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Improving Governance to Reduce Administrative Burden and Increase Funding for School-Based Health Services

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ABSTRACT

Public schools are critical sites to address children's emergent health needs, yet they face ongoing challenges to finance and sustain health initiatives. Medicaid is an important funding source for school-based health services, accounting for over $8 billion in revenue for school-based health services in 2024 (Furtado et al., 2026), but it is underutilized. Drawing on interviews with state Medicaid and local educational agency personnel, this study illuminates administrative burdens in school Medicaid billing and the collaborative governance arrangements developed among states, localities, and third-party organizations to ease burdens. We find that cooperation between educational service agencies and school districts increased billing capacity and shifted administrative burdens up to higher-level educational units better equipped to manage them. Adopting collaborative governance models that leverage the comparative strengths and scaling capacities of public and private organizations may lessen administrative burdens and increase school Medicaid billing, although low Medicaid reimbursement remains a significant disincentive.

KEYWORDS

School-based health; Medicaid; administrative burden; collaborative governance; intergovernmental cooperation

Introduction

School-based health services have been an important component of public education systems for decades, and more recently, local educational agencies have developed comprehensive and integrated models of health services delivery.[1] As public schools become more proactive in developing a range of preventative services and early and intensive interventions to support children's physical health and mental health, increased funding is needed to expand and sustain these supports. School-based health services have the potential to increase child access to health care and improve health equity, and for some low-income children, schools serve as a primary source of health care (Boudreaux et al., 2023; Love et al., 2019).

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Medicaid, a public health insurance program jointly financed by state contributions and federal matching funds, serves eligible children in low-income families and is a significant source of funding for school-based health services. Local educational agencies can leverage Medicaid funding, working closely with their state Medicaid agencies to support health care services, staffing, and equipment in school settings (Mandle et al., 2025). Until 2014, the federal "free care rule" restricted local educational agencies from drawing on Medicaid funding to provide health services unless the services were delivered to students as part of an Individual Education Program.[2] In 2014, the Centers for Medicare & Medicaid Services (CMS) reversed the free care rule, allowing states to opt into authorizing Medicaid reimbursement for comprehensive health services delivered in schools to Medicaid-enrolled students. One study found that in school Medicaid expansion states, school-based health services increased by 8.9 percentage points among a subset of children with heightened risk of health issues and barriers to care (Meinhofer et al., 2025). Despite the opportunity to receive funding and increase child access to health services, only 28 states have adopted school Medicaid expansion to date (Healthy Schools Campaign, 2026).

Many local educational agencies have not yet taken advantage of the opportunity to bill Medicaid for services provided to eligible students. Schools are not typical health care providers, and school-based Medicaid billing and reimbursement arrangements differ by state, depending on factors such as local school capacity and state guidance for billing (CMS, 2023).[3] Meeting Medicaid service, documentation, and billing requirements can require significant capacity building efforts at the local level. For example, expanding the pool of eligible services and the school-based providers who provide these services may pose additional challenges often unfamiliar to schools, such as ensuring that providers are licensed by the State Medicaid agency. Addressing these complex challenges at the appropriate scale and level of government requires intergovernmental and collaborative strategies.

While school Medicaid expansion represents an important opportunity for intergovernmental cooperation and collaborative governance to promote children's health, there are administrative barriers to developing formal arrangements between local educational agencies and state agencies, health care organizations, and managed care organizations for school-based health services billing.[4] State Medicaid agencies have the primary authority in determining which school-based health services are covered and reimbursable by Medicaid, as well as the processes through which providers, including schools, are paid. The level of cooperation between state Medicaid agencies and local educational agencies in facilitating billing and reimbursement for school-based health services varies across states and

localities, along with the collaborative roles of health care organizations, managed care organizations, and billing vendors.

We leverage this state and local variation in intergovernmental cooperation and collaborative governance, along with variation in state Medicaid and school Medicaid expansion, to examine the administrative burdens that arise in adoption of school Medicaid billing and how governance models can overcome them to increase Medicaid billing and reimbursement for school-based health services. Specifically, we address the following research question: how do state Medicaid agencies, local educational agencies, and third-party organizations develop and sustain intergovernmental and collaborative arrangements to reduce administrative burdens and improve billing for Medicaid-eligible school-based health services? Using data from interviews with individuals in state Medicaid agencies and local educational agencies, we construct detailed case-comparisons of states that: (1) are/are not a Medicaid expansion state, (2) have/have not adopted school Medicaid expansion, including school Medicaid billing, and (3) are/are not receiving federal CMS funding for increasing school-based Medicaid billing. Through theory-informed analyses of these case study data, we illuminate how states, localities, and third-party organizations developed intergovernmental and collaborative governance arrangements and how these arrangements eased administrative burdens in adopting school Medicaid billing.

We find that while local educational agencies want to receive Medicaid reimbursement for providing school-based services, high learning and compliance costs and low reimbursement are disincentives to billing. In addition, local educational agencies not only navigate contractual and billing arrangements, but also the parameters of care coordination, such as differing rules and procedures across organizations for referrals, documentation and data sharing, student insurance coverage, and parental consent. Through our comparative case analyses, we identify two promising models of intergovernmental cooperation and collaborative governance that merit further exploration for reducing these administrative burdens and facilitating school Medicaid billing. One model is educational service agencies, which are positioned at the regional level.[5] These agencies are authorized by state law to develop, manage, and provide services or programs to schools and can employ school health providers and billing support on behalf of school districts. The other model involves collaboration with private third-party organizations—including billing vendors, health care organizations, and managed care organizations—to help support state and local educational agencies in adopting and implementing school Medicaid billing. Amid rising student health needs and substantial declines in federal funding for school-based health, this study identifies governance models and incentive structures that states and localities can explore and

adapt to reduce administrative burdens and leverage sustainable Medicaid funding (Bitsko et al., 2022).

Integrated conceptual framework

In this study, we integrate the concepts of intergovernmental cooperation and collaborative governance to frame our analysis of administrative burdens in school Medicaid billing. Informed by these concepts, we illuminate how burdens arise or are mitigated in governance arrangements, including the learning and compliance costs associated with properly submitting service claims to receive Medicaid reimbursement. Though both collaborative governance and intergovernmental cooperative arrangements have the potential to ease burdens in Medicaid billing, they can also add complexity, layering on additional obligations for managing intergovernmental relationships and meeting Medicaid requirements. Applying the lenses of intergovernmental cooperation and collaborative governance to understand how states, localities, and third-party organizations respond to governance challenges contributes toward understanding and formalizing models of governance that ease administrative burdens imposed in policy implementation.

Cooperation between levels of government is a critical, driving force behind implementing school Medicaid billing. We define intergovernmental cooperation as the arrangements between two or more governmental agencies to achieve common goals or provide services. Applying the concept of collaborative governance to our analysis directs focus toward uncovering the complexities of public agencies engaging across government levels and with private actors. We use the definition of collaborative governance developed by Emerson et al. (2012) as the "processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and the public, private, and civic sectors."

By integrating intergovernmental cooperation and collaborative governance in our analysis, we aim to elucidate how particular intergovernmental and collaborative governance arrangements shape local and state experiences of administrative burden and the tradeoffs of pursuing these arrangements, recognizing that different arrangements may have distinctive challenges and benefits. For example, the challenges or advantages of particular collaborative governance arrangements may vary by the level of support provided by the state Medicaid agency and by the types of private organization that public agencies contract with (i.e., managed care, billing vendors, and health care organizations). By attending to both intergovernmental and collaborative arrangements across government levels and between different governmental and non-governmental actors, this analysis

can illuminate governance models and cooperative approaches to more effectively address administrative burdens. This framework also allows for exploration of the mechanisms, and under what conditions, different types of governance arrangements may alleviate or worsen administrative burdens and motivate local and state actors to pursue Medicaid billing.

