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*Joint Informational Bulletin*

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**SUBJECT: GUIDANCE TO STATES AND SCHOOL SYSTEMS ON ADDRESSING  
MENTAL HEALTH AND SUBSTANCE USE ISSUES IN SCHOOLS**

Together, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS) are issuing this Joint Informational Bulletin (Bulletin) to provide the public, including states, schools, and school systems, with information about addressing mental health and substance use issues in schools. Specifically, this guidance includes examples of approaches for mental health and SUD<sup>1</sup> related treatment services in schools and describes some of the Medicaid state plan benefits and other Medicaid authorities that states may use to cover mental health and SUD related treatment services. Additionally, the guidance summarizes best practice models to facilitate implementation of quality, evidence-based comprehensive mental health and SUD related services for students.

**Background**

There is an urgent need to identify children and adolescents who have or are at risk for mental disorders, including SUDs, and connect these children and adolescents with other services they need. Schools can fill a critical role in both identifying such children and adolescents and connecting them with treatment and other services they need.<sup>2,3</sup> An estimated ten percent of children and adolescents in the United States have a serious emotional disturbance (SED),<sup>4</sup> yet approximately 80 percent of those children and adolescents with an SED do not receive needed services.<sup>5,6,7</sup> Approximately 80 percent of children and adolescents with mental health diagnoses have unmet mental health needs.<sup>8</sup>

Substance use rates among adolescents remain concerning, with over 16 percent of adolescents ages 12 to 17 reporting illicit drug use during 2017,<sup>9</sup> and more than 31 percent of adolescents endorsing use of tobacco or alcohol during the same timeframe.<sup>10</sup> Further, during 2017, four percent of 12 to 17 year olds met criteria for a substance use disorder,<sup>11</sup> with 82.5 percent of those adolescents not receiving needed care.<sup>12</sup>

Intervening early is critical, given that half of all lifetime cases of mental illness begin by age 14 and three-fourths by age 24.<sup>13</sup> Research has shown that early identification and treatment improves outcomes. For example, early interventions conducted by comprehensive school-based mental health and substance treatment systems have been associated with enhanced academic performance,<sup>14,15</sup> decreased need for special education,<sup>16</sup> fewer disciplinary encounters,<sup>17</sup> increased engagement with school,<sup>18</sup> and elevated rates of graduation.<sup>19</sup>

However, most communities and schools lack high quality, comprehensive treatment for children and adolescents. Many areas of the nation entirely lack or have insufficient numbers of psychiatrists, psychologists, social workers, and other professionals, especially those with experience in treating children and adolescents, to meet the growing needs.<sup>20</sup> Navigating complex systems to seek care often presents challenges for families and caregivers, such as long wait times, insufficient available services, and poor insurance coverage.

Based on the aforementioned access challenges, schools are particularly critical in identifying and supporting students with mental health issues. Unfortunately, schools often lack the capacity to both identify and adequately treat mental disorders including SUD needs of their students. School principals report that student mental health needs are one of their biggest challenges.<sup>21</sup> Despite these challenges, integrating evidence-based mental health and SUD services into schools can provide many benefits, including increased access to care and decreased stigma when seeking treatment. Schools also can use multidisciplinary approaches to help provide early identification, intervention, and a full continuum of services. Schools often collaborate with community providers as a strategy to expand needed services. Typically, schools access funds for school-based mental health and SUD services through a number of statutory authorities. These include Medicaid benefits available under state plan authority, including benefits required under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit; Medicaid demonstrations and waivers, such as Section 1115 demonstration projects and Section 1915(c) home and community-based services (HCBS) waiver programs; Section 1915(i) HCBS available under the state plan; and non-Medicaid authorities, such as the Individuals with Disabilities Education Act (IDEA) and Title I of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act (ESSA). It is important to also note that the Americans with Disabilities Act (ADA) compels states to provide certain services for people with disabilities including mental disorders within integrated settings,<sup>22</sup> and Medicaid's EPSDT benefit mandates that states provide and arrange for services necessary to meet children's medical needs, including mental health needs.<sup>23,24,25</sup>

## **Best Practice Models**

There are a number of best practice models, which are potentially funded by non-Medicaid funding sources that can assist with supporting students with mental health and SUD related needs in schools. As detailed below, states also have several options within Medicaid to support school-based services.

### *Multi-tiered System of Supports*

Mental health and substance-related services in schools may be organized into a multi-tiered system of supports (MTSS) that ranges from offering services universally to all students to providing more intensive services for select students based on medical necessity.<sup>26</sup> MTSS is an umbrella term for an approach designed to respond to the needs of all students within a system that integrates, but is not limited to, tiered behavioral and academic supports, and is part of the structure of a comprehensive school-based mental health system. MTSS is a whole school, data-driven, prevention-based framework for improving learning outcomes for all students through a layered continuum of evidence-based practices and systems.<sup>27</sup> Universally offered Tier 1 services (i.e., services offered to all students within a school system) typically include widespread screening, social-emotional based learning curricula, and prevention-based activities that foster healthy functioning in a generative school climate. Tier 2 services allow for early intervention and targeted support (e.g., for students exhibiting risk factors often associated with potential issues but for whom the issues have not fully manifested), and may include more directed student screening and interventions to reduce the likelihood of issues developing or resolve early manifestations of difficulty. Tier 3 services are generally for students identified as experiencing mental health or substance-related difficulties, and may include individual or family/caregiver treatment or other individualized interventions to address the identified illness or condition.

