol/substance use services
- Nursing services
- Physical therapy services
- Occupational therapy services
- Speech therapy services Augmentative, or alternative, communication device (ACD), audiological supplies, and disposable medical supplies
- Personal Care Services (PCS)
- Applied Behavioral Assessment services
- Dental services
- Optometry services
- Case management services
- Community Health Worker Services

In addition to in-person services, telehealth may be used to substitute certain services such as consultations, office visits, psychiatry services, and limited medical services.

Service limitations include the following:

- Only qualified health care providers will be reimbursed for participation in student POC development, as described in Nevada Medicaid Manual, Chapter 2800
- Coverage is limited to procedure codes covered under DHCFP Provider Type (PT) 60[24]
- SHS may not be provided to children under the age of three (3) or to students twenty-one (21) and older

content/uploads/2023/10/Status-of-School-Medicaid-Expansion_-How-and-How-Many-States-Have-Taken-Action-to-Increase-School-Health-Access-and-Funding.pdf

[21] Id.

[22] The Centers for Medicare and Medicaid Services. (2023). *Delivering Services in School-Based Settings: A comprehensive guide to Medicaid services and administrative claiming*. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf

[23] American Academy of Pediatrics. (n.d.). Bright Futures. https://www.aap.org/en/practice-management/bright-futures

[24] Provider Type 60 is uniquely defined as Nevada Medicaid provider. Services under Provider Type 60 are carved out of Managed Care Organization (MCO) coverage, meaning that all SHS are billed as FFS.

ENROLLMENT OF SCHOOL HEALTH PROVIDERS

To bill Medicaid for school health services, LEAs must be enrolled with Medicaid as a DHCFP PT 60. Below is an outline of the general steps an LEA must take in order to start billing Medicaid for SHS.

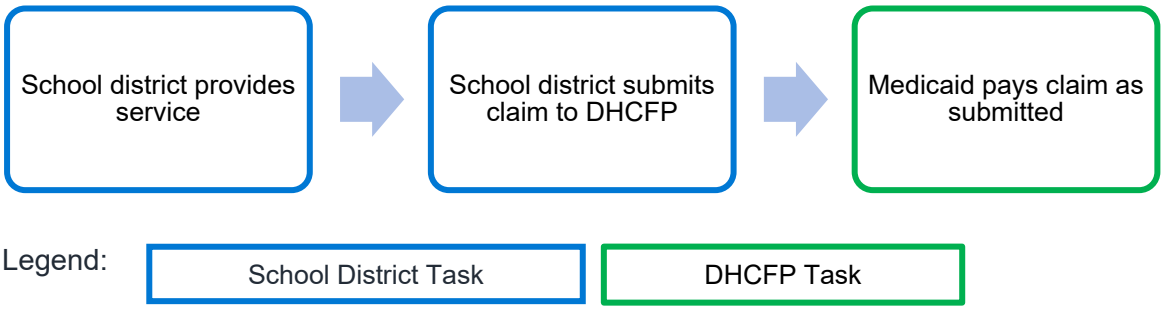
FIGURE 1. STEPS TO COMPLETE TO BILL NEVADA MEDICAID FOR SHS

1.	Obtain a national provider identifier (NPI) number for the LEA
2.	Email DHCFP at schoolhealthservices@dhcfp.nv.gov to notify of the LEA's interest in billing Medicaid for SHS
3.	Complete online enrollment at www.medicaid.nv.gov on the Online Portal
4.	Determine if the LEA will work with a billing agent (Trading Partner) or bill independently
5.	Train staff (e.g., administrators, furnishing providers, and compliance staff)
6.	DHCFP approves LEA to begin billing

PAYMENT METHODOLOGY FOR SCHOOL HEALTH SERVICES

Nevada pays for SHS on a fee-for-services basis. Covered services are provided to an eligible child and then a claim for that service is submitted for payment.

FIGURE 2. NEVADA SHS PAYMENT METHODOLGOGY



Provider Type 60 services are carved out of Managed Care Organization (MCO) coverage, meaning that all SHS are billed as fee-for-service. DHCFP identified four main advantages to this arrangement:

- LEAs only enroll with Nevada Medicaid, not each individual MCO
- There is one set of billing rules, in a centralized location
- There is one administrative process
- There is no need to identify which Medicaid plan a student is enrolled with; the LEA is only responsible with identifying whether a student has Medicaid.[25]

[25] Id.

DELIVERY OF SERVICES

The way services are delivered may vary depending on the school district. An LEA may choose to deliver care to its students via any of the following:

- LEA employee
- LEA contractor
- Vendor entity
- Community provider

Provider types that are eligible to enroll in the state Medicaid program must complete their enrollment before they may bill for services through the SHS program. If an individual practitioner is not a provider type that is eligible to be enrolled in Medicaid, they can provide services if they are employed or contracted by an entity that is enrolled in Medicaid while not being personally enrolled. The overarching employer or contracting provider organization must always be enrolled in Medicaid.

National Landscape and Analysis of Selected States

DHCFP requested that Milliman perform a review of how other states approach structuring their school-based services programs to determine if there were any leading practices that Nevada could consider for its program. Milliman conducted a general scan of national practices across all states and then selected four states for a deeper review (called "comparator states" below), including an evaluation of those states' programs for:

- The structure of each state's delivery system
- Populations covered
- Services covered
- Payment methodology utilized

Four comparator states were analyzed to review their approach to providing Medicaid school health services: California, New Mexico, Oregon, and Utah.

While each state program has unique features, SHS in these states are predominately offered via the fee-for-service delivery system. All comparator states use a cost-based reimbursement methodology.

Selection criteria for the comparator states were based upon a number of factors:

New Mexico: Selected as a program of interest due to CMS attention in its 2023 guidance as an example for states to consider in development of school-based services design.

Oregon: Selected as a program of interest due to CMS attention in its 2023 guidance as an example for states to consider in development of school-based services design.

Utah: Selected for review due to its close proximity to Nevada and its similarities of rural and urban geographic distinctions and populations.

California: Selected based on its robust level of written guidance provided to schools for how to operate within the school health services program.

OVERVIEW OF COMPARATOR STATES

Below is a high-level summary of the program elements for Nevada and the four other states reviewed. Full state scan details can be found in the later part of this section.

TABLE 3: SUMMARY OF STATE SCHOOL HEALTH PROGRAMS ANALYZED

State	School Health Delivery System	Covered Populations	Categories of Covered Services	Payment Methodology
California	MCO* and FFS[26,27]	All students under age 22 that meet other Medi-CAL enrollment criteria	▪ Services identified in IEP/IFSP or an IHSP ▪ EPSDT services ▪ Rehabilitative mental health services	Cost-based payment model with annual reconciliation
New Mexico	FFS	Students age 3-20 with IEP or IFSP	▪ Services identified in IEP/IFSP, section 504 accommodation plan (504 plan), or Individualized Health Care Plan (IHCP)	Cost-based payment model with quarterly reconciliation
Oregon	FFS	Students in grades K-12 with IEP or IFSP	▪ Services identified in IEP or an Individualized Health and Support Plan ▪ EPSDT services	Cost-based payment model
Utah	FFS	Students age 3-21 with IEP	▪ EPSDT services if student has IEP	Cost-based payment model

**California covers the majority of school-based services through the FFS program. However, there are some populations that receive school-based services through managed care.*

THEMES IN DELIVERY OF SERVICES

Milliman's review of the national landscape for state school-based services can be summarized as follows, with callouts for the comparator states as applicable.

Some states include school-based services as part of their managed care programs, while others have opted to separate these services from managed care, instead covering school health services through the fee-for-service program, similar to Nevada. Still other states utilize a combination approach, where some students are in a managed care system and others are billed as fee-for-service. In the four reviewed comparator states, the school-based services were largely carved out of the states' managed care programs. One exception is California, where a small number of students are served in a pilot program and receive school-based services through managed care.