Background and literature

Administrative burdens—onerous or difficult experiences in interacting with government that impose barriers to accessing public services or supports—are well-documented in the U.S. health care system (Burden et al., 2012; Cutler, 2020; Health Affairs, 2022), and in the Medicaid program in particular (Herd et al., 2013; Herd & Moynihan, 2021; Kyle & Frakt, 2021). Examples include high learning costs in understanding health insurance coverage and service options, difficulties in navigating and complying with complex eligibility and tiered care access processes, and stressful and time-consuming appeals of denials of care and payment (Herd & Moynihan, 2021). Estimates of administrative costs in delivering health care indicate that they account for about 15–30 percent of medical spending, including billing- and insurance-related expenses (Cutler, 2020). Moreover, when excessive, they may impede or deny access to health care (Kelman & Reicher, 2021; Kyle & Frakt, 2021).

Many health care administrative activities serve legitimate purposes and are critical to effective functioning of health care systems and to coordination across an array of actors that facilitate health care access and services (Halling & Baekgaard, 2024; Herd & Moynihan, 2018). Kyle and Frakt (2021) highlight that cost sharing activities, which require coordination across multiple actors and individuals needing care, aim to increase efficiency. In their case study of Wisconsin's Medicaid program, Herd et al. (2013) demonstrated that state governments have the authority to exercise policy levers to shift burdens associated with Medicaid program application, enrollment, and eligibility determination from individual actors to the state, thereby increasing program access without compromising program integrity.

Research on Medicaid program implementation has long pointed to federal and state program rules and policies that could reduce barriers to Medicaid access and burdens on those who help to facilitate Medicaid enrollment (Fox et al., 2020; Herd et al., 2013; Kaiser Family Foundation & Georgetown University Health Policy Institute, 2009). Abrogast et al. (2024) found that administrative burdens that reduced Medicaid coverage had the largest consequences for the poorest families, driving enrollment churn. The extent to which states have exploited these opportunities to reduce burdens varies extensively, reflecting in part differing political and

social views of safety net programs as options of last resort to be rationed or of administrative barriers as tools for screening out the less needy or undeserving from public programs (Fox et al., 2020; Heinrich et al., 2022; Madsen et al., 2022; Schuck & Zeckhauser, 2006). Fox et al. (2020) estimated the effects of variation in reforms to reduce Medicaid administrative burdens across states and found that states that adopted more of these strategies realized greater increases in program enrollments, particularly child Medicaid enrollments.

Specific to school-based health, just over half of states have adopted school Medicaid expansion since the 2014 free care rule reversal (Close, 2024; Healthy Schools Campaign, 2026). CMS recognized the administrative burdens schools and states encounter in billing Medicaid for school-based health services and released updated guidance for school health services billing in 2023, allowing states flexibility to pursue less onerous reimbursement and documentation requirements (Close, 2024). CMS now allows states to eliminate fee-for-service billing and instead receive interim reimbursement through methods such as cost settlement. Although cost settlement requires a claim submission for every service provided, it can be less administratively burdensome than fee-for-service. Cost settlement estimates the actual costs of providing services to allocate interim, often monthly, payments to schools until the yearly cost settlement is determined, smoothing out payments for schools across the year.

The newer CMS guidelines also substantially reduce the number of Medicaid-related surveys that must be completed by school providers (CMS, 2023). A Random Moment Time Study (RMTS) is a frequently used survey that determines how much time school staff spend performing Medicaid reimbursable work activities based on a sample of random moments of school providers during a work day. In addition to reducing compliance costs, CMS has also sought to reduce the learning costs associated with understanding the role of Medicaid in supporting school-based services, providing educational opportunities to pediatricians, local educational agency staff, and others about the benefits of school Medicaid billing and reimbursement in supporting child health.

Administrative burdens exist not only by policy design, as Tiggelaar & George (2025) argue, but are also embedded in organizational processes that involve entities beyond formal government agencies, suggesting that third-party organizations may also play a role in reducing administrative burdens in design and implementation. Particularly as states have shifted Medicaid delivery systems toward managed care, some local educational agencies have sought to manage the burdens of billing Medicaid by working collaboratively through third-party organizations, including billing vendors and health care providers. In arrangements where a school-linked health care organization provides health care staffing in schools or receives

student referrals to an off-site health care center, the health care organization may assume full responsibility for insurance billing to get reimbursed for the cost of services. Alternatively, some local educational agencies that provide health care services to students at school may contract with a third-party organization to handle the tasks associated with securing reimbursement, where the billing vendor takes some share of the reimbursement. Stein and Schwartz (2024) suggest that these types of public-private collaborations can aid in facilitating a more tightly coordinated system of care for students who receive services in schools as well as in other community settings. Public-private collaborations may address positional burdens placed on lower levels of government, such as schools, with limited capacity (Hofmeyer, 2026).

Recent studies recognize the costs associated with managing the burdens of receiving public dollars in multi-actor arrangements, as reflected in staff time and positions required to handle contracts and funding, billing and compliance, and tracking of services (Herd & Moynihan, 2018; Stein & Schwartz, 2024; Yu, 2023). Wiley and Berry (2018) draw attention to circumstances when the funding available for providing certain functions is less than cost recovery levels, suggesting that while public funding is critical to providing the core services, it is inadequate to cover the regulatory and administrative costs of utilizing it. Moreover, the cumulative effects of administrative burdens on parties trying to navigate it often diverts valuable time away from core programmatic activities (Heinrich et al., 2022). Wiley and Berry characterized the organizations that frequently serve in these roles as the "compassionate bureaucracy," i.e., organizations or individuals that aid in overcoming administrative burdens by taking on the "the maze of regulations" and complexities of these processes, thereby releasing time for other parties to attend to their core work.

By design and expressly in the context of managed care delivery systems, adopting school-based Medicaid requires intergovernmental cooperation and collaborative governance, which depend on both formal interactions and relationship-building (i.e., the active cultivation of trust and partnerships) (Osborne, 2006). We draw on both conceptual lenses, which are distinguished primarily by the actors and interactions they involve (Ansell and Gash, 2008). Intergovernmental cooperation focuses on formal interactions between government agencies, including interactions between agencies located at different levels of government, whereas collaborative governance extends beyond public agencies to collaborations with private, non-state actors. Both theories are useful for investigating complex societal challenges that cannot be resolved by a single government actor or level alone. As Stein and Schwartz (2024) discuss, relationships between health care and managed care organizations and local educational agencies do not come naturally, and without support and facilitation from state

Medicaid agencies, they may be difficult to develop and sustain. Local educational agencies may also have insufficient information on the types of services and supports health care organizations can provide, and these organizations may also need time and guidance to understand how health services can be operationalized in school settings.

Consequently, in the context of school Medicaid billing, both intergovernmental cooperation—between state Medicaid agencies and local educational agencies—and collaborative governance across state Medicaid agencies, local educational agencies, and third-party organizations (billing vendors, health care organizations, and managed care organizations) are central and may reduce administrative burdens in the billing processes (Emerson & Nabatchi, 2015; Tiggelaar & George, 2025; Yang, 2026). Considering intergovernmental cooperation and collaborative governance arrangements together illuminates a range of strategies that states and localities can leverage to address particular forms of administrative burdens. We explore these arrangements and how they help to reduce administrative burdens in school Medicaid billing through interviews across diverse state and local settings (Donahue & Zeckhauser, 2011; Scott & Thomas, 2017; Weiss, 1987). We focus on administrative burdens in the form of learning and compliance costs from the perspective of state and local educational agencies, using the same framework as those studying administrative burden from the beneficiary perspective. In our study, learning costs include the costs associated with learning about school Medicaid billing and its requirements, and compliance costs include meeting these requirements to receive funding.

