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MaineCare Billing in Public School Districts

Amy F. Johnson

Patricia Lech

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MaineCare Billing in Public School Districts

Prepared by:

Amy Johnson, Ph.D. and Patricia Lech, M.D.

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College of Education and Human Development
University of Maine, 5766 Shibles Hall, Orono, Maine 04469-5766 (207) 581-2475
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MaineCare Billing in Public School Districts

Amy Johnson
amyj@maine.edu

Patricia Lech
patricia.lech@maine.edu

Executive Summary

Why was this study conducted?

To understand how Maine public schools could be encouraged to maximize use of Maine's Medicaid program, MaineCare, to increase federal funding for medical services provided to qualifying students in grades K-12. School districts are uneven in their MaineCare billing practices, and many are not accessing all of the federal funds for which they are eligible. This could be a significant source of additional revenue to support Maine schools' rising special education costs.

What do you need to know to put this study into context?

Medicaid funds can pay for certain medical services and therapies that are delivered to eligible public school students as part of an approved Individualized Education Plan (IEP). However, not all IEP services are Medicaid eligible.

Moreover, the federal Centers for Medicare and Medicaid (CMS) have basic requirements that state Medicaid programs must meet, but some elements are up to each state to design and administer. Thus the billing policies and systems—including the types of costs that are eligible for reimbursement—are different from one state to the next. For example, Vermont's "Green Mountain Care" Medicaid program may pay for some services or supports that are not covered under MaineCare regulations and vice versa.

Each year, a formula determines the federal share of a state's Medicaid costs based on its per capita income relative to the national average.[1] In recent years, the federal government has been paying 63% to 70% of Maine's Medicaid costs. The remaining share of 37% to 30% is passed along to the local school districts for services provided under an IEP. The Maine Department of Education manages this process by calculating the amount not covered federally – known as the MaineCare Seed – and withholding that amount from the state subsidy that is paid to the district.[2] This practice is different from medical services provided outside of the public educational system; when MaineCare is used to cover health care costs for eligible low-income Mainers, the leftover share after federal reimbursement is paid by the Maine Department of Health and Human Services out of state funds.

[1] https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier

[2] https://www.maine.gov/doe/funding/reports/mainecareseed

The scope of this study is restricted to special education services provided in grades K-12 under IDEA part B (not including Chapter 619 services for ages 3 to 5). Special education services and policies for younger children are managed by Child Development Services under a different framework, including different MaineCare billing practices. At the time this study was conducted, a more detailed external review of Maine's special education services for children birth to age 5 was underway by the Public Consulting Group. Our study did not attempt to replicate their work in either scope or depth of analyses.

What did we learn from the study?

MaineCare is a very complex system. It uses the same regulations for both healthcare entities and schools, unlike some other states that have streamlined system with separate rule chapters for public schools. Maine does, however, provide separate guidance for education in an abbreviated 41-page MaineCare billing manual for school-based services. The overall complexity is a barrier for school districts that lack the knowledge, expertise, information systems, or time to manage the billing process.

The scope of MaineCare services does not encompass all of the services that could be allowed under federal CMS requirements. For example, coordination of services can be included in state Medicaid plans but Maine does not include that provision in its state plan. Certain clinical mental health services are also allowed under CMS regulations yet are not currently being billed through MaineCare unless part of a behavioral day treatment program. There also is a discrepancy between MaineCare's minimum qualifications of paraprofessionals who provide behavioral health services to children depending on whether services are provided in a school vs. a community setting; this may be an adder barrier to hiring, training, and paying for staff who can provide needed services. To fully maximize federal resources, Maine would need to request revision of its federally-approved plan to include more allowable services.

A review of recent (FY2020) MaineCare Seed payment data revealed that only 45% of Maine school districts participated in reimbursement for eligible services provided in the public school setting. While some lack of billing can be explained by the possibility that the district did not offer any eligible services, the more likely reason is that districts choose not to seek reimbursement. These MaineCare Seed data findings were corroborated by our survey results.

Most Maine school districts reported not billing MaineCare for all eligible services due to the complexity of the system, fear of an audit resulting in penalties, and the time and energy that must be invested to recoup a portion of costs. In our survey of special education directors, 38% of all respondents reported that their district does not typically bill MaineCare for any service. In small districts (i.e. with fewer than 100 students), the proportion increased to 63% of special education directors. Statewide, only 30% of special education directors reported that their districts *always* billed MaineCare when eligible. Most special education directors instead indicated that their districts billed selectively for some services, some of the time. The most common reason special education directors gave for their districts underbilling MaineCare was

that the net reimbursement was not worth the time and effort required (selected by 47% of respondents, n=28).

Administrators reported that MaineCare reimbursement rates do not always cover the schools' actual costs of providing services. This is compounded by the fact that the districts do not receive the full amount and must share in the costs through the MaineCare Seed payments. If rates were higher, districts would have more incentive to seek reimbursement.

Other states such as New Hampshire have separate simplified Medicaid regulations for schools that are tailored to their needs, allow for more services to be billed, and tie reimbursement to the school's cost of providing the service. These states may offer some examples that Maine could emulate.

What did we conclude overall from the study? What are the potential implications for policy or practice?

Maine has an opportunity to expand resources to support students with special education needs through increased utilization of federal Medicaid funds for medically-necessary services. This could reduce the costs borne by state and local governments, and/or provide increased levels of services to students. An increase in MaineCare reimbursements can be facilitated by changing Maine's system for school-based services to one that is simpler for districts to use, covers more of the services allowed by the federal Centers for Medicare and Medicaid, and reimburses the districts for more of the costs of providing medical services to eligible students.