The approach a state takes for delivery of school-based services may depend on the overall structure of Medicaid service delivery to school-aged children. States with managed care systems may choose to keep school-based services within the managed care structure as well, in order to allow for greater care coordination for a child. This approach also enables the managed care organizations to have full

[26] Student Behavioral Health Incentive Program FAQ. (n.d.). California Department of Health Care Services. https://www.dhcs.ca.gov/services/Documents/DirectedPymts/SBHIP-FAQs-March-2024.pdf
[27] CalAIM Behavioral Health Initiative. (n.d.). California Department of Health Care Services. https://www.dhcs.ca.gov/Pages/BH-CalAIM-Webpage.aspx

insight into the services delivered through the school-based program,[28] as well as allowing the managed care organizations to play a role in helping LEAs develop their school-based services programs.[29] However, a managed care delivery system also means that a school may have to enroll with multiple managed care entities and follow different billing practices for each. This can add administrative complexity to LEAs billing activities.

THEMES IN COVERED POPULATIONS

States have the option to limit school-based services to individuals who have an IEP or IFSP or expand beyond the special education population. Three of the four comparator states currently limit the enrolled population to individuals with disabilities. In this scenario, school-based services are limited to students with an IEP or IFSP, which are services already being provided by the LEA as a requirement of the IDEA. However, it is the state's option to expand the eligible population to include any student who is eligible for Medicaid. Nevada has already expanded SHS to cover all Medicaid eligible students.

This decision can significantly expand the number of students eligible for school-based services and introduce a new range of services that are commonly needed by this population. Additionally, this also allows the LEA to have a new funding source by billing Medicaid for services that may already be provided to a Medicaid eligible child, such as services provided by the school nurse or services provided to all students.[30] In California, the services have been expanded to include Medicaid individuals up to the age of 22. This has also led to the inclusion of community colleges as a potential provider of school-based services.

THEMES IN COVERED SERVICES

States also have the option to choose what range of services are covered by their school-based services program. All LEAs must provide services as identified in a student's IEP or IFSP (per IDEA) and under the SHS program, Medicaid must fund those services as the payer of first resort.[31] Beyond those IDEA-required services, it is a state option to expand coverage to include EPSDT services, or an extended range of Medicaid covered services. As of October 2023, twenty-two (22) states, including Nevada, have submitted a state plan amendment to cover some services outside of an IEP.[32] All four comparator states cover IEP/IFSP services, with Oregon and Utah, like Nevada, adding EPSDT services to the covered services list. One state, California covers IEP/IFSP, EPSDT and additional rehabilitative mental health services.

THEMES IN PAYMENT METHODOLOGY

States have the option to pay for school-based services using one of several payment methodologies as described in the "Federal Guidance on School-Based Medicaid—Payment Methodology" section of this report. This includes traditional fee-for-service billing, by which a provider renders a covered service and submits a bill to be paid at the set rate or a cost-based payment methodology, which reimburses the provider for its cost to deliver the service.

All four comparator states have elected to develop a cost-based methodology for school health services (rather than paying on a fee schedule basis), although the implemented specific cost-based methodology is unique to each state. Variables include the funding formulas and timeframes for when

[28] The Center for Medicare and Medicaid Services. (2023, May 18). Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming. https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf
[29] Id.
[30] Id.
[31] Id.
[32] School Medicaid Expansion: How (and How Many) States Have Taken Action to Increase School Health Access and Funding. (2023, October 17). Healthy Students, Promising Futures. Status-of-School-Medicaid-Expansion_-How-and-How-Many-States-Have-Taken-Action-to-Increase-School-Health-Access-and-Funding_2023.pdf

interim payments are made. Each of these states require a time study as part of the cost-based methodology.

STATE SUMMARIES

CALIFORNIA

California allows for the billing of school health services through its State Plan. This set of school health services, are covered under California's Medicaid program, Medi-Cal. The Department of Health Care Services (DHCS) developed the Local Education Agency Billing Option Program (LEA BOP) which allows LEAs to bill Medicaid for school health services. See Figure 3 for an explanation of how LEA BOP works in California.[33]

Covered Services

LEAs provide services identified in the student's IEP, IFSP, or IHSP, as well as EPSDT services and rehabilitative mental health services.

California's full list of covered school-based services include:[34]

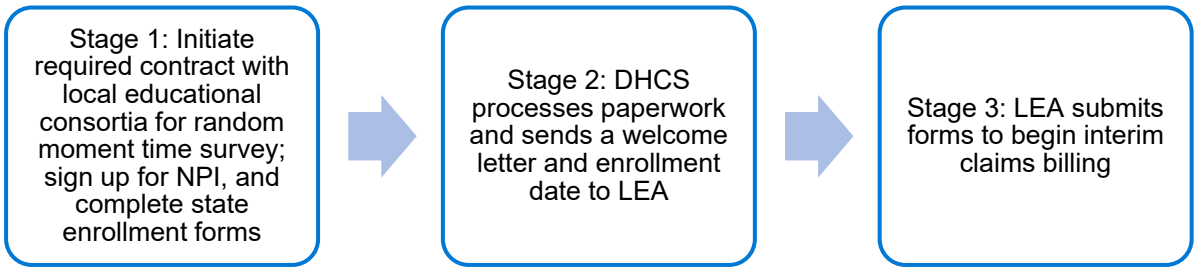
- Hearing services
- Health, mental health evaluation, and education assessments
- Nursing services
- Activities of daily living
- Nutrition services
- Occupational therapy
- Physical therapy
- Orientation and mobility services
- Physician services
- Psychology and counseling services
- Respiratory care services
- Speech-language and audiology services
- Specialized medical transportation services
- Targeted care management (TCM)
- Vision

Delivery of Services

Delivery of school health services in California may depend on the LEA and how they determine who will provide services. At a minimum, the LEA may choose to either employ or contract with practitioners to provide services on site.[35] Those practitioners are responsible for delivering services. Eligible LEA providers include the following: school districts, County Office of Education, charter schools, state special schools, community college districts, California State University campus, and University of California campus.[36] See Figure 3 below on how an LEA can become a provider.

[33] California Department of Health Care Services. (n.d.). Local Educational Agency Medi-Cal Billing Option Program Onboarding Handbook. https://www.dhcs.ca.gov/provgovpart/Documents/Onboarding-Handbook.pdf
[34] California Department of Health Care Services. (2023, August). California Local Educational Agency Medi-Cal Billing Option Program. https://www.dhcs.ca.gov/provgovpart/Documents/AB-3192-Program-Guide-2021-22.pdf
[35] California Department of Health Care Services. (2018, January). Local Educational Agency Medi-Cal Billing Option Program. https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/LEA%20BOP/Program_Req_and_Info/Overview_Jan_2018.pdf
[36] Id.

FIGURE 3. STEPS TO BECOME SHS PROVIDER IN CALIFORNIA

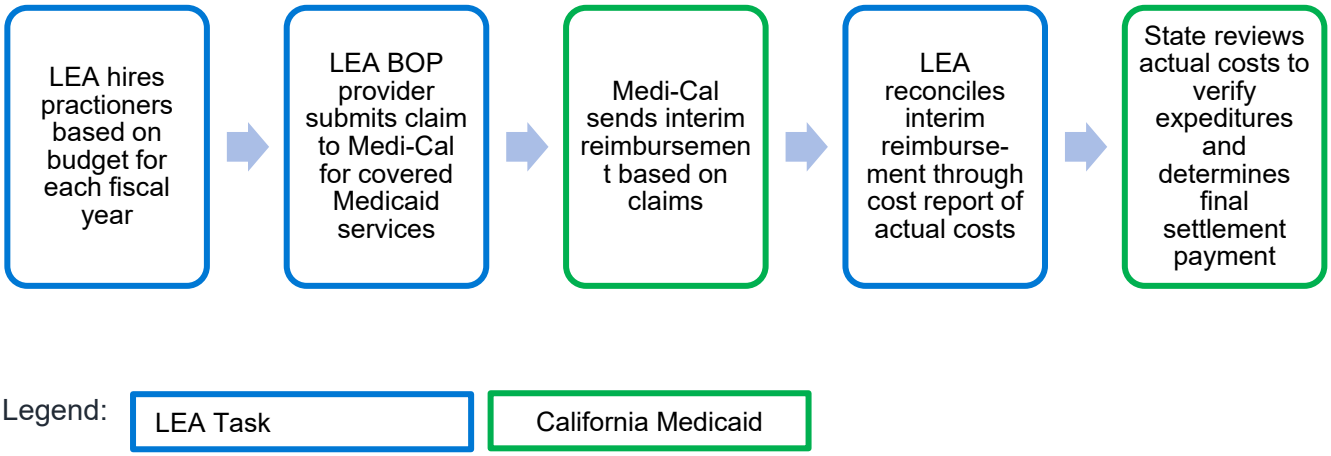


DHCS characterizes the enrollment process as occurring in three stages. They estimate that it will take an entity up to six months to complete the enrollment process.

