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DEPARTMENT OF HUMAN SERVICES

Legislative Report

Behavior Health Services Reimbursement

School and community provider CTSS reimbursement process review

Behavioral Health Division

March 2022

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $17,710.

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Contents

I. Executive summary

School districts throughout the United States have recognized the increasing student need for access to mental health services, but also may struggle to maintain the necessary funding. For students who are eligible for Medicaid, Minnesota school districts have the option to use the state's Medicaid program to receive reimbursements of the federal share of covered health-related services identified by an individualized education program (IEP) or an individualized family service plan (IFSP). Minnesota's Medicaid program is known as Medical Assistance[1] (MA) and is administered by the Department of Human Services (DHS). For mental health services specifically, school districts request the federal reimbursement through Children's Therapeutic Services and Supports (CTSS) MA service. The goal of CTSS is to increase access to multidisciplinary rehabilitation services to MA-eligible children and young adults under 21 years old who have mental health disorders.[2]

Stakeholders providing input to DHS, the Minnesota Department of Education (MDE), and the Minnesota legislature often describe the CTSS process as complicated. According to data from MDE, the count of school-age children with identified emotional or behavioral disorders has continued to increase over the past several years. However, the number of school districts receiving reimbursement through CTSS has remained relatively small.

State and federal law, DHS and MDE policies, school district practices, and provider practices can all contribute to the complication. In 2021, the Minnesota Legislature directed DHS and MDE to identify strategies to review the CTSS process (Laws of Minnesota 2021, First Special Session, chapter 13, article 5, section 2 and Laws of Minnesota 2021, First Special Session, chapter 7, article 17, section 9). Specifically, the Legislature directed DHS and MDE to:

- Streamline access and reimbursement for mental health services for children with an IEP or an IFSP who are enrolled in medical assistance.
- While streamlining access and reimbursement, avoid duplication of services and procedures when possible.
- Identify strategies to reduce administrative burden for schools while ensuring continuity of care for students accessing services when not in school.
- Review models in other states.

For CTSS-certified school districts, the designed CTSS process that moves from initial identification and student assessments for special education services to receiving the mental health services to submitting reimbursement

[1] More information about Medical Assistance can be found at: https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/overview.jsp.

[2] CTSS Provider Manual. Accessed on November 29, 2021. https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058361.

requests involves many steps as well as coordination between providers, school staff, students, and families. The order, timing, and administrative structure varies depending on the school district and the type of certification it pursues. A detailed description of the process begins on page 12.

For this report, DHS and MDE sought initial input from school districts with CTSS certifications and community mental health providers who work with school districts. Ten interviewees provided feedback and ideas, which are summarized on page 15. Some of their suggestions included:

- Reducing duplication by allowing a student's IEP or IFSP to be sufficient documentation of medical necessity.
- Making the CTSS processes and services more adaptable by exploring more options for who can provide CTSS core services and how they are provided as well as expanding the list of reimbursable CTSS services.
- Expanding billable service options so that providers can sustainably cover costs of additional support and outreach services.

In a parallel process, the CTSS workgroup developed recommendations for improving specific aspects of CTSS. The workgroup members prioritized four topic areas or recommendations including: certification requirements and challenges, CTSS service components, reimbursements, and integration and alignment. DHS and MDE will continue to work collaboratively with the CTSS workgroup to improve the CTSS process by strategizing and prioritizing focus areas and related recommendations.

To give more guidance to states and school districts regarding school-based mental health services, the US Department of Health and Human Services' (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS) released a Joint Informational Bulletin in 2019 that summarized examples of approaches for treatment services related to mental health and substance use disorders (SUD) in schools. The most common Medicaid billing and reimbursement approach among the states cited in the bulletin is referred to as "recognized cost reimbursement."[3] The two most common approaches used by states for billing and reimbursement of Medicaid-covered services in schools are fee-for-service (claim-based payment) and recognized cost reimbursement.

Based on targeted research; review of the CTSS process; and the feedback from school representatives, community mental health providers, and the CTSS workgroup, the DHS and MDE subject matter experts worked together to develop recommendations. As a result, DHS and MDE make the following administrative recommendations to streamline access and reimbursement for mental health services for children with an IEP or an IFSP who are MA-eligible while also avoiding duplication of services and procedures.

