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Holland Children's Institute

MEDICAID + PUBLIC SCHOOLS REPORT

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Mission

Holland Children's Institute serves as the trusted destination for research and analysis related to income disparities and equitable access to opportunities essential to prosperity for Nebraska children and families.

Vision

Nebraska will become the national beacon in economic security and opportunity for all children and families.

Acknowledgements

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Glossary

Children's Health Insurance Program (CHIP): Provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states according to federal mandates. The program is funded jointly by states and the federal government.[1]

Centers for Medicare & Medicaid Services (CMS): Part of the federal Department of Health and Human Services (HHS), charged with the oversight of national aid programs Medicare, Medicaid, CHIP, as well as the state and federal health insurance marketplaces.[2]

Continuous Eligibility: State option to provide children 12 months of continuous coverage through Medicaid, CHIP regardless of household income changes during that time, so long as the child, family were determined initially eligible.[3]

Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.[4]

Express Lane Eligibility (ELE): Allows states the opportunity ensure simple, fast eligibility determination and enrollment/re-enrollment process for Medicaid, CHIP beneficiaries by relying on the findings of another state program to determine eligibility.[5]

Express Lane Agency (ELA): Designated state program which serves as the clearinghouse for collecting and disseminating the information required to determine Medicaid, CHIP eligibility. Used in conjunction with facilitating Express Lane Eligibility.[6]

Federal Medical Assistance Percentage (FMAP): Determined annually, and specific to each state, the FMAP formula specifies the federal share of Medicaid, CHIP related costs states incur. FMAP varies based on state per capita income, ensuring lower per capita income states receive more federal assistance while higher per capita income states receive less. States receive a statutory minimum of 50 percent federal reimbursement, and a statutory maximum of 83 percent.[7]

Federal Poverty Level (FPL): A measure of income issued annually by the federal Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid, CHIP coverage.[8]

Free Care Policy: Prior to 2014, federal guidance prevented the use of Medicaid funds to pay for covered services provided to Medicaid eligible beneficiaries when the provider did not bill the individual recipient, or any other individuals for services provided.[9]

Individuals with Disabilities Education Act (IDEA): A law that makes available a free and appropriate public education to eligible children with disabilities in the United States and ensures special education and related services to those children. The IDEA governs how states and public agencies provide early intervention, special education, and related services to eligible children with disabilities.[10]

Individualized Education Program/Plan (IEP): Each public school child receiving special education and related services must have an IEP. Each IEP must be designed for one student and must be a truly individualized document. The IEP creates an opportunity for teachers, parents, school administrators, related services personnel, and students to work together to improve education results for children with disabilities.[11]

Individualized Family Service Plan (IFSP): A document for an infant or toddler with a disability, age birth through two years and the child's family. Early intervention services are designed to meet the developmental needs of the child as well as the family's needs related to the child's development. IFSP's must specifically list the special education and related services that are necessary to ensure the child receives free and appropriate public education.[12]

Medicaid Administrative Claiming (MAC): Title XIX of the Social Security Act authorizes federal grants to states for a proportion of expenditures for medical assistance under an approved Medicaid state plan, and for expenditures necessary for administration of the state plan.[13]

Medicaid and CHIP Payment and Access Commission (MACPAC): A non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid, CHIP.[14]

Modified Adjusted Gross Income (MAGI): MAGI is used to determine financial eligibility for Medicaid, CHIP, and premium tax credits and cost sharing reductions available through the health insurance marketplace. By using one set of income counting rules and a single application across programs, the Affordable Care Act made it easier to apply and enroll in the appropriate program.[15]

Medicaid: Medicaid is a government program, providing health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people experiencing disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.[16]

Medicaid in Public Schools (MIPS): The school-based health services component of identifying and providing health care coverage for children, in accordance with Individualized Education Plan (IEP) and Individualized Family Service Plan (IFSP) as well as requirements for Early and Periodic Screening, Diagnostic and Treatment (EPSDT).[17]

Nebraska Education-Based Medicaid Administrative Claiming (NEBMAC): Nebraska's Education-Based Medicaid Administrative Claiming guide approved by Centers for Medicare and Medicaid Services in January 2018. The guide includes information for schools and other interested parties on the appropriate methods for claiming reimbursement for Medicaid administrative activities performed in school settings.[18]

Random Moment Time Study (RMTS): A methodology used to tally and calculate the amount of time spent by school-based health service providers and/or administrators in performing Medicaid, CHIP-related activities. These are then categorized and reported to the state's Department of Health and Human Services (DHHS) to determine appropriate rates of reimbursement to school providers.[19]

State Plan Amendment (SPA): State plans serve as an agreement between a state and the Federal government to describe its administration of Medicaid and CHIP programs. This agreement provides assurance that states will comply with Federal rules and regulations governing Federal matching funds for eligible program activities. When a state plans to make a change to its program, not otherwise provided for in the agreement, states submit state plan amendments (SPAs) to the Centers for Medicare & Medicaid Services for review and approval.[20]

Share of Cost: Also known as "cost sharing" and/or "spend down." States are permitted to charge premiums and to establish out of pocket spending (cost sharing) on most Medicaid-covered inpatient and outpatient benefits in accordance with household income.[21] Maximum out of pocket costs are limited but states may impose higher charges for targeted groups of somewhat higher income enrollees.[22]

Executive Summary

Medicaid, Children's Health Insurance Program (CHIP) make it possible for low-income Americans, specifically children and families, to access free or low-cost health care. While some may not be familiar with the role of school-based Medicaid, others may be familiar with its primary role funding special education services to millions of students in need of individualized education plans (IEPs). A well-developed Medicaid in Public Schools (MIPS) program can bolster one of states' largest expenditures, public education. Public schools are "among the most efficient systems to reach children and families" in terms of determining and enrolling Medicaid-eligible children and/or families.[23]

While use of Medicaid funds varies, a 2017 School Superintendents Association study found nearly 70 percent of schools use Medicaid reimbursement dollars for salaries of health care professionals; 45 percent to expand health services; and 39 percent to facilitate outreach and coordinate services for students.[24]

To qualify, an individual must meet both 1) categorical eligibility and 2) financial eligibility.[25] Many children are first identified, enrolled through public schools. To qualify for MIPS in Nebraska:

1) Services must be medically necessary[26]
2) Student recipients must be eligible for Medicaid[27]
3) Associated special education or family support services MUST be included in their Individual Education Plan (IEP) and/or Individualized Family Service Plan (IFSP).

Nebraska Department of Health and Human Services defines medical necessity as:

- Necessary to meet the basic health needs of the client
- Rendered in the most cost-efficient manner
- Rendered in a type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or government agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the client or the physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
- Relative to the goal of improved patient health outcomes

**Services and supplies which do not meet the definition of medical necessity are not covered. This definition is provided for purposes of Medicaid fee-for-service and Managed care.*

A Medicaid-eligible child may receive some, or all, of the following health care services via Nebraska's Medicaid school-based health services, MIPS program:[28]

All Nebraska Medicaid Covered Services

- Ambulance services
- Chiropractic services
- Dental services
- Durable medical equipment, orthodontics, prosthetics, and medical supplies
- Family planning services
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Health Check
- Hearing aid services
- Home health agency services
- Hospice services
- Hospital services
- Intermediate care facilities (ICF) for persons with developmental disabilities (ICF/DD)
- Laboratory and radiology (X0ray) services
- Medical transportation services
- Mental health and substance abuse services for children and adolescents
- Nursing facility services
- Nurse Midwife services
- Nurse Practitioner services
- Nursing services
- Physician services
- Podiatry services
- Prescribed drugs
- Private-duty nursing services
- Adult psychiatric, Substance Use Disorder, and Medicaid rehabilitation option
- Screening services (mammograms)
- Services provided by clinics
- Therapies: physical, occupational, speech pathology & audiology
- Visual care services

All Nebraska Medicaid in Public Schools Covered Services

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT), Health Check
- Medical Transportation Services
- Mental Health and Substance Use Disorder Services
- Nursing Services
- Occupational Therapy Services
- Personal Assistance Services
- Physical Therapy Services
- Services for individuals with Speech, Hearing, and Language Disorders Visual Care Services

Source: https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Health_and_Human_Services__Department_of/107_20211130-091110.pdf

**Provider personnel must be employed by or under contract with the school district, ESU, or approved cooperatives providing special education and related services.*
***Eligible Nebraska Medicaid-eligible services overlapping with Nebraska MIPS-eligible services are bolded for emphasis.*

In Nebraska, 88.6 percent of children eligible for Medicaid, CHIP are receiving coverage.[29] As a result, approximately 11.4 percent of eligible children remain uninsured statewide, though they are both categorically and financially eligible.

As schools are one of the most effective partners in identifying, enrolling, and serving Medicaid-eligible children, changes to Nebraska's state Medicaid program and its administration 1) reduce the state's percentage of uninsured children, 2) increase service to Medicaid-eligible children, and 3) preserve continuity of service, ensuring brief, inconsistent lapses in eligibility don't adversely affect enrolled the health and safety of enrolled children nor produce a cliff effect for a child's household.

Respectfully, Holland Children's Institute proposes revisiting Nebraska's Medicaid-eligible children's coverage, to produce better health outcomes with three technical changes:

1. Address Nebraska's 'free care policy' language

- Consider amending current statutory language (Neb. Rev. Stat. § 68-911(4)) to omit the requirement that school-based reimbursable services when provided as part of an individualized education program (IEP) or individualized family service plan (IFSP)

2. Provide 'continuous eligibility' for Medicaid, CHIP

- Consider amending Nebraska's six-month continuous eligibility standard to meet the federally recommended standard of 12-month continuous eligibility. Nebraska is one 16 states not currently offering 12-month continuous Medicaid and/or CHIP eligibility, while 34 states offer continuous eligibility for Medicaid or CHIP, and 19 offering it for both programs.[30]

3. Provide Express Lane Eligibility for Medicaid, CHIP

- Consider utilizing express lane eligibility (ELE) to simplify the Medicaid/CHIP administrative process and name an express lane agency (ELA) to aggregate and provide all information required for state program eligibility determination and enrollment.[31]

Proposed changes may increase Nebraska's state Medicaid expenditures in the short term but provide return on investment through enrolled children's 1) long-term academic achievement, 2) workforce participation rates, and 3) increased lifetime earnings. Additional savings may result from 1) decreased frequency of complex, cumbersome applications, 2) streamlining and harmonizing application/enrollee data collection, and 3) reduced administrative staffing costs to manage applications and data

School-based health services are an essential component of providing Medicaid, CHIP Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screenings as well as ensuring reliable, quality services to participating children.

Expanding Medicaid in Public Schools is a path forward to increasing the health coverage of Nebraska's children through school-based health services. A school-based program focused on EPSDT interventions is essential to building a healthy foundation for immediate and future positive outcomes for children's health.

MEDICAID IN PUBLIC SCHOOLS

expanding access to health care for kids

To qualify: A child must be categorically & financially eligible

To receive services:
1) Services must be medically necessary
2) Child recipients must be Medicaid eligible
3) Special education services, family support services must be included in a student IEP, IFSP

88.6% of eligible children receive care

11.4% eligible children uninsured

24-40% eligible as 'medically needy'

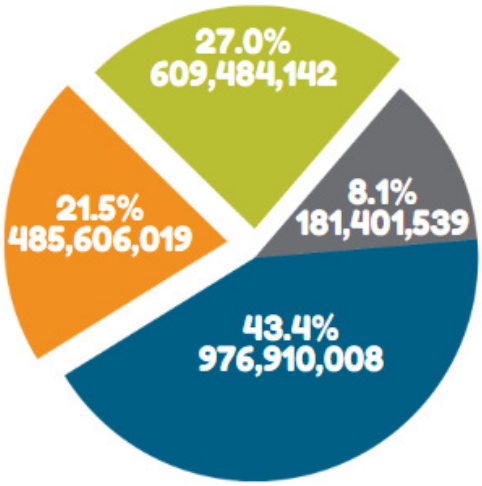
Nebraska children covered by Medicaid, CHIP

10.5% 0-137.99% FPL $0 - $27,916.76

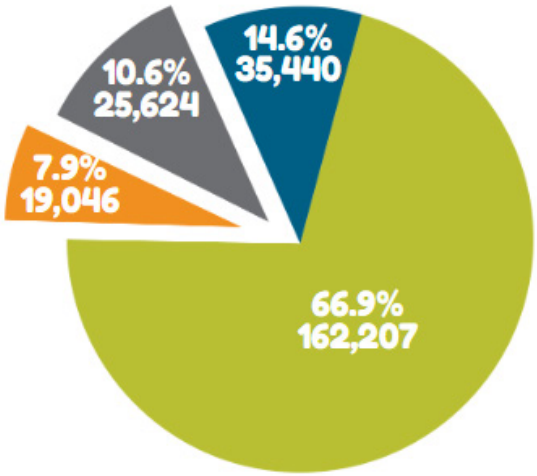
7.4% 138-249.99% FPL $27,916.78 - $50,575.48

3.0% 250% FPL OR ABOVE $50,577.50 OR ABOVE

Rate of Uninsured Children by Poverty Threshold: Income by Percentage and Annual Income in Nebraska



Nebraska Medicaid, CHIP Annual Cost by Eligibility Category - 2019



Nebraska Medicaid, CHIP Average Monthly Enrollment by Eligibility Category - 2019

Children | Blind & Disabled | Aged | ADC Adults

70% health care professional salaries

45% expanded health services

39% outreach, coordinate services

A 2017 School Superintendents Association study found schools depend on Medicaid reimbursement dollars.

How do we achieve these goals?

1) Ensure every eligible student has health coverage

2) Prioritize comprehensive health needs of children as a critical coexisting element of successful learning

3) Increase access to school-based/linked preventative health care

4) Help schools serve as a resource to families and caregivers in underserved, remote communities

"Schools are among the most efficient systems to reach children and families."

- Georgetown University

What changes can we make in Nebraska to expand access to children's health care?