Payment Methodology

The LEA Billing Option Program is operated through the fee-for service claims payment system. The interim payments are billed off a statewide fee schedule and are reconciled using a formula that is based upon the total cost of providing the service (via a cost report), the federal match, the ratio of Medicaid eligible students in the LEA and the percentage of time that is spent on direct services as determined by a Random Moment Time Survey.

FIGURE 4. CALIFORNIA FUNDS FLOW



NEW MEXICO

New Mexico's School Health Services program is called the Medicaid School-Based Services (MSBS) program, which allows for schools to receive reimbursement for services delivered to Medicaid eligible students, as services are listed in the youth's IEP, IFSP, section 504 accommodation plan (504 plan), or IHCP. New Mexico's long-standing MSBS program, originally named Medicaid in the Schools (MITS), has been serving youth in schools since 1994[37].

[37] New Mexico Human Services Department. (2023, August). New Mexico Medicaid Guide for School-Based Services. https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/887e7510-3775-4185-b5ed-f4f9d01d6211/MSBS%20Guidebook%202023

Covered Services

New Mexico covers services identified in IEP or IFSP. LEAs can be reimbursed for the following services:

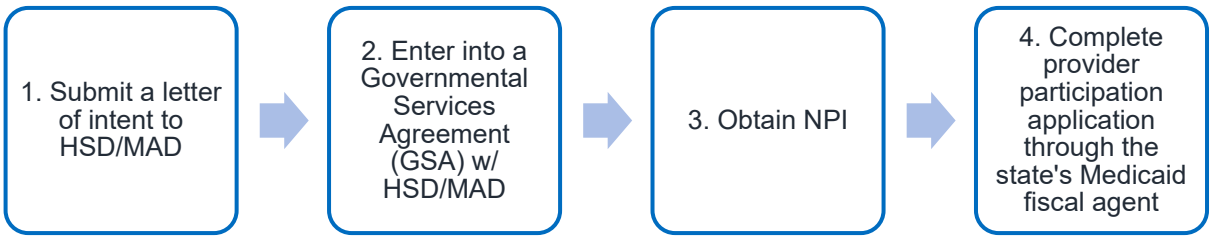
- Physician services
- Nursing services
- Psychology services
- Counseling services
- Social work services
- Speech-language services
- Audiology services
- Occupational therapy (OT)
- Physical therapy (PT)
- Specialized transportation

LEAs may also be reimbursed for certain administrative activities related to delivering the services. Such activities may include outreach, Medicaid eligibility determinations, coordinating transportation for services, service coordination, conducting referrals, and engaging with creation of service plans.[38]

Delivery of Services

New Mexico's Local Education Agencies, Regional Education Cooperatives (RECs), and other State-Funded Education Agencies (SFEAs) are eligible to participate in the MSBS program. Eligible entities must first submit a letter of intent to participate in the MSBS program. The letter must be signed by a person with the authority to confirm the entities interest in program participation. This may be a district superintended, president of the school board, or a chairperson of the entity. After the Human Services Department Medical Assistance Division (HAS/MAD) has reviewed the letter of intent, additional directions will be sent to the entity. These directions will provide information on how to enter into a government services agreement, obtain an NPI and complete a provider participation application.

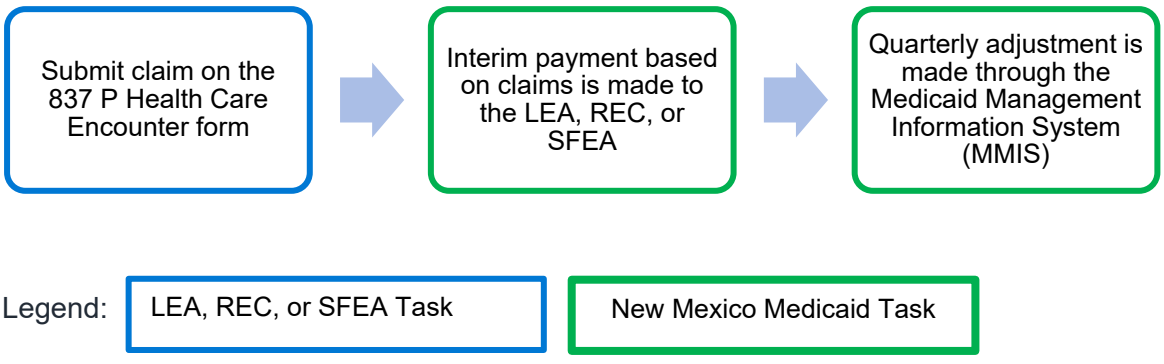
FIGURE 5. NEW MEXICO STEPS TO BECOME A MSBS PROVIDER



Payment Methodology

Local Education Agencies, Regional Education Cooperatives, and other State-Funded Education Agencies may be reimbursed for covered services and administrative activities.

FIGURE 6. NEW MEXICO FUNDS FLOW



[38] *Medicaid School-Based Services Program*. (2022, November 21). New Mexico Human Services Department. https://www.hsd.state.nm.us/providers/medicaid-school-based-services-program/

Administrative services are reimbursed through a time study model. Using this model, approved by CMS, a rate of 50% comes from federal funds and 50% comes from state general funds.

OREGON

Oregon implemented a School-Based Health Services (SBHS) program in 1985. Under Oregon rule, school health services can be reimbursed to publicly funded education agencies who provide services under the Individuals with Disabilities Education Act to Medicaid eligible youth.[39] This program is operated under a FFS model. The covered services must address physical or mental disabilities and health-related needs/devices that allow the youth to improve skills and functioning that may otherwise be hindering their educational performance. Services must also be identified in the students' IEP or IFSP. The covered population includes students enrolled in grades K-12.[40]

Covered Services

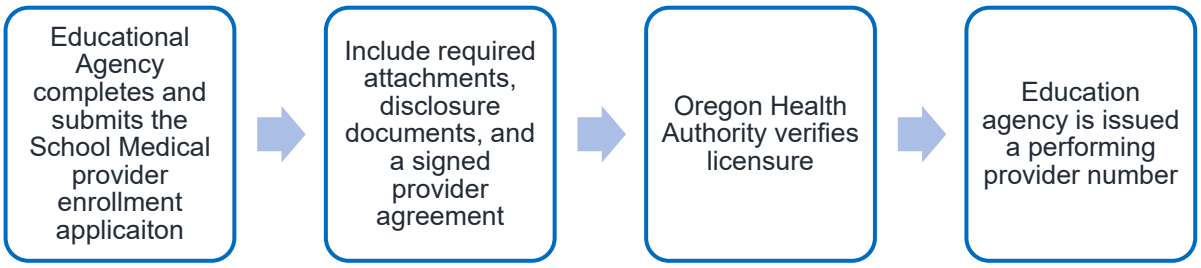
Covered services include the following:[41]

- Audiology services
- Behavioral health services
- Dental health services
- Diagnostic, screening, preventive, developmental and rehabilitative services
- Nursing services
- Nurse practitioner services
- Nutritional health services
- Occupational therapy services
- Personal care services
- Physical therapy services
- Physician services
- Respiratory therapy services
- Specialized transportation Services
- Speech-language pathology services

Delivery of Services

The following figure outlines the steps a provider must take in order to become an SBHS provider.