However, streamlining policies will not completely address the challenge of the time, effort, infrastructure, and expertise that is needed to request MaineCare reimbursements. Most of Maine's numerous small, rural districts lack the information systems and dedicated staff that are needed to make billing feasible. At the time of writing, discussions are underway to explore consolidating MaineCare billing at the state (or regional) level in order to relieve individual school districts of the burden. Our research suggests that this proposal has much merit.

Given the critical need for supporting students' social and emotional well-being as a result of the myriad challenges from the COVID-19 pandemic, we wish to particularly highlight the emerging finding that federal Medicaid funds may be an underutilized source of support for mental health services. While it was beyond the scope of this study to delve into this finding in detail, this should be a key priority when exploring how to expand MaincCare to include additional CMS-approved services.

What methods were used to conduct this study, and how robust are the findings?

Empirical data was obtained for this study by surveys and through interviews with clinicians that provide occupational therapy, physical therapy or speech therapy in schools. Administrative data on MaineCare Seed payments was obtained from public sources and analyzed for patterns based on districts' special education spending levels. Documents from the federal Medicaid and CHIP Payment and Access Commission as well as Maine, Massachusetts

and New Hampshire school-based websites were reviewed and used as data sources, as was the the MaineCare billing manual for school-based services and DHHS MaineCare rule chapters.

Confidential online survey invitations were emailed to special education directors, therapists, and special education teachers. The response rates were 28% (n=28) for occupational therapy, 39% (n=29) for physical therapy and 13% (n=42) for speech therapy. Thirty-eight percent of surveyed special education teachers from Maine (n=182) responded. All 205 special education directors and assistant special education directors on file at Maine Department of Education were invited to take the survey and the response rate was 47% (n=97).

We deem the results to be adequately representative. The interview and survey findings highlighted the same concerns, which were corroborated by administrative data and documents. There was good agreement between special education directors and special education teachers on staffing questions. Our findings based on review of the school-based Medicaid manuals were similar to other published findings.

Introduction

Beginning with the Rehabilitation Act in 1973, the federal government has required states to provide all students with a free and appropriate public education (FAPE). Requirements for schools are laid out under the Individuals with Disabilities Education Act (IDEA). To qualify for special education services under Individuals with Disabilities Education Act (IDEA), a child would have one of 13 qualifying disabilities and the disability must impact educational performance that the child needs specially designed instruction beyond what is offered to peers. Schools are to develop Individualized Education Plans (IEPs) for students with disabilities and provide education in the Least Restrictive Environment (LRE). IDEA does not allow cost to be considered when an Individualized Education Plan (IEP) is developed.

The primary source of federal support for schools to provide special education services is through the Individuals with Disabilities Education Act (IDEA), Part B. As a condition of IDEA funding, districts and states must allocate and keep track of their spending to support students with disabilities. In FY2020, Maine received $59.5M in federal aid for special education.[3]

The federal government also allows states to use Medicaid funds to cover some of the costs of providing services to children with disabilities. In 2017, Medicaid spent $4 billion in schools nationally. This is only one percent of the total $400 billion Medicaid budget but is significant to schools (Gorman & Rodriquez, 2018). Around 63% to 70% of all costs billed to Medicaid in Maine are paid by the federal government, and the remaining 37% to 30% are paid by the school district in what is known as the "Seed" matching requirement. There is a slight variation each year. In 2020, the federal share was 70%. (Congressional Research Service 2020).

In FY2020 Maine school districts billed MaineCare, Maine's Medicaid program, for a total of $13.1M in medical services provided by the school districts; $9.2M of this was reimbursed through federal funds and $3.9M was covered by the district's "seed" match. Special purpose private schools billed MaineCare for a total of $30.9M for services provided to students enrolled in their intensive day-treatment and residential programs, with 70% or $21.6M paid by Medicaid funds and the 30% seed match of $9.3M paid by the public school district in which the students reside. Thus the total FY20 amount billed through MaineCare for eligible medical

[3] https://www2.ed.gov/about/overview/budget/statetables/index.html

services provided under an IEP totaled $44.0M. The federal government paid 70% of these costs, or $30.8M, and local school districts paid the remaining $13.2M.

Within the federal Medicaid requirements, states have considerable latitude in how they design and implement state-specific Medicaid regulations. Certain school services are covered when a student is enrolled in their state Medicaid program. Schools can help identify children who are eligible for Medicaid and Childrens' Health Insurance Program (CHIP) and help their families with the enrollment process (Schubel, 2017; Baller and Barry, 2016). Then Medicaid can be used to pay for some services included in the Medicaid-eligible student's IEP that are medically necessary, delivered by a federally qualified provider, and included in the state Medicaid plan (MACPAC 2018). Medicaid can also pay for medical services that are delivered in schools to Medicaid eligible youth even if not provided under an IEP. The services do not have to create improvement—a treatment goal can be to prevent worsening of a condition (MACPAC 2021). State Medicaid can pay for screening or group treatment of eligible students even if the screening or group treatment is provided to all students without charge.

Because there is state discretion on how they administer their Medicaid programs, there is substantial variation from state to state. Some school districts receive significant sums from their state Medicaid programs. In Fairfax, Virginia one district receives an average of $1.5 million annually from Medicaid. In Los Angeles, $20 million of the $7.5 billion annual school budget comes from Medicaid. In a 2017 national survey 68% of school superintendents said they took advantage of Medicaid to help fund school nurses, counselors and other staff members. Wyoming is one state that does not use Medicaid funding for school-based therapies (Gorman & Rodriquez, 2018; Schubel, 2017). Other states leverage federal Medicaid funds to deliver needed specialized education services to school students (Baller and Barry, 2016).

Prior MEPRI studies of Maine's special education funding system within the Essential Programs and Services school funding model have noted that many districts are not billing MaineCare. This study was undertaken to better understand why Maine districts are not fully billing for the qualifying services provided to eligible students enrolled in MaineCare, and to identify potential policy interventions that could increase MaineCare funding for schools.