[3] "Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools," Joint Information Bulletin, July 1, 2019, 15, https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

Report recommendations

Short-term recommendations

- **Recommendation 1:** DHS and MDE should develop additional technical assistance for school districts and community mental health providers on the following topics:
    - Clarify CTSS providers' ability to provide mental health services to students who meet the medical necessity requirement regardless of IEP or IFSP status.
    - To reduce redundancies, clarify to providers that component assessments, as found in the special education evaluation, IEP, or IFSP can be used to meet applicable requirements in the Diagnostic Assessment (DA), if diagnostic formulation and other portions related to medical necessity are completed and signed by an independent mental health professional. When completed by a team led by a credentialed mental health professional, a special education evaluation or individualized education program or individualized family service plan completed according to Minnesota Rules, parts 3525.2710 or 3525.2810 or 3525.1350 or 3525.1351 or Minnesota Statute § 125A.32, can determine medical necessity as long as it also meets all the requirements for the diagnostic assessment under Minnesota Rules, part 9505.0372. In addition, DHS and MDE will support mental health professionals performing DAs with children outside of the school setting, to utilize special education evaluations as an important source of information.
- **Recommendation 2:** DHS should explore and identify mental health screenings and referral systems that can be reimbursed through CTSS (if not currently reimbursed). This will also include review of current data reporting requirements to mitigate possible redundancies in reporting requirements for providers.
- **Recommendation 3:** DHS and MDE should work collaboratively to simplify the CTSS Certification process for schools and community mental health providers. DHS and MDE should work to clarify and streamline requirements for all CTSS providers (school and community) to facilitate seamless transition of children from one provider to another, if needed.

Long-term recommendations

- **Recommendation 4:** DHS and MDE should continue to work with the CTSS workgroup to streamline processes for community- and school-based CTSS services as well as define Minnesota's vision and long-term recommendations for the delivery of CTSS services to MA-eligible students.

II. Legislation

Laws of Minnesota 2021, First Special Session, chapter 13, article 5, section 2:

Sec. 2. REPORT ON BEHAVIORAL HEALTH SERVICES REIMBURSEMENT.

The commissioners of education and human services shall consult with stakeholders to identify strategies to streamline access and reimbursement for behavioral health services for children with an individualized education program or an individualized family service plan who are enrolled in medical assistance and, whenever possible, avoid duplication of services and procedures. The commissioners shall identify strategies to reduce administrative burden for schools while ensuring continuity of care for students accessing services when not in school and shall review models in other states. The commissioners shall provide an update, including any recommendations for statutory changes, to the chairs and ranking minority members of the committees with jurisdiction over kindergarten through grade 12 education and human services by November 1, 2021.

Laws of Minnesota 2021, First Special Session, chapter 7, article 17, section 9:

Sec. 9. CONTINUITY OF CARE FOR STUDENTS WITH BEHAVIORAL HEALTH AND DISABILITY SUPPORT NEEDS.

This act includes $70,000 in fiscal year 2022 and $0 in fiscal year 2023 for the commissioner of human services to collaborate with the commissioner of education and consult with stakeholders to: (1) identify strategies to streamline access and reimbursement for behavioral health services for students who are enrolled in medical assistance and have individualized education programs or individualized family services plans; and (2) avoid duplication of services and procedures to the extent practicable. The commissioners must identify strategies to reduce administrative burdens for schools while ensuring continuity of care for students accessing services when not in school. By January 15, 2022, the commissioners must report their findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over early learning education through grade 12 and health and human services policy and finance. The general fund base in this act for this purpose is $0 in fiscal year 2024 and $0 in fiscal year 2025.

III. Introduction

Access to quality mental health services can be critical to a student's success in school and for their overall well-being. School districts throughout the United States have recognized the increasing student need for these services, but also may struggle to maintain the necessary funding.[4] Districts can seek reimbursement for health-related services from third parties, and in most states, they have the option to use the state Medicaid program to pay the federal share of covered health-related services for eligible students with an individualized education program (IEP) or an individualized family service plan (IFSP). Minnesota's Medicaid program is known as the Medical Assistance[5] (MA) and is administered by the Department of Human Services (DHS). MA reimburses Minnesota school districts when a student who has a disability and an IEP or IFSP requires health-related services to benefit from special education. For mental health services specifically, school districts request the federal reimbursement through Children's Therapeutic Services and Supports (CTSS).