FIGURE 7. OREGON STEPS TO BECOME AN SBHS PROVIDER



The School Medical (SM) provider is the provider responsible for delivering the services in the school setting. The SM may be an individual, agent, business, clinic, group, or entity.

[39] *Oregon Healthy Authority*. (n.d.). Oregon Secretary of State Administrative Rules. https://secure.sos.state.or.us/oard/displayDivisionRules.action;JSESSIONID_OARD=ESm6b0hqsOUjpHfGtaYRN6of877R7wdIbUAkR6edcOa8OK1Tl-sd!-1656123463?selectedDivision=1721

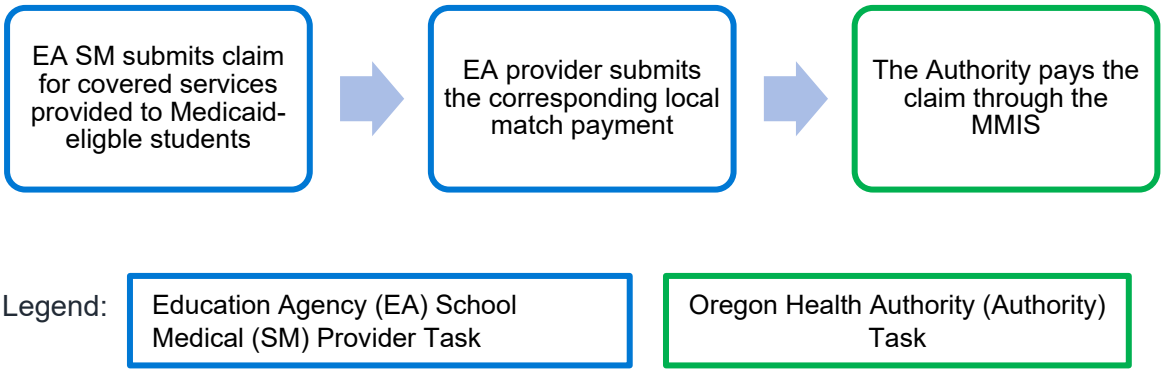
[40] *Oregon Healthy Authority*. Oregon Secretary of State Administrative Rules. (n.d.). https://secure.sos.state.or.us/oard/displayDivisionRules.action;JSESSIONID_OARD=ESm6b0hqsOUjpHfGtaYRN6of877R7wdIbUAkR6edcOa8OK1Tl-sd!-1656123463?selectedDivision=1721

[41] Oregon Health Authority. (2019). State Plan Amendment (SPA) #: 19-0011. https://www.medicaid.gov/sites/default/files/2023-05/OR-19-0011.pdf

Payment Methodology

Covered services in Oregon are reimbursed under a cost-based methodology. The Oregon program reimburses for direct costs, indirect costs, as well as specialized transportation services. For direct services, a cost-based model is used, based on the previous year's cost reports on the allowable covered services. Indirect costs are determined by applying "specific LEAs Unrestricted Indirect Cost Rate (UICR) established for the current year by the cognizant federal agency. The Oregon Department of Education is the cognizant agency for LEAs and approves UICR cost rates. LEAs are not permitted to certify indirect costs that are outside their UICR. The indirect cost rate is calculated from costs that are not included in the allowable reported expenditures so there is no duplication of costs." Specialized transportation costs are also reimbursed using a cost-based reimbursement methodology.[42]

FIGURE 8. OREGON FUNDS FLOW



UTAH

Utah's school services program is called "School Based Skills Development Services." The School Based Skills Development program began in 1988 as Utah authorized specific services under the state plan.[43] This program covers medically necessary diagnostic, preventative, and treatment services for Medicaid eligible youth between the ages of 3 and 21 who have eligible services defined in their IEP. These services are rendered under a FFS cost-based model.

Covered Services

Covered services include the following and are "specifically designed to enhance a student's health and functional abilities and/or prevent further deterioration":[44]

- "Evaluation and Assessment for the purpose of identifying and documenting a Special Education student's health related service need.
- Motor Skills Development services are rehabilitative, active or restorative therapies designed to enhance a student's fine and gross motor skills including muscle coordination and strength, ambulation, range of motion, grasp and release, and oral motor functioning. Examples of these services are occupational therapy and physical therapy
- Communication Skills Development services are speech, language, and hearing services designed to enhance a student's ability to communicate through the development of functional expressive speech, functional use of adaptive equipment and devices, or improved oral-motor functioning. An example of this service is speech language pathology
- Personal Care and Nursing Services

[42] Id.
[43] Utah Medicaid. (2023, November). *School Based Skills Development Services Provider Manual*. Utah Department of Health & Human Services. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/School-Based%20Skills%20Development/School-BasedSkillsDev11-23.pdf
[44] Id.

- Behavioral Health Services
- Itinerant Nursing Services for medically fragile youth
- Vision and Hearing Adaptation Services necessitated by a student's absence or loss of vision and/or hearing) are specifically designed adaptation training services to develop/enhance a student's functional abilities to assist him or her to benefit from special education. Examples of these services are Orientation and Mobility as well as Aural/Auditory Rehabilitation."

Telehealth services are also covered under this set of services which include consultation services, evaluation and management services, and mental health services. In order for a provider to bill Medicaid for School-Based Skills Development Services, the provider must enroll as a provider with Utah Medicaid and have a current contract and Provider Agreement with the Department of Health.

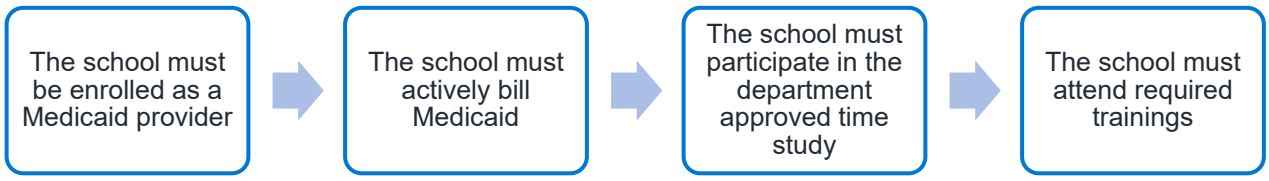
Utah allows school districts to bill Medicaid for administrative services. Eligible administrative tasks are reimbursed at a 50% match.

Delivery of Services

The State of Utah School-Based Skills Development Provider Manual outlines requirements for the provision of services allowed under the School-Based Skills Development program.[45] The rendering and supervising providers must possess current licenses and NPI numbers. Additionally, the provider must be a Medicaid-enrolled provider except for those providers exempted as paraprofessionals and teachers.[46] The Supervision and Licensure details the licensure, certification, and other credentials required to deliver or supervise the delivery of Medicaid covered School-Based Skills Development Services. However, in Utah, LEAs are solely responsible for submitting claims and providers should not be listed individually for School-Based Skills Development claims. The LEA must submit the claims to Medicaid in order to justify the cost reporting process for the interim payments.

In order to participate in the School-Based Skills Development program, a school must take the following actions.