Address Nebraska's Free Care Policy

Amend Neb. Rev. Stat. § 68-911(4) language to omit the requirement that school-based reimbursable services may only be provided as part of an IEP or IFSP.

Provide Continuous Eligibility

Amend Nebraska's six-month standard to meet federally recommended standard of 12-month continuous Medicaid, CHIP eligibility.

Provide Express Lane Eligibility

Simplify administrative Medicaid, CHIP eligibility determination and enrollment, and name an express lane agency to provide data.

ADDITIONAL RESOURCES

CCF.GEORGETOWN.EDU
HEALTHYSCHOOLSCAMPAIGN.ORG
MACPAC.GOV

Holland Children's Institute

ABOUT US

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Introduction

Public education and Medicaid are among the most important commitments of the United States government. Each delivers on a historical commitment, part of the social contract between the government and its people, foundational to our experiment in democracy. Arguably, government primarily, if not exclusively, is charged with delivering programs and services which meet at the intersections of quality and quantity of life for its people.

Free, high-quality public-school education shapes the workforce of tomorrow by instilling children with curiosity, critical thinking, and social emotional learning today. Medicaid provides critical access to a health care standards floor for low-income Americans. Together, education and preventive/interventive health care services are essential to, at best, transcending low-income socioeconomic strata to self-sufficiency. More often, socioeconomic subsistence, resulting from intervening social conditions perpetually disadvantaging low-income individuals and families.

Medicaid, CHIP make it possible for low-income Americans, specifically children and families, to access free or low-cost critical health care services. At one time it was nearly impossible for working families to receive health care without financial ruin. For many, that is still a very stark reality. This lack of access is not limited to adults, with negative consequences for children often manifesting in real-time in educational spaces.

While Medicaid is not mandated in schools, it is one of the most important ways Nebraska children can receive care. Nebraska children are frequently identified, enrolled, and provided with Medicaid-funded, school-based health services. A 2014 expansion of federal Medicare policy afforded the opportunity for states to increase services to eligible children through school-based services. Most states have failed to realign programs to match federal policy, and don't maximize federal match funding for Medicaid in Public Schools (MIPS).

Funding of public schools are dependent upon state legislatures, revenue, budget priorities, and individual tax bases within public school districts. In Nebraska, this has sparked a longstanding debate on local versus state funding and urban versus rural funding levels. Many public schools, including those receiving state aide, do not receive equal or adequate state resources or investment.[32] As a result, widespread disparities in student performance and access are perpetuated. From test scores and graduation rates to absenteeism and post-high school lifetime earning potential, students' school experiences vary greatly based on geography and school/district funding levels. These inequities are exacerbated when children experience disability in any form or require additional services to fully engage in school activities.

While some may not be familiar with the role of Medicaid in Public Schools (MIPS), many may be peripherally familiar with its primary role of supporting special education services for millions of students in need of individualized education plans (IEPs) or, for infants and toddlers, individualized family service plans (IFSPs) across the country.[33] IEPs utilize specialists, faculty, staff, and/or specialists to customize educational plans and special education services in conjunction with parents and students to improve educational outcomes. IEPs may, and often do, include behavioral, health, and skilled care proportionate to a child's needs.

Despite the dramatic, positive impacts of Medicaid at-large, MIPS is often underutilized. Many states forgo the potential to maximize federal reimbursements through underdeveloped programs or a lack of understanding around the program and its benefits. A well-developed MIPS system can bolster one of states' largest expenditures, public education. Increasing services to state's future workforce can foster a well-educated, happy, and healthy generation of children.

Through this document, Holland Children's Institute amplifies the importance of Nebraska's Medicaid in Public Schools (MIPS) program, and better positions readers with the knowledge to:

1) **DEVELOP** insight into the purpose of the MIPS program, and how it is facilitated in Nebraska.
2) **UNDERSTAND** current procedural and financial challenges of the state and public-school providers in creating access/providing MIPS to Nebraska children within educational spaces.
3) **GAIN** a plan of action necessary to expand access, increase efficiencies, and deliver better outcomes for Nebraska children.

WHAT IS MEDICAID, CHIP?

The United States' Medicaid program, established in 1965, provides low-cost or free health care coverage to low-income Americans, including eligible adults, children, people experiencing disabilities, pregnant people, and seniors.[34] Medicaid is among the country's largest health care providers, serving 69.8 million people per year.[35] Nebraska began Medicaid participation in 1966.

All states, the District of Columbia, and U.S. territories may access coverage through state administered Medicaid programs. Federally mandated coverage exists for state participation, but states and territories have broad flexibility in administration, optional coverage provision, and delivery of Medicaid services (Table 1).[36] [37]

With many similarities to Medicaid, the Child Health Insurance Program (CHIP) was created as part of the 1997 Balanced Budget Act,[38] specifically providing health care coverage for qualified children based on family income, unique health care needs, or foster care status.[39] Children of low-income families receive health insurance coverage though their family's income may exceed Medicaid eligibility.

Through combined efforts and expanded nationwide eligibility, enrollment of children in Medicaid and CHIP is credited with the decline of 10 million uninsured children in 1997 to 3.8 million by 2016.[40]

HOW DO MEDICAID AND PUBLIC SCHOOLS INTERACT?

Medicaid coverage of certain services for low-income adults and children is mandated. But federal and state joint administration of the program means participant and coverage eligibility beyond the mandated minimum is subject to state's broad discretion. States determine which, if any, optional Medicaid coverage is available to enrollees (Table 1).

This prerogative is intended to allow state construction of individualized plans which match state-specific needs. In practice, children may be unable to access all possible and/or needed care, especially if a state does not harmonize state statute and federal policy providing for expansion of Medicaid's school-based services.

Despite federally mandated minimum coverage for Medicaid-eligible beneficiaries, no mandate stipulates school-based service delivery. As a result, Medicaid-enrolled children may, or may not, receive Medicaid-funded services through school-based providers, subject to state policy. This is the case even when a child may still receive similar school-based services, but perhaps funded through a different source. In these cases, states may utilize CHIP, Individuals with Disabilities Education Act (IDEA), or other federal and state funding mechanisms to provide services in the absence of Medicaid in Public Schools.

Table 1. Federally Available Medicaid Benefits, by Mandate and Option

Mandated Coverage

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner Services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Optional Coverage

- Case management
- Chiropractic services
- Clinic services
- Dental services
- Dentures
- Eyeglasses
- Health homes for enrollees with chronic conditions
- Hospice
- Inpatient psychiatric services for individuals under age 21
- Occupational Therapy
- Optometry services
- Other diagnostic, screening, or preventive and rehabilitative services
- Other practitioner services
- Personal care
- Physical Therapy
- Podiatry services
- Private duty nursing services
- Prosthetics
- Respiratory care services
- Speech, hearing, and language disorder services
- Services for those 65 or older in an institution for Mental Disease
- Intermediate care facility services for individuals with intellectual disability
- State Plan home and community-based services
- Self-directed personal assistance services
- Community First Choice Option- 1915
- TB related services
- Other services approved by the Secretary

Source *http://dhhs.ne.gov/Pages/Medicaid-Services.aspx*

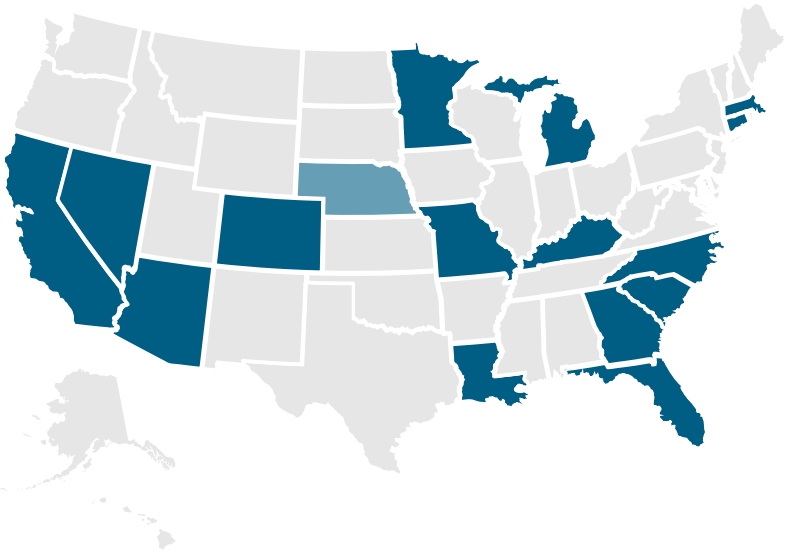
Some states, like Wyoming, choose not to utilize Medicaid for school-based services, arguing "we couldn't begin to get those professional staff people to serve our kids in a rural state like Wyoming."[41] Nebraska utilizes a combination of federal funding sources to supplement school-based health services, including Medicaid. Federal policy change in 2014, by the Centers for Medicare & Medicaid Services, expanded Medicaid-reimbursable services to include school-based health for all Medicaid-enrolled students.[42]

Medicaid and public schools can, and often do, work together in providing critical health, behavioral, specialist, and other services. In Nebraska, Medicaid-enrolled children receive school-based services upon physician referral and/or as part of IEP/IFSP.[43] MIPS reimburses school districts directly for essential health screenings, diagnoses, and other treatment services from eligible providers. Reimbursement is also provided for administrative costs incurred while screening, enrolling, and administering Medicaid programs and services.[44]

A 2017 study by the national School Superintendents Association found nearly 70 percent of schools use Medicaid reimbursement dollars for salaries of essential health care professionals. These include 45 percent to expand health services; and 39 percent to facilitate outreach and coordinate services for students.[137]

While most states utilize Medicaid for public school services, just 16 states with MIPS programs have taken steps to realign state programs seven years after a 2014 change in federal policy to expand its use in public schools (Figure 1). Nebraska is among 34 states which have not taken action to align state Medicaid plans with federal Medicaid policy (Figure 2).

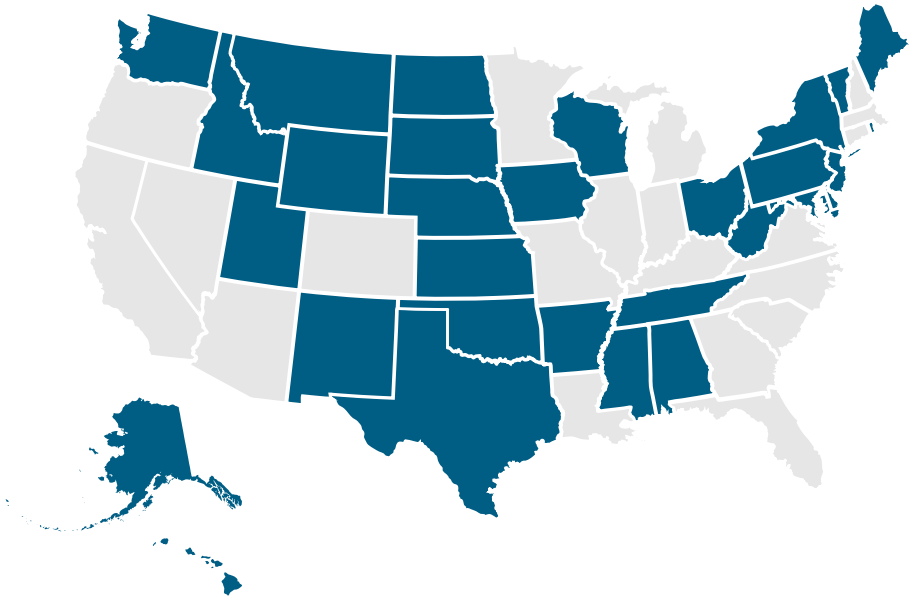
Figure 1. States With No Action on Medicaid in Public Schools Expansion



Nebraska
Nebraska has not yet taken action on Medicaid expansion in schools

Source: https://healthystudentspromisingfutures.org/map-school-medicaid-programs/#0

Figure 2. States With No Action on Medicaid in Public Schools Expansion



Nebraska
Nebraska has not yet taken action on Medicaid expansion in schools

Source: https://healthystudentspromisingfutures.org/map-school-medicaid-programs/#0

Failure to take appropriate action to realign state Medicaid in Public Schools and federal Medicaid policy ignores the needs of children and families met by school-based services.

WHY MEDICAID IN PUBLIC SCHOOLS?

Most youth spend large portions of their day in school settings, making public schools a valuable partner in identifying and enrolling eligible children to receive special education services. Public schools present a unique, localized point of access, where existing relationships with students, infrastructure, and standardization is leveraged to make public schools "among the most efficient systems to reach children and families."[45] [46] [47]

Medicaid provides immediate and long-term benefits for enrolled children, including stronger academic performance, fewer instances of absenteeism due to sickness or injury, and increased likelihood to complete high school as well as attend, graduate college.[48] [49] [50] The results of coverage are clear, "In addition to the immediate health and financial benefits that Medicaid provides, children covered by Medicaid experience long-term health and economic gains as adults."[51] System-wide benefits are also realized when children's needs are adequately addressed through Medicaid. Enrolled children record fewer emergency room visits and hospitalizations and are ultimately higher income earning adults.[52] Fewer emergency room visits improve efficiency of care for children directly, and for others. Medicaid, especially when used in public schools, brings us closer to living the proverb "an ounce of prevention is worth a pound of cure."

At one time, children of all economic statuses experiencing physical, psychological, linguistic, intellectual and/or learning disabilities were cruelly denied access to public education, institutionalized, or went undiagnosed and/or unserved.[53] However, in accordance with the Individuals with Disabilities Education Act (IDEA), first enacted in 1975, public schools became required to provide special education programs and services to children experiencing disabilities with federal financial assistance. Identifying need and delivering systems of care to children and families requiring special education services is often found in MIPS, CHIP, and IDEA. By deploying services within public school settings, qualified providers are more easily accessed and programs/services more consistently delivered.