According to data from the Minnesota Department of Education (MDE), the count of school-age children with identified emotional or behavioral disorders has continued to increase over the last several years. These are the children who would likely benefit from mental health services. In the previous five years, for example, emotional or behavioral disorder child count has increased 10 percent (from 15,448 in the 2016–2017 school year to 16,951 in the 2020–2021 school year).[6] However, the number of school districts receiving reimbursement through CTSS is relatively small and has decreased in recent years. According to DHS records, 60 districts were certified through CTSS to receive mental health reimbursements from MA in the 2015–2016 school year. By the 2020–2021 school year, the number had decreased to 34 (Minnesota had 562 public school districts in the 2020–2021 school year[7]).[8] Similarly, the number of students receiving school-based mental health treatments that were reimbursed with MA through CTSS has also been decreasing each year. In the 2015-2016 school year, 1,478 students received mental health services that were reimbursed with MA through CTSS while the total was 468 in the 2020–2021 school year (Table 1).

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[4] "Accessing Medicaid Funds for School-Based Mental Health Services," Issue Brief, Now Is the Time Technical Assistance Center, 2015, 1, http://www.fredla.org/wp-content/uploads/2015/09/Medicaid-for-School-Based-MH-Services.pdf.

[5] More information about Medical Assistance can be found at: https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/overview.jsp.

[6] Detailed child count data summaries can be found at: https://public.education.mn.gov/MDEAnalytics/DataTopic.jsp?TOPICID=455.

[7] Detailed counts of Minnesota public schools can be found at: https://public.education.mn.gov/MDEAnalytics/Summary.jsp.

[8] The full list of school CTSS providers can be found at: https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mental-health/ctss/.

Table 1. CTSS reimbursements for school-based mental health services

School year	Number of students receiving mental health treatments	Total CTSS reimbursement claims from school districts	Total MA reimbursement amounts
2015-2016	1,478	70,786	$3,721,468
2016-2017	1,202	53,746	$3,294,403
2017-2018	1,016	43,051	$2,762,157
2018-2019	736	37,240	$2,608,376
2019-2020	596	29,740	$1,681,529
2020-2021	468	23,082	$1,333,831

Purpose of report

Stakeholders providing input to DHS, MDE, and the Minnesota Legislature often describe the CTSS process as complicated. State and federal law, DHS and Minnesota Department of Education (MDE) policies, school district practices, and provider practices can all contribute to this complication. In 2021, the Minnesota Legislature directed DHS and MDE to identify strategies to:

- Streamline access and reimbursement for mental health services for children with an IEP or an IFSP who are enrolled in medical assistance; and
- While streamlining access and reimbursement, avoid duplication of services and procedures when possible.

DHS and MDE are also required to identify strategies to reduce administrative burden for schools while ensuring continuity of care for students accessing services when not in school and review reimbursement models in other states. This report is submitted to the Minnesota Legislature pursuant to Laws of Minnesota 2021, First Special Session, chapter 13, article 5, section 2 and Laws of Minnesota 2021, First Special Session, chapter 7, article 17, section 9.

Report and input methodology

To respond to the legislative requirements, DHS and MDE subject matter experts met regularly to design a stakeholder-centric approach to collect input and to ensure the report development was on track and in scope.

DHS and MDE contracted with Management Analysis and Development (MAD)[9] to facilitate coordination between the agencies, assist in gathering stakeholder feedback, and prepare initial draft sections of this report.

In October 2021, two two-hour online CTSS stakeholder interview sessions were conducted to better understand how schools and licensed mental health providers experience the CTSS process. MAD facilitated the sessions while the DHS and MDE subject matter experts participated to provide background information and guidance, as needed. The DHS and MDE subject matter experts also invited stakeholders. The stakeholder list included members from a CTSS workgroup, whose purpose is to educate providers and improve the CTSS process. The group is convened by DHS with support from MDE.

Each group interview session started with an orientation to a draft CTSS process map. MAD asked participants to describe their experience with the process, identifying where they experience difficulties, and suggesting ways to improve their experience by streamlining access or reducing duplication. MAD identified key themes and insights from interviewees to create brief summaries describing identified issues and improvement suggestions starting on page 15. The school user group included seven school staff representing schools that have enrolled as licensed CTSS providers and the provider user group included representatives of three community mental health providers that work with school districts to treat students.

The CTSS process described in this report is based on publicly available CTSS guidance documents, the policies guiding school-based mental health services in Minnesota, CTSS reimbursement data provided by DHS and MDE, insights from DHS and MDE representatives, and national research summarizing best practices for school-based mental health services. This report also includes a summary of nationwide approaches for mental-health-related treatment services in schools as described by a 2019 Joint Information Bulletin from the US Department of Health and Human Services' (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare and Medicaid Services (CMS). Finally, the summary CTSS data used in this report that was not publicly available was compiled by subject matter experts at DHS per MAD's request.