Positive Behavioral Interventions and Supports (PBIS),<sup>28</sup> the Interconnected Systems Framework,<sup>29</sup> and the Response to Intervention,<sup>30</sup> are examples of approaches using an MTSS framework. These MTSS programs involve modeling and practicing social skills with students, then prompting and supporting their application in different contexts. Training students on prosocial behaviors and supporting their use has been associated with improved school climates, an enhanced sense of safety, and the perception of greater trust and respect in student-teacher relationships.<sup>31</sup> Additional evidence-based approaches using the MTSS framework to improve pro-social skills and emotional awareness that can be incorporated into curriculum are referred to as Social Emotional Learning (SEL), and their implementation has been associated with improved academic achievement, reduced behavioral problems, and a positive economic return on investment.<sup>32</sup> Evidence-based programs and practices are those that have been carefully evaluated and are supported by empirical data demonstrating improved outcomes. There are multiple evidence-based programs and practices from which schools can choose to respond to the needs of their students. Many evidence-based programs and practices, such as trauma responsive school programs, positive disciplinary practices and bullying prevention programs, cut across the three tiers to meet the comprehensive needs of students.

### *Comprehensive School Mental Health Systems*

Comprehensive school mental health systems (CSMHSs) are an effective and broad multi-tiered approach to caring for students. CSMHSs are school-community collaborations that provide a continuum of mental health services across all three tiers of care (i.e., promotion and prevention for all students, early identification and interventions for those students at risk, and indicated treatment for those students with more intensive needs). There are innovative opportunities for these collaborations to enhance the mental health of students, improve the school climate, and decrease student social isolation and marginalization.<sup>33,34</sup> Key aspects of the CSMHS approach

include evidence-based universal prevention efforts, training for school and community members to identify and respond to early warning signs of mental health difficulties, and targeted prevention and intervention programs and services supporting the mental health of students. The CSMHS framework includes integrating mental health care delivery within school settings.

In addition to collaborations with community mental health providers and families, CSMHSs with their host schools, can develop collaborations with the faith community, law enforcement, physical health care providers, community mental health and substance treatment providers, local businesses, and government agencies. These collaborations can be utilized to help prevent mental health or substance use issues among children and adolescents in schools, better identify and support children and adolescents with mental disorders including SUDs, and make referrals to needed treatment for mental health and substance use issues. Although the school system plays an integral role in ensuring the sound mental health of its students, a comprehensive community approach has been essential to the successful expansion of school-based mental health systems.

Schools and their community partners that have implemented CSMHSs often utilize the School Health Assessment and Performance Evaluation system (SHAPE), a free, web-based portal that provides a virtual workspace for self-assessment of their CSMHS's level of quality implementation based upon the National Indicators for School Mental Health.<sup>35</sup> SHAPE also provides schools and community partners with a "blue print" to inform ongoing planning and implementation in building their CSMHS based best practices and quality indicators. The SHAPE system can also help CSMHSs identify needed services, such as global screening, wellness education, psychotherapy and counseling, access to medication when indicated, and case management. The SHAPE system also addresses factors that can facilitate the expansion of the mental health and substance treatment workforce within and outside of schools in order to support the provision of school-based mental health and substance related services. The National Center for School Mental Health (NCSMH) at the University of Maryland School of Medicine,<sup>36</sup> a sub-recipient of a Health Resources and Services (HRSA) grant to support the Collaborative Improvement and Innovation Network on School-Based Health Services (CoIIN-SBHS) project,<sup>37</sup> also supports the SHAPE system, which it offers at no cost to all schools and school districts nationally that are interested in improving and strengthening their school mental health and substance related services.

States have also received SAMHSA funding to implement Safe Schools/Healthy Students (SS/HS) or Project Advancing Wellness and Resilience in Education (AWARE) grants. The SS/HS framework provides schools and communities with a template for implementing best practices to prevent violence among children and adolescents, and has been found to reduce suspensions and expulsions by half, reduce risks associated with depression by 51 percent, and decrease the number of students staying home from school due to feeling unsafe by 37 percent.<sup>38,39</sup> SAMHSA has provided SS/HS funding to seven states, and profiles of the initiatives in these states are available online.<sup>40</sup> While SAMHSA no longer funds SS/HS grants, SAMHSA's Project AWARE grants support states in developing quality comprehensive school mental health systems that seek to meet the needs of all students. The first Project AWARE grants funded 20 States in 2014. A second Project AWARE cohort of 24 states and tribes began in 2018, and a third cohort is planned for implementation in the spring of 2019 when

approximately six additional states and two tribes are expected to receive Project AWARE grant funds.<sup>41</sup> Project AWARE has demonstrated improved ability to identify and refer children and adolescents with mental health problems to appropriate treatment, with nearly a 10-fold increase in referrals achieved from fiscal year 2015 to fiscal year 2016.<sup>42,43</sup> Further, Project AWARE participants who were non-clinician mental health helpers, received Youth Mental Health First Aid training, after which they reported significantly improved mental health literacy, and significantly enhanced confidence in being able to provide appropriate help to students when indicated.<sup>44</sup> Additionally, Project AWARE performance outcomes reported by grantees included improved school climate, improved school safety, and improved student coping and resiliency skills.<sup>45</sup>

It should be noted that the cost of implementing a comprehensive system varies due to the range of student needs, evidence-based practices used, and reimbursement for services by public and private insurance. Financing of CSMHSs may require multiple streams of funding. Federal grants, such as SS/HS and Project AWARE, have assisted or are currently assisting over 50 states, territories, and tribal entities in the development of school mental health systems.

### *Building Mental Health Literacy*

Building mental health literacy is a universal prevention strategy that schools can implement with all staff and students within a specific school, school district, and/or more broadly within the community. Raising awareness and literacy around mental health issues is a critical component of improving school-based mental health. Mental Health First Aid and Youth Mental Health First Aid are examples of mental health literacy training programs designed to provide a basic understanding of common mental health issues and how to refer people in mental health crises appropriately. These training programs are widely available to school personnel, parents/families/caregivers, first responders, law enforcement, and others in communities, with more than one million people across the nation already trained.

