Mental Health Research in Tennessee Schools

POLICY BRIEF

Strategies for Increasing School-based Medicaid Billing to Support Student Health

By Carolyn Heinrich, PhD, Vanderbilt University, and Caroline Kelly, PhD, Univ. of Chicago & Harvard University

Public schools are critical sites for addressing children's emergent health needs. School-based health services have the potential to increase children's access to health care and improve health equity, while for some low-income children, schools serve as a primary source of health care.

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). Working closely with state Medicaid agencies, school districts can leverage Medicaid funding to support health care services, staffing, and equipment in school settings, yet it is underutilized.

Using data from interviews with individuals in state Medicaid agencies and local educational agencies (see Data Collection Details Table), we constructed detailed case-comparisons of states that: 1) are/are not a Medicaid expansion state, 2) have/have not adopted school Medicaid expansion, and 3) are/are not receiving federal Centers for Medicare and Medicaid Services (CMS) funding for increasing school-based Medicaid billing. Schools are not typical health care providers, and school-based Medicaid billing and reimbursement arrangements are based on state and local factors.

Our research illuminated administrative burdens in school Medicaid billing processes, including high learning and compliance costs and low reimbursement rates that are disincentives to Medicaid billing. Meeting Medicaid service, documentation, and billing requirements can require significant capacity building efforts at the local level and may pose additional challenges unfamiliar to schools, such as ensuring that providers are licensed by the State Medicaid agency.

In addition, school districts not only navigate

KEY IMPLICATIONS

Medicaid is currently underutilized by school districts as a source of funding to support health care services, staffing, and equipment in school settings.

School staff often encounter high learning and compliance costs in meeting Medicaid service, documentation, and billing requirements, and they sometimes find that "once you get to the minutia of it, the juice isn't always worth the squeeze…".

The percentage of Medicaid reimbursement returned to local educational agencies differs by state and shapes incentives for participation in school Medicaid billing, with more generous reimbursements (such Illinois' 100% rate) yielding greater returns for school districts.

In this brief, we describe two promising models of intergovernmental cooperation and collaboration identified in our research as having the potential to reduce these administrative burdens and facilitate school Medicaid billing:

- **Educational service agencies** cooperating with school districts can increase their billing capacity and shift administrative burdens up to these higher-level (regional) educational units that are better equipped to manage them.
- Collaboration with **private third-party organizations** such as billing vendors, health care organizations, and managed care organizations can also help school districts to strengthen the capacities required for adopting and implementing school Medicaid billing.

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 identified two promising models of intergovernmental cooperation and collaboration that merit further exploration for reducing these administrative burdens and facilitating school Medicaid billing. One model involves educational service agencies, which are positioned at the regional level and authorized by state law to develop, manage, and provide services or programs to schools, allowing them to employ school health providers and billing support on behalf of school districts. Cooperation between educational service agencies and school districts can increase billing capacity and shift administrative burdens up to higher-level educational units better equipped to manage them.

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.

Detailed Findings

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 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 for school-based services through the 2014 free care reversal issued by CMS, common expansion services include mental health services provided by school social workers and health assessments administered by school nurses. However, the percentage of reimbursement returned to local educational agencies differs by state and shapes incentives for participation in school Medicaid billing. For example, while Wisconsin provides 60 percent and Nebraska provides 80 percent of the federal reimbursement back to local educational agencies, Illinois passed 100 percent of the federal reimbursement back to school districts. The Wisconsin State Medicaid Agency official lamented their comparatively low reimbursement rate:

"[Reimbursement] definitely is a barrier…it might not really be worth the extra administrative requirements for how much [schools 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."

Even at a reimbursement rate of 80 percent, a local educational agency in Nebraska commented:

"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."

In contrast, the Illinois State Medicaid agency representative called attention to their success:

"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 [method of Medicaid reimbursement] 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."

In Tennessee, TennCare does not determine the reimbursement percentage that localities receive because the Medicaid program is run by private managed care organizations.

The administrative burdens of Medicaid billing are more challenging for smaller and rural districts, as a

Data Collection Details

State and Number of Interviews	Agency/Organization and Number of Participants	
Illinois (N = 56)	State Medicaid Agency – 2 interviews, 2 participants	Local Educational Agency – 54 interviews and participants
Nebraska (N = 2 interviews)	State Medicaid Agency – 1 interview, 1 participant	Local Educational Agency – 1 interview, 1 participant
Wisconsin (N = 2 interviews)	State Medicaid Agency – 1 interview, 2 participants	Local Educational Agency – 1 interview, 2 participants
Tennessee (N = 92 interviews)	State Medicaid Agency – 1 interview, 1 participant, Third-party Health Care Organizations (HCO) – 9 interviews, 9 participants	Local Educational Agency – 82 interviews; participants in each interview ranged from 1-8

Wisconsin Medicaid agency official explained:

"One of our biggest issues that rural 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."

We found that when a local educational agency is too small to effectively provide and bill for services, intergovernmental cooperation through educational service units (ESUs), a type of educational service agency, can help to leverage the unique resources and direct administrative support of a higher educational unit that shifts administrative burdens and their costs upward.

"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]. And 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."[Nebraska State Medicaid agency official]

Third-party billing vendors were key actors in school Medicaid billing in each of our study states, filling a diverse range of roles and alleviating the learning and compliance costs associated with expanding school Medicaid billing in school districts.

"[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." [Illinois State Medicaid agency official]

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.

TN LEA 12: "[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 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]."

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. 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... 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 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."

Although tensions have long existed at the nexus of education and health systems, school Medicaid billing at state and local levels often brought these tensions to the forefront as schools navigate complex

and intersecting education and health laws when providing and submitting services eligible for Medicaid reimbursement.

Implications

Just over half of states have adopted school Medicaid expansion since the 2014 free care rule reversal that allows states to opt into authorizing Medicaid reimbursement for comprehensive health services delivered in schools to Medicaid-enrolled students. We draw on our study findings to highlight specific actions that state Medicaid and local educational agencies can take to expand and improve school Medicaid billing, depending on their state and local context.

1. 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.
2. Government agencies can provide grants to support the expansion of Medicaid billing, following the example of the $2.5 million grants awarded by CMS to states.
3. 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.
4. 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.
5. 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 can help to facilitate collaboration among the various parties.
6. 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.

At the center of efforts to increase school Medicaid billing are the children for whom school-based health services are critical to their learning and development.

Read More

See the full journal publication, "Improving Governance to Reduce Administrative Burden and Increase Funding for School-Based Health Services," in *Public Performance & Management Review*, https://doi.org/10.1080/15309576.2026.2699897, or linked at https://mentalhealthresearchtnschools.com/

ACKNOWLEDGEMENTS & DISCLOSURES

We would like to thank and extend our appreciation to our research partners and research team. This work was funded by grants from the National Institutes for Mental Health, #1R01MH132686-01, and Institute of Education Sciences, #R305B200015.

Learn more at mentalhealthresearchtnschools.com.

VANDERBILT School of Medicine Dept. of Health Policy

VANDERBILT UNIVERSITY