Methodology

Four methods of obtaining data were used for this report: surveys, interviews, document review, and quantitative analysis of MaineCare Seed payments. Three separate surveys were conducted. The first survey was directed at special education teachers. The second survey was sent to occupational therapists, physical therapists and speech-language therapists. Both looked at the delivery of services to students with an IEP via telehealth when the student was physically in the school building and when the student was learning remotely at home. The third survey asked special education directors for perspectives on various issues including MaineCare billing.

Therapist Sample. The Maine Department of Education has a listing of occupational therapists, physical therapists and speech-language therapists employed by school districts. However, this list did not have contact information for many of the therapists; there were 484 therapists with emails listed and 203 therapists without contact information. A random sample of 100 occupational therapists and 100 speech therapists with emails was selected, and all of the 56 physical therapists with emails were selected for the sample. This group of 256 therapists was sent an initial survey invitation and two reminder emails.

We also learned from practitioners involved in our interviews that the staff listings did not appear to fully capture therapists providing contracted services. Because of this, we also obtained a contact list of speech therapists from a professional network and sent survey invitations to the 218 unduplicated therapists that were not already included in the 100 person random sample. Survey links were also distributed through the Maine Occupational Therapist Association, gathering an additional 11 responses, and to the Maine Physical Therapist pediatric study group. The total number of responses was 39 occupational therapists, 29 physical therapists and 42 speech therapists. The response rates to those replying to direct email invitations were 28% (n=28) occupational therapy, 39% (n=29) physical therapy and 13% (n=42) speech therapy.

Special Education Teacher Sample. The Maine Department of Education staff listing was also used to identify public school special education teachers. School location was identified as “populated” or “rural”. Schools that were in central and southern Maine counties (Cumberland, Kennebec, Knox, Lincoln, Sagadahoc, Waldo and York) were classified as being in populated counties as were schools that were along the I-95 corridor (e.g. Lewiston, Auburn, Hampden, Bangor, and Brewer). The other schools in Northern and Western Maine counties and

virtual charter school teachers were categorized as rural. In the directory listing, 1429 special education teachers worked at schools in populated areas and rural schools employed 625 special education teachers. Since more School Administrative Units are in rural schools, an over sampling of rural schools was done. This panel of 500 teachers consisted of 300 rural teachers and 200 teachers from populated areas. Teachers were sent an email invitation to take a confidential online survey followed by two additional reminders to complete the survey. The response rate on this survey was 38% (182 teachers of 476 teachers with a valid email address).

Special Education Director Sample. The Maine Department of Education database was used to obtain contact information for all special education directors (n=145) and assistant special education directors (n= 60). All were sent an email invitation to participate in an anonymous survey. The following week, the Maine Administrators of Services for Children with Disabilities (MADSEC) also emailed the anonymous survey link to members with encouragement to participate. Reminder emails were also sent. A total of 97 surveys were completed; based on the MDOE mailing list of 205 contacts, the response rate was 47%.

Interviews. Interviews were conducted with an occupational therapist, physical therapist, and two speech therapists who are involved in graduate education or continuing education of therapists. They were based at four different institutions. Two Maine Department of Education employees who are involved in school Medicaid billing were also interviewed. The interviews were approximately thirty minutes in length and focused primarily on telehealth delivery of services and also included MaineCare billing questions.

Document review. Pertinent sections of the MaineCare manual were reviewed along with federal Medicaid websites. The Maine, Massachusetts, and New Hampshire School-based Medicaid websites were viewed. Maine licensing descriptions were also reviewed. News articles and journal articles were considered as sources.

Sample demographics. When it is conducted, billing for MaineCare is by district. Maine has 267 listed school districts. Sixty-one of these districts do not operate schools and send their resident students to other districts. More than three-quarters of Maine students are in the largest 64 districts enrolling 1,000 or more students. Half of the special education directors worked in these larger districts. Most special education directors described their district as primarily small town (52%, n=41) or remote rural (24%, n=19). A quarter (24%, n=19) said their district was city or suburban. Central Maine (19%, n=15), Northern Maine (30%, n=24), Southern Maine

(29%, n=23), and Western Maine (23%, n=18) were approximately equally represented in the special education director respondents.

The therapist respondents were primarily employed by a school district (74%, n=83). Equal numbers of physical therapists were employed in school districts (52%, n=15) as in private clinics (self-employed, private clinic or academic setting) (52%, n=15). The primary employer for Occupational therapists (77%, n=30) and Speech therapists (90%, n=38) were school districts. Most of the therapists employed by a school district reported no other employment (84%, n=70). Therapists primarily worked in elementary schools (89%, n=82). Almost all physical therapists worked with students of more than one grade level. Seventy-four percent of physical therapists (20) worked with elementary and high school students. Most occupational therapists (72%, n=23) and physical therapists (93%, n=26) worked at more than one school. The situation was the opposite for speech and language therapists. The majority of speech and language therapists (57%, n=20) worked at only one school. The sample had therapist respondents primarily from the southern part of the state (52%, n=49). Seven therapists worked in more than one area of the state.

Few special education teachers (3%, n=5) taught at more than one school. The largest proportion were in elementary schools (48%, n=74). Middle schools (39%, n=59) and high schools (40%) were equally represented. The teacher responses reflected the oversampling of teachers in rural areas; there were fewer city and suburban schools (26%, n=41) than small town schools (48%, n=74) represented. Teachers of rural schools composed a quarter of the sample (25%, n=38). There were more teachers from northern Maine (37%, n=56) and western Maine (31%, n=48) than southern Maine (20%, n=31) or central Maine (12%, n=18).