Research design

We employed a qualitative multiple-case study design following the interpretive approach of Creswell (2016) to address our research question. We used semi-structured interviews aimed at understanding governance arrangements that reduce administrative burdens and facilitate school Medicaid billing. The research team read and coded transcripts and developed themes to address the research question. Data collection took place between Fall 2023 and Spring 2025 for all interviews.

This multiple-case study approach allows us to closely examine the adoption and implementation of school Medicaid billing at state and local levels in four states: Illinois, Nebraska, Tennessee, and Wisconsin. We construct in-depth case comparisons of these states that (1) are/are not a Medicaid expansion state, (2) have/have not adopted school-based Medicaid billing, and (3) are/are not receiving federal CMS funding to increase school Medicaid billing. We illuminate how these factors influence state Medicaid agency and local educational agency interactions and interactions

Table 1. State selection.

State characteristics	Adopted school medicaid expansion	Did not adopt school medicaid expansion
Adopted Affordable Care Act Medicaid Expansion	Illinois	Nebraska
Did Not Adopt Affordable Care Act Medicaid Expansion	Tennessee	Wisconsin

between these agencies and third-party organizations, including health care organizations, managed care organizations, and billing vendors that support school-based health services and billing.

The states included in this study had differing political orientations toward the Medicaid program and each has a range of small and large, urban and rural local educational agencies, which allowed an exploration of how political and geographic variation shapes state and local educational agency decisions to adopt and expand school Medicaid billing. Illinois provides an example of an Affordable Care Act (ACA) Medicaid expansion early adopter state that more recently expanded school Medicaid billing. Tennessee provides an example of a state that expanded Medicaid for school-based services while not pursuing ACA Medicaid expansion to increase program eligibility at the state level. Nebraska provides an example of a later adopter ACA Medicaid expansion state that had not expanded school-based Medicaid billing. Wisconsin provides an example of a state that had expanded neither program at the time of the interview and where CMS federal funding helped overcome state political obstacles to pursuing school Medicaid billing (see Table 1).

While Table 1 describes how we selected states by school Medicaid expansion status and ACA Medicaid expansion status, we focus on the adoption of school Medicaid billing in our interviews with state and local agencies. One reason we chose states by ACA expansion status is because expanding Medicaid via the ACA shapes the amount of federal match that states receive and the eligible population, including children. When a state receives a higher federal match, this increases federal dollars toward all eligible Medicaid services, including school-based services.

Qualitative data collection and analysis

Interview procedures

We interviewed individuals across state Medicaid agencies, local educational agencies, and health care organizations that provide and coordinate school health services and bill Medicaid for these services. We used purposive sampling to interview at least one individual at the state level and at least one individual at the local level. Employing this approach allowed us to examine both intergovernmental and collaborative governance arrangements across governmental levels (i.e., state Medicaid agency agreements to

transfer Medicaid reimbursement from the state to local school districts) and within levels of government (i.e., school district contracts with local health care organizations). We recruited participants through interview outreach using publicly available emails or through our existing state and local research partnerships, which facilitated access to both state and local participants who engage in school Medicaid service provision, billing, or policy implementation. We provided informed consent, including that each participant's participation in the study was voluntary, through verbal consent before each interview, and in Tennessee, a REDCap electronic consent form.

This study took place in the context of two larger research studies focused on the implementation of school-based health service delivery in Tennessee and Illinois, which both included a focus on school Medicaid billing. This study leverages the rich qualitative data collected in both studies, including insights into the role of managed care and health care organizations in school-based health services delivery in the case of Tennessee and into the role of billing vendors and educational service agencies in facilitating billing in the case of Illinois. The two studies were approved by the Institutional Review Boards at the University of Chicago (IRB 230379) and Vanderbilt University (IRB 230422).

Tennessee presents an important example of how schools and states navigate managed care in the context of school Medicaid billing. The U.S. Government Accountability Office (2025) reports that in more than forty U.S. states, about 85 percent of the thirty-three million Medicaid-enrolled children received health coverage through managed care. Given that most children are enrolled in managed care plans nationwide, an increasing number of local educational agencies will likely pursue contracts with managed care organizations to pay for these services. Contracting with managed care to receive Medicaid reimbursement for school-based health services requires developing collaborative governance arrangements across private and public actors. This form of contracting for school health services through Medicaid managed care may exacerbate administrative burdens experienced by school districts, as they have to navigate contracts with managed care organizations that set their own fee schedule rates with the schools. Additionally, Tennessee has a high child poverty rate (ranking among the bottom fourth of all states in 2022) and administrative data show that over the last two decades, more than two-thirds of Tennessee school-aged children have been enrolled in Medicaid (TennCare) at some point (Heinrich et al., 2025).

Relative to other states in our study, Illinois presents an example of how investments in state resources facilitate school Medicaid billing. For example, the Governor's Office led state-wide working groups with school districts and other partners to develop solutions to school Medicaid billing,

including updating school Medicaid billing guidance to address billing challenges identified through these working groups. Additionally, Illinois illuminates an example of a state that has dedicated significant internal state resources toward pursuing collaborative governance arrangements between the state Medicaid agency and third-party billing vendors to provide technical assistance for school Medicaid billing and toward facilitating intergovernmental cooperation between educational service agencies and local school districts. Given the decades-long efforts of the state Medicaid agency to promote school Medicaid billing, Illinois presents a case where agencies across levels of government have developed processes to pursue Medicaid reimbursement. However, even in this context, complexities within governance arrangements across a range of government and third-party entities challenge the ability of school districts to receive this reimbursement, motivating our close examination of Illinois' implementation of Medicaid billing.

We also interviewed Nebraska and Wisconsin as two states that, at the time of the interviews, had not adopted school Medicaid expansion or pursued school Medicaid billing, but were considering or taking steps toward doing so. For example, Wisconsin had applied for and received CMS funding to support efforts to pursue school Medicaid expansion and was developing plans at the state-level to expand school Medicaid billing. This timing and context in both states presents the opportunity to examine the pre-implementation context and how states weighed their decision to expand school Medicaid billing, including what intergovernmental cooperative or collaborative governance arrangements they developed during this pre-implementation period. This context also allowed the research team to examine how ACA Medicaid expansion status shaped decision-making, including how this policy affected the federal reimbursement the state and localities within each state would receive if they adopted and pursued school Medicaid billing.

In total, we interviewed 29 individuals in Medicaid agencies across 19 states, 139 individuals in local educational agencies (54 in IL, 1 in NE, 82 in TN, and 2 in WI), and 9 individuals across third-party health care organizations in Tennessee (see Table 2). The imbalance in data collection at the local level reflects that our sample includes interviews collected as part of two larger studies on school-based health in Tennessee and Illinois. Drawing on these interviews provides an opportunity to (1) examine school Medicaid billing from an intergovernmental cooperation perspective by including both state and local staff, and (2) explore how collaborative governance arrangements may lessen or exacerbate administrative burdens.

Our diverse sample—in work experience, professional background, employment tenure, and organizational role—allows for exploration of the array of individuals involved in school Medicaid billing (see Table 3).

Table 2. Interview detail.

State and Number of Interviews	Agency/Organization and Number of Participants		
Illinois ($N=56$)	State Medicaid Agency – 2 interviews (2 participants – IL SMA 1, IL SMA 2)		Local Educational Agency – 54 interviews (54 participants in 1 school district – IL LEA 1–54)
Nebraska ($N=2$ interviews)	State Medicaid Agency – 1 interview (1 participant – NE SMA)		Local Educational Agency – 1 interview (1 participant – NE LEA)
Wisconsin ($N=2$ interviews)	State Medicaid Agency – 1 interview (2 participants – WI SMA 1, WI SMA 2)		Local Educational Agency – 1 interview (2 participants – WI LEA 1, WI LEA 2)
Tennessee ($N=92$ interviews)	State Medicaid Agency – 1 interview (1 participant, TN SMA)	Third-party Health Care Organizations (HCO) – 9 interviews (9 participants; TN HCO 1–9)	Local Educational Agency – 82 interviews; the number of district participants in each interview ranged from 1 to 4, except for 1 district with 8. Districts are not individually identified to protect participant confidentiality; TN LEA 1–82)

Table 3. State Medicaid agency respondent demographics.