Research has indicated that gains in mental health knowledge over the course of the mental health literacy trainings were associated with increased help-seeking intentions, suggesting that mental health literacy may facilitate treatment utilization. Generally, as of 2018, instructor training costs between \$1,500 and \$2,000, while individual course training varies, with an average cost of \$119. This training can empower school staff with skills to recognize and assist students experiencing mental health needs and better prepare them to make appropriate referrals. Various non-Medicaid funding sources for mental health literacy training may be explored, such as those listed in the section below entitled, “Funding for School-Based Mental Health and Substance Use Related Prevention and Treatment Services.”

### *Counseling, Psychological, and Social Services Coordinators*

Establishing counseling, psychological, and social services (CPSS) coordinators can have a positive impact on the quality and delivery of mental health and other related services.<sup>46</sup> CPSS coordinators can coordinate various providers within and outside of schools to meet students’ needs.<sup>47</sup> Coordination of services can also result in a clear mission, goals, and objectives that promote the integration of procedures and programs.<sup>48</sup> Integration of services within the larger school environment helps secure resources, such as provision of confidential space for providing

services, and helps minimize lost class time for students seeking services. A recent survey of school districts nationwide revealed that 79.5 percent had staff to oversee or coordinate CPSS.<sup>49</sup>

### *School Resource Officers*

The National Association of School Resource Officers (NASRO) underscores three primary roles of the school resources officer (SRO)—namely, that of educator and guest lecturer, that of informal counselor or mentor, and that of law enforcement officer.<sup>50</sup> The SRO is a non-Medicaid covered mechanism utilized by many schools. When implemented with a highly trained officer, SROs can be an invaluable component of creating a safe and supportive school climate. SROs can be an integral member of multi-disciplinary teams within schools, collaborating with teachers, administrators, mental health providers and guidance counselors in the best interest of the students. SROs can directly help identify students with mental disorders including SUDs to connect them with appropriate mental health or substance use services in the school. By fostering positive relationships with students, SROs can also help address situations that students bring to their attention for other children or adolescents who may need support. Further, SROs can have an online presence to help identify potential student needs and encourage indicated help seeking through school-based mental health and substance related resources.<sup>51</sup>

### *Crisis Intervention Teams (CITs)*

Law enforcement officers well trained in mental health issues can be a tremendous asset to the local school systems. CITs are a community partnership of law enforcement, mental health and substance use practitioners, individuals living with mental disorders including SUDs, their families/caregivers and other advocates that provide specific training to law enforcement and other first responders in safely responding to people with mental disorders or experiencing a mental health emergency who are in crisis. While CITs are not limited to a school environment, they can help address crises within school settings as they may in other parts of a community. This innovative first responder model helps people with mental disorders including SUDs access medical treatment rather than the criminal justice system and promotes officer safety and the safety of the individual. The CIT model reduces both stigma and the need for further involvement with the criminal justice system and provides a forum for effective problem solving. Research also suggests that communities that subscribe to the CIT model have higher success rates in resolving crises.<sup>52</sup>

### *Behavioral Health Aides and Peer Supporters*

Support from behavioral health aides and peers can be critical to help children and adolescents and their families and caregivers navigate challenges associated with mental and substance use issues, and can enhance efforts of practitioners and others in the school and health system. Trained peers can develop trust and effective relationships through similar lived experiences with others facing mental and substance use difficulties,<sup>53</sup> and have been found to improve quality of life, engagement, and satisfaction with services and supports, improve overall health, and reduce overall cost of services.<sup>54</sup> While not specific to school-based settings, research has demonstrated the clinical and social/emotional benefits for individuals with mental illness receiving peer support, including reductions in hospitalizations, increased feelings of respect, humanity, and

trust, and increased empowerment to engage in care and pursue personal goals.<sup>55,56</sup> Peer supporters are included in various settings across the nation including child-serving systems, and include student peer counseling programs and statewide peer and family support organizations.<sup>57,58</sup> In 2015, 37 states used various funding sources to provide peer and consumer run services.<sup>59</sup>

### *Workforce and Rural Setting Considerations*

Some settings, including rural locations, have unique challenges regarding building an adequate mental health and SUD treatment workforce. While important, these factors are beyond the focus of this document, so will not be addressed in detail. However, Appendix A highlights information addressing workforce shortages, training the mental health and SUD treatment workforce, and using “telemental health” to expand access to mental health and substance related services in rural schools or other settings in which particular difficulty may be experienced recruiting or retaining qualified mental health and SUD treatment practitioners.

### **Funding for School-Based Mental Health and Substance Use Related Prevention and Treatment Services**

Various funding sources can be utilized to pay for the costs of school-based mental health services, including to:<sup>60</sup>

- 1) leverage diverse funding streams and resources to support a full continuum of services;
- 2) increase reliance on more permanent funding;
- 3) apply best practices strategies to retain staff;
- 4) use economies of scale to maximize efficiencies;
- 5) utilize third party reimbursement mechanisms (i.e., Medicaid, Children’s Health Insurance Program (CHIP), private insurance) for these services;
- 6) implement evidence-based practices and programs to maximize return on investment;
- 7) evaluate and document outcomes, including impact on academic and classroom functioning, using outcome data to inform states, school districts, and community partners; and
- 8) apply for public grants, formula grants (e.g., via ESSA, or the Office of Juvenile Justice and Delinquency Prevention), block grants such as the Community Mental Health Services Block Grant or discretionary/program grants (e.g., Garrett Lee Smith Suicide Prevention, Project AWARE, SAMHSA Systems of Care, HRSA Workforce Development), as a time-limited bridge to more sustainable funding streams.

