



An Exploratory Policy Brief

Leveraging Medicaid to Fund School-Based Primary Prevention Programs and Services

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Executive Summary

This brief explores how Medicaid could be leveraged to strengthen access to primary prevention programs and services, inclusive of building essential social and emotional skills, and ensure all Medicaid-eligible students gain access to those programs and services in their school setting. Pursuing Medicaid coverage to this end could help sustain needed resources and mitigate the need for higher-cost services if challenges develop into crises. It could further promote stronger outcomes for learning, safety, and wellness. This is because school-based primary prevention programs and services can build protective factors, mitigate

risk factors, and obviate crises.¹ Building social and emotional skills as a primary prevention service is particularly important for students' safety, learning, and mental wellness, and has been shown to help to decrease symptoms of behavioral health conditions such as anxiety, depression, and substance use.^{2,3}

This brief investigates the opportunity for states to leverage Medicaid coverage to help young people build essential social and emotional skills as a part of prevention services in a full continuum of care. Because states, in adherence to federal law, decide what services are required for Medicaid coverage in their state, proposed changes and advocacy to ensure coverage should be targeted at the state level. This brief offers several recommendations for states to advance this work. Additionally, federal guidance could help to clarify and ensure that Medicaid-eligible students have access to primary prevention programs and services in states that utilize school-based reimbursement.



Leveraging Medicaid to Fund School-Based Primary Prevention Programs and Services

There has been pronounced attention across the nation and historic federal investment in efforts that support young people's mental health and well-being. See the [Surgeon General's Advisory on Protecting Youth Mental Health](#), [federal COVID-19 relief funding](#), and the [Bipartisan Safer Communities Act](#) as just a few examples. The youth mental health crisis worsened prior to the COVID-19 pandemic, then continued to intensify during the pandemic.⁴ Now, though the US appears to have moved beyond the height of the pandemic, the youth mental health crisis does not seem to be lessening.⁵ Meaningful, effective, and sustainable action needs to attend to this crisis.

Federal and state governments can leverage Medicaid reimbursement for school-based services that sustain recent investments and maximize the benefit of existing programs for young people's mental health and well-being,⁶ especially where those programs allow young people to access preventative services before a mental health crisis develops. Recently, there has been federal action to advance this work. In response to the Bipartisan Safer Communities Act, the Centers for Medicare and Medicaid Services (CMS) issued guidance on [delivering behavioral health services for children and youth](#) and [expanding school-based services in Medicaid](#). Previously, CMS's [2019 joint issue brief](#) with the Substance Abuse and Mental Health Services Administration (SAMHSA) recognized multi-tiered systems of support and social-emotional learning as best practices, noting that Medicaid can fund school-based prevention and treatment services related to mental health and substance use. Further clarity in federal guidance could help states leverage Medicaid so young people can access effective, upstream prevention programs and services. Such guidance would help states sustain efforts from recent investments that support youth mental health and wellness, improve access to upstream support through a public health approach, and ultimately save the social, health, and economic costs of higher-tiered levels of care when effective prevention programs are accessible to young people.

Aside from federal-level action and guidance, the implementation of Medicaid varies by state. States have much in their power to advance Medicaid coverage for school-based prevention programs and services. This brief explores what states can

do to further Medicaid coverage of school-based primary prevention programs and services, inclusive of social and emotional skill-building. It also examines school-based Medicaid expansion and current requirements for reimbursable services, innovative approaches (including 1115 waivers, health services initiatives, and value-added services), financing options, and the potential for advancement through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. This brief will elucidate state activity already underway and provide recommendations for immediate consideration.

Background: Medicaid, School-Based Services, and Prevention Programs

This section provides background on Medicaid, Medicaid expansion in schools, and the importance of access for all children to school-based primary prevention programs and services, inclusive of building social and emotional skills.