The report recommendations were developed collaboratively by the DHS and MDE subject matter experts and were informed by a series of recommendations developed by the CTSS workgroup in a parallel process. DHS and MDE will continue to work collaboratively with the CTSS workgroup to further clarify and improve the CTSS process.

[9] More information about Management Analysis and Development can be found at: https://mn.gov/mmb/mad/.

IV. CTSS process review

According to Minnesota law, school districts must seek reimbursement for all individualized education program (IEP) or individualized family service plan (IFSP) health-related services from insurers or other third parties (Minn. Stat. §125A.21, subd.2). School districts can seek reimbursement through Children's Therapeutic Services and Supports (CTSS) for any mental health services identified in a MA-eligible student's IEP or IFSP.

CTSS is defined as a collection of mental health services for children requiring therapeutic and rehabilitation services interventions.[10] Originally established in 2003, CTSS expanded access to licensed mental health professionals through community mental health providers. To further expand access for school-age children, schools and school districts became eligible to provide mental services through CTSS beginning January 1, 2008. Currently, both mental health professionals and mental health practitioners can provide a set of core and optional services to students in school settings under CTSS.

The goal of CTSS is to increase access to multidisciplinary rehabilitation services to MA-eligible children and young adults under 21 years old who have mental health disorders in order to:

- "Restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or
- Enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills, deficits or maladaptive skills acquired over the course of a psychiatric illness."[11]

Current process overview

For CTSS-certified school districts, the designed CTSS process that moves from the initial identification and student evaluation for special education services to determining medical necessity to providing the mental health services to submitting reimbursement requests involves many steps as well as coordination between providers, school staff, and students and their families. Below is a general summary of the process and descriptions of the major components. The order, timing, and administrative structure varies depending on the school district and the type of certification it pursues.

[10] CTSS Provider Manual, accessed on November 29, 2021, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058361.

[11] CTSS Provider Manual, accessed on November 29, 2021, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058361.

To become certified to provide CTSS services, a school district's representatives complete an application with DHS, participate in two required trainings, and enroll with MA. As part of the certification application, school districts choose from one of two CTSS options:

- School CTSS: The school district employs mental health staff and then submits a reimbursement for services to DHS.
- Contract CTSS: The school district contracts with a CTSS-certified community mental health provider that provides the services and then the school district submits a reimbursement for services to DHS.

Of the 34 CTSS-certified school districts in the 2020–2021 school year, 24 were set up as contract CTSS and 10 were set up as school CTSS. More detailed information describing eligible providers, important definitions, and statutory requirements can be found in the CTSS Provider Manual.[12]

Certification requires the district to have at least one primary Minnesota-licensed mental health professional and at least one backup mental health professional (Minn. Stat. §256B.0943, subd. 5a) who can provide or oversee the delivery of CTSS core services. The core services include psychotherapy, skills training, crisis assistance, treatment plan development and review, and administering and reporting standard measures. Providers can also apply for certification to provide additional services, including CTSS day treatment and mental health behavioral aide service.

Identifying students for mental health services

Students who would benefit from mental health services are first identified for special education referral by school social workers, psychologists, or other special education staff through several strategies such as IDEA Child Find,[13] Positive Behavioral Interventions and Supports (PBIS),[14] Behavioral MTSS,[15] school-linked mental

[12] CTSS Provider Manual, accessed on November 29, 2021, https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058361.

[13] More information about Child Find in Minnesota can be found at: https://mn.gov/mnddc/partnersinpolicymaking/class32_materials/Child_Find_Article_2014.pdf.

[14] More information about Minnesota PBIS can be found at: http://www.pbismn.org/about/index.php.

[15] More information about Minnesota Multi-tiered System of Supports can be found at: https://education.mn.gov/mde/dse/mtss/.

health grants,[16] and Comprehensive School Mental Health Systems (CSMHS).[17] If a student is referred to special education services following a mental health screening, the relevant school staff conduct a comprehensive evaluation of the student's needs.