Many states have used multiple financing strategies for school mental health and SUD related prevention and treatment services, including the use of Medicaid. Medicaid is a state-federal program in which states have the flexibility to design their programs and the services offered, subject to federal requirements. Each state develops and operates its Medicaid program under a state plan outlining the nature and scope of services. Subject to federal requirements, states choose which eligibility groups and services to include (some eligibility groups and services are mandatory, while others are optional), which providers may participate and the payment methods that will be used to pay for services. The Medicaid state plan and any amendments to the state plan must be approved by CMS. States may also pursue other Medicaid statutory

authorities to support the populations and services they wish to cover, subject to CMS approval. The FY 2016 CMS Medicaid Financial Management Report indicates that forty-five states and the District of Columbia offer reimbursement for a range of school-based services, which would include all Medicaid reimbursable school-based services.<sup>61</sup>



Some specific examples of state-level strategies for Medicaid and other financing of school-based mental health services can be found in the table below.

STATE	DESCRIPTION
Alabama	Alabama Departments of Education and Mental Health developed cross system funding to support school-based mental health programming. <sup>62</sup>
Arkansas	Developed administrative procedures to finance a school-based mental health program. Arkansas also formed a state-level collaboration between their Departments of Education, Mental Health/Behavioral Health, and Juvenile Justice for shared funding of school-based services, <sup>63</sup> and a comprehensive manual of Arkansas’s approach to school-based mental health within their State is available online. <sup>64</sup>
California	Passed the “Mental Health Services Act,” which levies a “1% income tax on personal income in excess of \$1 million” <sup>65</sup> to support mental health initiatives, including comprehensive school-based mental health systems.
Florida	Utilized a SAMHSA Project AWARE <sup>66</sup> grant to produce a “Universal Screening Planning Packet,” designed to guide schools in implementation of broad-based mental health screening so that students may receive further support and mental health services when indicated.
Louisiana	Used Medicaid state plan authority in LA 15-0019 to cover the services of a licensed nurse in the school setting for Medicaid-eligible students with an “individualized health plan” thereby not limiting the nursing services to services in an Individualized Education Plan (IEP.)
Massachusetts	Amended their Medicaid state plan to cover services within Individual Health Care Plans, Individualized Family Service Plans, Section 504 plans, or services otherwise deemed medically necessary. The state plan amendment MA 16-012 was approved on July 17, 2017 and was effective on July 1, 2016.
Michigan	IDEA revisions expanded counseling sessions for students at elevated risk for mental health concerns (i.e., “Tier 2”) and for those with existing mental health needs (i.e., “Tier 3”).
Nevada	The governor’s state-funded block grant called “Social Workers in Schools” began in the 2015-2016 school year, and provides full-time social workers to address mental health/behavioral health issues identified on school climate surveys. Through “Social Workers in Schools,” the Department of Education’s Office for a Safe and Respectful Learning Environment has placed over 225 social workers in 170 schools over the past two years. <sup>67</sup>
South Carolina	Department of Education created a “Psychosocial Behavioral Health Rehabilitative Medicaid Standard” for students in Tiers 2 and 3 to enhance coverage for school-based services. <sup>68</sup> South Carolina also developed a recurring line item in the state budget to ensure funding for rural communities to develop school mental health programs. <sup>69</sup>
Tennessee	Johnson City designated school mental health funding for case managers in schools to provide Tier 2 and Tier 3 level services. <sup>70</sup>

## **Medicaid Coverage of Mental Health and Substance Treatment Services**

The following section describes general Medicaid requirements, state plan benefits that may be used to cover services to treat mental disorders including SUDs, and other Medicaid authorities that may be used to cover these services.

### **Section 1905(a) State Plan Services**

The Medicaid state plan is a comprehensive written statement that describes the nature and scope of a state's Medicaid program and contains assurances that the program will be operated per the requirements of Title XIX of the Social Security Act (Act) and other official guidance. While there is no distinct Medicaid state plan benefit called "school health services" or "school-based services," states may submit a state plan amendment (SPA) to provide such services and ensure that services are covered by Medicaid and eligible for federal financial participation (FFP). The state's Medicaid state plan must provide for coverage of mandatory services and include any optional services that the state elects to cover and must include a comprehensive description of the state's method of payment for those services.

A coverage SPA must meet three basic tenets of comparability, freedom of choice of provider, and statewideness, except in the limited circumstances where a particular benefit included in that SPA allows for any of these requirements to be disregarded.

**Comparability:** A Medicaid-covered benefit generally must be provided in the same amount, duration, and scope to all enrollees within a group;

**Freedom of choice:** Medicaid beneficiaries must be permitted to choose a health care provider from any qualified provider who undertakes to provide the services, and any willing and qualified provider must be able to participate in the Medicaid program;

**Statewideness:** The plan will be in operation statewide under equitable standards for assistance and administration that are mandatory throughout the state.

In addition, a coverage SPA must meet the requirements for coverage under the particular benefit, and include any limitations on amount, duration, and scope of services.

#### *Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Benefit*

The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for Medicaid-enrolled children under age 21 as specified in section 1905(r) of the Act. The EPSDT benefit requires states to have a schedule for screening services both at established times and on an as-needed basis. Covered screenings for children include medical, mental health, vision, hearing, and dental. Incorporating an age appropriate, evidence-based screening tool designed to identify behavioral health conditions into well-child examinations is an important step to identify mental health and SUD conditions early. In addition, the EPSDT benefit requires that states provide all medically necessary services covered under the benefits in section 1905(a) of the Act to correct or ameliorate physical and mental illnesses or conditions.

Behavioral health counseling, for example, could be covered under the rehabilitative services benefit at section 1905(a)(13) of the Act, but states would not need to amend their state plans to add EPSDT coverage for screening and behavioral health services. However, some states choose to do so in order to clarify the services covered in school settings.

## **Examples of Medicaid Benefits for Coverage of Mental Health and SUD Treatment Related Services**

### Mandatory Section 1905(a) Benefits

#### *Physicians' Services Benefit*

The physicians' services mandatory benefit is defined in section 1905(a)(5) of the Act and in regulations at 42 C.F.R. §440.50. Physicians' services are furnished within the scope of practice of medicine or osteopathy as defined by state law whether furnished by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy. Physicians' services can be furnished in the school, office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere. Since psychiatrists are physicians, their services could be covered under this benefit.