FIGURE 9. UTAH STEPS TO PARTICIPATE IN SCHOOL-BASED SKILLS DEVELOPMENT PROGRAM



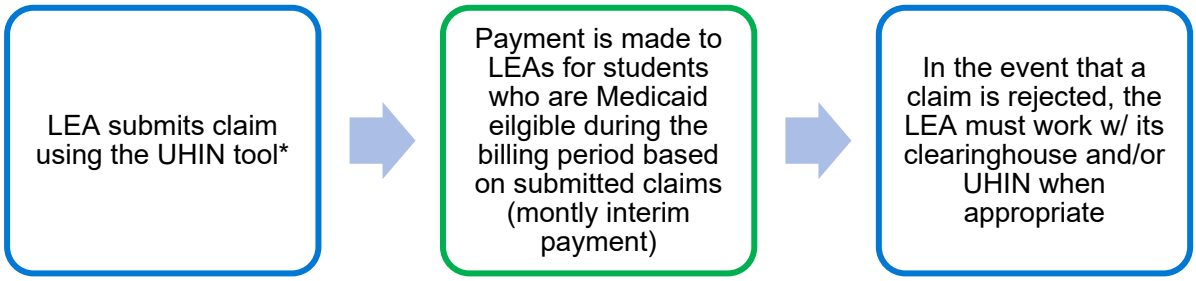
Payment Methodology

School-Based Skills Development services are reimbursed using a cost-based model. On an annual basis, LEAs must submit a cost report outlining cost associated with direct services.[47] LEAs must also submit a cost report outlining costs associated with administrative costs related to the program on a quarterly basis. Using the administrative cost report, LEAs are able to claim FMAP and be reimbursed at a 50% match rate. The LEA can also claim FMAP for direct services related to the service rendered to the eligible student. Interim payments will be made to the LEAs by taking the maximum allowable cost calculation from the previous period. LEAs will then select to receive either 80% or 90% of the estimated maximum allowable cost to be paid out monthly, which is to reduce the possibility of

[45] Utah Medicaid. (2023a, July). *Appendix 3- School based Supervision and Licensure 7-23*. Utah Department of Health & Human Services. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/School-Based%20Skills%20Development/Attachments/APPENDIX%203-SCHOOL%20BASED%20SUPERVISION%20AND%20LICENSURE%207-23.pdf
[46] Utah Medicaid. (2023, November). *School Based Skills Development Services Provider Manual*. Utah Department of Health & Human Services. https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid%20Provider%20Manuals/School-Based%20Skills%20Development/School-BasedSkillsDev11-23.pdf
[47] Id.

creating a situation where the school would have to pay funds back to the state. At the end of the district's school year, a cost settlement is performed by comparing interim payments with the actual maximum allowable costs for the year. Services may either be provided by a LEA staff member or contracted staff.

FIGURE 10. UTAH FUNDS FLOW



*Utah Health Information Network

Review of Stakeholder Feedback

To inform the understanding of challenges impacting participation in the Nevada SHS program, DHCFP asked Milliman to facilitate two, one-hour stakeholder sessions held on May 28 and May 29, 2024, to gather additional feedback related to SHS in Nevada. The agenda for each session included a project background, review of federal requirements and SHS approaches nationally, and review of Nevada's SHS program, followed by discussion about operational and payment considerations for participating schools. Fifty-two (52) participants were invited to the stakeholder sessions. In total, thirty (30) stakeholders attended one of the two sessions. The participants included school administrators, school nurses, school compliance officers, and Medicaid billers. Several county school districts, as well as charter school representatives, were represented in the stakeholder mix.

DHCFP and Milliman hosted two one-hour virtual meetings with school representatives in order to receive stakeholder feedback about the current program. Stakeholders noted a range of barriers to participation in the program including:

1) **Providers are not eligible to bill Medicaid**
2) **Obtaining signed FERPA-required consent forms**
3) **Administrative complexity in Medicaid program rules**

Below is an overview of comments received during these sessions.

TABLE 4. STAKEHOLDER FEEDBACK

TOPIC	SUMMARY OF COMMENTS
Obtaining Signed Family Educational Rights and Privacy Act Required Consent Forms	▪ The issue of obtaining parental consent for the school to bill Medicaid was noted as a barrier by multiple stakeholders. Discussion included: ▪ Stakeholders expressed the burden of having multiple forms that must be signed (e.g., consent to provide services, consent to bill Medicaid, etc.) as well as having different consent requirements from different governing agencies (e.g., Center for Medicare and Medicaid Services, Nevada Medicaid, and Department of Education). ▪ Stakeholders also noted issues with a lack of parent understanding of the forms or a feeling that the forms do not apply to them, as well as the difficulty of getting signed forms when visits occur via telemedicine or when forms are sent via email. ▪ Stakeholders reported that many services could be Medicaid-eligible but are not billed to Medicaid. Stakeholders noted that while only about five (5) percent of eligible Medicaid students currently have Medicaid-reimbursed SHS claims, many more services remain unbilled due to lack of parental consent.

TOPIC	SUMMARY OF COMMENTS
	▪ Stakeholders expressed interest in getting help navigating the consent form issues, as it is a prevalent administrative barrier.
Provider Eligibility to Bill Medicaid for Services and Other Workforce Issues	▪ Several comments were added about a lack of sufficient staffing/workforce, which creates challenges including: ▪ Insufficient providers to cover all schools ▪ Varying credential expectations for school providers vs. medical or clinical providers ▪ Other workforce challenges, including a lack of funding ▪ In particular, schools are not able to hire the number of Licensed Clinical Social Workers (LCSWs) that are needed to provide services. ▪ Some licensed provider types who deliver services in schools (e.g., school counselors) are not eligible to bill for rendered services under current Medicaid policy. ▪ Mid-level practitioners in schools must have supervision and treatment plans that include medical necessity authorized by other providers. ▪ The requirement that if a diagnosis is made in the student's Individualized Education Program, it still must be confirmed by a medical provider to be recognized as a Medicaid-billable service.
Complexity in Medicaid Billing and Administrative Procedures	▪ Several stakeholders noted uncertainty regarding the appropriate billing codes the school should use to submit claims for Medicaid services. It was acknowledged that a list of covered services has been documented, but specific billing codes to use for those services have not been provided. ▪ Several other administrative burdens of the current SHS program were mentioned, including: ▪ Volume of paperwork needed for the program (e.g. documentation of medical necessity, documentation of services delivered) ▪ Insufficient time available to train school staff on program policy and procedures ▪ Significant time needed to ensure that a student's information matches what is in the Medicaid system, which is a requirement in order to be able to bill for a Medicaid service
Payment and Funding Concerns	▪ Some stakeholders noted that while previously, staff could be funded by grants, these grants no longer exist to help support staffing for the program, which presents funding challenges. ▪ Several concerns were raised with the impact of making future payment changes and how this could affect districts with smaller budgets (both in terms of ability to

TOPIC	SUMMARY OF COMMENTS

	implement new systems as well as sufficiency of the rate when a school has fewer students).
	▪ As part of the discussion about a possible move to a reconciled cost methodology, concerns were raised about:
	  ▪ The overall funding available for the SHS program. Instances of past rate decreases for Medicaid services were cited, and concerns were raised about the inability to count on consistent payment rates.
	  ▪ Payment equity relative to the size of the school and the number of students served. Stakeholders wanted to further understand how smaller schools would be impacted by this type of payment structure.

General Concerns	▪ A number of overall concerns were also voiced:
	  ▪ One stakeholder mentioned there is misinformation around school health services and general misunderstanding about the program in Nevada.
	  ▪ Nevada should be careful in looking at programs from other states, because these may not have comparable programs or budgets, and thus could be flawed examples to.
	  ▪ Broad concerns were noted about the process of change, including how it may impact smaller districts.
	  ▪ The issue of mistrust in DHCFP due to past communication and program changes was also mentioned by one stakeholder, who felt that in the past, even though the state had communicated one thing, the opposite happened (e.g., lowering of rates). However, other stakeholders expressed they were glad DHCFP was actively trying to improve communications and hoped that collaborative meetings like this would continue.