State	Role	Tenure at Agency
Illinois (IL SMA 1)	Program Manager	19 years
Illinois (IL SMA 2)	Policy Director	6 months
Nebraska (NE SMA)	Program Coordinator	1 year
Wisconsin (WI SMA 1)	Program and Policy Analyst	11 years
Wisconsin (WI SMA 2)	Benefits Policy Manager	3 years
Tennessee (TN SMA)	Managed Care Director	7 years

State Medicaid Agency interviews included individuals with differing prior professional experience, including those who worked as school health services providers before working at the state-level. Local educational agency interviews included interviews with administrators, school health coordinators, and school health service providers to examine local factors that shape decisions about Medicaid billing and health services delivery.

The state Medicaid agency and local educational agency interview guides examine adoption and implementation of school-based Medicaid billing. We apply our integrated conceptual framework to explore how intergovernmental and collaborative arrangements addressed administrative burdens. The guides were tailored to the specific agency or organization and to state expansion details using publicly available state documents to ensure appropriateness and applicability. They included: (1) individual position and work experience, (2) work role and duties, (3) changes in work routine or role due to school Medicaid billing adoption or implementation, and (4) reactions to these changes and anticipated or experienced challenges, successes, and opportunities in expanding school-based Medicaid billing. The coauthors worked individually in conducting the interviews, which lasted between 30 and 60 minutes each. The interviews were transcribed using Zoom AI or Otter.ai software and transcripts were checked with audio recordings for accuracy.

Qualitative analysis

We developed thematic analysis in five phases following Braun and Clarke (2022). Throughout each phase of analysis (see Table 4), the research team kept detailed notes, including memos on how the analysis was evolving and questions and reflections on how the data were interpreted through the theoretical lenses of intergovernmental cooperation and collaborative governance. We present findings on key themes from our analysis to illustrate diverse perspectives on the school Medicaid billing process, including how states and localities develop intergovernmental and collaborative governance arrangements. We use acronyms for the key actors that we refer to in the context of the quotes: State Medicaid Agency (SMA), local educational agency (LEA), and health care organization (HCO).

Findings

Intergovernmental challenges aligning reimbursement to billing incentives

Across all interviews, state Medicaid agency and local educational agency staff reported that their decision to expand school Medicaid billing was rooted in increasing reimbursement revenue to support student health. Medicaid reimbursement is one of the few sustainable revenue sources

Table 4. Qualitative thematic analysis phases and activities.

Phase of analysis	Research team tasks
First: systematically engaging with transcripts before beginning the coding process.	Team read and listened to all transcripts while making sense of the data in the context of our research question.
Second: developing codes from a second read of the interviews to identify parts of data that appear interesting, relevant, or meaningful to the research question. The team refined the codebook from 76 to 33 codes to reduce redundancy through discussion and returning to the data.	Team applied analytically meaningful descriptions (codes) to them, where each code captured a single idea or concept, building toward theme development. Codes were developed deductively (drawing on theoretical concepts) and inductively (from transcripts). The team developed consensus that the refined codebook provides a summary of the diversity in meanings in the dataset and indicates team members' analytic insights. Throughout the analytic process, team members addressed conflicting interpretations through in-depth discussion and returning to data.
Third: generating initial themes through team discussions and thematic mapping to explore patterns across all interviews.	Initial themes were developed so each had its own central organizing concept with codes related to each theme. Team identified themes that required further development to more fully explore various ideas and richness or that were too complex to represent one central concept.
Fourth: reviewing initial themes against all interview transcripts identified with the refined codes related to each theme, followed by team discussion.	Each theme was checked by all team members to ensure that it had a clear and distinct organizing concept with meaningful and rich evidence across the dataset and that the themes compellingly addressed the research question.
Fifth: refining, defining, and naming themes to signal their meaning and analytic direction and to define a central organizing concept and boundaries.	Analysis concluded when each theme was named and defined, and the team reached consensus that each theme individually and collectively addressed the research question.

schools receive to support school-based health services and is often used to cover the costs of local school providers' salary and benefits. Now that states can expand Medicaid reimbursement beyond services provided in an Individualized Education Program through the free care reversal, schools can receive reimbursement for a wider range of services. Common expansion services eligible for Medicaid reimbursement include mental health services provided by school social workers and health assessments administered by school nurses. The percentage of reimbursement returned to local educational agencies differs by state and shapes incentives for participation in school Medicaid billing.

The process of local educational agencies receiving federal Medicaid reimbursement first involves the transfer of federal reimbursement dollars to the state Medicaid agency, which then transfers all or some portion of these dollars to the locality that generated the reimbursement. Some states' legislative policies stipulate that a portion will be retained by the state and held in the state general fund. At the time of our interviews, Wisconsin and Nebraska were in the process of expanding school Medicaid billing. This timing provided an opportunity to examine how state politics and budgetary priorities shape reimbursement, with Wisconsin providing 60 percent and Nebraska providing 80 percent of the federal reimbursement back to local educational agencies (Coleman, 2025; Furtado et al., 2026; Hudak et al., 2026; Kaiser Family Foundation, 2026).

When asked about how the state spends the reimbursed amount, both states' Medicaid agency and local educational agency staff responded that they did not know. Wisconsin Medicaid staff shared that these dollars go to the general fund and "can really be spent on anything." Nebraska local educational agency staff shared that in the upcoming budget cycle, the state might further reduce the percentage of reimbursement to localities: "We're up to 80 percent [reimbursement] now. But there was a conversation that might drop back again with our unicameral [legislature] right now redoing our budget…We were at 40 [percent before]." Wisconsin described how these incentives shape local decisions to participate in the program:

> WI SMA 1: "[Reimbursement] definitely is a barrier…it might not really be worth the extra administrative requirements for how much [LEAs are] getting reimbursed… that has been an issue with the willingness of schools to claim for services…a high administrative burden for something that does not give them a huge amount of reimbursement."

Administrative burdens interact with incentives, shaping local agencies' willingness to participate in Medicaid billing (Guo et al., 2026). To address reimbursement barriers to billing, Wisconsin's Democratic governor proposed a budget that would increase reimbursement back to local

educational agencies from 60 to 100 percent in addition to other Medicaid provisions. However, the Republican legislature previously rejected a similar budget proposal and "threw it out the window." The state's decision not to pursue policy levers to reduce burdens may reflect differing political and social views of safety net programs, even if the school Medicaid program, as a small component of the larger Medicaid program, is not particularly divisive. (Fox et al., 2020; Schuck & Zeckhauser, 2006).

> WI SMA 1: "I don't think there's anyone directly opposed [to increasing reimbursement to 100 percent]. Just that hesitancy…We have to work through the legislature… So that is kind of some of the roadblocks that we come up against…The willingness of the legislature to do anything that 'expands' Medicaid can be a bit of a touchy subject in Wisconsin."

The Wisconsin state legislature decisions reflect state-level politics surrounding the Medicaid program, shaping the reimbursement that all Medicaid providers receive in the state. Although Medicaid reimbursement alone was reported to only cover up to a third of school-based provider costs across states, it is a key source of revenue given that most states rely on and braid this funding with Individuals with Disabilities in Education Act (IDEA) funding, state and local educational funding, and grants. These decisions further complicate local decisions to participate in billing, given that Medicaid only covers a portion of the costs of school providers.

> WI LEA 1: "We are limited…to a schedule for reimbursement for the amount of what the Medicaid funding doesn't cover. It's not anywhere near our total cost for providing the services."

> WI LEA 1: "[Reimbursement is] certainly worth it in terms of funding, but it's not an easy, low burden threshold to receive the funding."