In 2017, the CMS School Health Affinity Group was formed by federal Centers for Medicare and Medicaid Services (CMS). Its purpose, to better "grow partnerships between state Medicaid programs, public health, and schools to improve access to and the delivery of preventative health services for children and adolescents."[54] Nebraska joined as one of eight states to research theory and practice of MIPs in public schools, concluding "the role of schools can be further enhanced by partnering with local community resource providers to facilitate effective referrals for students and families."[55] Despite such an endorsement, Nebraska has not maximized the use of MIPS to identify, enroll, and serve eligible children.

HOW IS NEBRASKA CHILD MEDICAID ELIGIBILITY DETERMINED?

To qualify, an individual or family must meet both 1) categorical eligibility and 2) financial eligibility.[56] In Nebraska, children under age 19 are categorically eligible. Then, an individual must meet financial requirements to determine initial eligibility, and subject to income-based determination of service levels and/or associated fees or premiums.

The 'medically needy' pathway is an exception to the financial eligibility or 'financially needy' pathway.[57] In accordance with Medicaid's medically needy designation, members of a household categorically eligible but whose income does not meet the financial eligibility requirement due to higher income may be eligible after incurring a certain amount in medical expenses.[58] [59] Also known as a share of cost or spend down, Nebraska's qualifying households are required to designate the difference between their monthly income and $392 / month to meet their share of cost.[60]

While children may become enrolled in Medicaid via independent parental application, many children are first identified and enrolled through public schools. To qualify for MIPS in Nebraska:

1) Services must be medically necessary
2) Student recipients must be Medicaid eligible,[61] and
3) Associated special education or family support services MUST be included in their Individual Education Plan (IEP) and/or Individualized Family Service Plan (IFSP)

The primary determinant of Medicaid, CHIP eligibility is family household income according to Federal Poverty Level (FPL),[62] described in Table 2. As of 2014, states are required to calculate household income using modified gross adjusted income (MAGI) to determine Medicaid, CHIP eligibility for children other than those experiencing disability.[63] MAGI is unique to this process and is not identifiable on annual tax filings or returns, though for many it is identical or close to adjusted gross income.[64] Additional eligibility consideration include:

- Age
- Assets or other financial resources
- Disability
- Foster care, guardianship, adoption assistance
- Medically needy
- Residence or homeownership
- Other forms of insurance coverage

Table 2. State Medicaid, CHIP Income Eligibility Standards by State*

State	Medicaid Coverage for Infants Ages 0-1		Medicaid Coverage for Children Ages 1-5		Medicaid Coverage Children Ages 6-18	
	Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children
Nebraska	162%	162%-213%	145%	145%-213%	133%	109%-213%

Source: https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-35.-Medicaid-and-CHIP-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Children-and-Pregnant-Women-by-State-April-2020.pdf

** Medicaid (Title XIX of the Social Security Act (the Act)) funding continues to finance Medicaid coverage of children under age 19 in families with incomes below state eligibility levels in effect as of March 31, 1997. Any expansion of eligibility to uninsured children above those levels—through expansions of Medicaid or through separate CHIP programs— is generally financed by CHIP (Title XXI of the Act) funding.*
***The MAGI-based rules generally include adjusting an individual's income by an amount equivalent to a 5% FPL disregard. Other eligibility criteria also apply, such as citizenship, immigration status, and state residency.*
****CHIP funding is not permitted for children with other coverage. Thus, where Medicaid coverage in this table may show overlapping eligibility levels for Medicaid funding and CHIP funding, children with no other coverage are funded by CHIP, while children with other coverage are funded by Medicaid. Pregnant women can receive Medicaid- or CHIP-funded services through regular state plan eligibility pathways or through waivers under Section 1115 of the Act; in addition, the unborn children of pregnant women may receive CHIP-funded coverage under a state plan option.*

As of April 2020, only seven states covered wider income eligibility ranges, according to percent of FPL than Nebraska. But, in January of 2017, 28 states and the District of Columbia all covered more children as a percent of FPL than Nebraska.[65] Regionally, among its six neighboring states, only Colorado (375%) covers a higher top percent of FPL than Nebraska. Four states (Colorado, Iowa, Kansas, and Missouri) provided for coverage of higher-income families at a rate above Nebraska, see Table 3.[66]

Table 3. Regional State Medicaid, CHIP Income Eligibility Standards

State	Medicaid Coverage for Infants Ages 0-1		Medicaid Coverage for Children Ages 1-5		Medicaid Coverage Children Ages 6-18	
	Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children
Colorado	142%	-	142%	-	142%	108%-261%
Iowa	375%	240%-375%	167%	-	167%	122%-167%
Kansas	166%	-	149%	-	133%	113%-133%
Missouri	196%	-	148%	148%-150%	148%	110%-150%
Nebraska	**162%**	**162%-213%**	**145%**	**145%-213%**	**133%**	**109%-213%**
South Dakota	182%	147%-182%	182%	147%-182%	182%	111%-182%
Wyoming	154%	-	154%	-	133%	119%-133%

Source: https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-35.-Medicaid-and-CHIP-Income-Eligibility-Levels-as-a-Percentage-of-the-FPL-for-Children-and-Pregnant-Women-by-State-April-2020.pdf.

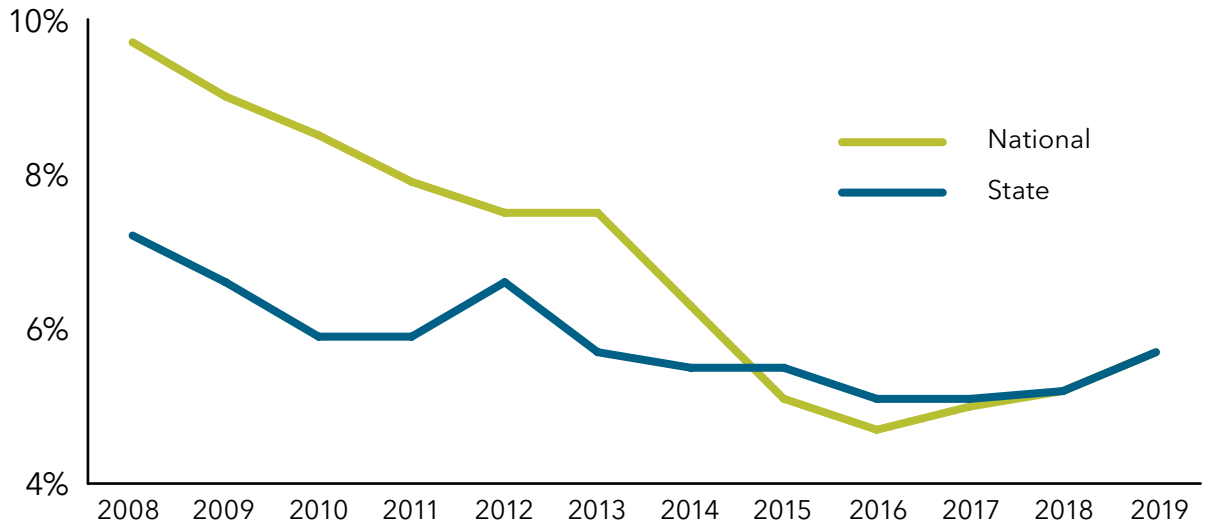
WHAT HAS IMPACTED NEBRASKA'S CHILD HEALTH CARE ELIGIBILITY, COVERAGE?

From 2008-2015, children's health insurance coverage in Nebraska achieved historic highs, largely due to the efforts of Medicaid, CHIP, and the Affordable Care Act (ACA).[67] Nebraska children's health care coverage reached its highest coverage in 2016 and 2017 at 5.1% uninsured, before rates began declining, following a national trend line from 2015-2019 (Figure 3).

As of 2019, 5.7% of the state's children were uninsured. Nationally, Nebraska ranks 31 of 51 states and District of Columbia for rates of child health insurance coverage.[68] Perhaps most concerning is the national trend of increasing failure to insure children, but decreasing participation in state enrollment in Medicaid, CHIP despite Medicaid expansion (Figure 3, Figure 4).[69] Nationally, more than a million children lost health Medicaid, CHIP insurance coverage from December 2017 through June 2019.[70]

Figure 3. Rate of Health Insurance Coverage for Nebraska Children

**Rate of uninsured children under 19*



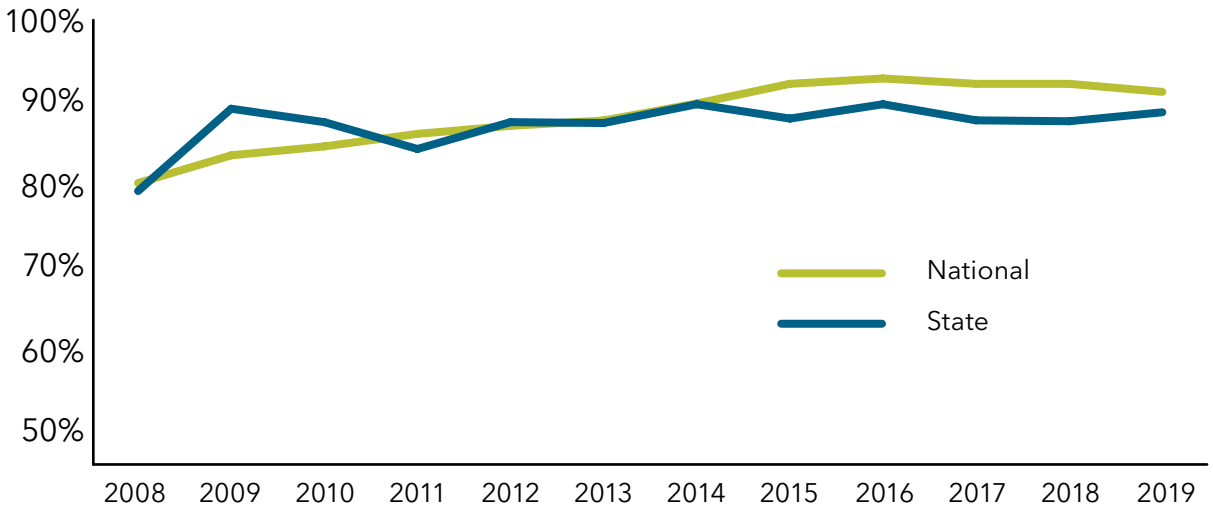
Source: https://kidshealthcarereport.ccf.georgetown.edu/states/nebraska/

**Georgetown University Center for Children and Families analysis of the Table HIC-5, Health Insurance Coverage Status and Type of Coverage by State - Children Under 19: 2008 to 2019, Health Insurance Historical Tables, U.S. Census Bureau American Community Survey (ACS). *Change is significant at the 90% confidence level relative to the prior year.*

In Nebraska, 88.6 percent of children eligible for Medicaid, CHIP are receiving coverage (Figure 4).[138] As a result, approximately 11.4 percent of eligible children remain uninsured statewide, though they both categorically and financially qualify. While national Medicaid, CHIP coverage rates have increased over the previous decade, Nebraska's enrollment rate has run below national coverage rates 2015-2019, with data for 2020 not yet available (Figure 4).[139]

Figure 4. Participation in Nebraska Medicaid, CHIP

- Children's participation rate in Medicaid, CHIP over previous 10 years



Source: https://kidshealthcarereport.ccf.georgetown.edu/states/nebraska

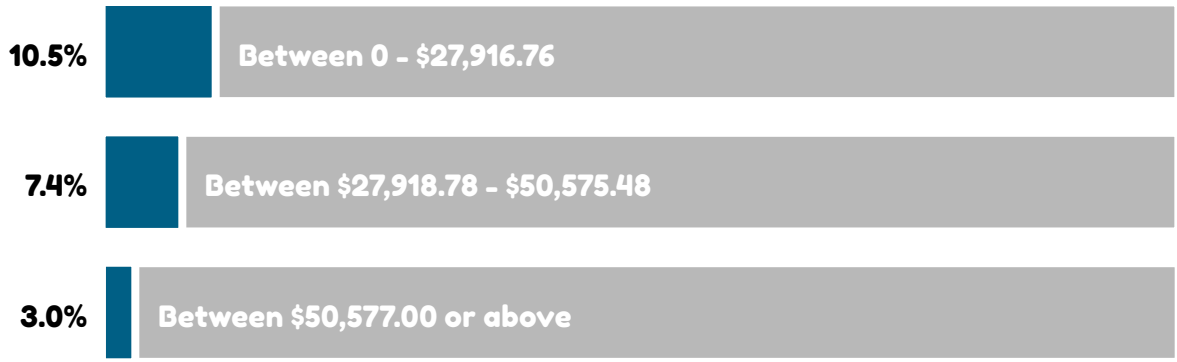
**Statistical significance only reported for last year of available data. All reported statistical significance results directly from the related Urban Institute publication.*

Looking further into Nebraska's rates of uninsured children, 10.5 percent of eligible uninsured children were among the most financially qualified to receive Medicaid health care coverage (Figure 5a).[140] Figure 5b translates child uninsured rates by annual income poverty threshold.