Medicaid is an important state and federal program, and its operation varies by state. Medicaid provides comprehensive health insurance to people, including children and youth, with low income and/or a disability.⁷ This program has a wide reach to children and young people across the US—37 percent of school-aged children and youth receive Medicaid and Children's Health Insurance Program (CHIP) benefits.⁸ Medicaid is funded by state and federal government; the federal government will reimburse a state at least half of the state's cost of providing Medicaid services to enrollees (the rate of reimbursement depends on the [Federal Medical Assistance Percentage](#)).⁹



States have significant discretion in what they cover under Medicaid beyond federally required services.¹⁰ A state can elect, albeit within limits, to cover optional benefits through its Medicaid state plan (which, depending on the state, would require legislation or simply agency rulemaking), waiver authority, or nonmandatory benefits. States should use their discretion under Medicaid to cover prevention programs and services in the school setting, inclusive of building social and emotional skills, not only because doing so would have important social and mental wellness benefits for its beneficiaries and their communities,² but also because it would ultimately result in cost savings.¹¹

School-Based Medicaid Expansion: The Free Care Policy Reversal. All 50 states and Washington, D.C., have school Medicaid programs that reimburse participating school districts for eligible school health services, including mental health services. In 2014, the Free Care Policy Reversal gave states the option to cover a broader range of school-based health services.¹² This policy change in [federal guidance](#) allowed states the flexibility to provide school districts with Medicaid reimbursement for school-based health services to all Medicaid-enrolled students. Medicaid used to pay only for eligible health services included in an eligible student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Now, with the policy change, states can tap into Medicaid for many other eligible services that schools provide, easing states' cost burden.¹³ As explained by CMS in an informational bulletin, "[We] encourage states to promote the use of schools as a setting in which to provide Medicaid-enrolled children and adolescents with medically necessary Medicaid-covered services, where appropriate to the student's needs and the capabilities of the setting and practitioners, thereby promoting access to needed care and promoting health equity."¹⁴

Most states needed to amend their state plans or update guidance to benefit from this change in federal policy. [Some states](#) have updated their Medicaid state plan or passed legislation to implement the Free Care Policy Reversal (see the Healthy Schools Campaign's [map of school Medicaid programs](#)).¹⁵

To be sure, there is no "school-based service" Medicaid benefit.¹⁴ Rather, services in a school setting that are reimbursable by Medicaid must be listed under Title XIX of the federal Social Security Act and coverable under a state's Medicaid plan (or section 1115 demonstration waiver); they must demonstrate and document medical necessity criteria (the definition of which

varies by state); and they must be provided to Medicaid-eligible students by a qualified provider enrolled in the Medicaid program.^{14, 16} The state must also have oversight as well as appropriate methods to bill and document the services (recent audits have shown that some schools have not adequately documented services).^{8, 14} Additionally, there must be parental consent to bill insurance for a provided service; high consent rates would be needed to ensure Medicaid billing as a viable option for school-based services.¹⁷ Medicaid-covered services in a school setting can still include a student's IEP and IFSP, but with the Free Care Policy Reversal, depending on the state, they can further include services delivered to the general student population.¹⁸ This presents an especially important opportunity to access sustainable funding for behavioral health services, such as counseling and substance use treatment, and nursing services, including immunizations, nutrition, and medication management. Consider: if a school provides hearing screenings or vaccines free to all students, Medicaid could be billed for any students who are Medicaid-eligible. Furthermore, the Free Care Policy Reversal provides more opportunity to ensure students can access trauma-informed care and services that promote their learning, health, and well-being.¹⁹

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Given these requirements, for Medicaid to cover in-school primary prevention programs and services, a state must ensure that its state plan or waiver covers the program or service, that eligible providers deliver the service, and that medical necessity is demonstrated and documented, with parental consent to bill.