#### *Federally Qualified Health Center (FQHC) Benefit*

FQHC services are defined in section 1905(a)(2)(C), section 1905(l)(2), and section 1861(aa)(3) of the Act. This mandatory benefit includes services provided by certain core providers including physicians, nurse practitioners and physician assistants (subject to any state law prohibition on furnishing primary health care), nurse midwives, clinical psychologists, clinical social workers and visiting nurses in areas with a shortage of home health agencies. FQHC services also include other ambulatory care services otherwise included in the Medicaid state plan, such as mental health and substance use related treatment services. Although FQHC services are a mandatory benefit and a state must cover services furnished by the core providers, the state has flexibility in determining the other ambulatory care services covered under this benefit to the extent that the services are already covered in another benefit of the state plan. An FQHC could provide covered school-based services, and be located at or near a school as a school-based health center.

#### *Rural Health Clinic (RHC) Benefit*

RHC services are defined in section 1905(a)(2)(B), section 1905(l)(1) and section 1861(aa) of the Act and federal regulations at 42 C.F.R. §440.20(b) and (c). RHC mandatory services are provided by a rural health clinic certified in accordance with 42 C.F.R. Part 491 and include services provided by certain core providers including physicians, nurse practitioners and physician assistants (subject to any state law prohibition on furnishing primary health care), nurse midwives, clinical psychologists, clinical social workers and visiting nurses in areas with a shortage of home health agencies. The state has flexibility in determining the other ambulatory care services covered under this benefit to the extent that the services are already covered in

another benefit of the state plan. Like FQHCs, RHCs could provide covered school-based services, and be located at or near a school as a school-based health center.

### Optional Section 1905(a) Benefits

#### *Rehabilitative Services Benefit*

Rehabilitative services are an optional benefit as specified in section 1905(a)(13) of the Act. Medicaid regulations at 42 CFR § 440.130(d) broadly define rehabilitative services as “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” The state will need to describe the services it seeks to cover and list the practitioners who will furnish the services, along with their qualifications. For example, a state may seek to cover individual and group counseling, or peer support services for children in schools with mental illness or substance use disorders. On August 15, 2007, CMS issued State Medicaid Director Letter, #07-011, to provide guidance to states seeking to cover peer support services under the Medicaid program.<sup>71</sup>

#### *Other Licensed Practitioner Services Benefit*

Section 1905(a)(6) of the Act provides states flexibility in covering services provide by licensed practitioners as defined by state law. As set forth in 42 C.F.R. § 440.60(a), other licensed practitioner services are, “any medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” Under the state plan, states may elect to cover services furnished by state licensed practitioners. For example, this benefit could be used to cover the services of a licensed clinical social worker to furnish counseling, a licensed psychologist to administer psychological tests, or a licensed nurse to administer medications for the treatment of depression or other mental illnesses, to children in schools.

#### *Clinic Benefit*

Under the optional clinic benefit at 42 C.F.R. § 440.90, a state could cover a school-based health clinic that furnishes physical health, as well as mental health and substance related services. Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients by or under the direction of a physician or dentist. Services must be furnished at the clinic. Services furnished outside the clinic, by clinic personnel, are only available to eligible individuals who do not reside in a permanent dwelling or have a fixed home or mailing address. A clinic could be located at or near a school and provide Medicaid covered school-based services.

### *Prescription Drug Benefit*

While coverage of outpatient prescription drugs is an optional service under section 1902(a)(54) of the Act, all states currently provide prescription drug coverage to all state plan eligible individuals. When providing the optional prescription drug benefit, states are required under section 1927 of the Act to cover all outpatient drugs of manufacturers that participate in the Medicaid drug rebate program. However, states may subject drug coverage to utilization management mechanisms, such as step therapy, quantity limits, and prior authorization. Many states use preferred drug lists that attempt to encourage prescribers to use more cost effective drugs for their patients. However, Medicaid beneficiaries typically have very generous drug coverage. This benefit can assist with providing access to needed SUD treatment as children and adolescents may need prescribed medications, such as antidepressants, during the school day.

### *Case Management Benefit*

Case management, an optional benefit defined at 42 C.F.R. § 440.169 and 42 C.F.R. § 441.18, includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Case management services must include all of the following: comprehensive assessment of an eligible individual, development of a specific care plan, referral to needed services, and monitoring activities. Under this benefit, states may target case management services for a specific group of individuals, or to individuals who reside in specified areas of the state (or both). Direct services for a beneficiary are not covered under the case management benefit. However, the state may cover otherwise coverable direct services under a different benefit. The state has flexibility to define qualifications for practitioners to deliver these services, which can include specialized qualifications for case management services for individuals with intellectual disabilities or with chronic mental illness (or other conditions as appropriate) and does not have to meet comparability or statewideness requirements. States may wish to target children with SED or SUDs in order to ensure that they have access to all needed medical, social, educational, and other services. This would include all Medicaid children in schools who meet the state's medical necessity criteria for the case management services.

### **Other Relevant Medicaid Authorities**

Depending on how a state determines the design and scope of their school services, Medicaid authorities described in this section may be used in concert with state plan benefits to achieve desired goals. These authorities can be used in a variety of ways such as changing the delivery system and incorporating services beyond those coverable in the traditional coverage authorities. These authorities are available at state option.

### *Section 1945 of the Act - Health Home Benefit*

This authority allows states to implement health homes for Medicaid beneficiaries (both children and adults) with chronic conditions. A Medicaid beneficiary's eligibility for participation in a health home is based on whether the beneficiary has the chronic conditions

identified in the approved health home provisions of the state plan, and could also be based on whether the beneficiary is in an approved targeted geographic area for health home services, but does not depend on what general Medicaid eligibility category the beneficiary is in. Health home services are intended to promote integration of all primary care, acute care, mental health care, substance use related care, and long-term services and supports to treat the “whole person.” Health home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, individual and family support, and referral to community and social support services. The health home benefit allows states to provide a multi-disciplinary team approach to coordinating care. States are also able to target the provision of health home services geographically. Additionally, states receive a time-limited enhanced federal match for their expenditures on the health home services listed in the state plan.