Findings

MaineCare Billing Patterns for District-Provided Services

To provide general grounding for this study, we used publicly available administrative data on MaineCare Seed payments[4] to analyze public school districts' billing patterns. In FY2020 there were 243 Maine school districts with special education allocations; some of these units directly provided services to students, and others were fiscal agents for resident students

[4] https://www.maine.gov/doe/funding/reports/mainecareseed

attending school in a different district. Of those 243 districts, 133 (55%) did not have any MaineCare Seed payments in FY2020, meaning that they did not bill MaincCare for any district-provided services. Another 30 school units (12%) had Seed payments under $3,400, meaning that their total billing amount was about $10,000 or less. Thus about two-thirds of all Maine school districts did not bill MaineCare for services to a substantial extent in that year. At the other end of the spectrum, there were 29 districts that each billed MaineCare for over $100,000 (totaling $10.7M).

Some of the districts that did not have very active billing also had very small numbers of students with IEPs, and therefore may not have provided any MaineCare eligible services. To further investigate, we next compiled the FY2020 MaineCare billing information based on the size of districts' total special education funding level, as seen in Table 1.

Table 1. FY2020 MaineCare Billing Patterns by Total Special Education Spending Category

FY2020 Total Special Education Spending Category	Number of districts in spending category	Number (%) of districts billing MaineCare for district-provided services	Total amount billed to MaineCare ($Thousands)
$1 to $100,000	47	9 (19%)	$102.2
$100,001 to $500,000	66	19 (29%)	$498.0
$500,001 to $1.0M	37	19 (51%)	$1,677.0
$1.0M to $5.0M	66	43 (65%)	$6,784.6
$5.0M and up	27	20 (74%)	$4,086.3
Total	243	110 (45%)	$13,148.1

These patterns affirm the anecdotal wisdom that some districts are foregoing MaineCare billing. While districts with small programs may not have needed to provide any medical services that would have been eligible for reimbursement, the same cannot be said for districts with larger programs.

MaineCare Billing Patterns for Private School Services

The public data that was used to analyze public school billing patterns also contains information on services that are provided at special purpose private schools and billed to MaineCare. By federal and state policy, the resident school district is fiscally responsible for special education services. When a student needs more intensive services than can be provided by the local district and is placed in a private school program (typically for day treatment

services), the private school can bill MaineCare for eligible services. However, the MaineCare seed payment is covered by the sending (resident) district. By analyzing the amount of seed payments send from public school districts on behalf of private school billing we were able to explore the fiscal impact on local school districts.

In FY2020, local school districts paid a total of $9.3M in seed payments on behalf of students served at private schools. Because the seed amount was 30% of the total, this means that the private schools were reimbursed a total of $30.9 M for MaineCare eligible services. This is more than double the $13.1M that was billed for services provided by public schools.

MaineCare Billing Practices

Both directors and therapists were asked questions about their districts' billing of MaineCare for school-based services. Over a third of district special education directors said that they did not typically bill MaineCare, and those that billed often did not bill for all eligible services. There was a distinct difference in billing based on district size. Almost two-thirds of districts of a hundred or fewer students (63%, n=5) and half of districts with under 500 students said they did not typically bill MaineCare at all. Thirty percent of larger district special education directors said their district did not bill MaineCare for some services. About half of the special education directors reported billing MaineCare for occupational therapy (54%, n=46), speech and language therapy (51%, n=43), and physical therapy (49%, n=42). Less than one in four directors said their districts billed for mental health providers (24%, n=20) and behavioral health providers (20%, n=17). No director reported that their district billed for care coordination. Statewide only 30% of special education directors felt their districts always billed MaineCare.

Table 2. Services Billed to MaineCare (Directors' survey)

	All Districts	District 1000 students	District 501-999 students	District 101-500 students	District 100 or fewer students
	n=85	n=40	n=12	n=19	n=8
None; we do not typically bill Mainecare	38%	30%	25%	47%	63%
Occupational Therapy	54%	70%	67%	26%	38%
Speech Language Therapy	51%	60%	50%	42%	38%
Physical Therapy	49%	70%	67%	11%	13%
Mental Health (Psychologist, Counselor, Social Worker)	24%	30%	25%	11%	25%
Behavioral Health Providers	20%	25%	25%	11%	13%
Nursing services	2%	3%	0%	0%	0%
Adaptive Physical Education	0%	0%	0%	0%	0%
Interpreter	0%	0%	0%	0%	0%
Health Aide	0%	0%	0%	0%	0%
Care coordination	0%	0%	0%	0%	0%
Other	1%	0%	0%	5%	0%
Total	100%	100%	100%	100%	100%

The special education directors who said their district does not always bill were then asked why. The most common reasons special education directors felt their districts did not bill was the net reimbursement was not worth the time and effort to bill (47%, n=28). The second most common reason was fear of audit (30%, n=18). In the comments for of those who selected "other", eight special education directors elaborated on the complexity of the billing system requiring administrative time. Three said that they want therapists to be providing services not doing extensive billing paperwork. As seen in Table 2 below, directors indicated some common therapy services such as coaching and group sessions are not billable. Thirteen percent of directors (8) said they did not know why their district did not bill for all eligible services.