Figure 5a. Child Uninsured Rate by Poverty Threshold: Income by Percentage in Nebraska

Source: https://kidshealthcarereport.ccf.georgetown.edu/states/nebraska/
**Georgetown University Center for Children and Families analysis of the U.S. Census 2019 American Community Survey (ACS) data using 1-year estimates from Data.Census.Gov (B27016).*

Figure 5b. Child Uninsured Rate by Poverty Threshold: Income by Annual Income in Nebraska

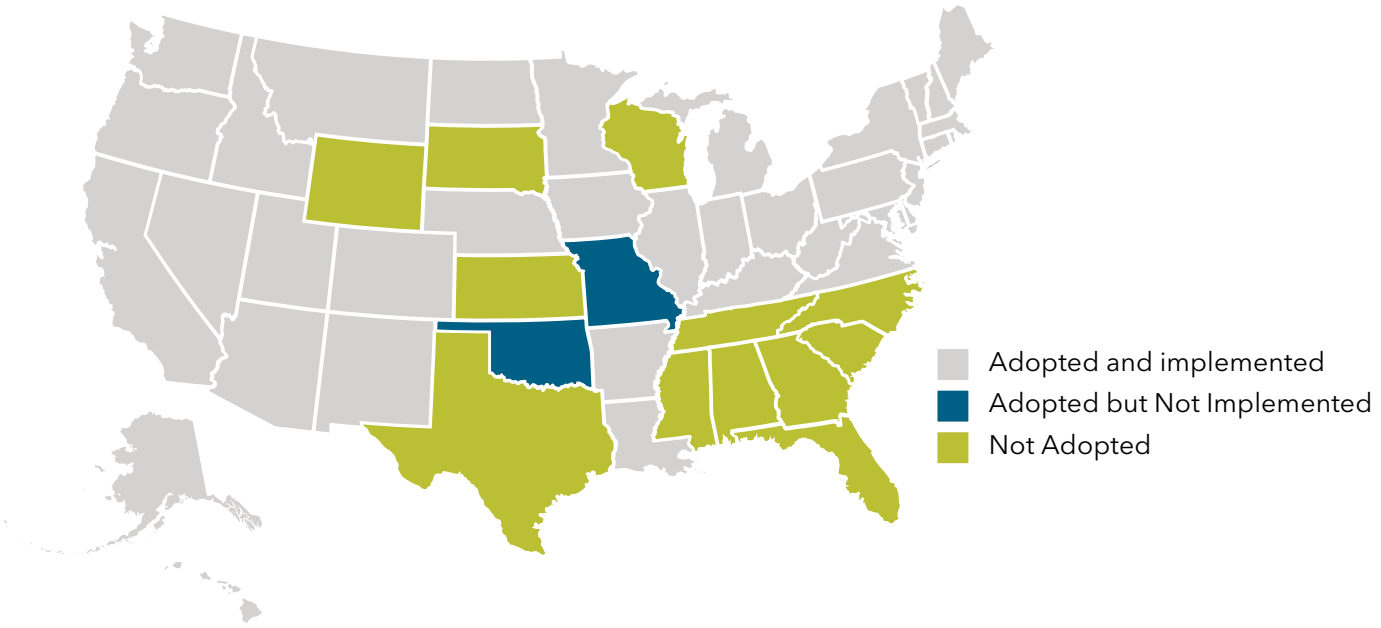


Source: https://kidshealthcarereport.ccf.georgetown.edu/states/nebraska/
**Georgetown University Center for Children and Families analysis of the U.S. Census 2019 American Community Survey (ACS) data using 1-year estimates from Data.Census.Gov (B27016).*

The passage of voter ballot initiative 427 in November 2018 increased enrollment, despite severely delayed implementation.[141,142] Nebraska's Medicaid expansion initially projected extending coverage to more than 90,000 adults and children.[143] Due to the COVID-19 pandemic, it is estimated as many as an additional 30,000 qualified for expanded coverage.[144]

As of 2018, Nebraska is among 34 states providing Medicaid eligibility through the "medically needy" pathway.[145] Nebraska officially joined 34 states in implementing Medicaid expansion as of 2020, despite two years of largely self-imposed delays[146] (Figure 6). As of August 1, 2020, total Medicaid enrollment had already "increased 4% since February, while the number of children and families enrolled [rose] by 6.9%."[147]

Figure 6. Status of State Action on Medicaid Expansion Decisions



Source: https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

**Coverage under the Medicaid expansion became effective January 1, 2014 in all states that have adopted the Medicaid expansion except for the following: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), Louisiana (7/1/2016), Virginia (1/1/2019), Maine (1/10/2019 with coverage retroactive to 7/2/2018), Idaho (1/1/2020), Utah (1/1/2020), Nebraska (10/1/2020), Oklahoma (planned for 7/1/2021), and Missouri (planned for 7/1/2021).*

Nebraska's child Medicaid, CHIP enrollment as of August 2020 totals 172,430, with enrollment for all eligible Nebraskans totaling 262,715.[148] While Medicaid expansion delivers increased access for many Nebraskans, a governor-sponsored Section 1115 Waiver proposed barriers to access through a two-tiered system of benefits for enrollees.[149] This two-tiered system – "Basic" versus "Prime" - prevents access to dental, vision, and over-the-counter drug coverage for Basic enrollees unless certain "personal responsibility" (as of April 2021) and "community engagement" (as of April 2022) requirements are met.[150] Additional requirements do not affect eligibility to qualify for Nebraska's Medicaid expansion but do restrict access to "Prime" benefits.[151]

The state's Section 1115 waiver to implement the proposed two-tier system was initially accepted under the Trump administration in October 2020. Post-election, the state resubmitted a waiver in December 2020, ostensibly in time to begin providing 'premium coverage' (Prime) in April 2021. With a change in federal administration, Nebraska Department of Health and Human Services (DHHS) was alerted that its waiver was under review.[152]

On June 1, 2021, Nebraska DHHS announced withdrawal of the state's application for a Section 1115 Heritage Health Adult (HHA) demonstration program waiver, after new administration made clear such waivers would not be approved.[153] This effectively dissolved the proposed two-tier system of eligibility and benefits. Importantly, despite Medicaid expansion, "making health care affordable and accessible" remains the top policy priority among Nebraskans.[154]

WHAT SERVICES DOES NEBRASKA'S MEDICAID IN PUBLIC SCHOOLS PLAN COVER?

A Medicaid-eligible Nebraska child may receive Medicaid-reimbursed school-based services through MIPS, as described in Title 471: Nebraska Medical Assistance Program, Chapter 25: School-Based Services (471 NAC 25).[155]

Source: https://www.nebraska.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-25.pdf

While schools are legally liable to provide IDEA-related health services at no cost to eligible students, Medicaid reimbursement is available for these services because Section 1903(c) of the Act requires Medicaid to be primary to the U.S. Department of Education for payment of the health-related services provided under IDEA.

The direct medical services are paid by the Nebraska Medical Assistance Program (NMAP/Medicaid) and referred to as "Medicaid in Public Schools" (MIPS). Currently, Occupational Therapy (OT), Physical Therapy (PT) and Speech/Language Pathology/ Therapy (SLP/ST) related services are claimed for reimbursement by public school districts, with an intended expansion of services effective September 1, 2017 to include Nursing Services, Vision Services, Mental and Substance Abuse Services, Personal Assistance Services and Transportation Services. Associated costs are excluded from any calculation of administrative costs and the administrative claim.

As prescribed in the Medicare Catastrophic Coverage Act [of 1988] (MCCA), Medicaid covers these direct services only under the following conditions:

- Services are identified in the child's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP) to meet the his/her unique needs as required to provide a Free Appropriate Public Education (FAPE);
- Services are medically necessary and included in a Medicaid covered category (speech therapy, physical therapy, etc.);
- Services are included in Nebraska's plan or available under EPSDT; and
- Medical services are only claimed for those provided to Medicaid eligible students

Eligible reimbursable expenses must be listed in the approved Nebraska Education-Based Medicaid Administrative Claiming Guide.[71] The Guide informs stakeholders of eligibility requirements to receive reimbursement for program administrative costs and school-based services. All Medicaid/MIPS provided programs and services must meet the same DHHS rules and regulations as non-Medicaid providers. Some services are federally mandated, while others are optional (Table 1). Tables 4a/b outlines Medicaid-reimbursable services/providers according to federal/Nebraska state policy versus Nebraska Medicaid's eligible school-based services/ providers.

State-based discretion for service providers versus federal allowance complicate budgeting and staffing of important school-based provider roles. In Nebraska, certain credentialed staff are independently eligible for Medicaid reimbursement with others only eligible if directly supervised by a credentialed provider. At times, Nebraska also distinguishes between which services and providers are eligible for reimbursement through Medicaid generally versus MIPS. Nebraska also elects to not extend Medicaid eligibility to certain school-based mental health providers already on staff.

Exclusion of Medicaid-eligible staff is especially visible in behavioral health. Attempts to increase availability of mental health training and services funding in schools have failed in recent years.[72] [73] [74]Failings to expand school-based services around mental health are especially troubling on the heels of strong support from a University of Nebraska Medical Center behavioral health needs assessment recommending "increase[d] awareness of behavioral health issues" in "settings including schools, workplaces, and faith communities," and "increase[d] access to and use of behavioral health treatment," including "target[ing] high school students for prevention, screening, and timely interventions…"[75]

Table 4a. Nebraska Medicaid Reimbursement Eligibility by Role

Role		Nebraska Medicaid			Nebraska MIPS		
		Eligible	Eligible w/ Supervision	Not Eligible	Eligible	Eligible w/ Supervision	Not Eligible
Medical Transportation	Aide	x			x		
	Bus Driver	x			x		
	Other Transportation Personnel	x			x		
Mental Health & Substance Use Disorder	Board Certified Behavioral/ Assistant Behavioral Analyst			x	x		
	Licensed Clinical Social Worker			x			x
	Licensed Independent Mental Health Practitioner (LIMHP)			x	x		
	Licensed School Counselor			x			x
	Licensed School Social Worker			x			x
	Physician	x			x		
	Provisionally/Fully Licensed Mental Health Practitioner (LMHP)	x			x		
	Provisionally/Fully Licensed Psychologist	x			x		
	Provisionally/Fully Licensed Alcohol & Drug Counselor	x			x		
	Registered Behavior Technician			x	x		
	School Psychologist (Master's Level)			x			x
Personal Assistance	Personal Assistance Provider	x			x		
Nursing Services	Licensed Registered Nurse (RN)	x			x		
	Licensed Practical Nurse (LPN)	x			x		
	Health Technician			x		x	
	Health Paraprofessional			x		x	

Table 4b. Nebraska Medicaid Reimbursement Eligibility by Role

Role		Nebraska Medicaid			Nebraska MIPS		
		Eligible	Eligible w/ Supervision	Not Eligible	Eligible	Eligible w/ Supervision	Not Eligible
Personal Assistance	Personal Assistance Provider	x			x		
Speech, Hearing, Language Providers	Licensed Audiologist	x			x		
	Licensed Speech Pathologist			x	x		
	Paraprofessional			x		x	
Various Therapy Providers	Licensed Occupational Therapist	x			x		
	Licensed Occupational Therapy Assistant		x			x	
	Licensed Physical Therapist	x			x		
	Licensed Physical Therapy Assistant		x			x	
	Paraprofessional					x	
Visual Care Providers	Licensed Optometrist	x			x		
EPSDT	Early Periodic Screening, Diagnostic and Treatment (EPSDT, Health Check)	x			x		

Source: https://healthystudentspromisingfutures.org/map-school-medicaid-programs%20.#0
Source: https://dhhs.ne.gov/Documents/Provider%20Screening%20Risk%20Levels.pdf
Source: https://dhhs.ne.gov/Documents/Guide%20for%20School-Based%20Direct%20Services.pdf

** Eligible Nebraska Medicaid-eligible services overlapping with Nebraska MIPS-eligible services are bolded for emphasis.*

It seems both possible and reasonable to expand access and availability of school-based behavioral health services by including licensed school counselors, clinical social workers, social workers, and master's level psychologists among those eligible to provide Medicaid-reimbursable school-based services. Doing so allows schools to significantly increase staffing pools and/or credit for providers already on permanent staff assignment.

Because MIPS is not federally required, Nebraska does not currently permit all available state Medicaid-eligible services to be offered through school-based delivery (Table 5), nor make use of all potential school-based services and providers (Table 4a/b). One prominent way MIPS impacts schools is explained in a 2017 study by the School Superintendents Association found nearly 70 percent of schools use Medicaid reimbursement dollars for salaries of health care professionals; 45 percent to expand health services; and 39 percent to facilitate outreach and coordinate services for students.[76]

Table 5: Nebraska Medicaid vs. Nebraska MIPS by Service Coverage Eligibility

Role	Nebraska Medicaid			Nebraska MIPS		
	Eligible	Eligible w/ Supervision	Not Eligible	Eligible	Eligible w/ Supervision	Not Eligible
Ambulance services	x					x
Chiropractic services	x					x
Dental services	x					x
Durable medical equipment, orthodontics, prosthetics, and medical supplies	x					x
Family planning services	x					x
Hearing aid services	x					x
Home health agency services	x					x
Hospice services	x					x
Hospital services	x					x
Intermediate care facilities (ICF) for persons with developmental disabilities (ICF/DD)	x					x
Laboratory and radiology (X-ray) services	x					x
Nursing facility services	x					x
Nurse Midwife services	x					x
Nurse Practitioner services	x					x
Podiatry services	x					x
Prescribed drugs	x					x
Private-duty nursing services	x					x
Adult psychiatric, Substance Use Disorder, and Medicaid rehabilitation option	x					x
Screening services (mammograms)	x					x
Services provided by clinics	x					x
Therapies: physical, occupational, speech pathology & audiology	x					x

Source:https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Health_and_Human_Services__Department_of/107_20211130-091110.pdf

**Provider personnel must be employed by or under contract with the school district, ESU, or approved cooperatives providing special education and related services.*

Additional services are provided to children as part of Medicaid's commitment to categorical, financial, and medical eligibility provisions. Children under 21 enrolled in Medicaid are eligible to receive the above services (Table 4a/b), as well as automatically enrolled to receive EPSDT benefits (Table 6). Accordingly, Medicaid uses EPSDT to outline five commitments required of states.[76]