Although expanded Medicaid billing was considered worthwhile by the local educational agency, deciding to participate in school Medicaid billing is not a straightforward decision. The reimbursement may not justify the administrative burdens required to learn how to properly and effectively bill and comply with federal and state billing requirements. Nebraska's local educational agency staff provided context for how localities evaluate this tradeoff, including the burden of participating in the CMS-administered random moment time study:

> NE LEA: "Once you get to the minutia of it, the juice isn't always worth the squeeze when it comes to it. I mean the design from the 10,000 foot view is that, you know, it sounds great, that [reimbursement] on all of these services that you provide. But it is built on these time studies and how well [LEAs are responding to the time studies] and all of those things which relies on training and understanding…That just creates a lot of stress that the juice isn't always worth the squeeze when you look at what you're actually getting back."

> NE LEA: "It's always demoralizing when your revenue is barely enough to cover what your actual costs were…it becomes really challenging for [school] districts to muddle through because it's just not worth it to them."

Comparatively, in Illinois, Medicaid agency staff reported that "100 percent of [the federal reimbursement] service money goes to the local educational agencies." Medicaid agency staff shared that local educational agencies have received Medicaid reimbursement "once a month for 25 years." The continuity and consistency of support for school-based services, even before the recent expansion, is facilitated by cooperation between the state Medicaid agency, governor's office, and local educational agencies. A key reason Illinois decided to expand was to switch reimbursement to cost settlement, which improved the amount of reimbursement that localities received. Cost settlement payments to local educational agencies can be higher than either rate settlement or fee for service billing, because cost settlement bases payments on local educational agencies' costs of providing services to students, accounting for provider salaries. Medicaid agency staff reported that this successful move to cost settlement was promoted by the governor's office, publicly directing efforts to align support for the expansion process across state-level health and education agencies.

> IL SMA 1: "Success to me right now [in expansion] is that we were able to pass 92 million extra dollars out to the [school] district through the cost settlement last year. I know the governor was really putting that amount out. I am so happy to see that much increased funding go out to the schools."

Illinois' decisions to switch to cost settlement and transfer 100 percent of the reimbursement for services to local educational agencies incentivize local educational agency participation in school Medicaid billing. Comparatively, the Tennessee Medicaid agency does not determine the reimbursement percentage that localities receive because the Medicaid program is run by private managed care organizations. As the only state where all school-based services are run by managed care, Tennessee local educational agencies navigate highly complex billing and care arrangements with third-party organizations, while receiving variable reimbursement amounts dependent on their contracts with managed care organizations.

Intergovernmental cooperation shifts up administrative burdens

The concept of scale and how educational agencies leveraged their scaling capacities was present throughout interviews with state Medicaid agencies and local educational agencies. Interviews included a wide array of small and large school districts and rural and urban school districts to facilitate a close examination of how local educational agency choices to implement school Medicaid expansion differ by geography and size. Wisconsin

underscored the scaling challenges for small and rural districts to participate in school Medicaid billing.

> WI SMA 1: "One of our biggest issues that rural [school] districts face is with that administrative burden, not having the capacity to hire someone who can do Medicaid claims, or they have less of an ability to. A lot of larger school districts will hire out their claims processes to [billing vendor], and so the smaller and more rural school districts [don't] have the same capacity to do those things. I think they definitely struggle more with claiming for Medicaid services, because they just don't have that same infrastructure that larger districts have."

Illinois and Nebraska developed models of educational service agencies to support school districts in billing and providing services. In Nebraska, all school districts are located within educational service agencies, called educational service units (ESUs). ESUs were created as political subdivisions by the Nebraska Legislature in 1965. All ESUs provide similar core services and individualized services, with a master service agreement for schools within their county-defined area in partnership with other ESUs. We interviewed a large ESU, which serves over 15 school districts across differing scales, including districts with hundreds to thousands of students enrolled. This local educational agency shared that as an ESU, they increased the capacity of districts to provide student services by employing providers at the ESU-level who can work across districts of various sizes. In this model, districts have flexibility to hire their own providers or have the ESU provide practitioners to their school. The ESU does not require districts to pay for billing support, unlike billing vendors, and have long-standing, cooperative relationships with districts. ESUs can adapt to local context and need without imposing the financial and transaction costs of billing vendors, which may strengthen the availability, sustainability, and effectiveness of school-based health services.

> NE LEA: "One of the perks [is] we've been in Nebraska for almost 50 years. We have deep relationships with our schools, so they really rely on us for a wide variety of services that we provide…it ranges from everything, from mental health supports that we're providing in some of our [school] districts to Autism services, transition services, to direct services like vision and mobility, deaf and hard of hearing support."

The ESU model can tailor their support to school districts based on individual district need, while also retaining significant capacity to manage billing across districts. When a local educational agency is too small to effectively provide and bill for services, intergovernmental cooperation through this model can serve to shift efforts to the relevant scale and leverage the unique resources of a higher educational unit. ESUs are a model for how educational service agencies can effectively provide small and rural districts direct and administrative support, which shifts up

administrative burdens on these districts to ESUs and encourages participation in school Medicaid billing. Cooperative partnerships across local educational agencies help share the costs of public services and help districts fulfill policy mandates for children with disabilities (Bel & Warner, 2008; Feiock, 2013; Scott & Thomas, 2017; Weiss, 1987). In Nebraska, this was reported to be particularly important given the number of rural and small districts.

> NE SMA: "If the physical therapist works for the ESU, the ESU will do the claims for the physical therapist services where they might be going to: small school district A, B, and C. But because they work for the ESU, they get that claim [for reimbursement]. Then there's just a contract between the school district and ESU…The ESUs tend to take the lead. I know a lot of ESUs will actually manage our provider enrollments and things like that for school districts that are really small."

> NE LEA: "The main tenets of [my] role is administration and supporting school districts build systems of support around behavioral and mental health in underserved communities, primarily rural communities that don't have direct access to mental health services. They're pretty under-resourced when it comes to psychologists, counselors, social workers, and other related providers who would provide direct behavioral mental health support in schools. So I've been able to help them learn how to build systems of support to help kids in schools."

In Illinois, some school districts participate in cooperatives (co-ops), another type of educational service agency that can help school districts participate in billing. Cooperatives are established by multiple school districts to "provide needed special education facilities and to employ a director and other professional workers…for the purpose of providing comprehensive and cost-efficient special education services" (Illinois School Code, 2012). Medicaid agency staff in Illinois elucidated how this model helps alleviate school district administrative burdens by shifting up administratively time-intensive and complex tasks to educational service agencies, including school Medicaid billing.

> IL SMA 1: "A lot of the co-ops will employ the medical people because I know the southern Illinois one, it's a lot of tiny rural [school] districts that might need a nurse for one kid. The co-op employs them and then splits their time over the different districts. I know the person I deal with at that district is heavily involved with the billing and so she will ask a lot of questions along the way. Co-ops in Illinois, they will employ a lot of staff and can do part-time at different districts, so that you don't have to try to employ a full-time person for less services."

> IL SMA 2: "Often in the…small, rural districts, [resources are] just not there. But I've heard of districts kind of forming some agreement that they're going to share staffing. Maybe there's one Medicaid expert or multiple doing billing for multiple rural districts. So I think that's one way to kind of help make the case for it is when you can combine [efforts for school Medicaid billing]."

Co-ops, similar to ESUs, help address capacity vacuums in small and rural school districts to engage in administratively burdensome tasks like billing. Larger districts are less likely to have capacity constraints; they benefit from the ability to smooth investments in capacity-building efforts across multiple individuals and departments to promote both internal cooperation and capacity to bill. For example, in the larger Illinois district we interviewed, the district employs many administrators whose role focuses on building and maintaining billing and student service systems. This capacity may make investment in Medicaid billing systems and in hiring Medicaid-eligible staff providing critical health services more worthwhile relative to the administrative burdens that billing imposes, while simultaneously generating reimbursement revenue. For larger districts with greater scaling capacity, the ability to shift up administrative tasks within the district by employing designated staff may reduce local administrative burdens.