While reimbursement for Medicaid services can be complicated and state-specific, it is economically beneficial to draw federal money from the state to increase and ensure more students, who are already Medicaid eligible, can access school-based services.^{13, 19} As noted by the Healthy Schools Campaign, "When a state increases the number of eligible services that are billed to Medicaid, the state gets back more money from CMS."¹³

The need for access to school-based prevention programs and services. Schools are often where young people access prevention programs and services that promote their wellness.²⁰ Research- and evidence-based programs and practices that



help students build social and emotional skills in the school setting—sometimes called social-emotional learning—have been shown to reduce symptoms of externalizing challenges (like aggression), as well as internalizing challenges (like anxiety and depression).^{2, 21, 22} Social and emotional skills are protective factors, and helping young people develop them is a part of primary prevention in a full continuum of care.¹ For example, building social and emotional skills is a component of comprehensive youth suicide prevention because building these skills helps to manage and mitigate potential risk factors, such as feelings of hopelessness, anxiety, substance use, and child sexual abuse.²³ Such skill-building is also closely associated with trauma-informed practices in schools, which help young people cope with trauma connected to the pandemic and recent violent events in schools and communities.²⁴ Fostering a supportive, safe, and caring learning environment that addresses the needs of the whole child also supports students living in poverty, many of whom may have experienced trauma.²⁵ CMS emphasizes the importance of this access for eligible students: "Research strongly suggests that when young people have health coverage and receive necessary and preventive health care, their academic and other important life outcomes improve."¹⁴ Not only do primary prevention programs and services provide important health, safety, and social benefits, but they are also a wise economic investment. Investing in effective primary prevention programs such as research- and evidence-based social and emotional skills instruction provides a return on investment and mitigates the need for higher levels of care. For example, research has shown that for every \$1 invested in prevention and early intervention programs, \$2 to \$10 is saved in other costs related to health care, legal, and education impacts.¹¹ And providing high-quality research- and evidence-based prevention programs is not costly: one year of teaching social and emotional skills in a school can cost approximately \$5 per student.²⁶ Evidence-based social-emotional learning

interventions specifically have been shown to return \$11 for every \$1 invested.²⁷

Additionally, in the context of the youth mental health crisis, it's essential to employ a comprehensive and public health approach. As Rose's prevention paradox asserts, "No mass disorder afflicting humankind has ever been eliminated or brought under control by attempts at treating the affected individual ... Individual treatment has no effect on incidence."²⁸

That is, to ameliorate a public health crisis such as today's youth mental health crisis, we need a population-wide, fundamentally preventative approach. While one-to-one and small-group interventions are still important, amelioration cannot be realized solely through these means.

Innovative Approaches for States to Cover Primary Prevention Programs and Services

Medicaid can already cover some primary prevention services in schools for eligible children. [CMS issued guidance](#) to states in 2021, and states have already used Medicaid to cover services to address social determinants of health.²⁹ One such determinant is access to quality education. Social and emotional skill-building in the classroom speaks directly to this determinant.³⁰ Thus, covering social determinants of health can extend to social and emotional skill-building. The following are pathways and innovative approaches that could help ensure coverage of school-based primary prevention programs and services.

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Section 1115 Demonstration Waivers. States could use their [Section 1115 demonstration waiver](#) for Medicaid to fund social and emotional skill-building in schools. This waiver allows states to experiment, pilot, or demonstrate projects that are likely to promote the objectives of Medicaid. Social-emotional learning

has been shown to help reduce conditions of anxiety and depression and benefit young people living within low-income households.^{2,21,22} Therefore, improving access to such prevention programs or services via waiver would likely promote health outcomes for beneficiaries in the state.³¹

Health Services Initiatives. States could also develop health services initiatives (HSIs).¹⁰ HSIs aim to improve the health of children (under age 19) in families with low income. Both direct services and public health approaches are allowable under the initiatives and serve children who are eligible for CHIP and/or Medicaid and may also serve children who are not eligible.^A Instruction that builds students' social and emotional skills would fit squarely into both approaches and could reach all children with universal implementation. For example, states have used HSIs to provide youth violence prevention programs in schools, but some social and emotional skill-building programs are already designed to help prevent youth violence.³²