For the students who demonstrate a need for special education services (including mental health services), a team of district or school staff develops an IEP or IFSP. To determine needs for mental health services, mental health assessments are conducted. According to state statute, the mental health assessments used for developing the IEP or IFSP can be provided by licensed school psychologists, school social workers, other licensed mental health professionals.[18]

Diagnostic assessment

If mental health services are listed in a student's IEP or IFSP and they are eligible for MA, the student and their family may be referred for a diagnostic assessment (DA). The purpose of the DA is to determine whether the mental health services meet medical necessity criteria and documents the impact of behavioral difficulties, functional impairment, subjective distress, and strengths and resources.[19] For other health-related services (e.g., physical therapy, speech or language therapy, and nursing services), medical necessity is determined through the comprehensive evaluation and IEP or IFSP process. Depending on a school district's CTSS certification, the DA can be conducted by a licensed mental health professional employed by the school district (i.e., school CTSS) or a community-based licensed mental health professional contracting with the school district (i.e., contract CTSS). Students who are MA-eligible are allowed to receive up to three psychotherapy or family psychoeducation sessions before the provider completes the DA.

Providing mental health services and reimbursement

Students who meet the medical necessity criteria determined through the DA can begin receiving the CTSS core services and any additional services, if applicable. The specific services are based on an Individual Treatment Plan (ITP) created by the mental health professional. At this stage, the student's IEP may also need to be

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[16] More information about school-linked mental health services through DHS can be found at: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/mental-health/programs-services/school-linked-mh-services.jsp.

[17] More information about Comprehensive School Mental Health Systems can be found at: https://education.mn.gov/MDE/dse/safe/CSMHS/.

[18] More information about Mental Health Services through DHS can be found at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_188690.

[19] More information about the Diagnostic Assessment can be found at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_058048.

updated to include the mental health services. The services may be provided directly by licensed district staff or a community provider.

In the final step, the district submits a reimbursement request to MA for the services provided by the school staff or a community provider to the MA-eligible student. Districts have up to 12 months from the date of service to submit the reimbursement claims.

School representative feedback

MAD consultants facilitated a group conversation with seven interviewees who work in school districts as mental health and social work staff. Both contract CTSS and school CTSS models were represented. The interviewees were asked for suggestions to improve the mental health reimbursement process for schools. The issues identified and suggestions offered by the interviewees included several themes, which are summarized below.

The Diagnostic Assessment (DA) requirement creates duplicative processes

Most frequently, the interviewees discussed how completing the DA to determine medical necessity in addition to the IEP requirements creates duplicative work on the school and medical provider sides, which increases the amount of time it takes to provide help to students in need. For other types of health-related services such as occupational therapy, school districts use the comprehensive evaluation with the IEP development process.[20] For mental health services, however, medical necessity must be determined through the DA process. As a result, many students must wait until all the necessary CTSS process approvals are in place, including waiting for the DA to be completed following the IEP approval. One interviewee said that some students do get help from school social workers while waiting for the CTSS services, but also noted that help cannot be reimbursed.

There was agreement among the interviewees that the special education evaluation and the IEP already contain the required elements for determining the medical necessity of services. Therefore, removing the requirement to also conduct a DA would help streamline the process and reduce the time students wait to receive mental health services. According to a few interviewees, billing for mental services should be like billing for speech and language therapy services, which can be billed to an IEP according to Minnesota's Medicaid state plan. Interviewees also noted that some schools are hesitant about CTSS because of the data privacy concerns they have related to managing the student health data in the DA. In the opinion of these interviewees, including the DA information in the IEP would help limit access to that health data.

Make CTSS processes and services more adaptive and expansive

Interviewees discussed the requirements for CTSS core services. For example, a few interviewees described confusion regarding the requirement to provide psychotherapy and whether it had to be provided to a child

[20] Determination of medical necessity is required to receive reimbursement for the federal share of the IEP or IFSP services provided.

prior to providing other core services. It is important to note that, according to Minnesota Statutes 2021, section 256B.0943, subdivision 9, a provider must deliver, or arrange for, psychotherapy when considered medically necessary. Providers are still able to provide other core services prior to any psychotherapy. Additionally, the statutory requirement that psychotherapy can only be provided by licensed mental health professionals (the other core services can be provided by mental health practitioners) may disproportionally disadvantage districts in less populated areas of Greater Minnesota, according to the interviewees, that have limited access to those professionals. The interviewees said more options for who can provide the core services and how they are provided should be explored.

In addition to reviewing how core services are delivered, interviewees discussed the need for expanding the list of reimbursable CTSS services. Interviewees described situations in which their school district provided services to students that were medically necessary but not considered CTSS mental health services and, therefore, could not receive a reimbursement. The interviewees acknowledged that any expansion would require amending the Medicaid state plan.