What is Working Well in Current System	▪ Stakeholders shared that they value their partnerships with DHCFP and appreciate the attitude to help when needed. ▪ The documentation system was noted as a positive. ▪ The system transformation currently taking place (policy updates and move toward state oversight of a consolidated Medicaid school billing and electronic health records system) was noted as a key step in the right direction. Stakeholders mentioned that these changes may present short-term challenges, but overall will be an improvement. ▪ One stakeholder noted that the additional staff that DHCFP have hired have been helpful in providing

TOPIC	SUMMARY OF COMMENTS
	assistance when needed. Appreciation for the program email inbox where questions can be submitted was also expressed.
Other Suggestions from Stakeholders	▪ Additional guidance from the State on billing and specific codes that are permissible to bill would be greatly appreciated. ▪ One stakeholder suggested that it would be helpful if the electronic health record documentation system could interface with the billing system to help reduce administrative burden. ▪ Several stakeholders suggested that if a provider is licensed or accredited to provide services in the state, that this should qualify the provider to meet standards to provide that service as a Medicaid provider in the schools as well. ▪ A stakeholder noted that it would be helpful to have additional resources and educational materials easily accessible to the schools to assist families who may be eligible to enroll in Medicaid. ▪ A stakeholder mentioned that an expansion of the six-month claims filing window should be considered because the current timely filing limit is sometimes difficult to meet. ▪ Stakeholders noted a desire for Medicaid State Plan updates to better reflect services provided in a school setting, not just clinical language. ▪ A stakeholder noted they would be interested in program changes to help build the workforce, as workforce is still a significant issue for school health services.

Options for Nevada Policy and Program Changes

Given the federal flexibilities now available to support SHS, as well as in response to stakeholder feedback about current program challenges, DHCFP may wish to consider several different approaches for policy and program changes to accomplish its goals of increased provider participation, administrative simplification, and increased school revenue. Several policy and program options have been identified for their potential efficacy in addressing the most significant barriers noted in stakeholder discussions. DHCFP may want to consider implementing multiple changes to reduce barriers and increase SHS participation.

DCHFP may consider a variety of policy changes to address stakeholder concerns as well as meet state program goals. It may be useful to pursue multiple options in concert, to help achieve the greatest impact toward the goals of increased program participation and overall reimbursement.

Below we summarize potential changes that may help address the barriers noted by stakeholders and support DHCFP program goals. We also identify potential factors that DHCFP may want to consider in determining if the solution is viable for Nevada. These considerations are grouped by the potential operational, administrative, and timing impacts.

NOTED BARRIER: PROVIDERS ARE NOT ELIGIBLE TO BILL MEDICAID

Stakeholders noted that some provider types (e.g., school counselors) are qualified to deliver services in schools but remain ineligible to provide services under current Medicaid policy. While school counselors are licensed providers in Nevada, they are not permitted to enroll in Nevada Medicaid.

Potential Solution #1: Expansion of the Provider Types who are Eligible to Bill Medicaid

The guidance released by CMS in 2023 highlights the expansion of providers eligible for Medicaid reimbursement. The state can establish provider qualifications for school-based providers that differ from the qualifications of non-school-based providers of the same Medicaid services, as long as the states' provider qualifications are not unique to Medicaid-covered services. Meaning that the Medicaid program cannot allow a provider to bill for services provided to a Medicaid child if that same provider would not be allowed to provide those services to a non-Medicaid recipient. This can allow licensed providers to be reimbursed by Medicaid for delivery of Medicaid covered services.[48] Additionally, these licensed providers can bill Medicaid for services that might be provided to other children in the school-based setting for free.[49] Allowing additional licensed providers to bill Medicaid through the SHS program would not automatically allow the same provider type to bill Medicaid outside of the SHS program. Nevada could continue to limit new provider types to the SHS program.

Nevada could consider evaluating current Medicaid policy to allow additional licensed providers, for example school counselors, to bill for some services delivered in school-based settings. When evaluating if a provider should be made eligible to bill for Medicaid SHS, consideration would need to be given to what services are in the licensed provider's scope of practice and how they align with the SHS covered services. If they are simply allowed to provide services through a policy decision, they would not have to individually enroll in Medicaid. If they were added as a Medicaid eligible provider type, they would be subject to Medicaid enrollment requirements.

[48] The Centers for Medicare and Medicaid Services. (2023). *Delivering Services in School-Based Settings: A comprehensive guide to Medicaid services and administrative claiming*. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf

[49] Centers for Medicare & Medicaid Services. (2014, December 15). Medicaid Payment for Services Provided without Charge (Free Care). https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

TABLE 5. CONSIDERATIONS FOR CHANGES TO PROVIDER ELIGIBILITY

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ Consider what providers to include based upon how the services within the licensed provider's scope of practice align with Medicaid covered services ▪ Consider options for how new provider types would be added for billing purposes. This could mean a new provider type or specialty would be created to allow these rendering providers to enroll in Medicaid. Conversely, new provider types could be a provider who bills under the school district provider type and no new enrollment is needed.

Operational	▪ Changes to eligible providers may require updates to:
	  ▪ Medicaid state plan
	  ▪ State policy and billing manuals
	  ▪ Provider enrollment policies

Timeline	▪ CMS requires a 90-day review of all Medicaid state plan changes and if this is the only change in the state plan amendment, it is reasonable to assume that this change will fall within the 90-day clock; however, CMS may extend the review period in which case, the "clock would be stopped". ▪ Updates to provider enrollment systems can take months to implement.

NOTED BARRIER: OBTAINING SIGNED FERPA-REQUIRED CONSENT FORMS

School stakeholders noted that obtaining signed parental consent forms from parents was a barrier to billing Medicaid for services rendered in schools. Stakeholders noted that while only about 5% of eligible Medicaid students currently have Medicaid-reimbursed services at school, there are many more services delivered that remain unbilled due to the lack of parental consent.[50] Additional barriers noted included lack of parental understanding of the forms, lack of technological understanding or access to print out forms that are delivered electronically, and parental determinations that the forms do not apply to them.

Potential Solutions #2: Change in Collection Procedures for Family Education Rights and Privacy Act (FERPA) Required Consent Forms

When the 2023 CMS guidance was created in consultation with the U.S. Department of Education (DOE), the DOE acknowledged the additional barrier that consent forms create to accessing Medicaid reimbursement and subsequently has proposed to amend those rules.[51] The proposed rule would repeal the IDEA regulation requiring parental consent before a LEA can seek payment from Medicaid and other public benefits or insurance for eligible services in a student's IEP. Since there is already a required consent form for sharing personally identifiable information about the student, the DOE states this additional form for billing is unnecessary and does not provide an additional protection for student confidentiality. The proposed rule was published on May 18, 2023, with public comments accepted until August 1, 2023. As of the date of this report, a final rule has yet to be published, so it is yet unknown how (or if) federal regulators will address this barrier.

[50] Feedback received from stakeholder during stakeholder engagement sessions. May 28 and 29, 2024.
[51] Department of Education (2023). Assistance to states for the education of children with disabilities. *Federal Register*, *88*(96), 31660. https://www.govinfo.gov/content/pkg/FR-2023-05-18/pdf/2023-10542.pdf

DHCFP, Nevada Department of Education (NDE), and LEAs may also consider changes to the consent form collection process that could ease the process to obtain signed consent forms. Assuming more consent forms could be obtained through a simplified process, this may in turn enable increased billing of Medicaid services.

In an effort to ease the administrative burden of obtaining parental consent for services and billing, some states have created streamlined processes to assist their districts.[52] For example, Massachusetts created a single, one-time, consent form to be signed by all parents when a child enrolls in a public school.[53] As a redundancy, the form is also provided to parents with all free and reduced lunch applications, in the start-of-school year packets, and at all health plan meetings for those students already receiving services as part of an IEP or IFSP.[54] By requesting this information for all students (regardless of Medicaid coverage), this approach allows for consent to already be on file newly identified Medicaid-eligible children as well as if there is a change in circumstance for a child. Each year, the school district sends a notice reminding parents of the form. The notice informs parents that there is a consent form on file, the form's purpose, and that it may be withdrawn at any point.