Value-Added Services. Managed care organizations (MCOs), when contracting with or for schools, could also provide or cover value-added primary prevention programs and services. In addition to covering required services under a state plan, [MCOs can voluntarily pursue](#) offering value-added services.¹⁰ Value-added services are typically nonmedical and can include services to address social determinants of health.^{29, B} At first, an MCO might not recognize the value of offering in-school social and emotional skill-building. Similar services are generally paid for out of the MCO's administrative budget and cannot be included in determining a capitation rate.²⁹ But adding value via beneficiaries' access to high-quality prevention programs reduces later health and wellness challenges ([something CMS has shown interest in](#)), leading to cost savings, which should remove any disincentive.³³ Moreover, under [federal rule](#), a value-added service that improves health care quality could be included as incurred claims in calculating the medical loss ratio (MLR).^{C, D}

Managed Care Organizations. Managed care could also be considered in some contexts as a mechanism to cover primary prevention services in the school setting. Managed care is the predominant model of Medicaid health care delivery, and MCOs

^A The federal portion of the initiative is funded through the state's CHIP allotment after the CHIP state plan is fully funded.

^B [MCOs can use capitation payments](#) to pay providers a fixed amount per patient determined by myriad factors such as the range of services provided, number of patients, local factors, etc. While dependent on the health plan, most capitation payment plans include prevention services and health education.

^C [Incurred claims](#) are direct claims to the MCO for covered services or supplies provided to the beneficiary.

^D [Calculating the MLR](#) is a part of setting the capitation rate in managed care to help ensure that total capitation is spent on services or quality improvement.

are the most common type of managed care.^E In [Washington State](#), for example, school districts have the option of contracting directly with MCOs to receive Medicaid reimbursement for services not listed on an IEP that are provided to eligible students. For states that contract with MCOs, the paid rates for services should be sufficient to provide the service.²⁹ It should be noted that most states' school Medicaid program is carved out of managed care.³⁴ Thus, the precedent for most states is for the school district to bill the state rather than the MCO. Federal guidance recommends that schools should be included as an integrated and coordinated part of the delivery system when states use managed care for service delivery.¹⁴ It also notes that managed care contracts should clearly describe what services are covered. There can also be a mix of service delivery, as states can deliver services through managed care as well as deliver some care via fee-for-service.¹⁴

Medicaid Reimbursement Methodologies Matter for School-Based Services

This section addresses the importance of ensuring the cost of prevention programs and services is adequately incorporated in reimbursement rates and can clearly be addressed when a cost-based methodology is employed.

To begin, considering a state's fee schedule services is paramount in looking to advance access to school-based primary prevention programs and services. Consistent with the federal Social Security Act, states set base payment rates for Medicaid-covered services. States' options to pay for school-based services include state plans that a) establish the rates (or fee schedule) for services provided in out-of-school settings, b) develop a different system for rates for services provided in schools, or c) use cost-based rates specific to the school. To establish a fee schedule, states can use several methods, such as a resource-based relative scale (value determined by the number of resources involved), a percentage of Medicare's fee, or rates influenced by local factors in the state.³⁵

Recent guidance from CMS has suggested that states increase Medicaid rates for school-based services to account for costs associated with staffing and training needs at the site.¹⁴ However, states can also use the same rates to provide

a service, as set by the state plan. The federal guidance notes that states should ensure that non-IEP services are included in the payment methodology, as states may have payment methodologies specific to the school setting.¹⁴ For example, there could be differences if a community provider versus a school contractor or employee provides a covered service. A school would also likely submit for the payment, whereas a community provider would submit directly based on the state's plan's fee schedule. This relates to an issue raised earlier—states also need to ensure that the administrative burden is not so great that it prevents schools from providing this benefit to help their students access health care. In calculating the actual cost to provide prevention services, it would be vital to incorporate the cost of high-quality research- or evidence-based materials needed to implement the service.