Streamline rules for schools and community providers

Interviewees also discussed how separate rules for school providers and community providers creates more confusion and can limit the ability to help students in a timely way. According to a few interviewees, there are situations in which a mental health professional or practitioner can provide services as both a school social worker and a community provider. However, because CTSS rules restrict the types of services and interventions used based on the setting (i.e., service delivery at a school or at a community provider location), those individuals providing services may operate under two sets of requirements. There was consensus among the group that CTSS rules should more accurately reflect the reality of how students in crisis are served. Interviewees also said community providers often experience confusion when navigating certain aspects of CTSS, such as the IEP process, the specific professional requirements in schools, and the complexities of identifying students in need of special education services.

Community mental health provider feedback

MAD facilitated a conversation with three interviewees from community mental health providers that work with school districts. The interviewees' organizations hold community provider CTSS certifications and have contracts or memorandums of understanding (MOU) with one or more school districts to work with and provide mental health services to students. Two of the organizations have agreements allowing their licensed providers and practitioners to treat students in the schools. While the interviewees do not operate within the CTSS process described in this report, their experiences allowed them to provide insights and offer suggestions to improve the mental health reimbursement process for providers. The issues identified and suggestions offered by the interviewees included two main themes, which are summarized below.

The CTSS documentation requirements are complicated

The interviewees discussed the need for further streamlining between school CTSS and contract CTSS processes so that students and their families are at the center. According to the group, there is too much separation between the two processes, which adds to the complication and increases confusion for the families in need of

help. There was consensus among the interviewees that statewide efforts could focus on a continuum of services in which students in need can have multiple entry points into the process and then have their necessary mental health services build as more needs are identified.

All the interviewees said the required documentation and approval steps creates a complicated process for providers and families, which adds to the amount of time it takes to begin treating students in need. The interviewees described the amount of effort provider staff spend completing the CTSS documentation needed to complete the DA and coordinate with school staff. According to one interviewee, their organization has built more of the documentation and coordination efforts into their own business costs but also acknowledged that is not possible for all providers.

The interviewees also described the pressures on the community mental health professionals to establish a diagnosis and create a treatment plan while they are still trying to understand an individual student's situation. To shorten the time to intervention for a student in crisis, interviewees said their staff may not bill for all the DA work or begin serving the students with other available funding sources. However, one interviewee noted that previous CTSS rule changes allowing for up to three psychotherapy sessions before the DA is completed provides more opportunities for intervention and for the students, their families, and the providers to figure out the best treatment plan.

Billable service options

All the interviewees described a need for expanded billable service options under CTSS as well as a review of the reimbursing rates. According to the interviewees, there are many cases where the work their staff do to complete the DA and create an ITP is not billable. Additionally, they described examples where the current reimbursement rates for specific services have not kept pace with inflationary price increases. Examples of the types of expanded billable service options discussed by the interviewees included observation services, additional assessments and screenings, care coordination, and outreach and engagement. However, the interviewees also emphasized their goal is to treat students in need so, when possible, there are situations in which they bring multiple funding sources together to cover costs and help the students.

CTSS workgroup recommendations

In a parallel process, the CTSS workgroup developed recommendations for improving specific aspects of CTSS. The workgroup members prioritized four topic areas and organized into sub-groups with each group analyzing one of the topics, developing related recommendations, and identifying additional resources needed. The four topic areas included:

- Certification requirements and challenges
- CTSS service components
- Reimbursements
- Integration and alignment

DHS and MDE will continue to work collaboratively with the CTSS workgroup to improve the CTSS process by strategizing and prioritizing focus areas and related recommendations.

V. Best practices for school-based mental health services

While Medicaid is a federally funded program, states have the flexibility to design and operate their Medicaid programs and the services offered within the scope of federal requirements. States operate their programs based on state plans approved by the Centers for Medicaid and Medicare Services (CMS). Because each state administers its own Medicaid program and has latitude to establish its own eligibility criteria, the type and amounts of services, and rates for service payment, a variety of state Medicaid models exist. More specifically, there are a variety of models for financing school-based mental health services, whether through Medicaid or other sources.

As described in an issue brief from the US Department of Health and Human Services' (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA), the differences between states' programs can cause confusion for school districts. According to the issue brief, "School districts will find some disconnect between the regulations of the State Plan and the scope of services on school sites. Medicaid primarily functions in the world of health care and schools are not traditionally arranged as full-fledged health service providers."[21] The brief goes on to say that the ideal Medicaid reimbursement program for a state or school district will depend on many variables unique to a district, including local needs, district size, and geographic location.