Table 3. Reasons why district does not bill Mainecare for IEP services

	All Districts n=60	District 1000 students n=29	District 501-999 students n=7	District 101-500 students n=15	District 100 or fewer students n=6
The net reimbursement amount is not worth the amount of time and effort required for billing	47%	52%	57%	33%	50%
District fears an audit	30%	41%	29%	7%	33%
Service provided by therapist is needed for FAPE, but is not medical	18%	17%	14%	13%	33%
Providers are contracted to bill MaineCare directly	17%	14%	29%	27%	0%
Therapist coaching and preparation time is not billable	13%	14%	0%	7%	33%
District does not want to pay individual/ company for billing of services to MaineCare	12%	14%	0%	13%	0%
Parent refusing to allow billing of MaineCare	12%	14%	29%	0%	17%
Children losing eligibility for MaineCare	10%	7%	0%	13%	17%
When two or more children receive therapy at the same time, it is not billable	8%	7%	0%	13%	0%
District is unsure which services are billable	5%	7%	14%	0%	0%
Service is provided by an individual who is not eligible for MaineCare reimbursement (ex. EdTech I)	5%	7%	14%	0%	0%
Service provided is needed for FAPE, but is medical	5%	7%	0%	7%	0%
District is not able to find a knowledgeable individual/company to handle billing	3%	0%	0%	7%	0%
MaineCare rejects claims	2%	3%	0%	0%	0%
Services are provided by an individual who is not enrolled with MaineCare (ex. out-of-state provider)	0%	0%	0%	0%	0%
Other	28%	38%	43%	20%	0%
I do not know	13%	7%	0%	20%	17%
Total	100%	100%	100%	100%	100%

Therapists were also asked how they billed their services. Sixty-seven percent of therapists (n=65) said their school district handles the billing for MaineCare, which is in line with the responses given by directors (62%). Overall therapists did not have much knowledge of issues with school MaineCare billing. Only 63% of the total therapists (n=71) responded to a question asking what are the issues with the schools billing MaineCare. Fifty of these therapists

responded that they did not know or that they entered their hours into a system but did not know if the district was able to successfully bill MaineCare. Several therapists commented here and in other questions about the low reimbursement paid by MaineCare. They felt school therapy was underfunded, and did not pay for necessary supplies such as manipulatives. A few therapists said some therapy was academically necessary but not medically necessary according to MaineCare regulations. One wrote:

> “When it comes to MaineCare, to meet the minimum requirements for billing, services need to be: "All services categorized as school-based services must meet the following minimum: Be medically necessary; Be ordered, prescribed, or recommended by a physician or other licensed practitioner; Be included in the member’s Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP); and Be medical in nature (rather than educational). " This language does not fit with IDEA and has been a challenge for licensed providers billing MaineCare. This may also be a reason why some districts do not bill MaineCare.”

Other therapists felt providing resources, consulting with parents, and developing weekly activity packets with manipulatives, should be recognized by MaineCare. Consults are also not covered. Some therapists felt that driving time between schools could be considered; not covering transportation time could limit where therapists practice.

Table 4. Therapist issues with MaineCare billing by employer of therapist

	District employee n=73	Not a district employee n=24	Total n=97
My district bills MaineCare for eligible student services	71%	25%	60%
My district does not bill MaineCare for eligible student services	19%	13%	18%
I do not know if my district bills for eligible student services	5%	17%	8%
My employer or I bill MaineCare for eligible student services	7%	25%	11%
My employer or I bill the district then they bill MaineCare for eligible student services	3%	21%	7%
My employer or I bill the district but they do not bill MaineCare for eligible student services	0%	13%	3%
My employer or I bill the district. I do not know if they bill MaineCare for eligible student services	1%	0%	1%
Total	100%	100%	100%

The special education directors were also asked to name the primary decision maker that decides whether a particular service is billed to MaineCare. Overall, 42% of the directors said that they made the decision, 25% said that the provider (therapist) made the decision on billing, 14% said the decision was made by the district financial staff (business manager), and 5% reported that administrative support staff made the determination.

Billing Complexity

The Maine, Massachusetts and New Hampshire state websites for Medicaid in schools were reviewed. Maine's Medicaid for schools website stood out for its complexity. This same finding was seen by Baller and Barry in a 2016 review of all 50 state school Medicaid systems Baller and Barry found more than half of the states had ten or fewer unique billing codes for school-based speech-language services and occupational and physical therapy codes. Maine stood out among states as having the most unique billing codes for speech-language services (42) and occupational and physical therapy codes (40). Some states use a bundled code for these therapies. (Baller and Barry, 2016)

States write their own Medicaid regulations that have to comply with some federal guidelines. Massachusetts Medicaid program, MassHealth, has a separate school based program that is marketed as a way to offset local education agency costs. There are regular communications posted to districts and providers on their web site as well as contact information for a help desk run by University of Massachusetts Medical School (MassHealth 2021).

New Hampshire has clearly separate Medicaid regulations for school-based services. Their website has updates that emphasize how schools can add billable services such as behavioral screenings. The website emphasizes the benefits to schools by their program explanation on the website:

> "Medicaid to Schools (MTS) is a benefit of the NH Medicaid state plan that offers local education agencies (LEAs) and school administrative units (SAUs) the opportunity to receive federal Medicaid dollars to offset costs for Medicaid covered services performed by qualified medical or behavioral health treatment providers in a school setting to a Medicaid eligible student."

New Hampshire guidelines show that therapy services, vision services, manipulatives and documentation time are billable. They have a code for rehabilitative aide for carry-over of services occupational, physical, speech, and behavior therapies. (New Hampshire Department of Health and Human Services 2020)

While most states base their school-based service coding on Common Procedural Codes (CPT) codes that are used in healthcare with some modifications, it appears that Maine asks school districts to bill as a healthcare entity. Maine has a manual for schools with each page linking to the Medicaid manual rather than providing explanations or clarifications tailored to the school-based audience. Districts are expected to use separate coding modifiers for services provided under an IEP and other non-academic medical services provided in schools. In the Public Consulting Group (PCG) early childhood consultation report (2020), it was found that most services billed were under section 28, Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations or section 65, Behavioral Health services including day treatment. For section 28 services, the system did not include modifiers to indicate if a service was provided under an IEP (Maine DHHS, 2020; Public Consulting Group, 2020).

The MaineCare school-based website states that "This webpage provides information and important updates about policy and billing changes to MaineCare-covered services that are provided in an educational setting" but does not attempt to persuade or explain why pursuing federal funding is in the districts' best interest. In school-based MaineCare presentations and in the manual there were links to trainings that district employees could undertake to understand some of the nuances of the system, and there was an explanation of seed money billing by the state to districts (Maine DHHS, 2021; Maine DHHS, 2020).