> IL SMA 2: "The big thing is resources, how well-resourced a [school] district is, how large it is. I think it's just easier when, even though I wouldn't say that [large school district] is the most well-resourced, but there are so many kids there and so many kids that are Medicaid-eligible. That is a worthwhile investment when you think about the return on investment, when so many Medicaid dollars could come to the school."

> IL LEA 4: "Success [of expanded school Medicaid billing in our school district] would be that we could either directly provide or link a student to any care that they would need, and be Medicaid reimbursed for that service…I would just love to see this closed loop kind of system where we see a need, we help the student get it, and then everyone's paid back."

ESUs, co-ops, and large school districts are models of public educational units that benefit from and realize economies of scale, which refers to the process by which the cost per unit of service delivered decreases as more services are delivered (Scott & Thomas, 2017). School providers present a significant upfront and relatively fixed cost to school districts and are usually hired for the long-term, unlike school provider contractors. Given the returns to scale for larger local educational agencies, the cost per unit of service delivered is relatively lower than for rural and small districts.

Collaboration with third-party organizations alleviates billing burdens

Across all states, third-party billing vendors were key actors in school Medicaid billing. Vendors fill a diverse range of roles and alleviate both learning and compliance costs for state and local agencies associated with expanding school Medicaid billing. Vendors can help states learn about opportunities to expand and effectively implement by drawing on their national-level expertise developed through assisting other states on their

school Medicaid billing processes and learning from their previous successes and challenges. Paying a vendor for their services limits the time that the Medicaid agency and local educational staff dedicate to seeking out information, thus limiting learning costs associated with expanding school Medicaid billing. Medicaid agency staff in Illinois and Nebraska shared the critical role of the same vendor in the expansion process.

> NE SMA: "[Vendor] has been tremendously helpful, and I know they helped do expansion services in Colorado and other places…seeing what worked for them, what didn't work for them, and just having those conversations."

> IL SMA 1: "[Vendor] has been so helpful in this whole [expansion] process. I don't know if we would have gotten as far as we did as quickly as we did without their help. I think other states looking into doing this should definitely look into outside resources that are on a national level and can help."

> IL SMA 2: "[Expansion] required a lot of collaboration with [vendor]…and a lot of the direct LEA support is coming from [vendor], but also from [our] staff too. A lot of support was needed for schools in this shift, we were learning. This was a big change for [LEAs] too. And they're still learning…There was…technical assistance that was needed for schools [that vendor provided]."

At the time of our interview, the Wisconsin Medicaid agency intended to submit a state plan amendment to revise their state Medicaid plan that lists all covered services within the state Medicaid program, with the objective to expand school Medicaid billing to a wider range of school-based services. This decision was motivated by the recent 2023 CMS guidance that requires changes to most states' Medicaid state plans for the purpose of receiving school-based services reimbursement. The CMS guidance encourages states to adopt an expansion of school Medicaid billing and provides flexibilities in pursuing this expansion. CMS has encouraged and provided resources to adopt through this guidance, along with $2.5 million grants allocated through the 2022 Bipartisan Safer Communities Act. The Wisconsin Medicaid agency was awarded this grant by CMS to support school Medicaid expansion billing, which they used to pay for local educational agency training.

> WI SMA 1: "A big part of our grant is expanding the capacity of our vendor…so that they can help us create a training program…we're hoping to create more trainings on what happened with expansion [for LEAs] …[we're] trying to give schools a lot more information because we don't have a lot of information out there for people [to assist them with school Medicaid billing]."

State Medicaid agencies and local educational agencies pay vendors to leverage and adapt their procedural and billing expertise for their specific contexts, contributing capacity that individual government agencies often do not have. Vendors have invested in understanding federal guidance and requirements and much of their work is focused

on providing technical assistance, which reduces learning costs for both state Medicaid agencies and local educational agencies. The elevated role of vendors providing direct technical assistance demonstrates the embeddedness of collaborative governance structures in the school Medicaid program. Across Illinois, Nebraska, and Wisconsin, billing vendor technical assistance was particularly critical during the first phase of expansion, when state Medicaid agencies and local educational agencies were learning about how to implement expansion. In Tennessee, the state Medicaid agency (TennCare) does not use a specific vendor, as the Medicaid program is largely operated by managed care. However, TennCare was highly cognizant that school districts were often turning to third-party organizations, primarily billing vendors, to support billing managed care for Medicaid-eligible services delivered to their enrollees.

Tennessee acknowledged challenges in contracting with third-party organizations, primarily difficulties in properly credentialing school providers for Medicaid billing purposes, given the numbers of parties involved in the billing process and need for communication among them. TennCare oversees these processes by tracking (and denying) claim payments and auditing the credentialing process, with the objective to support and improve coordination between managed care organizations, health care organizations, and local educational agencies in these processes (Stein & Schwartz, 2024). This Medicaid agency role is important in Tennessee, given that the state does not have a Medicaid managed care contract template or centralized credentialing process for school districts.

Local educational agencies in Tennessee described two primary ways that they drew on partnering organizations to assist with billing Medicaid: one, relying on health care organizations to manage all billing, with no Medicaid reimbursement funding coming back to the schools, or two, working through a vendor for billing, where the vendor receives a portion (typically 20 percent) of Medicaid dollars returned to local agencies for providing school-based health services. With both options, local staff were relieved of the burdens of managing billing responsibilities, although the reimbursed amount school districts ultimately received differed depending on their arrangements with third-parties. In Tennessee, health care organizations perform a similar role as educational service units and co-ops, providing practitioners to schools, managing the Medicaid billing process, and overseeing the health care provider credentialing and supervision processes as required by the Medicaid agency. They reduce some administrative burdens, especially for small, rural school districts, but require a high-level of collaboration between the state Medicaid agency, local educational agency, and billing vendors.

> TN LEA 8: "[HCO sends] mid-level providers in, so they bill individual insurance. All of that occurs in their organization. Their services are provided at school, and we don't have to do any kind of documentation for those services provided, which is very nice."

> TN LEA 10: "We also are billing through third-party. The third-party is [vendor], they're billing for nursing services. It's my understanding that the income from those services is what's really helping to fund nurse supplies."

The Tennessee Department of Mental Health and Substance Abuse Services has also played a role in helping to facilitate student access to mental health supports and reducing the burdens on local educational agencies of making these services accessible. The department initiated a School-Based Behavioral Health Liaisons (SBBHL) program—a unique collaborative governance arrangement—that has now expanded to all Tennessee counties. This program provides SBBHLs in local educational agencies through funding for local community mental health centers (third-party health care organizations) that partner with local educational agencies. The SBBHLs are employees of the community mental health centers and co-located in schools identified by and in coordination with local educational leadership. The SBBHLs provide a range of services, from mental health assessments and individual and group interventions to referrals for services and supports and training and consultations for teachers and school personnel. Importantly, they also manage the billing of different types of insurance, not only TennCare.

> TN LEA 12: "[HCO] started [a] program in 2015 that placed therapists into schools. This was a difficult program to fund due to the number of days schools are closed and other factors. Once the SBBHL program began, that was the perfect mix of billable services as well as [state grant] funds to support other needs of the program."

> TN HCO 4: "I think currently, because of the state-funded SBBHL programming, there's a lot more consistency now than historically. We still have separate contracts with school districts that we do kind of pockets of things, but in the 15 counties that we contract with the state for those schools, it is that multi-tier system of support within the school [developed with the SBBHLs]. We keep the scope fairly consistent with those across the board."