To give more guidance to states and school districts, SAMHSA and CMS released a Joint Informational Bulletin in 2019 that summarized examples of approaches for treatment services related to mental health and substance abuse disorders (SUD) in schools.[22] The bulletin also described Medicaid state plan benefits states can use to cover mental health and SUD-related treatment services, and provided best practice models for implementing mental health and SUD-related services for students.

The most common approach used by states for providing billing and reimbursement of Medicaid-covered services in schools is referred to as "recognized cost reimbursement."[23] With recognized cost reimbursement, the school or school district aggregates costs of providing services and then allocates those costs between

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[21] "Accessing Medicaid Funds for School-Based Mental Health Services," Issue Brief, Now Is the Time Technical Assistance Center, 2015, 4, http://www.fredla.org/wp-content/uploads/2015/09/Medicaid-for-School-Based-MH-Services.pdf.

[22] "Guidance to States and Schools Systems on Addressing Mental Health and Substance Use Issues in Schools," Joint Informational Bulletin, July 1, 2019, 15, https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

[23] "Guidance to States and Schools Systems on Addressing Mental Health and Substance Use Issues in Schools," Joint Informational Bulletin, July 1, 2019, 15, https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

Medicaid-enrolled students and non-Medicaid students, usually on a quarterly or annual basis. The two most common approaches used by states for billing and reimbursement of Medicaid-covered services in schools are fee-for-service (claim-based payment) and recognized cost reimbursement. Another less common reimbursement approach for school-based services, referred to as "fee-for-service" or "claim-based payment," involves the state establishing a fee schedule for services that providers use to submit detailed payment requests for each student.

The ten states summarized in the bulletin have used a variety of strategies to expand or increase funding for and expand access to mental health services.[24] Most frequently, five of the states described used state or federal grants, a new state Medicaid standard, or expanded definitions based on federal law to increase mental health screenings and expand or enhance mental health services to more students. Three of those states specifically expanded or enhanced mental health services to students identified as having an elevated risk for mental health concerns (referred to as Tier 2) and students with existing mental health needs (referred to as Tier 3). In four states, administrative budgeting procedures or tax policies were created to fund school-based mental health programs. Two states formed state-level collaborations between their Departments of Education and Human Services to share funding of school-based mental health services. Two states amended their Medicaid state plans to expand coverage of mental health services.

Highlights from individual states' actions

The bulletin provided highlights from individual states' actions, including:

- Alabama: The state's Departments of Education and Mental Health jointly developed cross-system funding to support school-based mental health programming.
- Arkansas: The state's Departments of Education and Human Services (Mental Health programs and Division of Youth Services—Juvenile Justice programs) collaborated for shared funding of school-based services. The state also developed administrative procedures to finance a school-based mental health program.
- California: Created a law that levies a 1 percent income tax on personal income over $1 million to support comprehensive school-based mental health systems and other mental health initiatives.
- Florida: Using funding from a SAMHSA Project AWARE grant,[25] the state created a planning document to guide schools in implementing broad-based mental health screening for students.
- Louisiana: Under the authority of the state's Medicaid state plan, the state covers services by licensed nurses in a school setting for Medicaid-eligible students with an individualized health plan. As a result, nursing services were not limited to services in a student's IEP.

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[24] Several states from the list used multiple strategies.

[25] The Project AWARE (Advancing Wellness and Resiliency in Education) grant program is available to state education agencies and is administered by SAMHSA. More information can be found at: https://www.samhsa.gov/grants/grant-announcements/sm-18-006.

- Massachusetts: The state amended its Medicaid state plan to cover services within Individualized Health Care Plans, IFSP, Section 504 plans, and services deemed medically necessary.
- Michigan: Based on revisions to the federal Individuals with Disabilities Act (IDEA), the state expanded counseling sessions for students at elevated risk for mental health concerns and for students with existing mental health needs.
- Nevada: Through a state-funded block grant called "Social Workers in Schools," money is available to schools to pay for full-time social workers who address mental health issues identified through school climate surveys.
- South Carolina: The state's Department of Education enhanced coverage for students showing initial signs or symptoms of a difficulty and students with existing mental health needs. The state budget also includes a line item for rural communities to develop mental health programs.
- Tennessee: The City of Johnson City created school mental health funding for case managers in schools to provide services to students with elevated risk for mental health concerns and existing mental health needs.[26]