In our surveys and interviews, therapists expressed confusion over how to interpret basic sections of the MaineCare regulations. For example, each therapy section says services must be performed one-on-one. Some therapists felt that any work performed by a graduate therapy student under direct supervision of a licensed therapist had to be repeated by the licensed therapist to be billable. Others felt this one-on-one phrase precluded group therapy. Other interpretations of one-on-one was that this prevented billing of time spent coaching family/caretakers to provide continuity. Most therapists felt the time they spent preparing materials, providing videos, and speaking to patients and their families during remote learning was not billable. Yet there were others who disagreed with these interpretations, and some who questioned whether Maine regulations were more restrictive than other states.

Another example of the complexity of MaineCare in schools is the billing requirements for behavioral health providers (BHPs). Depending on the situation and location, the

qualifications for a behavioral health provider vary. In all situations, a BHP must complete a thirty-five-hour state course (Woodford Family Services, 2021). However, additional requirements depend on whether the BHP is working in the community or in a school-based setting. The former must be 18 years old with a high school education or G.E.D., while the latter must have 90 hours of college credits. (Maine DHHS, 2021; Maine DHHS, 2020)

A recurring theme was Maine districts expressing fear of needing to return federal funds as a result of a Medicaid audit. On MaineCare's school based website there are two prominent links for providers and school administrators. The first is a Powerpoint presentation saying which services are eligible the second is an audit checklist. The MaineCare's website audit checklist has three Excel sheets, mentions very specific details that need to be in every student's records and does not mention school calendar or attendance data (Maine DHHS 2021). In contrast, New Hampshire's website explains federal regulations require audits. Their website stresses maintaining daily (specifically not period) attendance, provider qualifications, and service time records (New Hampshire DHHS 2020).

Therapists in this survey noted that MaineCare reimbursement is low. Most therapists surveyed in this study are employed by school districts, but therapists often contract independently with districts to provide their services. Districts are paying market rate for therapists. When MaineCare reimbursement is less than the rate paid to the provider, matching federal funds are not available for the full rate. A recent listed rate was $19.40 for a physical therapy session. If the district paid $60 for the physical therapy service, then $40.60 of the cost was not eligible for federal funding. The federal share, 70% of $19.40, would be only $13.58. If MaineCare paid the full $60 cost of providing the service, the federal share would rise to $37.80. New Hampshire's reimbursement appears to be tied more closely to the cost of providing service (Maine DHHS, 2020; New Hampshire DHS, 2020).

Allowable Medicaid Services

The Centers for Medicaid and Medicare Services (CMS) define state coverage of school-based health care as an optional requirement of state participation in Medicaid. This gives states latitude in determining what is covered. States that cover more services typically receive more matching federal funding and have greater service use. (Baller and Barry, 2016)

MaineCare appears to be fairly restrictive in what school based services it covers. Maine's school based Medicaid website lists behavioral health, nursing, occupational therapy,

physical therapy, speech and hearing services as covered school-based services. It does not list screening services, coordination of care or program administration (Collins, 2019). One regulation states private duty nursing must be in IEP to be school-based service (Maine DHHS, 2020). Medicaid has a provision to pay some school administrative fees that are considered necessary for proper administration of the program. These include outreach, enrollment care coordination, referrals and transportation. In 2016 when total federal spending for school Medicaid was $4.5 billion, payments for administration of Medicaid were $1.2 billion. In 2016, Maine did not use Medicaid to pay for administrative fees. (MACPAC 2018).

The most recent comprehensive review of all states' school-based Medicaid programs was done in 2014, and there was a large variation in what states covered. Almost all states' Medicaid programs covered school-based speech-language, physical and occupational therapy. Behavioral health was also covered under almost all state Medicaid programs. Half of the state Medicaid programs covered personal aides. In 2014, less than half of the state Medicaid programs covered development diagnostic services, case management, intake/evaluation, vision, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and nutrition services. IDEA acknowledges the need to provide services to parents and caregivers of children with a disability to facilitate their child's participation in the classroom. About half of the state Medicaid programs covered school –based family treatment for students with behavioral health conditions. (Baller and Barry 2016)

In recent years, there has been an increased emphasis on providing preventive screening to all children. Educators and the government are realizing the importance of early identification and intervention for students with disabilities. Timely interventions may prevent the need some students to receive special education services. Lately, there has been a steady increase in the number of students identified as needing special education services. The largest and fastest growing group of students needing special education services are students with specific learning disabilities (Koelbe, 2019). When all students have care such as vision screenings, hearing tests or vaccines, Medicaid will pay for the services of children and youth that are Medicaid eligible as long as the screening provider meets state qualification standards. It is important to note, that coverage for screenings under EPSDT does not require that the family be actually enrolled in Medicaid but only be eligible. Federal recommendations are for youth under the age of 21 are to

receive specific periodic screenings that include mental health and substance abuse screening (MACPAC, 2021).