### *Managed Care*

States may use a managed care delivery system, involving contracts with managed care plans and/or to provide some or all Medicaid-covered services to eligible Medicaid beneficiaries. There are several authorities, from which states have the option to elect, to set up and design a managed care delivery system, including a 1932 state plan amendment, section 1915(a) and (b) waivers, or section 1115 demonstration projects. In most instances, states must meet the requirements of sections 1903(m) of the Act, which incorporates many of the requirements in section 1932 of the Act. While states can choose what services will be covered under the managed care plan, they must continue to assure access to the full set of state plan services, including the EPSDT benefit. When using a managed care delivery system, a state generally must provide beneficiaries with a choice of at least two managed care plans. Payments to managed care plans are generally made on a risk basis, meaning that the managed care plan is paid a set amount per enrollee for the scope of services covered under the contract called a capitation payment. Contracts, which must include the capitation rates payable to managed care plans, are subject to CMS approval and capitation rates must be actuarially sound.

States may contract with a managed care plan to cover the full range of EPSDT screening, diagnostic, and treatment services, including services to children in schools, or states may carve out some EPSDT services, or services beyond contracted limits, and retain responsibility for them in fee-for-service coverage, or contract with another managed care plan to provide those services.

### *Section 1915(b) of the Act - Freedom of Choice Waiver*

In addition to the use of section 1915(b) of the Act to authorize a managed care delivery system, CMS may grant a waiver to permit states to restrict a beneficiary within a more limited fee-for-service provider network. When using this authority, states may be able to use the savings accrued through the use of more efficient care delivery to authorize additional services beyond what is included in the state plan.

## *Section 1115 - Demonstration Projects*

Section 1115 of the Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that further the objectives of the Medicaid and Children's Health Insurance Program (CHIP). These demonstrations give states additional flexibility to design and improve their programs and to demonstrate and evaluate policy approaches subject to CMS approval.

### **Medicaid Payment for School-Based Services**

Medicaid payments can play a vital role in the provision of comprehensive school-based mental health care services. The availability of payment for these services has been noted to be a central issue in the ability to provide services in school settings for Medicaid-eligible beneficiaries.

Mental health and substance use services provided in the school setting are subject to the same federal and state laws and regulations that apply to Medicaid services provided in other settings. Since the EPSDT benefit requires states to make available all medically necessary services for children under age 21 that are coverable under the benefits listed in section 1905(a) of the Act, states are not required to submit state plan coverage pages that include school-based services for children. However, a comprehensive description of the payment methodology must be included in the reimbursement section. The provider must meet the state's licensing, certification or other applicable qualifying criteria and must document the provision of the service by creating and maintaining clinical and billing records that would be required of any other provider. Also, CMS relies on states to implement policies and procedures to help ensure freedom of choice of providers while also ensuring that services are not duplicative of any services provided elsewhere.

The most common approaches that states use for provider billing and payment for Medicaid-covered services provided in schools to Medicaid-enrolled students are:

1. Fee-for-service/claim-based payment: Under this approach, the state establishes a fee schedule and any coverage limitations for each service. The provider then submits a request for payment to the Medicaid program in essentially the same way that any medical provider would bill a health insurance company by submitting a claim that details the name and Medicaid identification number of the Medicaid-enrolled student, the date and billing code of the service provided, the supporting diagnosis code and any other information required by the Medicaid program. However, this process is not commonly used for school-based services not only because most schools do not have medical claim billing systems that provide a means to bill in this way but also, perhaps even more importantly, because most state Medicaid programs pay for these services on a reconciled cost basis.
2. Recognized cost reimbursement: The overwhelming majority of school-based services are reimbursed by state Medicaid programs using a reconciled cost methodology. Under this method, each Local Education Agency uses a cost reporting system to compile and aggregate the costs of providing the services, usually on a quarterly or annual basis.

These costs are then allocated between services that were provided to Medicaid-enrolled students and those that were provided to non-Medicaid students. This effort not only requires direct service providers working in schools to maintain appropriately comprehensive clinical records to support the reported expenditures, but also requires that school districts maintain sufficient cost data and service utilization documentation to facilitate an accurate allocation of cost to Medicaid consistent with federal cost principles. Schools are strongly encouraged to work with their state's Medicaid program staff and CMS staff to develop an appropriate cost identification and allocation methodology that meets federal requirements. It must also be noted that even though individual claims for services are not submitted to the Medicaid agency in order to request payment, CMS requires that the Medicaid program use its Medicaid Management Information System to record all school-based services in order to document services at the individual level and to provide information necessary to assess the economy and efficiency of the payments.

#### *Medicaid Payment for Services without Charge (Free Care)*

Historically, CMS guidance on “free care” was that Medicaid payment was generally not allowable for services that were available without charge to the beneficiary. CMS issued a State Medicaid Director Letter (SMDL), #14-006,<sup>72</sup> on December 15, 2014, stating that, “Medicaid reimbursement is available for covered services under the approved state plan that are provided to Medicaid beneficiaries, regardless of whether there is any charge for the service to the beneficiary or the community at large. As a result, Federal Financial Participation (FFP) is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met.” Accordingly, CMS no longer limits FFP to Medicaid covered services included in a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP). Medicaid coverage may include covered services in a child's individual service plan pursuant to section 504 of the Rehabilitation Act of 1973, covered services in some other written health care plan, or services covered under the benefits in section 1905(a) of the Act that are determined to be medically necessary. FFP is available only when all of the following elements are satisfied:

- The individual is a Medicaid beneficiary.
- The service is a covered Medicaid service, provided in accordance with approved state plan methodologies, including coverage under the EPSDT benefit provided to children.
- The provider is a Medicaid-participating provider and meets all federal and/or state provider qualification requirements.
- The state plan contains a payment methodology for determining rates that are consistent with efficiency, economy and quality of care or provides for payment at cost using a CMS approved methodology.
- Third party liability (TPL) requirements are met.