Third-party organizations—health care organizations, community-based organizations, county health departments, and vendors—were frequently described as important partners for securing additional funding and programmatic supports to sustain school-based health services. These partnerships with third-party organizations are emblematic of what Wiley and Berry (2018) characterized as the "compassionate bureaucracy." Third-party organizations working with school districts and other community partners help lighten the load of their core work and to assist them with the

burdens of federal and state regulations in funding including billing. Although billing vendors may lighten the load, agencies must carefully weigh the costs of relying on a vendor and weigh the share of reimbursement they ultimately receive. Additionally, some local educational agencies have little to no direct contact with managed care organizations, and care coordination between managed care organizations, local educational agencies, and health care organizations can be limited. The state Medicaid agency may need to provide more robust support to local educational agencies or more directly mediate points of disconnection to address these collaboration challenges and provide forums for localities to assess tradeoffs, given its stated goal of encouraging participation (Stein & Schwartz, 2024).

Collaboration with managed care and health care organizations poses complexities

One premise of shifting Medicaid delivery systems toward managed care is that with more effective management of costs and utilization in a better coordinated system of care, both access and quality of care may improve. For school districts, the promise of both increasing students' access to care and funding for those services is a key motive for endeavoring to work with a complex range of actors, including those in the state, health care organizations, and managed care organizations to secure Medicaid reimbursement for school-based health services.

> TN LEA 1: "The nurses can get funded, they get as much as we bill. We'll get money back from it…because the nursing budget is not very high. We tried to get to where we could start billing, so that we could get more money for [nurses] to buy the things that they need [to provide services]."

From the state Medicaid agency perspective, they've worked hard to encourage and assist with strengthening relationships between TennCare managed care organizations and other health care organizations, local educational agencies, and individual providers within the school districts, with the goal to have as many school districts as possible working through health care organizations to bill Medicaid for school health services provided. Accordingly, TennCare has taken some specific actions to ease the burdens of billing Medicaid for health services delivered to Medicaid-enrolled children in school, such as eliminating requirements for prior authorization of services, which previously required local educational agency staff to navigate state bureaucratic procedures to determine a student's managed care plan, get approval, and bill the plan (Stein & Schwartz, 2024).

In addition, in 2022, Tennessee passed a law that explicitly mandates managed care to "contract with any school district that seeks to contract

with the managed care organization to receive reimbursement for medically necessary, covered school-based services." To implement this law, Tennessee developed strategies to encourage closer collaboration between managed care organizations, health care organizations and local educational staff. For example, recognizing that differences in terminology and expertise can be barriers to cooperation in school-based health services delivery, the state requires managed care organizations to submit an "Annual Stakeholders in Education Engagement Plan." The plan details specific strategies for engaging a broad range of education stakeholders—state education agencies, local educational agencies, individual school health service providers, and students and their parents or legal guardians—with the objective of receiving their input into enhancing the state's provision of school-based services. Health care organization staff described how stakeholder relationships were cultivated across schools.

> TN HCO 1: "Our approach has definitely emphasized a collaborative effort with the schools in identifying the school's needs and gathering as many resources and participating in as many opportunities as we can at the schools, whether it be health fairs, things like that, to provide resources, but also with the staff that work in the schools, interventions for students, whether that be individual or through groups. Our partnership with the school is a big part of our advocacy for our services, whether it be at parent-teacher conferences, health fairs. We also have referral forms located at each school that we partner with. So, if the school identifies a need for a student, they can collaborate with the personnel that's assigned to that school to help with students and services."

While Tennessee's efforts to reduce administrative burdens in school-based Medicaid have made progress, local educational agencies still have to individually contract with health care organizations, navigate their specific contract and billing procedures, and undertake school provider credentialing to be reimbursed. Stein and Schwartz (2024) found in their analysis that many local educational agencies lack the infrastructure and expertise to arrange contracts and comply with the required procedures. Health care organization staff in Tennessee described their experience arranging a contract with school districts.

> TN HCO 2: "It took us forever to get a [Memorandum of Understanding that specified service agreements] with the schools because [the schools] were like, 'We don't need you.' And the state was like, 'Yes, you do.' And it was a whole thing. Once we finally got in there, we had to start ironing out wrinkles."

School district staff described their school district's resistance to Medicaid billing with health care organizations.

> TN LEA 2: "I came in trying to figure it out [Medicaid billing], because my goal early on was sustainability, and so I was trying to think of ways how can we make this to where there's going to be some dollar signs attached [to the delivery of school-based health services by health care organizations] so that we can continue it on. And how do we do that? Let's go through insurance [including Medicaid]. Okay, so let's look at trying to bill for medical services. You can get [health care organization] nurses involved with [billing]. We can do that. And I was shut down in an [school district] administrative meeting… [Administrator in my district] said: 'We've tried that with special education students,' and she says it is a beast, and you don't want to go there. So it was never brought back up again. And because she says that…this will never happen, I thought, well, this is not going to work."

Once an arrangement is established between a local educational agency and health care organization for providing health services in schools, the organizations must collaboratively develop working partnerships with strategies to address numerous collaborative governance issues. How school districts navigate these partnerships depends on their capacities and contexts. For instance, smaller rural districts with fewer total students enrolled may have comparatively fewer resources or lack access to staff with necessary credentials or familiarity with Medicaid regulations, compared to larger districts with more in-house staff and nearby health care facilities. TennCare recognized these challenges, including the added burden of securing supervision to bill.

> TN SMA 1: "We're never going to get a hundred percent of those LEAs to contract with our TennCare managed care organizations, and that's simply because some LEAs just don't see it worth their while to contract with TennCare, because they don't have that many TennCare members or students to make it worth their while."

> TN SMA 1: "The biggest impact is just schools having that infrastructure, meaning the [in-school] supervision component. Not a lot of schools have the resources to have on site a nurse practitioner, or a physician assistant, or a physician to be able to supervise their school nurses to be able to bill [Medicaid] for those services."

A rural local educational agency staff member similarly explained how limitations in staffing made it difficult for them to bill Medicaid.

> TN LEA 3: "We didn't have nurse practitioners on staff, and we needed [their supervision to bill Medicaid]. We were going to use their license with their nurse practitioner to work with our school nurses to get billing…done."

Many local educational agency staff described the challenges of navigating different types of student insurance coverage or eligibility, and how this affected their decision to partner with health care or managed care organizations. Some school districts with large numbers of students without insurance coverage and ineligible for Medicaid preferred to serve students with district-employed staff and to forego the complex administrative activities associated with partnering to deliver services with third-party organizations. These activities involved securing required

documentation and billing different types of providers or at different fee scales, which was especially complicated among student populations whose insurance status might be dynamic. Some health care organizations also described being constrained in being able to see only students with Medicaid. As a result, many school districts regularly sought grants or worked with community partners to fund or provide the health staffing and services necessary to meet the needs of all students in their schools.

> TN LEA 4: "My programs are funded through contracts and grants. So, we're able to see every student in the school regardless of their insurance status; we're even able to see kiddos who are undocumented, because we're funded in different ways. So, we do bill TennCare if the student has TennCare. But if they don't have TennCare, we don't bill anything."

> TN HCO 3: "We used to have school-based therapists in [LEA 1] and [LEA 2]… We hired therapists and placed them in the schools. And [our health care organization providers] could only see students who had TennCare. They did [see] a lot of kids [in the school including those] that had TennCare. But they were limited on [receiving reimbursement for TennCare services and] that did not end up being sustainable [for us to continue providing these services]."

Both local educational agency staff and health care organizations referenced issues of equity and administrative challenges in how they handled delivering and billing for school-based health services. For local educational agencies that had their own school district-funded staff as well as partnerships with health care organizations, this sometimes engendered conflicts that they had to manage in the relationship between health care organizations and school districts.