The main ways schools bill Medicaid for provided services are through fee-for-service (FFS) and cost-based reimbursement.⁸ FFS provides a reimbursement rate that the state sets based on a variety of factors, one of which is the cost to provide the service.⁸ Cost-based reimbursements are periodic Medicaid payments from the state agency to the school that are based on what the school district projects it will cost to deliver the covered services.⁸ Cost-based reimbursement methodology includes statistics to determine service delivery and associated costs for providing services.^{36, 37}

States that use cost-based reimbursement methodology must use statistically valid methodologies (such as random moment sampling, worker day logs, and case counts) to allocate costs to Medicaid.¹⁴ Time studies are methodologies that allocate cost based on the time spent on activities that are Medicaid-covered services and require activity codes that reflect direct and administrative activities. When determining cost-based rates for services at schools, states can consider both the salaries of the professionals providing the service and the associated costs to operate or establish the service, which could be factored into the amount of cost per service. Associated costs could include things such as materials to provide the service. Another allocation statistic is the Medicaid Enrollment Ratio (MER), which schools can use to determine the percentage of students enrolled in Medicaid who are served. The MER can be used to allocate costs to Medicaid based on the ratio of the

^E The structure of MCOs aims to promote health and prevent more costly interventions down the road. Because MCOs are risk-based, they are under contract with states to pay for beneficiaries' care even if costs exceed reimbursement. This model focuses on quality over quantity of services provided (that is, a value-based payment model). States can choose to deliver some services through managed care and fee for service. Fee for service pays providers based on the quantity of services provided.

total number of Medicaid-enrolled children with an IEP divided by the total number of children with an IEP at a certain point of time (with adequate documentation to support this).¹⁴ For states that have expanded coverage for non-IEP services, CMS has approved calculating a separate MER for students not on an IEP. Thus, applying this method, eligible providers could bill for primary prevention services using an MER to cover costs of services provided to Medicaid-enrolled students where medically appropriate.

Medicaid Financing: CPEs Offer a Viable Pathway

In most states, school districts meet the state's portion of Medicaid. School districts fund this through certified public expenditures (CPEs), intergovernmental transfers (IGTs), and appropriations from state general funds.¹⁴ CPEs are public funds from local government that can be used to cover the full cost of providing a Medicaid service that is then eligible for the federal match so long as there is certification that the funds are spent on covered items or services.³⁸ IGTs are transfers of funds between government entities that also are eligible for a federal match.^{38, F} CMS encourages states to use IGTs and state appropriations to pay providers via a rate methodology as a less burdensome option for schools and local education agencies (LEAs) instead of a certified cost process, as required for CPEs, which might be more intensive.¹³ However, there are also benefits to using CPEs because they could lend to making a clear argument to cover expenses related to providing effective primary prevention services.

Given Medicaid financing, CPEs offer a viable pathway for Medicaid to cover school-based primary prevention services. CPEs can provide a clear path that supports implementing primary prevention programs and services. This is because the school or LEA must determine the actual cost to provide a service, according to a uniform cost report, for use of its non-federal share of dollars. A school or LEA will certify an amount as a CPE based on the cost identified and allocated to Medicaid via the cost report. The cost report must account for all direct and indirect costs for providing the service in a school. Direct costs are typically the staff/provider compensation and the costs of materials that can be identified specifically with a final cost objective.

Indirect costs, such as facilities and administration, benefit more than one cost objective. Based on the nature of the cost, statistics can be used to determine the amount allocated to

Medicaid's portion of the allowable cost. For example, the cost of electricity or facility space could be based on a square-foot percentage of that space in the whole school. Arguably, costs associated with Tier 1 primary prevention programs and services could be sustainably funded through this method—whether it helps to fund the provider's role or attends to indirect costs that enable the service. CPEs could be particularly helpful to this end because they factor in the full direct and indirect costs. CMS highly recommends that when CPEs are used, interim payments for the eligible services are developed and then reconciled based on the cost report.¹⁴ However, given the nature of certifying costs, this method is likely more accessible to larger schools and schools with more resources.