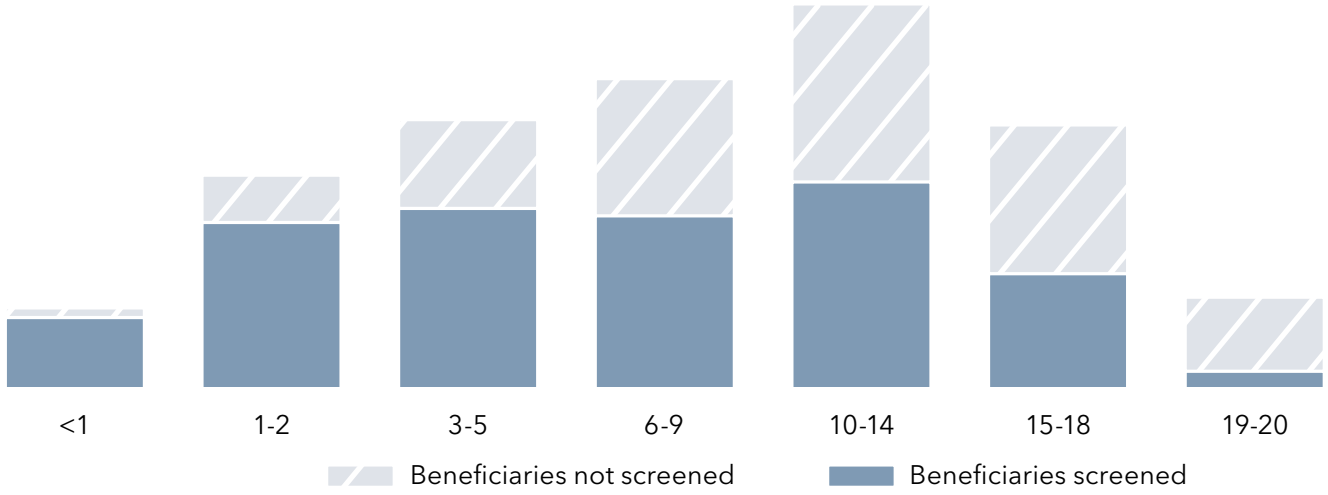
Table 6. EPSDT State Requirements under EPSDT in Brief

Informing families	• Program eligibility status • Cost of benefit • Other services provided
Screening	• Periodicity schedule for each child • Interperiodic screenings outside of periodicity schedule • Without prior approval, only qualified providers may receive approval for reimbursement
Diagnostic and treatment services	• Diagnosis and treatment of medical conditions are timely • Inpatient psychiatric care - with or without a state plan benefit • School-based free care is allowed • Home and community-based service waiver programs • A service need not cure a condition to be covered
Allowable Limitations	• Coverage limitations are permitted, so long as they are not inflexible • Experimental treatments may be defined by state provider
Monitoring	• Submission of participation data to federal Centers for Medicare & Medicaid Services (CMS) is required • State participation goals are established by Secretary of the U.S. Department of Health and Human Services • Coordination with other programs is mandated by law

Source: https://www.macpac.gov/subtopic/epsdt-in-medicaid/

A more detailed explanation of EPSDT benefits may be seen via Appendix A. In 1990, a CMS goal for 80 percent participation rate in EPSDT screenings referenced above (Table 6) by FY 1995.[77] In a national analysis of state-reported data from FY 2010 through FY 2017, the Government Accountability Office (GAO) researched the extent to which Medicaid beneficiaries aged 20-and-under EPSDT well-child screenings, and diagnostic and treatment services. A majority (59 percent) of beneficiaries (20.2 million) qualified to receive a well-child visit received one, while nearly 48 percent of qualified beneficiaries (18.3 million) received preventative dental care, both falling far below the originally desired 80 percent participation target.[78] The proportion of screened versus unscreened children vary by age group, represented graphically in Figure 5. Older children were less likely to have received their EPSDT screenings.

Figure 5. Number of Medicaid Beneficiaries Receiving and Not Receiving Well-Child Screenings in Fiscal Year 2017, by Age Group



Source: https://www.gao.gov/assets/710/700958.pdf

CMS has taken some limited steps to improve EPSDT participation, but with little real-time federal oversight, allowable flexibility, and the limited timeframe for critical periodic screenings, no solution has been widely implemented.[79] As a result, child Medicaid enrollees may continue not receiving preventative and interventive care in accordance with EPSDT regulations.

HOW ARE PUBLIC SCHOOLS REIMBURSED FOR MEDICAID SERVICES IN NEBRASKA?

According to the Nebraska's Department of Health and Human Services (DHHS), the agency employs a statewide Random Moment Time Study (RMTS) methodology to calculate reimbursement costs which more accurately reflect the time invested to administer the program and deliver the associated services.[80] Importantly, "any Nebraska public school district or Educational Service Unit (ESU) is eligible to participate in the MIPS reimbursement process, in accordance with the Nebraska Education-Based Medicaid Administrative Claiming (NEBMAC) program.

DHHS provides reimbursement for Medicaid Administrative Claiming (MAC), including functions such as: submitting billing information; enrolling eligible children; and/or assisting eligible children in acquiring necessary services, as well as Direct Reimbursement for any Medicaid-eligible school-based service provided by an eligible provider (Table 4a/b).

In January of 2018, Centers for Medicare & Medicaid Services (CMS) approved a guide for NEBMAC. Program and service-based expenses eligible for reimbursement must be listed in the CMS approved Nebraska Education-Based Medicaid Administrative Claiming Guide.[81] The Guide informs stakeholders of stipulations to receive reimbursement for the cost of providing MIPS services.

Quarterly, "each school district compiles a list of staff members who perform program-related activities that support the NEBMAC and MIPS programs and then reports them in the appropriate category," coded by activity. [82] In accordance with the payment methodology, all staff fall into one of two mutually exclusive cost pools.

- **Cost Pool 1** is made up of direct service/therapy personnel and is the same list of providers in the state plan
- **Cost Pool 2** is made up of staff involved in administrative activities rather than direct services.

The payment process for MIPS-related administration and direct costs is determined using the following steps:

- **Quarterly**
  - Random sampling for each statewide cost pool is taken
  - RMTS results are compiled by activity code
  - School districts submit a quarterly cost report, accounting for staff in Cost Pool 1, and additional expenses undertaken to provide direct service.
- **Annually**
  - School districts engage in a "cost settlement process." Each district compiles and submits an annual cost report, accounting for the district's Medicaid-allowable expenses versus the school's total expenses.
    - Final expenses are determined by evaluating the amount of paid to the district versus the amount spent on "allowable" expenses.
    - Overpayment in "interim payments" is resolved by providers when the "Annual Settlement" cost report is submitted. Should providers costs exceed interim payments, DHHS will reimburse the provider for the allowable difference.

Federal rates of state reimbursement for Medicaid, CHIP program services and administration are determined according to Federal Medical Assistance Percentages (FMAP). The FMAP formula is designed to calculate cost-sharing totals for Medicaid, CHIP, though it may provide a different cost-share for each program. FMAP ensures federal reimbursement:[83]

- provides a statutory minimum of 50 percent and a statutory maximum of 83 percent reimbursement to state Medicaid programs.
- increases or decreases Medicaid, CHIP reimbursements proportionally with state rates of per capita income (relative to national average).
  - i.e. states with lower per capita income receive a larger federal/FMAP percentage of reimbursement, while higher per capita income rates receive a smaller federal/FMAP percentage of reimbursement.

Emergency FMAP rates are calculated to provide states with increased federal support while states see significant increases in eligibility due to the COVID-19 pandemic.

Nebraska's current FY 2020 Medicaid FMAP reimbursement is 54.72 percent; CHIP FMAP is 79.80 percent.[84] FY 2020 Emergency FMAP rates are 60.92 percent (Medicaid), 84.14 percent (CHIP). FMAPs will decrease in 2021 once the emergency FMAP rate authorization is rescinded. FY 2021 will see Nebraska reimbursed at a rate of 56.47 percent for Medicaid; 69.53 percent for CHIP.[85] To view FMAP reimbursement percentages by state, see Appendix D

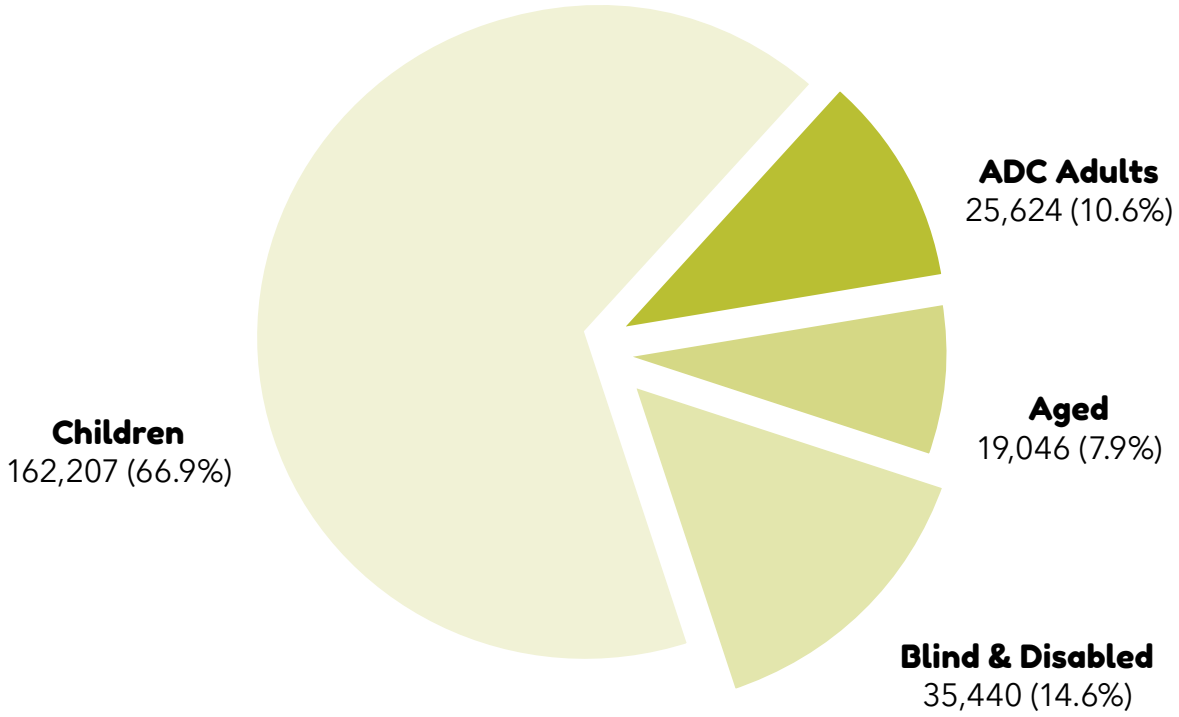
WHAT IS THE COST OF NEBRASKA'S CHILD ENROLLMENT?

Medicaid, CHIP program requirements and eligible reimbursement is administered jointly between state and federal governments. The federal government reimburses states for at least 50 percent of the program's approved costs. In exchange, states agree to certain mandates concerning participation eligibility, service delivery and program administration, while still retaining broad discretion.[86]

Medicaid, CHIP significantly affect state budgets, drawing special attention and increased scrutiny among lawmakers, especially as calls have increased to expand eligibility requirements and access to state-based aid programs. Nebraska, along with 34 other states have expanded Medicaid, further increasing access to critical health care coverage (Figure 6).

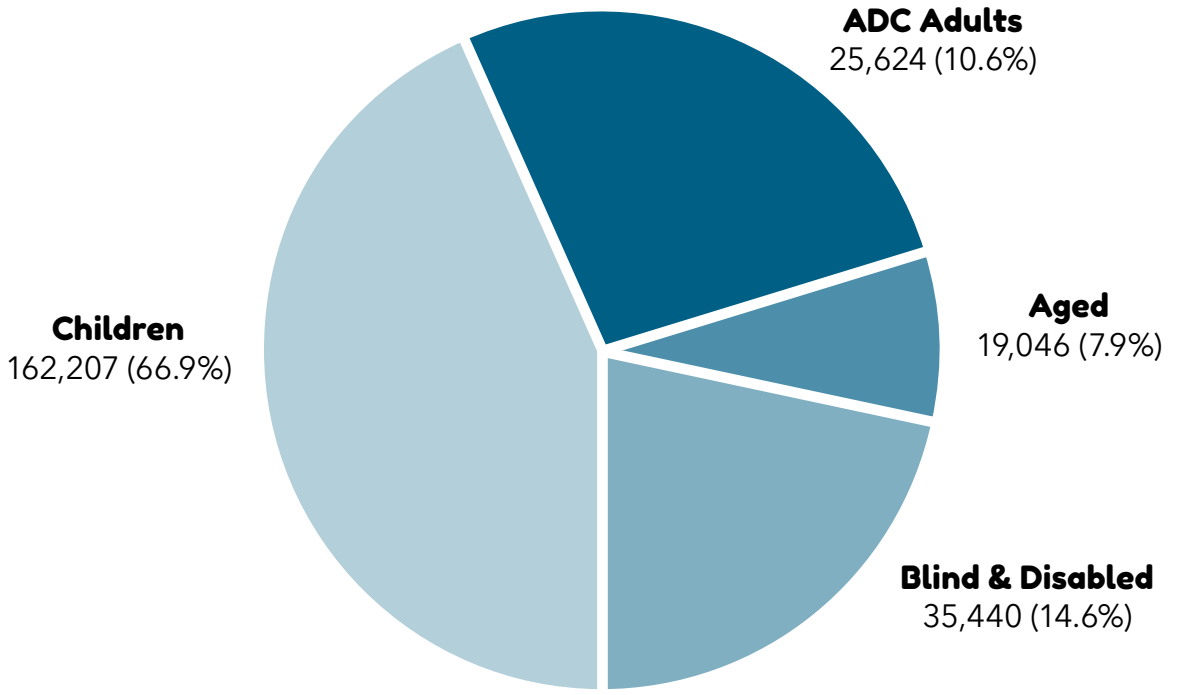
In Nebraska's most recent Medicaid Annual Report (SFY 2019), Nebraska appropriated more than $2 billion in Medicaid, CHIP spending on eligible services for 12 percent of the state's child population.[87] Of the 242,317 Nebraskans served by Medicaid, CHIP in SFY2019, 66.9 percent (162,207) are children (Figure 6) and received 27 percent ($609,484,142) of total spending in 2019 (Figure 7).[88]

Figure 6. Nebraska Medicaid, CHIP Average Monthly Enrollment
**SFY 2019 Total: 242,317*



Source: https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services__Department_of/107_20191203-092430.pdf

Figure 7. Medicaid, CHIP Annual Spending by Category
**SFY 2019 Total: $2,253,401,708*



Source: https://nebraskalegislature.gov/FloorDocs/106/PDF/Agencies/Health_and_Human_Services__Department_of/107_20191203-092430.pdf

A 2018 analysis of school-based spending by state shows Nebraska received over $23.9 million for MIPS-related services, administration. Of this total, $5.2 million was used to provide school-based services and $18.8 million dollars for the associated administration.[89] Concern is sometimes expressed at the cost of administration exceeding the reported cost of service, but it's reasonable to assume that school districts are likely meeting the state's federal match for direct services, so the cost of service is not being captured in the state's budget reporting.[90]

According to the Medicaid and CHIP Payment and Access Commission (MACPAC), Nebraska has enrolled 228,000 children in Medicaid, CHIP. However, CHIP only accounts for only 2,000 enrollments, while 168,000 Nebraska children received Medicaid-funded coverage, with an additional 58,000 children enrolled due to state Medicaid expansion.[91]

State spending on school-based health services has steadily increased, with the national average totaling $173 per enrolled child, as of a 2020 Child Trends study reviewing state spending from 2010 to the most recent available datasets of 2018.[92] At the historic height of Nebraska Medicaid, CHIP coverage in 2016/2017, Nebraska spent $142 per enrolled child and $121 per enrolled child, respectively (Appendix B, Appendix C), far below national averages of $167 and $175, during the same period. In the last available year of Child Trend analysis data (2018), while the national average was $173 per enrolled child, Nebraska spent only $48 per average child on school-based health services (Figure 8). During each of these periods, Nebraska spent significantly below the national average on school-based health services per enrolled child.