The recent COVID-19 pandemic increased the awareness of student mental health issues. The federal Medicaid and (Childrens' Health Insurance Plan) CHIP Payment and Access Commission (MACPAC) has made mental health a focus this year. MACPAC will be reporting to the US Congress this June on improving access for children and youth to behavioral health services. MACPAC recognizes schools as a major provider of behavioral health services to youth whose role could be expanded. Their draft report highlights one in four youth ages 12-17 received some form of mental health treatment. Fourteen percent received mental health services from education sources. Youths who were Medicaid beneficiaries were more likely than youth with private insurance or uninsured youth to receive mental health services from their schools. MACAC data showed that in 2019, 14.5% of 12-17 year olds had a major depressive episode (MDE). Among Medicaid beneficiaries, just 54% of those with MDE received some form of mental health treatment. Over 95% of youth that needed alcohol or substance abuse treatment did not receive it. Amongst Medicaid beneficiaries, white youth were also more likely to have a substance abuse disorder than non-white youth. Youth in Medicaid also were more likely than others to receive mental health treatment in overnight in a residential facility or hospital. (McMullen and Becker Roach, 2020, Becker Roach, 2021)

MACPAC feels states need additional guidance and support to address children and youth mental health services delivery. There is an access problem due to limited supply of providers. Home and community–based programs may prevent the use of more restrictive settings for children and youth with significance mental health conditions. (Becker Roach, 2021). Other scholars have noted mental health services in schools could be improved. Depression screening in adolescents was only covered in a few 2014 state school-based Medicaid reimbursement plans (Baller and Barry 2016). Koelbe found schools are expected to implement student support structures such as Response to Intervention (RTI) and Multi-tiered Systems of Support (MTSS) for all students, but these flexible models can conflict with federal and state regulations on how money for special education can be spent. Experts are recommending states and localities should be given flexibility to blend funding streams for early intervention and unifying regular and special education. (Koelbe, 2019). There are some instances when the system works well and Medicaid funds benefit all students. In a California

behavioral classroom, the support the district receives to pay a psychiatrist to provide therapy services to nine students and their parents also helps provide services to four other students who are in the class (Gorman & Rodriquez, 2018). The MACPAC draft recommendation for the June report to U.S. Congress is for federal agencies to issue joint regulations and guidance on the design and implementation of benefits for children and adolescents with significant mental health issues. There needs to be additional screening, "opportunities to reimburse for technology-enabled services and identify evidence based services. MACPAC states the desired outcome is enhanced state capacity to design and implement new benefits (McMullen and Becker Roach, 2020; Becker Roach, 2021).

Mental and Behavioral Health Providers

Under the current MaineCare regulations the billing of behavior and mental health services is confusing. Schools can employ the providers of their choice but there are strict MaineCare regulations on which services are reimbursed. The first area that was unclear is the difference between behavioral health services, mental health services and the need for additional assistance due to developmental delays. No clarification was found on MaineCare's website or manuals. In interviews and survey responses, it was learned that school-based behavioral health services are typically not considered reimbursable under MaineCare guidelines when provided by the school's Behavioral Health Providers (BHPs) due to provider qualification requirements. There are also multiple professionals providing behavior and mental health services within their scope of practice in schools. These scopes of practice overlap and the conditions of billing for these professionals is difficult to discern. There may be differences in the types of professionals providing mental health services to Maine students based on the school location. An example of the MaineCare billing regulations not being clear is for Occupational Therapists' (OTs) services.

Behavioral Health Providers.

As noted above the education requirements for behavioral health providers (BHPs) are situational. The minimum requirements for the BHP certificate are a high school diploma (or GED) and a 35-hour training course (Woodfords Family Services 2021). However, school-based BHPs must also be eligible for the Ed Tech III certificate meaning that they have at least 90 hours of college credits. In other studies, educators have mentioned that this is a hard position to staff and most do not stay in the position. They either complete a college degree or leave the profession.

Special education teachers and directors were asked to check-off which paraprofessionals provided support to students with intense behavioral needs in their schools. Very few (2%) of directors (n=2) and teachers (n=3) said their school does not employ this type of staff. Only about half of the special education directors (45%, n=38) and special education teachers (50%, n=80) said their schools employ Ed Tech IIIs with BHP training which are reimbursable under MaineCare. Over half of the directors (56%, n=48) and teachers (69%, n=111) said they employ Ed Tech IIIs without BHP or similar training. Forty-percent of special education directors (n=34) and special education teachers (n=64) said their schools use Ed Tech Is with BHP training to work with students that have intense behavioral needs. Ed Tech I authorization requires a G.E.D. certificate or a high school diploma. There was not a large difference in employment of these paraprofessionals by district size, but both special education directors in cities and suburbs (58%, n=11) and teachers in cities and suburbs (60%, n=21) reported more employment by their schools of Ed Tech IIIs with BHP training than remote rural directors (37%, n=7) and remote rural teachers (45%, n=17). There was an increase in the use of Ed Tech Is with BHP training in remote rural area directors' (42%, n=8) and teachers' (50%, n=19) responses compared to the city and suburban directors' (26%, n=5) and teachers' (20%, n=7) responses.

Table 5. Directors' report of the types of paraprofessional school employs to work with students who need intensive behavioral support by locale

	Total n=79	City or suburban n=19	Small town n=41	Remote rural n=19
Ed Tech III with Behavioral Health Provider (BHP) or similar training	43%	58%	39%	37%
Ed Tech III, no additional mandatory behavioral health training	56%	53%	59%	53%
Ed Tech I or II with additional training to work with behavioral challenges	39%	26%	44%	42%
Ed Tech I or II, no additional mandatory behavioral health training	18%	0%	24%	21%
Other	13%	11%	17%	5%
N/A, my school does not employ these staff	3%	0%	5%	0%
Total	100%	100%	100%	100%

Table 6. Teachers' report of the types of paraprofessional school employs to work with students who need intensive behavioral support by locale

	Total n=154	City or Suburban n=35	Small town n=81	Remote Rural n=38
Ed Tech III with Behavioral Health Provider (BHP) or similar training	47%	60%	42%	45%
Ed Tech III, no additional mandatory behavioral health training	66%	57%	64%	79%
Ed Tech I with additional training to work with behavioral challenges	38%	20%	41%	50%
Ed Tech I, no additional mandatory behavioral health training	36%	26%	38%	42%
Other	10%	3%	16%	5%
N/A, my school does not employ these staff	2%	0%	4%	0%
Total	100%	100%	100%	100%