Further Exploration: Addressing the EPSDT Benefit

The EPSDT mandatory benefit provides prevention, diagnostic, and treatment services that are medically necessary to children and youth under the age of 21 that qualify for Medicaid.³⁹ States must inform all eligible beneficiaries of these services, provide requested screening, and provide any treatment or intervention that mitigates the condition based on the screening. Per the Social Security Act, the EPSDT benefit must include services to eligible youth that would "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening," even if those services are not covered by the Medicaid state plan.¹⁰ Traditionally the EPSDT provides an individualized, targeted approach to allocating services. It does not automatically anticipate services that fall within Tier 1 primary prevention, such as in-school social and emotional skill-building.¹³ ¹⁴ As explained by the Healthy Schools Campaign, "Ultimately, the goal of the EPSDT benefit is to assure that children get the health care they need, when they need it—the right care to the right child, at the right time, in the right setting."¹³

The EPSDT benefit also warrants discussion and further exploration covering instruction on social and emotional skills as a prevention service in school settings because one of its core tenets is prevention. Recent federal guidance discourages requiring a behavioral health diagnosis for EPSDT services and provides that states can determine what is medically necessary without a behavioral health condition diagnosis for some services.¹⁴ Further federal guidance could help clarify and support EPSDT's applicability to further access to effective research- and evidence-based prevention. Such guidance might also shore up documenting "medical necessity" as it relates to

^F Generally, when the payment is made to a school-based provider, the provider retains the entire payment.

prevention programs under EPSDT or other benefits. Clarifying medical necessity could include ameliorating conditions in a way that prevents symptoms of anxiety and depression, which would be especially helpful for Medicaid-eligible young people with low-income backgrounds.^{2,25} Particularly as more states continue to implement the Free Care Policy Reversal to expand Medicaid in school-based services, clarification on what prevention services are under this benefit helps ensure kids are supported upstream in being healthy and ready to thrive.



Existing and Potential Pitfalls

As addressed in previous sections, there are potential pitfalls and limitations in looking to leverage Medicaid reimbursement to ensure access to primary prevention services for young beneficiaries in school settings. Furthermore, addressing Medicaid coverage for primary prevention services cannot take a one-size-fits-all solution. Every state is different—from the services covered to the reimbursement process to the types of, and requirements for, eligible service providers.

One aspect that likely needs to be further addressed is the documentation and reimbursement process. If policies were clarified for Medicaid to underwrite instruction on social and emotional skill-building in schools, some schools might still miss out on the benefit because of administrative burdens involved with documenting and processing reimbursements. Both CMS and the US Department of Education (USDOE) have urged states to address administrative burdens to make it easier for schools to access this benefit and ensure that every child eligible for Medicaid is enrolled.¹⁴ This guidance should be heeded, as doing so would have equity and access implications, particularly for schools and districts with fewer resources. The administrative costs of this program are significant, and some states have chosen to take money from districts for overhead and administrative expenses, despite not having financial

responsibility (given the unique district-federal partnership).⁸ Some states have required school districts to contribute from their budget toward the nonfederal portion of school-based services, and once states are reimbursed for their share of the services, they give some money back to the district.¹³ Rural districts with fewer resources, in particular, have been found to miss out on this funding.⁸

Workforce constraints also present a potential pitfall: there is a shortage of mental health providers across the country.⁴⁰ Additionally, low Medicaid reimbursement rates and burdensome administrative requirements can impact the workforce of eligible providers for covered services.^{41,42} Furthermore, some states do not consider school psychologists as qualified Medicaid providers, which could impact the implementation of primary prevention services addressing mental and behavioral health conditions in schools.⁹ While school psychologists are not the only professionals who can provide primary prevention services in schools, they are sometimes looked to begin, organize, augment, or lead the effort. However, given the primary prevention nature of building social and emotional skills, it is not necessary for a school psychologist to provide this service. Many states use the Free Care Policy Reversal to ensure that qualified providers who deliver school-based services are Medicaid-eligible. For example, Michigan has added a multitude of behavioral health care providers in its school-based Medicaid program.⁴³