In addition to describing specific state-level strategies, the bulletin also lists eight possible funding sources for school-based mental health services. Along with utilizing third-party reimbursement options such as Medicaid, three other strategies related to funding sources include diversifying funding streams and resources, increasing reliance on permanent funding, and applying for grants (e.g., public grants, formula grants, block grants, and discretionary/program grants). The four other funding sources relate to strategic decisions schools and states can make, such as applying best practices for staff retention, using evidence-based practices and programs, and evaluating and documenting outcomes to inform decision-makers.[27]

[26] "Guidance to States and Schools Systems on Addressing Mental Health and Substance Use Issues in Schools," Joint Informational Bulletin, July 1, 2019, 9, https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

[27] "Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools," Joint Informational Bulletin, July 1, 2019, 7, https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf.

VII. Report recommendations

The Minnesota Department of Human Services (DHS) and the Minnesota Department of Education (MDE) present the following recommendations to the legislature to streamline access and reimbursement for mental health services for children with an individualized education program (IEP) or an individualized family service plan (IFSP) who are MA-eligible while also avoiding duplication of services and procedures, when possible. The recommendations would apply to Children's Therapeutic Services and Supports (CTSS) school providers, CTSS partner providers contracting with schools, and CTSS community providers.

The recommendations are organized under short-term and long-term implementation stages. The short-term recommendations are ones that, if DHS and MDE act, would not require major changes to Minnesota's third-party reimbursement policies or an amendment to the Medicaid state plan, but would have positive impacts for children receiving mental health services and the school districts and mental health providers helping them. The long-term recommendation, however, would require more significant investment of time and resources to ensure collaboration and input across all the stakeholder groups.

Short-term recommendations

- **Recommendation 1:** DHS and MDE should develop additional technical assistance for school districts and community mental health providers on the following topics:
    - Clarify CTSS providers' ability to provide mental health services to students who meet the medical necessity requirement regardless of IEP or IFSP status.
    - To reduce redundancies, clarify to providers that component assessments, as found in the special education evaluation, IEP, or IFSP can be used to meet applicable requirements in the DA, if diagnostic formulation and other portions related to medical necessity are completed and signed by an independent mental health professional. When completed by a team led by a credentialed mental health professional, a special education evaluation or individualized education program or individualized family service plan completed according to Minnesota Rules, parts 3525.2710 or 3525.2810 or 3525.1350 or 3525.1351 or Minnesota Statute § 125A.32, can determine medical necessity as long as it also meets all the requirements for the diagnostic assessment under Minnesota Rules, part 9505.0372. In addition, DHS and MDE will support mental health professionals performing DAs with children outside of the school setting, to utilize special education evaluations as an important source of information.
    - **Timeline:** DHS issued guidance aligned with this recommendation on March 21, 2022. See "Policy clarifications" for Children's Mental Health.
- **Recommendation 2:** DHS should explore and identify mental health screenings and referral systems that can be reimbursed through CTSS (if not currently reimbursed). This will also include review of current data reporting requirements to mitigate possible redundancies in reporting requirements for providers.
    - **Timeline:** DHS and MDE currently facilitate an interagency workgroup on this topic. Final recommendations will be available in July 2022.

- **Recommendation 3:** DHS and MDE should work collaboratively to simplify the CTSS Certification process for schools and community mental health providers. DHS and MDE should work to clarify and streamline requirements for all CTSS providers (school and community) to facilitate seamless transition of children from one provider to another, if needed.
    - **Timeline:** DHS and MDE currently facilitate an interagency workgroup on this topic. Final recommendations will be available in July 2022.

Long-term recommendation

- **Recommendation 4:** DHS and MDE should continue to work with the CTSS workgroup to streamline processes for community- and school-based CTSS services as well as define Minnesota's vision and long-term recommendations for the delivery of CTSS services to MA-eligible students.

DHS and MDE are working collaboratively to engage larger groups of stakeholders to identify ways to improve how the CTSS reimbursement process works for students, schools, and mental health providers. Building on the initial CTSS process conversations facilitated by Minnesota Management and Budget's Management Analysis and Development (MAD), the agency staff are working with subject matter experts from DHS and MDE, school districts, and mental health provider organizations to develop improvement ideas. The ideas and assumptions about the process will also be tested with advocates, families, and other key partners such as the interagency CTSS working group.

VIII. Appendix

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