Figure 8. State MIPS Expenditures per Enrolled Child by Policy Barrier

Year
2018

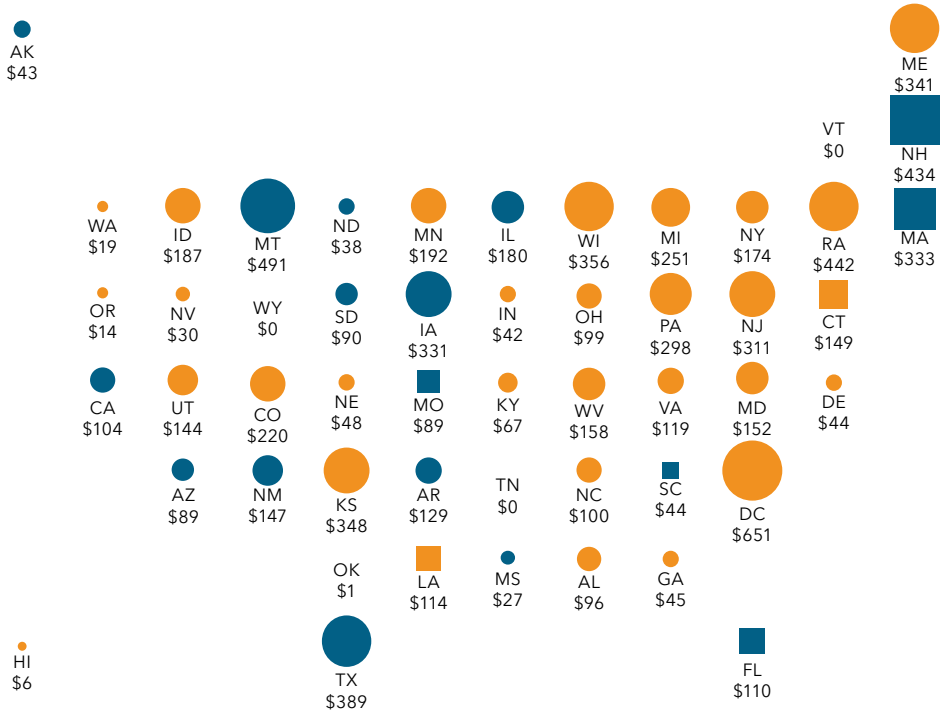
National Average (2018):
$173

Orange States (n=32)
explicitly prohibit or present a likely barrier for reimbursement of school-based health services.

Blue States (n=19)
explicitly authorize or present no likely barrier for reimbursement of school-based health serices.

shaped states (n=7) are implementing changes to their State Medicaid Plans.

Note: the sizes of state bubbles/squares is relative to the national average within a given year.



Source: https://www.childtrends.org/publications/early-evidence-medicaid-role-school-based-heath-services
**Data for 2019 and 2020 not yet available.*
***Data did not permit distinguishing between expenditures for free care and other school-based health services.*
***Finally, states have only just begun reporting specific school-based health expenditures separately.*

WHAT IMPROVEMENTS CAN BE MADE TO MIPS IN NEBRASKA?

Medicaid in Public Schools (MIPS) plays a crucial role in the facilitation of school-based health services; immediate and long-term childhood health; and the increasingly clear needs for existing eligible, but uninsured children. Opportunities exist to optimize statutory language and service delivery to increase childhood health and academic outcomes, as well as bolster future adult social and economic productivity by addressing shortcomings in existing state MIPS policy.

As a result of program analysis, thoughtful review of programmatic best practices and research-driven policy recommendations, potential interventions may be undertaken by Nebraska's gubernatorial administration and/or the State Legislature to improve Medicaid's school-based health services program (MIPS) and overall Medicaid, CHIP enrollment.

4. Address Nebraska's 'free care policy' language

- **Context**
  CMS maintained a longstanding "free care policy," stipulating that no-cost services available to Medicaid recipients would not be eligible for coverage by Medicaid funding. In December of 2014, CMS distributed guidance to State Medical Directors, rescinding its previous "free care policy" stance.[93]

  According to the Healthy Schools Campaign, "This allows for schools to bill Medicaid for services provided to all Medicaid enrolled students and not just those with a special education plan documented by an Individualized Education Plan (IEP)."[94]

- **Observation**
  Nebraska Revised Statute § 68-911, subsection 4[95] reads (underlining is added for emphasis):

  > On or before October 1, 2014, the department, after consultation with the State Department of Education, shall submit a state plan amendment to the federal Centers for Medicare and Medicaid Services, as necessary, to provide that the following are direct reimbursable services when provided by school districts <u>as part of an individualized education program or an individualized family service plan</u>: Early and periodic screening, diagnosis, and treatment services for children; medical transportation services; mental health services; nursing services; occupational therapy services; personal care services; physical therapy services; rehabilitation services; speech therapy and other services for individuals with speech, hearing, or language disorders; and vision-related services.

- **Policy Consideration**
  In order to:
  harmonize state legislative provisions with federal CMS guidance on the free care policy
  increase access to programs and services for ALL Medicaid/CHIP-enrolled students regardless of active IEP, IFSP, and
  better compensate school-based health service providers

  Consider amending current statutory language (Neb. Rev. Stat. § 68-911(4))

  from

  > …as necessary, to provide that the following are direct reimbursable services when provided by school districts <u>as part of an individualized education program or an individualized family service plan</u>…

  to

  > …as necessary, to provide that the following are direct reimbursable services when provided by school districts…

- **Rationale**
  The rescission of specific IEP and IFSP language allows school districts to provide more services to more children regardless of formal IEP, should a child be Medicaid, CHIP eligible. This could also increase state participation rates for eligible, but not enrolled and/or uninsured children. Currently, Nebraska's 2017 SPA serves as a "likely barrier" for children to access Medicaid, CHIP programs and services.[96] Notably, Nebraska's rates of uninsured children increased, Medicaid/CHIP enrollment have decreased since 2017 (Figure 3, Figure 4).

  Many states have submitted SPAs to expand Medicaid, CHIP coverage to children according to federal free care policy guidance. As of December 2021, 17 states expanded school-based Medicaid programs in accordance with reversal of the free care policy (Table 7). Nebraska can join the growing list of states eliminating restrictions on Medicaid-eligible children, allowing for increased service provision and federal reimbursement for Nebraska school-based health services.

Table 7. Action on Free Care Policy Reversal by State

Activity	States
Approved SPA to implement free care policy reversal	Arizona, California, Colorado, Connecticut, Florida, Georgia, Kentucky, Louisiana, Massachusetts, Michigan, Nevada, North Carolina
Expanded MIPS through free care policy reversal (no SPA required)	Minnesota, Missouri, New Hampshire, South Carolina
SPA submitted to CMS and pending approval	Illinois, Oregon, Virginia
Considering SPA	Indiana, Virginia
Passed legislation	California, Florida, Indiana, New Hampshire, Oregon, Utah, Virginia
Other opportunities for MIPS (e.g. managed contracts, community-based providers)	Oklahoma, Washington

Source: https://docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXlGX5l3s0PN2cuIDejXZQw/edit

**CMS approved Florida's SPA in October 2017 to set the state for expansion of Medicaid-billable services in schools to all children. IEP restrictions remained in Florida statute and legislation was passed in June 2021 to remove this language and allow for implementation.*
***Legislation is not required in Massachusetts, California, or Utah to implement reversal of the free care policy. These states took/are taking legislative action for additional reasons not related to free care policy reversal.*
****Missouri is currently only implementing the free care policy reversal for behavioral health services.*

5. Provide 'continuous eligibility' for Medicaid, CHIP

- **Context**
  Continuous eligibility allows states to provide uninterrupted Medicaid, CHIP coverage to children for 12 consecutive months, regardless of changes in household eligibility during the period of enrollment.[97] Nebraska enrollees are required to report any changes of status/eligibility within 10 days to DHHS, including changes in residence, employment disability, or income.

Nebraska is one of 34 states not currently offering continuous Medicaid and/or CHIP eligibility. Nebraska statewide health insurance rates for children trends below the national average from 2015-2019, with 2020 enrollment numbers not yet available (Figure 3). Decreasing and/or under-performing state Medicaid, CHIP enrollment contributes to lower rates of insurance coverage overall (Figure 1). This is especially evident when reviewing rates of uninsured Nebraska children according to economic eligibility by FPL (Figure 3 a/b).

Federally, states are required to determine Medicaid eligibility "once every 12 months, and no more frequently than once every 12 months."[98] A majority of states participate in federally recommended 12-month children's "continuous eligibility" for Medicaid, CHIP coverage.[99] This ensures a child may continue to receive coverage and maintain continuity of EPSDT screenings until/unless the date of annual Medicaid eligibility determination should terminate benefits.

- **Observation**
  Nebraska provides six months of continuous coverage, below the national standard.[100] Nebraska's six-month standard of continuous eligibility falls below the federally recommended 12 months standard of practice. Nebraska's use of modified continuous eligibility allows a child to potentially lose Medicaid, CHIP coverage midyear.

  Of Nebraska's uninsured children, 10.5 percent fall within the 0-137.99 percent FPL (Figure 3a/b), meaning they are among the most economically qualified to receive Medicaid, financially in need, but remain uninsured despite the availability of Medicaid, CHIP. Declining program enrollment and increasing rates of uninsured children, especially those most in need, indicates a need for further attention, research, and policy action.

- **Policy Consideration**
  To ensure more seamless Medicaid, CHIP coverage, Nebraska may choose to expand its continuous eligibility coverage period from six, to the federally recommended12 months.[101] Join the current list of 34 states providing continuous Medicaid and/or CHIP eligibility for children.[102]

- **Rationale**
  Children are particularly sensitive to change in formative years.[103] Frequently changing eligibility status cycles children on and off coverage, known as "churn." In many cases, churning children are disenrolled despite becoming eligible again soon after disenrollment or even continued eligibility but difficult to ascertain household records.[104] Unstable, changing levels of program and service availability due to lack of continuous eligibility hinders continuity of coverage, and negatively impact a child's ability to thrive.

  In 2003, Washington state replaced its 12-month continuous eligibility with six-month continuous eligibility, resulting in more than 30,000 children losing coverage in the following two years.[105] In January 2005, Washington reversed the decision, reverting to its 12-month continuous eligibility period, resulting in 30,000 children gaining or having coverage restored by the end of year.[106]
  Nationally, with historic and chronic low EPSDT performance, changing children's health coverage further complicates the ability to coordinate with providers and deliver required care.

  For disenrolled families, Nebraska does make Transitional Medical Assistance (TMA) available to qualifying families who no longer meet Medicaid, CHIP eligibility requirements, for a period of six months.[107] TMA may be used for both adults and children. TMA is an attempt at addressing unintended policy consequences commonly known as "the cliff effect." The cliff effect refers to a sudden and often unexpected revocation of income-linked benefits such as Medicaid, CHIP.[108]

Often, a modest increase in family's annual income can and does cease some or all eligibility and associated benefits.[109] Because of this, heads of household frequently decline incremental opportunities for professional advancement, as a small increase leads to loss of benefits which far surpass the increased wage. As a result, instead of a 'ladder' out of, it can become an 'anchor' into poverty, trapping beneficiaries in a cycle of systemic poverty, in which there is no way to bridge the gap between advancement and household stability.[110]

While continuous eligibility can ostensibly increase state costs, the cost burden is primarily related to keeping eligible children covered. "Continuous eligibility is one of the most effective strategies a state can take to ensure eligible but uninsured children are enrolled."[111] For states implementing 12-month continuous eligibility, expect:

- decrease health costs over time by ensuring better continuity of preventative and interventive care for children,[112] and
- allow states to minimize "churn," reducing administrative costs of processing frequent eligibility determination, enrollment, disenrollment, etc. as children and families cycle on and off Medicaid, CHIP.[113]

A study on the impact of 12-month continuous eligibility found payment per child enrollee could decrease as much as three percent, per month.[114] [115]A study of California's Medicaid enrollees showed more than 600,000 disenrolled children over three years were later reenrolled, costing the state $120 million in processing and associated administrative expenses.[116] [117]

Extending the term of continuous eligibility paired with the existing TMA program, Nebraska may better address the cliff effect for Medicaid, CHIP coverage. In a national study, nearly half of US children who were disenrolled from Medicaid reenrolled within one year, with higher risk demographics having shorter Medicaid enrollment gaps, but more likely to have instances of Medicaid enrollment.[118] Continuous eligibility alleviates this "churn" and ensure consistent coverage for children during years of important physical, psychological, and social-emotional development.