Another potential limiting factor is the current application of "medical necessity" for Medicaid-reimbursable services. While "prevention" services can be covered, the Social Security Act provides that those services are based on individual need, not necessarily from a universal or public health approach.¹⁶ However, we know that effective primary prevention and research- and evidence-based social and emotional skill-building is best implemented as a universal (community-wide) primary prevention program or service. Yet, there are ways to accommodate universal programs under a system set up for individualized care. Further guidance that clearly connects research- and evidence-based primary prevention to improved health outcomes would further help improve this issue (for instance, social and emotional skill-building for beneficiaries who may be at risk of anxiety and depression).

In consideration of braiding funding to provide primary prevention services, Medicaid is to be the payer of last resort to not duplicate other available funding streams.⁴⁴ Medicaid third-party liability requires all reasonable measures to be taken to receive payment from legally liable parties first. Schools are not viewed as legally

liable entities, but they are expected to bill liable third parties first when students have dual coverage.⁴⁵ (Note: The Individuals with Disabilities Education Act (IDEA) is an exception to third-party liability provisions.) Again, this could create an administrative burden, and it would require high levels of parental buy-in to sustainably carry out.

Finally, parental consent is needed both to deliver and bill for services under Medicaid. A great number of parents would need to consent to be able to tap into this funding stream sustainably.¹⁷ Given the recent misinformation about and politicization of social and emotional skill-building in school, this need could present another pitfall. However, misinformation and politicization could be mitigated, if not ameliorated, through proactive parental outreach from the school or school district.

State Examples

Using Medicaid to cover primary prevention services, inclusive of instruction on social and emotional skill-building, is dependent predominantly on state-level action. Specifically, a state could include primary prevention as a component of a covered service and incorporate it into their payment and reimbursement methodology.

For some states, this approach is already available, or perhaps at least sets precedent for Medicaid to cover the instruction of social and emotional skill-building. For example, **Colorado** has expanded school-based Medicaid services through a state plan amendment and already has billing codes for behavioral health prevention services in the overall state plan that include “activities [that] affect critical life and social skills,” inclusive of classroom education activities for children to build skills. This offers a promising example of how such services have potential to be covered and other states might look to this language. In states that haven’t expanded Medicaid in schools, there are examples of covered services that could arguably set precedent for similar services for all Medicaid-enrolled students. For example, **Utah**⁴⁶ covers services for Medicaid-eligible children pursuant to their IEP, inclusive of communication and behavioral health described as services designed to mitigate aggression; research shows that this mitigation is something instruction on social and emotional skill-building can do.²¹ In **Idaho**,⁴⁶ **Iowa**,⁴⁶ and **Pennsylvania**,⁴⁶ skill-building is a covered behavioral health service for students with an IEP. **California** has expanded its school Medicaid program, and it has legislation on the books (SB 276) that includes health and mental health education as a covered service from the local education agency. Such education



services could set a precedent to clarify that covered services for beneficiaries include social and emotional skill-building.

While not all states need legislation to amend their Medicaid state plan, several states have introduced legislation that would include instruction on social and emotional skill-building as a Medicaid-covered school-based service. Three states introduced bills in 2022 that explicitly included social-emotional learning as a service reimbursable by Medicaid:

- **Maine: LD 1910** (enacted) requires health insurance carriers to cover evidence-based practices, inclusive of services and programs for prevention, including high-quality social and emotional skill-building programs listed on the What Works Clearinghouse.
- **New Jersey: S 2416** (introduced) requires Medicaid reimbursement for covered behavioral health services provided by an LEA to any student who is an eligible Medicaid beneficiary. The legislation includes social-emotional learning as a reimbursable service for students and families. Services must be provided by a licensed medical practitioner approved as a Medicaid provider or an LEA approved as a Medicaid provider.
- **Massachusetts: HR 597** (died) allows for an LEA to obtain MassHealth reimbursement for providing direct nursing care services, administrative activities, or any other medical benefits to school-aged children. It also maintains the proceeds of that reimbursement to fund a program of nursing care services and related administrative activities that can be used for School Health Services Programming, which may include social-emotional learning.