To further support schools in the collection of consent forms, Nevada could also create a toolkit for LEAs with different strategies to gain signed forms. The kit could include best practices that are designed to address different types of challenges in gaining consent forms. For example, if the LEA has difficulty getting electronic signatures from parents due to low technology utilization, new strategies for printed forms and different collection activities could be provided. Alternatively, Nevada could create a single statewide form like Massachusetts and publish this material on the state website for easy access.

By creating more points of access, Nevada may see a greater rate of signed consent forms. However, access is only one part of the issue as IDEA and FERPA require annual notification of a parent's rights. One way to address annual notification challenges and to potentially increase consent would be to create an educational document for parents to explain the form's purpose and how the schools use it.

TABLE 6. CONSIDERATIONS FOR CHANGES TO FERPA CONSENT FORM COLLECTION PROCESS

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ DHCFP, NDE, and LEAs will need to work together to create a streamlined consent process, due to authority for these forms being outside of Medicaid
Operational	▪ Changes to policy and procedures may require NDE to make investments into new methods of form collection ▪ Depending on the changes that are pursued, state administrative policies may need to be updated
Timeline	▪ Expected to be the most effective if implemented prior to new school year enrollment

[52] Frontline Education. (2022, November 18). *Navigating Parental consent for Medicaid*. https://www.frontlineeducation.com/blog/parental-consent-school-medicaid/#_ftnconsent
[53] *Massachusetts Department of Elementary and Secondary Education. Administrative Advisory SPED 2013-1: Parental Consent to Access MassHealth - Special education.* https://www.doe.mass.edu/sped/advisories/13_1.html.
[54] Id.

NOTED BARRIER: ADMINISTRATIVE COMPLEXITY IN MEDICAID PROGRAM RULES

Stakeholders noted that the Medicaid program rules and claims billing in general are complicated processes with complex rules. Several questions and comments noted by SHS program providers included uncertainty in Medicaid billing processes, covered services, and appropriate billing codes to utilize.

There are different options for DHCFP to consider in helping schools understand the SHS program, reduce the complexity of billing, and possibly increase the funding provided to schools. The options below are not mutually exclusive, and DHCFP may choose to implement several of these approaches to maximize impact.

Potential Solution #3: Technical Assistance and Training

Nevada has created specific content for school health services in Chapter 2800 of the Medicaid Service Manual.[55] This manual chapter has been updated as recently as November 2023. However, additional technical assistance could be provided to help schools navigate the SHS program. Nevada may want to consider providing additional content to the manual or creating a standalone SHS manual directed at LEAs. The new content could provide additional technical assistance to LEAs on how to navigate the Medicaid program. Stakeholders specifically noted an interest in a set of billing codes that are appropriate for them to use in billing SHS services. Nevada may want to consider providing additional guidance to LEAs on the most commonly billed services.

As noted in the *National Landscape and Analysis of Selected States* section, California has created robust technical assistance and training guidance for their school-based program. Their extensive web-based materials include a LEA specific provider manual and an LEA onboarding handbook. California also offers a frequently asked questions (FAQ) resource and technical assistance for LEAs that may wish to join together to create a billing consortium. Extensive guidance regarding these topics can be accessed at: https://www.dhcs.ca.gov/ProvGovPart/Pages/LEA.aspx.

Nevada could consider creating additional resources for LEAs that are interested in participating or are already participating in the SHS program. This effort could be targeted to specific challenges expressed by the stakeholders. The level of effort and timeline required to provide additional technical assistance would vary based upon how many new resources are developed. DHCFP could consider a working group that includes representatives from Medicaid, the Department of Education and Local Education Agencies to determine what resources are most needed by LEAs as the program continues to grow and evolve.

TABLE 7. CONSIDERATIONS FOR TECHNICAL ASSISTANCE

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ The level of effort and timeline required to provide additional technical assistance would vary based upon how many new resources are developed.
Operational	▪ These guidance documents could likely be accomplished without a significant capital investment; however, they would be strengthened with participation from DHCFP, NDE, and LEAs. ▪ DCHCFP would need to dedicate resources to maintain the information and assure that it remains accurate over time.
Timeline	▪ The timeline for creating new materials would largely be at the discretion of DHCFP. ▪ Materials could be added over time.

[55] Angres, Casey. (2023, November 28). Medicaid Services Manual Transmittal Letter. https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/C2800/MSM_2800_23_11_29.pdf

Potential Solution #4: Change in Timely Filing Requirements

Stakeholders specifically noted the 6-month timely claims filing limit as a barrier for billing Medicaid for school health services. Per federal regulations the time that a state allows for claims to be submitted and considered timely is at the discretion of the state.[56] DHCFP could consider changing the timely claims filing limit to be a longer period of time than 6 months. A 12-month period is the standard used by the Medicare program and is also common among Medicaid programs.[57]

TABLE 8. CONSIDERATIONS FOR CHANGE IN TIMING FILING

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ The state can choose to maintain one timely fling standard for the fee-for-service program and a different standard for managed care.
Operational	▪ A change to the timely filing limit would require updates to policy manuals and the claims payment system.
Timeline	▪ The timeline for implementation would largely be at the discretion of DHCFP.

Potential Solution #5: Statewide Billing Consortium

Nevada could engage a vendor to act as a centralized billing consortium to provide schools statewide with assistance in billing for Medicaid services through the SHS. Each participating LEA would participate through its own National Provider Identification (NPI) number.

DHCFP would need to consider the exact role of the billing consortium vendor, including how broad its scope would be in providing technical assistance to individual LEAs. DHCFP would also want to determine the requirements for participation in a billing consortium and if the program is optional for schools who participate in the SHS. Nevada would need to consider how to oversee the billing vendor and data integration between technology systems (e.g., student information systems, Medicaid Management Information System (MMIS), data warehouses, etc.) and where those positions are housed within DHCFP.

A statewide billing vendor would shift certain responsibilities away from DHCFP and LEAs; however, DHCFP would also need to designate staff to oversee the vendor relationship and assure accountability and compliance with state and federal rules.

Depending on the level of LEA participation (assuming participation is optional; DHCFP could also make it mandatory if it chooses), it may not make financial sense for DHCFP to invest in this statewide billing tool. If DHCFP decides to move towards a cost reconciliation approach and use of an RMTS, the state will need to consider if the statewide billing vendor is the same as an RMTS vendor. States have taken different approaches with these contractual arrangements; while managing a single vendor may be easier for DHCFP, it also creates a contractual dependency on that one vendor as well.

[56] Timely claims payment, 42 CFR § 447.45 (1990). https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-A/section-447.45
[57] What are the exceptions to Medicare's general timely filing period? (n.d.). Medicaid.gov https://www.medicaid.gov/faq/what-are-exceptions-medicares-general-timely-filing-period/index.html

TABLE 9. CONSIDERATIONS FOR A STATEWIDE BILLING CONSORTIUM

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ DHCFP would need to oversee and manage the billing vendor and data integration between technology systems; the billing vendor would be a large expense to the state ▪ A statewide vendor contract will need to be managed and overseen by DHCFP staff
Operational	▪ DHCFP would need to procure a vendor through a bidding and contracting procurement process through State Purchasing ▪ Moving to a statewide billing vendor would not require a state plan amendment, if no additional changes to rates are made
Timeline	▪ A procurement and contract readiness review process could take multiple years ▪ May need to align with a budget request cycle

NOTED BARRIER: FUNDING FOR STAFFING AND WORKFORCE ISSUES

Stakeholders noted that previous grant funds are no longer available to support the full delivery of school health services. There are costs associated with hiring provider staff to deliver services and costs associated with the administrative tasks required to arrange services and submit claims. There are two potential options that DHCFP could pursue that could lead to more funding in the SHS program.