- Medicaid payment does not duplicate other specific payments for the same service.
- The state and provider maintain auditable documentation to support claims for FFP.
- The state conducts appropriate financial oversight of provider billing practices.
- All other program requirements (statutory, regulatory, policy) for the service, payment, and associated claiming are met.

## **Other Considerations and Regulatory Requirements**

### *Medicaid Qualified Providers*

In order for schools and practitioners to participate in the Medicaid program and receive Medicaid reimbursement, they must meet the applicable Medicaid provider qualifications and the requirements in 42 C.F.R. § 431.107, including having a provider agreement and a Medicaid provider identification number. Practitioners in schools are also subject to the screening and national provider identification (NPI) requirements in section 1866(j)(2) of the Act and 42 C.F.R. § 455.400 – 455.470. Rendering providers must meet the screening requirements and claims must include the NPI of the physician or other professional who ordered or referred such items or services. Finally, practitioners who furnish services in school settings must meet applicable qualifications established by the state and those qualifications must minimally be the same as those providers who furnish services in other settings in the community.

### *Collaborations with Community Providers Within or Near Schools*

Within federal requirements affecting coverage, payment and financing of Medicaid services, schools may establish collaborations with community providers. CMS encourages states to seek technical guidance for compliance with these requirements prior to committing to a collaboration arrangement. Commonly, these collaborations between schools and community providers result in what are referred to as, “school-based health centers” (SBHCs). To be covered as a facility service, an SBHC would need to operate under a recognized Medicaid facility benefit, such as the clinic benefit or under the FQHC benefit, provided the requirements for these benefits are met. Both benefits have certain requirements that may influence the way a school chooses to organize as a Medicaid recognized facility benefit. For example, to the extent that services would be furnished outside of the clinic, the clinic benefit may not be used, as there is a general prohibition at 42 C.F.R. § 440.90 on the furnishing of clinic services outside of the clinic for individuals except for those without a fixed dwelling or mailing address. Accordingly, the FQHC benefit may be a better option for a school and community provider collaboration. A state may elect to offer services of FQHC-affiliated practitioners in schools that trigger payment of the FQHC prospective payment system (PPS) rate.

In general, SBHCs provide health care services that help students succeed in school and in life and operate during school hours. They are staffed by qualified health care professionals and are focused on the prevention, early identification, and treatment of medical and mental health or substance related concerns that can interfere with a student’s learning. They are located in or

near a school facility and are organized through school, community, and health provider relationships. According to the 2013-14 Census Report from the School-Based Health Alliance,<sup>73</sup> there are three main models of SBHCs : 1) those that are staffed by primary care providers such as a licensed nurse or nurse practitioner; 2) those that are staffed by a primary care provider and also a mental health provider such as a licensed clinical social worker, a psychologist, or substance abuse counselor; and 3) those that are staffed by a primary care provider, a mental health provider, and also other practitioners such as a case manager, an oral health provider, a health educator, and a nutritionist.

### *Medicaid Reimbursement for Telehealth/Telemedicine*

Telehealth/telemedicine<sup>74,75</sup> is an alternative approach to providing face-to-face services, but the Medicaid statute does not recognize telehealth/telemedicine as a distinct service. Services furnished via telehealth/telemedicine are subject to the same Medicaid requirements that apply to the underlying service. Telehealth/telemedicine offers two-way, real time, interactive communication that links a Medicaid beneficiary and a practitioner at a distant site and can be helpful to ensure that Medicaid services are provided to Medicaid beneficiaries who are in rural areas or in areas where qualified practitioners are scarce. States have flexibility in designing their telehealth/telemedicine program parameters, including when and how services may be provided using telehealth/telemedicine. A state may allow the school to serve as an originating site, where the beneficiary is located, and/or as a destination site, where the direct service provider is located. Whether developing a rate to pay for services under a fee schedule or using a cost recognition reimbursement method, the state Medicaid program may recognize costs incurred by schools to provide covered services via telehealth/telemedicine but may not include the start-up costs incurred to set up their telehealth/telemedicine technology.

The Telehealth Network Grant Program (TNGP),<sup>76</sup> operated by HRSA's Office of Rural Health Policy/Office for the Advancement of Telehealth, demonstrates the use of telehealth networks to improve healthcare services for medically underserved populations in urban, rural, and frontier communities. The current TNGP encourages telehealth services delivered through school-based health centers, particularly those serving high-poverty populations. Services include behavioral health services.

### **Conclusion**

Mental health and substance use challenges negatively affect how well children and adolescents can learn, and there is an urgent need to identify students at risk or experiencing these challenges to connect them with appropriate prevention and treatment services. Early intervention improves outcomes, and comprehensive school mental health systems have been associated with multiple positive educational and performance outcomes. No single funding source can adequately support all mental health and substance-related prevention and treatment needs of students and their families and caregivers; however, federal, state, and community-level resources can be leveraged with philanthropic and other funding streams to ensure appropriate levels of support. Providing these services within schools increases the likelihood of children and adolescents receiving needed services, thus better ensuring academic and life success.

States interested in learning more on this topic and/or requesting technical assistance may contact Dr. Nainan Thomas, Chief, Mental Health Promotion Branch ([nainan.thomas@samhsa.hhs.gov](mailto:nainan.thomas@samhsa.hhs.gov), 240-276-1744) or Kirsten Jensen, Director, Division of Benefits and Coverage, ([kirsten.jensen@cms.hhs.gov](mailto:kirsten.jensen@cms.hhs.gov), 410-786-8146.) State Medicaid Agencies should contact their Medicaid Regional Offices for technical assistance. Schools systems and providers should engage with their state Medicaid agencies to discuss how Medicaid covers and reimburses for mental health and SUD treatment services in schools in their states.