Conclusion and Next Steps

Both the federal government and the states have a role to play to advance Medicaid coverage for school-based preventive services inclusive of social and emotional skill-building.

Per the federal government, the [President's Unity Agenda](#) and the Department of Health and Human Services are working to make it easier for school-based mental health professionals to seek reimbursement from Medicaid. CMS released an [information bulletin](#) with further expected guidance to come, as per the requirement in the [Bipartisan Safer Communities Act](#). The recent guidance and forthcoming efforts help clarify rules for state Medicaid agencies to make it easier for schools to bill for Medicaid services. Additionally, CMS and USDOE will establish a technical assistance center to support state Medicaid agencies, LEAs, and school-based entities to implement and expand Medicaid school-based services as well as [issue grants](#) to support states' efforts to strengthen school Medicaid programs. Further steps at the federal level to support this work could include guidance to clarify and ensure that Medicaid-eligible students have access to primary prevention programs and services in states that utilize school-based reimbursement.

While forthcoming federal efforts develop, states can leverage Medicaid coverage for in-school social and emotional skill-building programs as a part of prevention services within a full continuum of care. Such programs, as part of a prevention service, promote wellness and help decrease symptoms of behavioral health conditions such as anxiety, depression, and substance use, and can serve as a part of comprehensive youth suicide prevention.^{2,3,23} Schools and school systems can already be reimbursed for Medicaid-covered services via the Free Care Reversal Policy. Because states, in adherence to federal law, decide what services are required for Medicaid coverage, it's incumbent on states to lead on these policies. Pursuing Medicaid coverage to provide school-based prevention services to eligible students could help sustain needed resources and mitigate the need for higher-cost services if challenges develop into crises. To reach a maximum impact for all children in our country, Medicaid dollars used for this service could be braided with other federal funds, such as Title I, Title IV-A, Project AWARE, or other state and local coffers for non-Medicaid students.

Given the importance of a Medicaid state plan and variation by state, efforts that look to ensure Medicaid reimbursement for school-based prevention services should be targeted at the state level.

Recommendations

Where appropriate, to ensure coverage of wellness promotion and preventative services for behavioral health and wellness, states should:

- 1. Use the Free Care Policy Reversal** to allow school districts to receive reimbursement for all Medicaid-eligible services delivered to all Medicaid-enrolled students to further reach students who are already Medicaid eligible and draw down available federal funds to the state.
- 2. Advance innovative approaches** that cover primary prevention programs and services to obviate youth mental health crises among beneficiaries. Possible pathways include using Section 1115 demonstration waivers or HSIs, engaging MCOs, or providing value-added services to obviate youth mental health crises among Medicaid beneficiaries.
- 3. Ensure their Medicaid State Plan** clearly covers preventive services, inclusive of in-school social and emotional skill-building, shown to reduce symptoms of behavioral health conditions such as anxiety, depression, and substance use, and as a part of comprehensive suicide prevention.
- 4. Ensure the financing and payment structure** is conducive to reimbursing the cost of providing high-quality, research- or evidence-based social and emotional skill-building in the service. Where viable, consider the use of CPEs to reimburse the full cost of high-quality primary prevention programs and services. While this would not directly draw down federal funds, it would add to the state match for Medicaid, improving financing for prevention services in a school setting.
- 5. Clarify what medical necessity is** and how access to social and emotional skill-building relates to obviating symptoms of anxiety, depression, and substance use, and is a part of suicide prevention.
- 6. Ensure schools and districts have equitable and adequate access** to resources to fulfill documentation and reporting requirements to clearly connect providing primary prevention programs and services to demonstrate medical necessity for the student beneficiary.

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