Potential Solution #6: Enhanced Fee Schedule

DHCFP could adopt a fee schedule that is specific to the school health services program. Nevada currently uses a fee-for-service payment model for school-based services. Providers are paid based on each individual service delivered when an associated claim is submitted. New CMS guidance allows a state to set a separate rate for school-based settings, this means that Nevada could now choose to pay a higher rate to school-based providers for the same service. The state Medicaid agency must demonstrate that the rate is economic and efficient. DHCFP would be asked to document the rate calculations for these services in the school-based setting and assure that those rates are consistent with efficiency, economy, and quality of care. Adopting a higher fee schedule for the SHS program would lead to increased reimbursement for schools.

TABLE 10. CONSIDERATIONS FOR A SCHOOL HEALTH SERVICE FEE SCHEDULE

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ DHCFP would need to determine if all SHS services would have a different rate or if only select services would be set to new, higher rates.
Operational	▪ DHCFP would need to go through a rate setting exercise to determine new rates. ▪ DHCFP would need to confirm that the MMIS is capable of paying different rates based on provider type. ▪ DHCFP would need to submit an updated state plan amendment for CMS to approve.
Timeline	▪ Approximately two years total to complete a rate study, set rates, and prepare state plan amendment materials for CMS

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
	(CMS approval could take up to 90 days but with a retroactive effective date).

Potential Solution #7: Reconciled Cost Methodology

DHCFP could implement a reconciled cost methodology, where providers are reimbursed on an interim basis for the costs they incur when providing Medicaid-covered services. State Medicaid agencies make interim payments to providers throughout the year and then reconcile those payments based on reported incurred costs attributable to Medicaid. These costs are reported through a cost report that details which costs can and cannot be attributed to Medicaid services.

A cost reconciliation methodology could lead to increased reimbursement for schools, since costs are settled and the total annual reimbursement is not dependent upon claim volume, like a traditional fee-for-service model. However, a shift to a new cost-based methodology would require significant administrative work and costs on the part of both DHCFP and LEAs. Among other items, the providers would have to populate detailed cost reports consistent with instructions that adhere to reporting guidelines as well as use identify time attributable to Medicaid, typically through a RMTS.

DHCFP would likely need to rely on an outside vendor (or vendors) to develop the cost report templates, provide significant training for LEAs, manage the RMTS, and commit to ongoing support during the early years of implementation to be successful.

Additionally, CMS specifically notes the following types of documentation that may be needed to meet requirements for states and LEAs using cost-based reimbursement:[58]

- A finalized uniform cost report
- A copy of the Certified Public Expenditures (CPE) (for CPE-supported expenditures)
- Cost report instructions
- Documentation of the time study methodology
- Sign-in sheets from training sessions for time studies
- Time study source documents including study logs or an RMTS
- Copies of any manuals related to the time study, Cost Allocation Plan (CAP), procedures associated with Medicaid school-based services payment
- Documentation to support a Medicaid Enrollment Ratio

Some concerns were noted by stakeholders in discussion about a move to a reconciled cost methodology with questions about how this methodology may impact overall funding. A shift to a cost-based payment methodology, accompanied by interim billing, would remove the current link between SHS providers and the Medicaid fee schedule. As such, any future changes (increases or decreases) to the Medicaid fee schedule would not directly impact SHS providers. Instead, reimbursement would be tied to the actual cost for each LEA to provide the services each year. The actual cost for providing services includes such items as personnel salaries, benefits and other employment related expenses, as well as other indirect costs such as facilities and utilities, overhead, and transportation, as applicable.

Another stakeholder expressed concern about a reconciled cost methodology and payment equity, specifically, relative to the size of the LEA, and the number of students served. Stakeholders want to understand how smaller schools might be impacted by this type of payment structure.

[58] The Centers for Medicare and Medicaid Services. (2023). *Delivering Services in School-Based Settings: A comprehensive guide to Medicaid services and administrative claiming*. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf

Using the CMS interim billing flexibility, DHCFP would have each LEA independently report its actual costs regardless of the size of the school district or the number of enrolled students. In the cost-based payment methodology, there is no direct influence based on the LEA size.

A question was noted by stakeholders regarding the impact of a new payment methodology on the requirement for FERPA required consent forms. The 2023 CMS guidance related to billing flexibilities appears to indicate that parental consent is required in the calculation of the Medicaid Enrollment Ratio (MER), used under a cost reconciliation methodology, which is commonly used to allocate the costs of Medicaid-coverable services that are broadly available to all students. Therefore, unless a federal Medicaid rule change is finalized, consent forms will still be required (and it should be noted, this rule will apply even if DHCFP moves to a cost-based or interim payment methodology where individual claims are not submitted through the current billing process).[59]

Implementing a cost-based reimbursement system will likely increase the administrative burden on DHCFP and LEAs. DHCFP will need to provide technical support to LEAs for this process, which may require additional agency staff. DHCFP could review and complete the final cost reconciliation process within the Department or contract with a vendor for support. Since Nevada historically used an IGT process, some of those processes could be leveraged to support the cost reconciliation – i.e., the process to support a transfer of funds between the LEA and DHCFP.

If Nevada decides to implement an Administrative Claiming Program, it will need a time study system to support payment for those services. As such, Nevada could procure a single RMTS vendor and use it for both the school health services program and administrative claiming program. Nevada would need *at least* two years to implement the cost-based reimbursement methodology. Key implementation tasks that will take substantial time are:

- Updating Nevada policy and preparing materials for CMS approval – e.g., state plan amendment, Nevada Medicaid Manual, cost allocation plan, time study implementation plan, cost report and instructions, etc.
- CMS review and approval process – all materials will need to be reviewed and approved by CMS
- Procuring an RMTS vendor – e.g., defining the scope of the RMTS vendor, writing an RFP, choosing a vendor, and implementing the RMTS system
- Training and technical assistance – e.g., outreach to providers and completing trainings, develop training materials, technical support, etc.

TABLE 11. CONSIDERATIONS FOR A RECONCILED COST METHODOLOGY

ISSUE CATEGORY	POTENTIAL CONSIDERATIONS FOR NEVADA
Strategic/Design	▪ DHCFP would likely need to: ▪ Rely on an outside vendor (or vendors) to implement this methodology ▪ Provide significant training for LEAs ▪ Manage the RMTS vendor and provide all oversight ▪ Commit to enhanced support during the early years of implementation to monitor program implementation
Operational	▪ Implementing a cost-based reimbursement system may increase the administrative burden on DHCFP and LEAs.
Timeline	▪ A new cost-based reimbursement methodology could take at least 2 years to implement and potentially longer

[59] The Centers for Medicare and Medicaid Services. (2023c). *Delivering Services in School-Based Settings: A comprehensive guide to Medicaid services and administrative claiming*. https://www.medicaid.gov/sites/default/files/2023-07/sbs-guide-medicaid-services-administrative-claiming-ud.pdf

Conclusion

In conclusion, recent CMS guidance and highlighted best practices point to a variety of opportunities that Nevada may consider to promote its SHS program goals of increased provider participation, administrative simplification, and increased school revenue, while potentially leading to greater access to services for Medicaid eligible children. As discussed above, there are many considerations that DHCFP may wish to examine before moving forward with any given solution. Further examination to develop implementation plans and asses the costs of each solution, as well as conduct additional stakeholdering to assure alignment with LEA concerns would also be advised. A high-level chart is shown below which categorizes solutions by the likely short-, mid-, and longer-term timeline that may be possible for each policy option.

TABLE 12. SOLUTIONS BY LIKELY TIMEFRAME

SHORT TERM OPTIONS (6 MONTHS TO 1 YEAR)	MID TERM OPTIONS (1 TO 2 YEARS)	LONGER TERM OPTIONS (2+ YEARS)
▪ Expansion of the provider types who are eligible to bill Medicaid ▪ Technical assistance and training ▪ Change in collection procedures for FERPA-required consent forms	▪ Change in timely filing requirements ▪ Statewide billing consortium	▪ Enhanced fee schedule ▪ Reconciled cost methodology

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