It was unclear why MaineCare requires BHPs working in schools under a teacher's supervision to have 90 hours of college credits. There may or may not be a benefit to this educational requirement. As noted about over a third of schools hire individuals without this education to assist students with intense behavioral needs. Special education teachers were given a hypothetical question asking about the effect of allowing Ed Tech Is to be BHP providers in the school. Sixteen percent of special education teachers (n=25) felt nothing would change. Overall teachers felt more positively than negatively about this concept. About half of the teachers (54%, n=86) felt learning for students with a BHP might increase and class-wide student learning might increase (47%, n=75). About a third of special education teachers felt there would be a decrease in behavioral problems (39%, n=62) and more students would be assigned a BHP (35%, n=56). A quarter of teachers (24%, n=39) felt students would be assigned a BHP for a greater quantity of time. A higher percentage of teachers that had students with intense needs in their caseloads than teachers without these students in their caseloads felt these effects would occur. Under the other category, only one teacher commented that the paraprofessionals need to be ED Tech IIIs, the other teachers said they were unsure of the effects of changing requirements. It should be noted that most teachers and special education directors indicated their schools were using paraprofessionals other than ED Tech IIIs with BHP training to provide services to students with intense behavioral needs.

Table 7. Teachers' perception of the effects of allowing Ed Tech Is to be Behavioral Health Providers by whether they teach students with intense behavioral needs

	Total n=160	Teacher has students with intense needs n=73	Teacher does not have students with intense needs n=87
Learning for students with a BHP might increase	54%	64%	45%
Learning for students with a BHP might decrease	4%	0%	7%
Class-wide student learning might increase	47%	58%	38%
Class-wide student learning might decrease	5%	3%	7%
There would be an decrease in behavioral problems	39%	47%	32%
There would be an increase in behavioral problems	6%	4%	8%
More students would be assigned a BHP	35%	40%	31%
Students would be assigned a BHP for a greater quantity of time	24%	26%	23%
Other	11%	4%	16%
Nothing would change	16%	15%	16%
Total	100%	100%	100%

Occupational Therapists.

During data gathering for this project, there was some disagreement among professional societies about the role of occupational therapists in providing mental health services. MaineCare regulations were again confusing. Occupational therapy services are defined as

> "[T]he assessment, planning and implementation of a program of purposeful activities to develop or maintain adaptive skills necessary to achieve the maximal physical and mental functioning of the individual in the individual's daily pursuits. The practice of "Occupational Therapy" includes, assessment and treatment of individuals whose abilities to cope with the tasks of living are threatened or impaired by developmental deficits, the aging process, learning disabilities, poverty and cultural differences, physical injury or disease, psychological and social disabilities or anticipated dysfunction."

Behavioral day treatment clinicians include registered nurses (RNs) and Licensed Alcohol and Drug Counselors (LADC). Both of these licenses are associate degrees. Occupational therapy is a graduate degree but is not listed as a behavioral day treatment clinician (Maine DHHS, 2020).

Special Education directors were asked what professionals provided mental health services in their schools. Social workers were the primary type of provider in all locations (74%, n=74). All directors in districts with more than 500 students (100%, n=51) said social workers

provided mental health services in their districts. In districts with less than 500 students, the most common answers were counselor (62%, n=16) or social worker (62%, n=16). Occupational therapists were listed by only 12% (12) special education directors. None of these directors were from remote rural schools. There may be larger amount of mental health services being provided by occupational therapists and psychologists in more populated areas.

Table 8. Mental Health and/or Behavioral Health Service Provider in Directors' Schools

	Total n=100	City Suburban n=19	Small Town n=41	Remote Rural n=17
Psychologist	18%	21%	27%	6%
Counselor	47%	58%	46%	65%
Occupational therapist	12%	26%	12%	0%
Social worker	74%	100%	85%	76%
Other	19%	21%	29%	18%
Total	100%	100%	100%	100%

BCBA- 3 City, suburb. 7 small town, 1 remote rural

While schools are hiring the professionals they feel best suited to meeting their students' needs, the MaineCare regulations may not allow the districts to be reimbursed for their services. As the federal government looks to expand mental health services in schools this is an area of opportunity for MaineCare and schools to work together.

Conclusion and Implications

Maine has an opportunity to expand resources to support students with special education needs through increased utilization of federal Medicaid funds for medically-necessary services. This could reduce the costs borne by state and local governments, and/or provide increased levels of services to students. An increase in MaineCare reimbursements can be facilitated by changing Maine's system for school-based services to one that is simpler for districts to use, covers more of the services allowed by the federal Centers for Medicare and Medicaid, and reimburses the districts for more of the costs of providing medical services to eligible students.

However, streamlining policies will not completely address the challenge of the time, effort, infrastructure, and expertise that is needed to request MaineCare reimbursements. Most of Maine's numerous small, rural districts lack the information systems and dedicated staff that are needed to make billing feasible. At the time of writing, discussions are underway to explore consolidating MaineCare billing at the state (or regional) level in order to relieve individual school districts of the burden. Our research suggests that this proposal has much merit.

Given the critical need for supporting students' social and emotional well-being as a result of the myriad challenges from the COVID-19 pandemic, we wish to particularly highlight the emerging finding that federal Medicaid funds may be an underutilized source of support for mental health services. While it was beyond the scope of this study to delve into this finding in detail, this should be a key priority when exploring how to expand MaincCare to include additional CMS-approved services.

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Author Information

Amy F. Johnson is co-Director of MEPRI at the University of Southern Maine. She holds a doctorate degree in public policy and has expertise in education policy analysis, program evaluation, qualitative research methods and statistical analysis. Her areas of research interest include equitable school funding models, teacher preparation program accountability, STEM education and college readiness.

Patricia L. Lech is a Senior Research Associate in the School of Learning and Teaching, College of Education and Human Development, University of Maine. She has expertise in quantitative research methods and statistical data analysis, as well as education program evaluation.