> TN HCO 2: "We're currently funded under a grant. The grant does allow and actually encourages us to bill third-party resources, which for us would be TennCare… But we have been instructed by the school district that they do not want us to bill for services, even though there's never a cost to the individual [student]. [The school district does not] want us billing inside of the schools because they feel that it's a conflict that we would bill insurance, [because] they provide similar services inside the school with their own agency, and [this agency does not] bill insurance. So they feel that it's an issue of parity [between our organizations and] I've honored that, certainly we're a guest in their house, I'm not going to go in and you know, tell [the school district] we're going to do something they don't want us to do."

In addition, school districts and health care organizations also navigate the parameters of care coordination, such as differing rules and procedures across health and education organizations for staff interactions, referrals, documentation and data sharing, and obtaining parental consent. Interpreting and respecting privacy laws (i.e., FERPA[6] and HIPAA[7]) was at times both a source of burden and tension in these interactions,

including the process of gathering student information for billing. The process of gathering student information for Medicaid billing is not often routine procedure within educational agencies, as they are not typical providers of health services.

> TN HCO 4: "[We – health care organization- and the school district] stay in our lanes, because there's a boundary there with FERPA and HIPAA and, you know, confidentiality and understanding our roles, but integrated in the sense that that we're part of the school system."

Although these tensions have long existed at the nexus of education and health systems, school Medicaid billing at the state and local levels often brought these tensions to the forefront with a new frequency as schools navigate complex and intersecting education and health laws when providing and submitting services eligible for Medicaid reimbursement.

Limitations

Although we use a multiple case study design to deeply and closely examine each of the four states presented, we recognize that this study does not provide a comprehensive understanding across all states that have or have not chosen to expand school Medicaid billing. We examine political, policy, and funding variation by state Medicaid expansion status, school Medicaid status, and CMS grantee status; however, we recognize that there may be other state dimensions that shape the decisions and processes of school Medicaid billing adoption and expansion that we did not uncover. Another limitation is that our chosen states are all located centrally in the United States, and this analysis is unable to explore how these findings might apply to other larger geographic areas of the United States. Additionally, although the inclusion of Nebraska, Wisconsin, Illinois, and Tennessee allows us to examine variation across cooperative and collaborative governance arrangements in addressing administrative burdens in school Medicaid billing, the governance models identified as effective in these states may not be transferable to other states. We also acknowledge that our local educational agency interviews came primarily from Illinois and Tennessee; this overrepresentation reflects the researchers' partnerships with Illinois and Tennessee government agencies and data collection as part of larger studies on school-based health in these states, as well as capacity limitations to extend large-scale, high-quality data collection and analysis to other states. Finally, school Medicaid expansion is a dynamic policy area, and findings may need to be revisited considering changes in local, state, and federal policy environments.

Conclusion

In this study, we examined how variation at state and local levels in intergovernmental cooperation and collaborative governance—shaped by politics, policy, and funding—influenced state and local decisions to pursue and adopt school Medicaid billing. We integrated the theoretical concepts of intergovernmental cooperation and collaborative governance to frame our analysis of administrative burdens in school Medicaid billing and illuminate how burdens arise or are mitigated in differing governance arrangements across states and localities. We found that low reimbursement disincentivizes local educational agency participation in school Medicaid billing, and even states that provide higher reimbursement face challenges navigating administratively burdensome Medicaid requirements. This leads many states and local educational agencies to rely on external organizations and educational service agencies to manage billing. Given the high learning and compliance costs associated with billing, these third-party organizations and regional-level educational agencies augment critical government capacities and facilitate school Medicaid billing.

Our analysis identified two primary models of intergovernmental cooperation and collaborative governance that can help reduce administrative burdens and facilitate school Medicaid billing. First, we found that the educational service agency model (including ESUs and co-ops) eases local educational agency burdens by shifting responsibilities up to a higher educational unit with greater capacity and shared administrative structure to provide billing and provider support to districts. This model was especially useful in small and rural districts with more limited scaling capacity. Second, third-party organizations, such as health care organizations and billing vendors, can also provide billing and provider support to districts, although they frequently layer on complexities because of the infrastructure and expertise required to arrange contracts and the intricacies of care coordination across partners.

More generally, our findings illuminate when and why public agencies pursue collaborative governance, as well as the types of innovations that can emerge through collaborative governance arrangements to solve persistent societal challenges, such the School-Based Behavioral Health Liaison program in Tennessee (Scott & Thomas, 2017). Our analysis across states and localities with differing policies and political and funding configurations also suggests that context and capacity are critical factors influencing the types of governance arrangements that develop and their effectiveness in reducing administrative burdens. Below, we draw on our study findings to highlight a range of actions that state Medicaid agencies and local educational agencies can take to improve school Medicaid billing, depending on their state and local context.

Improving intergovernmental and collaborative arrangements to reduce burdens

To start, all states can expand school-based services billing through state legislation or a state plan amendment, depending on the state's existing State Medicaid Plan. Second, government agencies can provide grants to support the expansion of Medicaid billing, following the example of the $2.5 million grants awarded by CMS. Third, state Medicaid agencies can increase the percent of the federal reimbursement dollars returned to local educational agencies, including up to 100 percent as in Illinois, to better incentivize local participation in billing and support student health. Fourth, Medicaid agencies can contract with billing vendors to support state and local billing capacity, including providing local educational agencies with technical assistance for expanding or improving school Medicaid billing. Fifth, Medicaid agencies can publish and disseminate clear credentialing standards and documentation requirements for school providers. In states like Tennessee that utilize managed care organizations, Medicaid agencies may need to play a larger role in facilitating collaboration among the various parties, given that coordination challenges within local educational agencies can be amplified. Finally, among states beginning the process to expand school-based services billing, a pre-implementation planning period to support coordinating roles and duties between the state Medicaid agency, the state education agency, local educational agencies, billing vendors, and managed care or health care organizations (if applicable) may help to strengthen the intergovernmental collaborative arrangements.

Although most states have some form of educational service agencies, many states have not fully leveraged the scaling capacity of these agencies to support smaller and more rural schools with Medicaid billing. Additionally, in almost all states, children are enrolled into a Medicaid managed care plan. Given the complexities of managed care within the school Medicaid billing process, third-party organizations including health care organizations and billing vendors may alleviate managed care billing burdens on school districts. In states without educational service agencies or in districts that experience challenges contracting with a billing vendor, school Medicaid billing may depend more strongly on local institutional capacity. States can consider how to better implement models of governance that alleviate burdens and support school districts, such as developing intergovernmental cooperation and collaborative governance arrangements to expand Medicaid billing.

At the center of school Medicaid billing efforts are the children for whom school-based health services are critical to their learning and development (Golberstein et al., 2024; Heinrich et al., 2025; Kerns et al., 2011; Komisarow & Hemelt, 2024). Schools often strive to meet

students' needs and to leverage sustainable funding to support delivery of school-based health services, while minimizing burdens to staff and families. Our research suggests that developing intergovernmental and collaborative governance arrangements that reduce administrative burdens can accelerate adoption of school Medicaid billing and boost funding for local educational agencies to expand delivery of school-based health services.

Notes

1. Local educational agencies refer to a public board of education or other public authority legally constituted within a state for either administrative control or direction of, or to perform a service or function for, public elementary schools or secondary schools in a city, county, township, school district, or other political subdivision of a state, or for a combination of school districts or counties as recognized in a state as an administrative agency (U.S. Department of Education, 2017).
2. An Individualized Education Program ensures that a child with an identified disability receives specialized instruction and services.
3. In a typical health setting, health care providers bill the state Medicaid agency or patient's managed care plan through a claiming system. The State then claims federal Medicaid matching funds for its expenditures.
4. Managed care organizations provide and coordinate medical services for their members to reduce health care costs.
5. Educational service agencies are legally accountable to both state and local officials, and receive federal, state, and local revenue. All states except TN, DE, ID, NV, and VA have educational service agencies.
6. Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records.
7. Health Insurance Portability and Accountability Act is a federal law that sets national standards for protecting sensitive health information.

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