6. Provide Express Lane Eligibility for Medicaid, CHIP

- **Context**

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provides administrative tools for states to determine eligibility, and more effectively enroll children in Medicaid, CHIP.[119] Specifically, express lane eligibility (ELE) simplifies the determination and enrollment process by naming a single express lane agency (ELA), to aggregate and provide all information required for state program eligibility.[120]

ELA's **may** include, but are not limited to:[121]

- Head Start
- National School Lunch Program (NSLP)
- School Lunch
- Supplemental Nutrition Assistance (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Women, Infants, and Children (WIC)

ELA's may **not** include:[122]

- private, for-profit organizations; or,
- agencies only determining eligibility for programs under the title XX Social Services Block Grant.

States may also use ELE to expedite eligibility determination as well as reduce the administrative burden for the initial application and renewal process through use of tax filings.[123] State tax information can also be used proactively to identify and conduct outreach to prospective enrollees.

- **Observation**

  While an important option for improving efficiencies, only 14 states (Appendix F) utilize ELE for Medicaid, CHIP enrollment.[124] Nebraska does not currently utilize ELE.

  A 2016 federal DHHS report uncovered obstacles in 11 of 14 surveyed states utilizing ELE, typically related to interagency information sharing.[125] Most states overcame challenges through use of interagency agreements, outlining the working relationships of any participating state agencies. Few states effectively partnered with state level tax agencies, specifically because legislative action is often required to permit the sharing of residents' personal financial data.[126]

  Some critics of ELE cite the increased financial burden to states, while others have expressed concerns over the accuracy of the information sharing needed to facilitate the program successfully.[127] Two HHS Inspector general reports detail the high degree of accuracy of inter-governmental agency information sharing for Medicaid, CHIP.[128] Typically, 88 percent of Medicaid eligibility information, and 95 percent of CHIP information were correct in determining eligibility.
  States may currently utilize ELE through federal fiscal year 2027.[129] While effective and efficient, many states have not invested in developing the administrative infrastructure and/or procedures necessary to facilitate ELE. Some examples of states effectively utilizing ELE:

  - Louisiana[130]
  - Maryland[131]
  - Massachusetts[132]

  Nebraska Medicaid, CHIP enrollment has declined while rates of uninsured children have increased. Using all available policy strategies to grow enrollment is critical to ensuring children most in need receive the care and coverage to improve immediate and long-term outcomes.

- **Policy Consideration**

  To reduce the administrative burden for state agencies, providers, and enrollees, provide "express lane eligibility" (ELE) for Medicaid and CHIP coverage of Nebraska children. For effective implementation, it is also recommended the state designate an ELA, and draft interagency information-sharing agreements to facilitate efficient eligibility determination and enrollment processes.

- **Rationale**

  ELE may alleviate administrative burdens through streamlined processes, as well as increase Medicaid, CHIP enrollment for eligible Nebraska children. Studies of ELE use in other states "did not identify any significant impediments to continuing to allow voluntary use."[133]

  As states explore how to improve systems of delivery for Medicaid and CHIP, reconciling the cost of changes with immediate, short-term, and long-term benefits for low-income families, can and should include implementation of Express Lane eligibility. "All State Medicaid agencies [using] ELE reported associated benefits," and the ability to overcome any barriers to its effective use.[134]

States like Louisiana have expertly used ELE to drastically improve the rate of insured children, and significantly reduce the number of benefit terminations to less than one percent of children covered by both Medicaid, CHIP.[135] Louisiana also provides an auto-enrollment option using state tax filings. Massachusetts received an 1115 waiver to extend ELE to adults, using the same infrastructure to determine eligibility and enrollment for both children and adults.[136] And, Maryland engineered their enrollment process to include a single checkbox option on state tax filings to allow proactive outreach from the state's health care exchange as well as residents to self-select for eligibility.

Like other states, Nebraska must rethink its approach to insuring children (and potentially adults) through Medicaid, CHIP. Providing consistent health care coverage, continuity of care, as well as facilitating an easier eligibility/enrollment and administrative process can build more nimble systems of care.

Conclusion

With public schools as a primary source of identifying, enrolling, and providing children in many states with Medicaid, CHIP services, evidence-based strategies should continuously improve outcomes and inform policy solutions. School-based health services are a key component of providing Medicaid, CHIP EPSDT health screenings as well as ensuring reliable, quality services to children in every state.

Since 2017, Nebraska's rate of uninsured children has risen, while the rates of uninsured but financially qualified children have declined, trending below the national average. Nebraska can take steps to course correct these negative trends, including:

- Eliminate IEP, IFSP plan requirements to provide Medicaid, CHIP services to qualifying children through public-school providers
- Deliver continuous eligibility for Medicaid, CHIP to children in accordance with the federally recommended 12-month timeframe
- Allow for express lane eligibility for children by designating an express lane agency to aggregate and disseminate all data necessary for Medicaid, CHIP eligibility determinations, enrollment

Many states have implemented federally recommended and/or researched strategies to improve Medicaid, CHIP administrative processing and service delivery. These approaches can significantly reduce the administrative burden on states, providers, and enrollees, as well build continuity and continuum of care through school-based health services.

Ultimately, state administrative and legislative leadership as well as statewide stakeholder partnership is needed to craft policy changes that make the most sense for Nebraska's children. Changes should find the intersection of cost versus benefit, while prioritizing changes that prioritize the health coverage of children which best produce the immediate, short term, and long-term positive health outcomes.

Expanding Medicaid in Public Schools is possible and sensible. Using school-based health services can improve outreach to eligible children, families. A school-based program focused on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) interventions is critical to building a healthy foundation which yields positive outcomes for children's health now, and into adulthood.

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- *Nebraska Revised Statute 68-911: Medical Assistance Shall Include https://nebraskalegislature.gov/laws/statutes.php?statute=68-911*

Medicaid in Public Schools

- *Understanding the Medicaid Landscape https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/01/Understanding-the-Medicaid-Landscape.pdf*
- *3 Reasons Why Medicaid in Schools Matter https://www.ncld.org/news/policy-and-advocacy/3-reasons-why-medicaid-matters-in-schools#:~:text=To%20provide%20for%20early%20screening,reimbursements%20from%20Medicaid%20each%20year.&text=Children%20make%20up%20half%20of,are%20receiving%20services%20in%20school*
- *Medicaid in Schools: Issue Brief https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf*
- *Medicaid Helps Schools Help Children https://www.cbpp.org/research/health/medicaid-helps-schools-help-children#:~:text=Medicaid%20also%20helps%20schools%20by,health%2Drelated%20services%20for%20students*
- *Medicaid and CHIP Can Support Student Success Through Schools https://ccf.georgetown.edu/wp-content/uploads/2019/04/Student-Success-Report.pdf*
- *A Guide to Expanding Medicaid-Funded School Health Services https://healthyschoolscampaign.org/resources/single/a-guide-to-expanding-medicaid-funded-school-health-services/*
- *Expanding Medicaid in Public Schools Through "Free Care Rule" https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/01/Expanding-SB-Medicaid-Programs-Through-the-FC-Rule.pdf*
- *Medicaid 101 for School Superintendents https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/02/Medicaid-101-for-School-Superintendents.pdf*
- *Medicaid in the Schools: Medicaid Toolkit https://www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit-Schools/*

State and Federal Cooperation

- *Medicaid and CHIP Eligibility, Enrollment and Cost Sharing Policies, by State https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/*

Benefits of Childhood Medicaid Coverage

- *Medicaid Child Investment and Long-Term Tax Receipts https://www.nber.org/papers/w20835.pdf*
- *Effects of Child Health Insurance on Schooling Access https://www.nber.org/papers/w20178.pdf*
- *Childhood Medicaid Coverage and Future Health Care https://www.nber.org/papers/w20929.pdf*

Highlighted Resources by Topic

General Information – Medicaid

- *Medicaid and CHIP Data Book (2019)*
  https://www.macpac.gov/wp-content/uploads/2020/01/MACStats-Medicaid-and-CHIP-Data-Book-December-2019.pdf

Medicaid Eligibility

- *Express Lane Eligibility*
  - *Federal Policy Guidance*
    https://www.medicaid.gov/federal-policy-guidance/downloads/SHO10003.PDF
  - *Federal Enrollment Strategies by State*
    https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicaid-and-chip-coverage/index.html
  - *Understanding ELA for States, Low-Income Families*
    https://www.kff.org/wp-content/uploads/2013/01/8006.pdf

- *Continuous Eligibility*
  - *Federal Policy Guidance*
    https://www.medicaid.gov/medicaid/enrollment-strategies/continuous-eligibility-medicaid-and-chip-coverage/index.html
  - *Program Design: 12-Month Continuous Eligibility*
    https://ccf.georgetown.edu/wp-content/uploads/2012/03/CE-program-snapshot.pdf

- *Free Care Policy*
  - *Federal Guidance*
    https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf
  - *State Medicaid Plan Policy Review*
    https://healthyschoolscampaign.org/wp-content/uploads/2017/07/MedicaidFreePolicyCare.revd_.10.20.pdf
  - *State Efforts to Implement Free Care Policy Reversal https://docs.google.com/document/d/1u0j1so-se8ohhyl7AcHaaXlGX5l3s0PN2culDejXZQw/edit*

Coverage

- *EPSDT Federal Coverage Guide*
  https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf

Nebraska

- *Nebraska CMS School Health Affinity Group Report*
  http://dhhs.ne.gov/Documents/Nebraska%20CMS%20School%20Health%20Affinity%20Group%20Report%20of%20School%20Survey.pdf
- *Nebraska School-Based Services Statute*
  https://www.nebraska.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-25.pdf
- *Nebraska School-Based Services Website*
  http://dhhs.ne.gov/Pages/Medicaid-Provider-School-Based-Services.aspx
- *Nebraska State Plan Amendment (SPA): 17-0005*

Medicaid in Public Schools

- *Understanding the Medicaid Landscape*
  https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/01/Understanding-the-Medicaid-Landscape.pdf
- *3 Reasons Why Medicaid in Schools Matter*
  https://www.ncld.org/news/policy-and-advocacy/3-reasons-why-medicaid-matters-in-schools#:~:text=To%20provide%20for%20early%20screening,reimbursements%20from%20Medicaid%20each%20year.&text=Children%20make%20up%20half%20of,are%20receiving%20services%20in%20school
- *Medicaid in Schools: Issue Brief*
  https://www.macpac.gov/wp-content/uploads/2018/04/Medicaid-in-Schools.pdf
- *Medicaid Helps Schools Help Children*
  https://www.cbpp.org/research/health/medicaid-helps-schools-help-children#:~:text=Medicaid%20also%20helps%20schools%20by,health%2Drelated%20services%20for%20students
- *Medicaid and CHIP Can Support Student Success Through Schools*
  https://ccf.georgetown.edu/wp-content/uploads/2019/04/Student-Success-Report.pdf
- *A Guide to Expanding Medicaid-Funded School Health Services*
  https://healthyschoolscampaign.org/resources/single/a-guide-to-expanding-medicaid-funded-school-health-services/
- *Expanding Medicaid in Public Schools Through "Free Care Rule"*
  https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/01/Expanding-SB-Medicaid-Programs-Through-the-FC-Rule.pdf
- *Medicaid 101 for School Superintendents*
  https://healthyschoolscampaign.org/dev/wp-content/uploads/2020/02/Medicaid-101-for-School-Superintendents.pdf
- *Medicaid in the Schools: Medicaid Toolkit*
  https://www.asha.org/Practice/reimbursement/medicaid/Medicaid-Toolkit-Schools/

State and Federal Cooperation

- *Medicaid and CHIP Eligibility, Enrollment and Cost Sharing Policies, by State*
  https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-enrollment-and-cost-sharing-policies-as-of-january-2020-findings-from-a-50-state-survey/

Benefits of Childhood Medicaid Coverage

- *Medicaid Child Investment and Long-Term Tax Receipts*
  https://www.nber.org/papers/w20835.pdf
- *Effects of Child Health Insurance on Schooling Access*
  https://www.nber.org/papers/w20178.pdf
- *Childhood Medicaid Coverage and Future Health Care*
  https://www.nber.org/papers/w20929.pdf

Appendices

A. *State Medicaid requirements for children under EPSDT*
B. *State MIPS expenditures per enrolled child by policy barrier, 2016*
C. *State MIPS expenditures per enrolled child by policy barrier, 2017*
D. *Medicaid's federal medical assistance percentage (FMAP)*
E. *Medicaid spending by state, eligibility group, & Dually Eligible Status*
F. *States Currently Using Express Lane Eligibility, by State, Agency*
G. *Federal Requirements and State Options: Benefits*
H. *State Adoption of 12-Month Continuous Eligibility*

Appendix A.

State Medicaid Requirements for Children under EPSDT

Requirement	Included	Description
Informing Families	**Notification** Within 60 days of a child's initial Medicaid eligibility determination, and annually thereafter for families that have not used EPSDT services,	The state Medicaid agency must inform all eligible families about: • the benefits of preventative health care; • services available under EPSDT; • how to obtain EPSDT services; • EPSDT services are available without cost, except allowable enrollment fees, premiums imposed on "medically needy" beneficiaries; and • Transportation and scheduling assistance are available as requested
Providing Screening	**Periodicity Schedule** Children must receive regularly scheduled examinations of physical and mental health, growth, development, and nutritional status following a timetable determined by the state.	Screening services must include five components: • comprehensive health and developmental history, including assessing physical and mental health, as well as substance use disorders; • an unclothed physical examination; • appropriate immunizations; • laboratory tests; and • health education States must utilize a schedule which follows reasonable standards of medical and dental practice and must be developed through consultation with medical and dental organizations involved in the care of children.
	Interperiodic Screenings Examinations outside of periodicity schedule, as medically necessary.	Children are entitled to screenings at any time based on an indication of medical need.
	Qualified Providers Any provider operating within the scope of practice as defined by state law can provide a screening that qualifies for EPSDT coverage.	A family does not need to formally request an EPSDT screening to receive EPSDT benefits. A child may not need to be enrolled in Medicaid or other managed care plan for a qualified screening to have been performed. Families seeing non-participating providers without prior approval will be responsible for associated costs. Exceptions include: emergency services, post-stabilization care services related to an emergency condition.