## Appendix A

This appendix provides information specific to expanding access to mental health providers within and outside of schools, for the provision of school-based mental health services. See below for considerations regarding workforce shortages, training the mental health workforce, the use of “telemental health” to expand access to mental health services across settings in which particular difficulty may be experienced recruiting or retaining qualified mental health providers, and systems of care frameworks.

1. Mental Health and Substance Treatment Workforce Shortages: A lack of mental health professionals in schools or in centers that students and schools could easily access has been highlighted by school employees, governmental leaders, advocacy groups, and by families across the nation. The National Association of School Psychologists (NASP) recommends school districts have one school psychologist for every 500-700 students<sup>77</sup> to ensure comprehensive services, although the ratio across the U.S. was estimated to be one psychologist for every 1,383 students.<sup>78</sup> Further, research suggests that as the provider to student ratio increases, the availability and provision of mental health services provided within school settings decreases.<sup>79</sup> Other mental health professionals can also assist in addressing school-based mental health and substance-related student needs, in addition to support roles played by non-professionals. Peer and family support is critical to help children, adolescents and their families with serious emotional disturbance engage in and navigate complex systems of care. High turnover rates, aging workforce, and low compensation all contribute to workforce shortage across the mental health arena. Unfortunately, this shortage is all too apparent in the school system. Peer and family support providers may be used to enhance the workforce efforts by developing trust and effective relationships through similar lived experiences.<sup>80, 81</sup> They help to address critical caregiver supports and have been shown to improve quality of life, engagement, and satisfaction with services and supports, improve overall health, and reduce overall cost of services.<sup>82</sup> Research has shown the clinical and social/emotional benefits for individuals with mental illness receiving peer support, including reductions in hospitalizations, increased feelings of respect, humanity, and trust versus traditional providers, and increased empowerment to engage in care and pursue personal goals.<sup>83, 84</sup> Peer supporters are included in various settings across the nation including child-serving systems and include student peer counseling programs and statewide peer and family support organizations.<sup>85, 86</sup> In 2007, CMS issued a letter to state Medicaid Directors providing guidance on using Medicaid to reimburse peer support services.<sup>87</sup> In 2015, 37 states also used various funding sources to provide peer and consumer run services.<sup>88</sup>
2. Training the Workforce: It is important to support clinicians and others in providing high quality care to ensure broad use and appropriate implementation of best practices. Several new efforts have recently been initiated to accomplish this, including 1) the Clinical Support System – Serious Mental Illness, to support the implementation of evidence-based practices in the treatment and recovery of individuals with SMI; 2) twelve Mental Health Technology Transfer Centers, which provide regionally-focused assistance to clinicians and others; 3) a 90 minute Specialized Educational Tool on

Assessing and Addressing Risk of Youth Violence, developed in collaboration with the Department of Education, for teachers, first responders, parents, and students at no cost; and 4) mental health literacy training, such as Mental Health First Aid and Crisis Intervention Training. In addition, the Health Resources and Services Administration (HRSA) supports several training programs that include the training of future child and adolescent mental health and substance related treatment professionals. Within HRSA's Maternal and Child Health Bureau, the Developmental and Behavioral Pediatrics training program supports the advanced postdoctoral fellowship training of pediatricians to enhance the behavioral, psychosocial, and developmental components of pediatric care.

3. Using Technology to Address Workforce Issues: Technology can play a significant role in enhancing the workforce. "Telemental health" is the use of video-conferencing to conduct real-time mental health treatment between a clinician and patient. This can provide needed treatment to people who otherwise may not have access to mental health care, including those in underserved or rural areas. The use of telemental health services in both rural and urban environments, including schools, has been found to be effective, cost efficient, and met with high ratings of satisfaction by students. The cost of implementing telemental health services can vary; however, generally, the purchase of equipment can be between \$500 and \$10,000. Telehealth care extension strategies include ECHO-type models. ECHO (Extension for Community Healthcare Outcomes) is a SAMHSA distance education model that connects specialists with general practitioners via simultaneous video link for the purpose of facilitating care-based learning. These models have been very effective in supporting and educating practitioners in hard to reach areas. HRSA has a variety of telehealth-related grants and resources, including a Telehealth Network Grant Program, a Substance Abuse Treatment Telehealth Network Grant Program, an Evidence-Based Tele-Behavioral Health Network Program, among other resources.<sup>89</sup> Information on HRSA's telehealth grant programs can be found at <https://www.hrsa.gov/rural-health/telehealth/index.html>, and telehealth resources and technical assistance can be obtained through the HRSA-supported National Consortium of Telehealth Resource Centers at <https://www.telehealthresourcecenter.org/>. Telehealth provides a means to treatment access for those who might not otherwise be able to access it. Reimbursement for services delivered via telehealth will vary across payers. The Center for Connected Health Policy developed a document that outlines each state law around telemedicine and reimbursement for mental health services, which can serve as a resource to school systems desiring to incorporate telemental health into their schools.<sup>90</sup>
4. Systems of Care (SOC) framework: The SOC framework is an effective model that has been supported by SAMHSA grants. The systems of care (SOC) framework is an approach that explicitly includes all systems that are involved with providing services for children and is a proven best practice in providing comprehensive, community-based mental health treatment and support services for children and adolescents with SED or serious mental illness and their parents and families. Examples of the types of systems that are included in an SOC approach include departments of health, education departments, social services, juvenile justice and others. Recipients of services provided have demonstrated significant improvements in behavioral and emotional functioning; significant reductions in thoughts of suicide and suicide attempts; significant reductions

in unlawful activities; and significant cost reductions due to decreases in hospitalizations and arrest.<sup>91</sup> States such as Wisconsin include SOC in their MTSS framework that guides local districts in development of their school mental health systems.

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