Deliver Diagnostic and Treatment Services	**Diagnosis and Treatment** Must ensure timely initiation of treatment in accordance with reasonable standards of medical and dental practice, generally within 6 months of service request.	Must provide any additional services if a need is discovered, including services not included in a state plan. Only treatments or services that are medically necessary for a child are covered. *Federal law does not define medical necessity and definitions adopted by states vary
	Inpatient Psychiatric Care Children under age 21 can receive inpatient care services in limited facility types.	Children may receive inpatient psychiatric care services in one of the following facility types: • psychiatric hospitals; • psychiatric units of general hospitals; and • psychiatric residential treatment facilities. *Regardless of state plan inclusion, states must provide this care if deemed medically necessary for a child eligible for EPSDT.
	School-based Free Care As of 2014, Medicaid reimbursement is possible for care provided without charge to children through a school if all requirements are met.	Medicaid payment and eligibility requirements for both provider and beneficiary must meet all designated requirements to receive Medicaid reimbursement.
Deliver Diagnostic and Treatment Services Continued	**HCBS Waiver Programs** Children enrolled in HCBS waiver programs are also entitled to EPSDT	Children enrolled in home and community-based service (HCBS) waiver programs receive services beyond those defined as "medical assistance." This includes: • habilitative services; • respite services; and/or • other services to prevent institutionalization The waiver services encompass EPSDT, creating comprehensive benefits allowing children with disabilities to remain in their homes and communities.
	Services Need Not Cure Services that maintain or improve a health condition or relieve pain are covered under EPSDT, even if they do not cure the associated health condition.	Allowable services include: • physical therapy; • occupational therapy; and • durable medical equipment Rehabilitative services are also covered because they can alleviate a long-term physical or mental disability.

Allowable Limitations	**Coverage Limitations**	Firm limits or caps on services to children are not permissible under EPSDT, however soft caps or limits may be placed for purposes of utilization control. States may not deny a medically necessary service based only on cost, but it can consider cost as part of the prior authorization process. A state may choose to cover a less expensive but equally effective service. States must consider a child's quality of life as well as the requirement to cover services in the most integrated setting appropriate. A state's decision may be appealed under the state's fair hearing procedures.
	Experimental Treatments Not defined in federal Medicaid statute or regulations.	State may determine which treatments or services are deemed 'experimental,' but should utilize latest scientifically available information.
Monitoring	**Participation Data** States are required to report EPSDT data to Centers for Medicaid & Medicare Services electronically, using form CMS-416.	Data reported include: • participant ratio; the percentage of children who were expected to receive at least one screening, and who did receive the allowable screening. • number of children eligible for EPSDT; • number of children referred for treatment; and • number of children receiving preventive or diagnostic dental services. States report these data by age. CMS uses this information to ensure state programs meet statutory obligations under EPSDT.
	Participation Goals The Omnibus Budget Reconciliation Act of 1989 requires US' DHHS Secretary to set state participation goals.	In 1990, CMS established a goal of an 80 percent enrollee participation ratio in EPSDT in each state, per year, by federal FY 1995. Only complete screenings, comprised of all five components, may be included toward this goal.
	Program Coordination Coordination between Medicaid and Title V agencies are required by law.	Title V agencies include states and non-profit organizations that promote maternal and child health. State Title V agencies have contributed to beneficial coordination, such as assisting in development of EPSDT provisions in managed care contracts; monitoring network adequacy, and helping to develop EPSDT standards of care.

Appendix B

State MIPS Expenditures per Enrolled Child by Policy Barrier

Year
2016

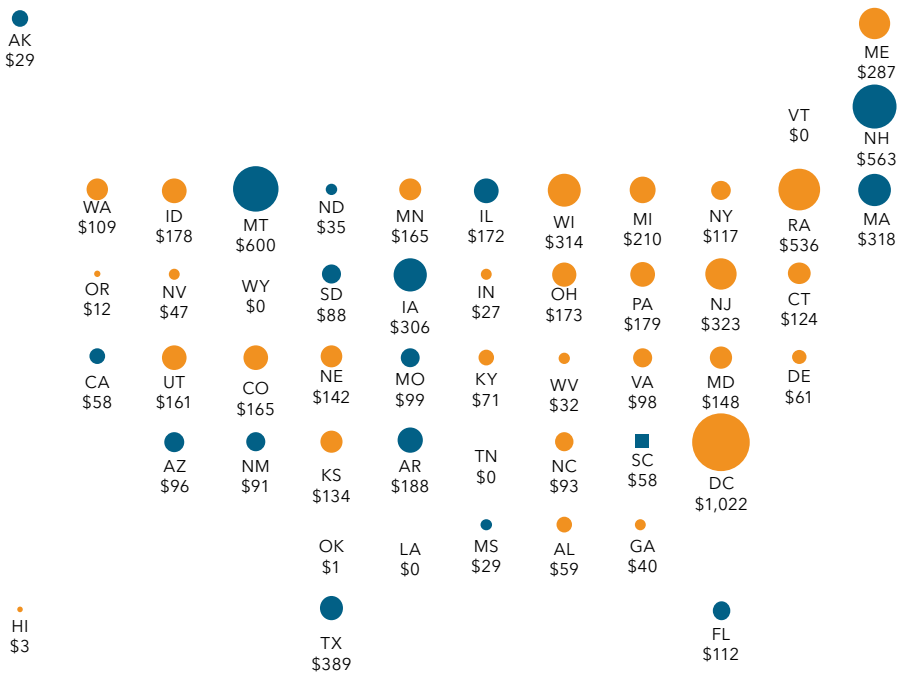
National Average (2018):
$167

Orange States (n=32)
explicitly prohibit or present a likely barrier for reimbursement of school-based health services.

Blue States (n=19)
explicitly authorize or present no likely barrier for reimbursement of school-based health serices.

shaped states (n=2) are implementing changes to their State Medicaid Plans.

Note: the sizes of state bubbles/squares is relative to the national average within a given year.



Source: https://www.childtrends.org/publications/early-evidence-medicaid-role-school-based-heath-services
*Data for 2019 and 2020 not yet available.
**Data did not permit distinguishing between expenditures for free care and other school-based health services.
**Finally, states have only just begun reporting specific school-based health expenditures separately.

Appendix C

State MIPS Expenditures per Enrolled Child by Policy Barrier

Year
2017

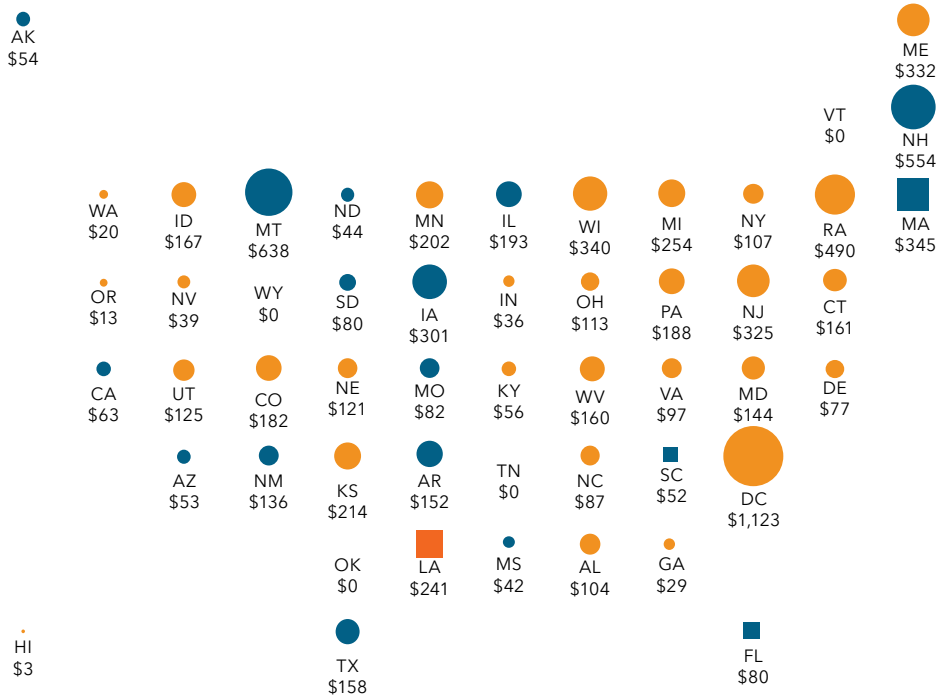
National Average (2018):
$175

Orange States (n=32)
explicitly prohibit or present a likely barrier for reimbursement of school-based health services.

Blue States (n=19)
explicitly authorize or present no likely barrier for reimbursement of school-based health serices.

shaped states (n=5) are implementing changes to their State Medicaid Plans.

Note: the sizes of state bubbles/squares is relative to the national average within a given year.



Source: https://www.childtrends.org/publications/early-evidence-medicaid-role-school-based-heath-services
*Data for 2019 and 2020 not yet available.
**Data did not permit distinguishing between expenditures for free care and other school-based health services.
**Finally, states have only just begun reporting specific school-based health expenditures separately.

Appendix D

https://fas.org/sgp/crs/misc/R43847.pdf *(Pages 19-23)*

Appendix E

https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-21.-Medicaid-Spending-by-State-Eligibility-Group-and-Dually-Eligible-Status-FY-2018-millions.pdf

Appendix F

States Currently Using Express Lane Eligibility, by State, Agency

State	CHIP	Medicaid	ELE Agency
Alabama	No	Yes	SNAP & TANF
Colorado	Yes	No	NSLP
Georgia	No	No	WIC
Iowa	Yes	Yes	SNAP Medicaid
Louisiana	No	Yes	SNAP & NSLP
Maryland	No	Yes	Office of the Comptroller
Massachusetts	Yes	Yes	
New Jersey	Yes	Yes	NSLP Division Taxation
New York	No	Yes	CHIP
Oregon	Yes	Yes	SNAP & NSLP
Pennsylvania	Yes	No	
South Carolina	No	Yes	SNAP & TANF
South Dakota	No	Yes	
US Virgin Islands	No	Yes	SNAP
Utah	Yes	No	Department of Taxation

Source: https://www.medicaid.gov/medicaid/enrollment-strategies/express-lane-eligibility-medicaid-and-chip-coverage/index.html

Appendix G

https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Benefits.pdf

Appendix H

State Adoption of 12-Month Continuous Eligibility for Children's Medicaid and CHIP

Location	Medicaid	CHIP
United States	23 Yes	25 Yes
Alabama	Yes	Yes
Alaska	Yes	N/A (M-CHIP)
Arizona	No	No
Arkansas	No	Yes
California	Yes	N/A (M-CHIP)
Colorado	Yes	Yes
Connecticut	No	No
Delaware	No	Yes
District of Columbia	No	N/A (M-CHIP)
Florida[1]	No	Yes
Georgia	No	No
Hawaii	No	N/A (M-CHIP)
Idaho	Yes	Yes
Illinois	Yes	Yes
Indiana[2]	No	No
Iowa	Yes	Yes
Kansas	Yes	Yes
Kentucky	No	No
Louisiana	Yes	Yes
Maine	Yes	Yes
Maryland	No	N/A (M-CHIP)
Massachusetts	No	No
Michigan	Yes	N/A (M-CHIP)
Minnesota	No	N/A (M-CHIP)
Mississippi	Yes	Yes
Missouri	No	No
Montana[3]	Yes	Yes

1 In Florida, children in Medicaid under the age of 5 receive 12-month continuous eligibility and children ages five and older receive six month of continuous eligibility.
2 Indiana provides 12-month continuous eligibility to children under age 3.
3 Montana and New York provide 12-month continuous eligibility to parents and expansion adults through a Section 1115 waiver.

Nebraska	No	N/A (M-CHIP)
Nevada	No	Yes
New Hampshire	No	N/A (M-CHIP)
New Jersey	Yes	Yes
New Mexico	Yes	N/A (M-CHIP)
New York	Yes	Yes
North Carolina	Yes	Yes
North Dakota	Yes	N/A (M-CHIP)
Ohio	Yes	N/A (M-CHIP)
Oklahoma	No	N/A (M-CHIP)
Oregon	Yes	Yes
Pennsylvania[4]	No	Yes
Rhode Island	No	N/A (M-CHIP)
South Carolina	Not reported	Not reported
South Dakota	No	No
Tennessee	No	Yes
Texas[5]	No	Yes
Utah	No	Yes
Vermont	No	N/A (M-CHIP)
Virginia	No	No
Washington	Yes	Yes
West Virginia	Yes	Yes
Wisconsin	No	No
Wyoming	Yes	Yes

Notes

Under state option, states may provide 12-month continuous eligibility for children, allowing them to remain enrolled by disregarding changes in income or family size until renewal. These columns indicates whether states have opted to cover children in Medicaid and/or CHIP for a full twelve months unless the child ages out, moves out of state, voluntarily withdraws, or does not make premium payments.

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Definitions

**N/A (M-CHIP)*: Indicates that the state does not provide a separate CHIP program for uninsured children.*

4. Pennsylvania provides continuous eligibility for children under age 4.
5. Texas provides a child in CHIP with income below 185% FPL 12 months of continuous eligibility; children in CHIP at or above 185% FPL receives 12 months of continuous eligibility unless there is an indication of a change at a six-month income check that would make the child ineligible for CHIP.

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