School Based Health Services

Medicaid Billing Manual

September 2025

OREGON
DEPARTMENT OF
EDUCATION

Oregon achieves . . . together!

School Based Health Services

Medicaid Billing Manual

Version no. 4

Jennifer Dundon
Operations and Policy Analyst,
Oregon Department of Education

OREGON
DEPARTMENT OF EDUCATION

255 Capitol Street NE
Salem, OR 97310
Office: 503-947-5670
Fax: 503-378-5156

Table of Contents

Version	Date	Revision
1.0	10/24/2019	First Issued
2.0	02/04/2020	Minor Corrections: Page 14 – Correction to state fiscal year dates and the development of Medicaid cost rates Page 16 - Clarifying language around MOE and Medicaid reimbursements Added FAQ about High Cost Disability and State Transportation Grant
3.0	3/1/2025	Update to entire manual due to Medicaid expansion.
4.0	9/5/2025	Update language to reflect updated SBHS administrative rules Added information on how to set up Automated Clearing House Accounts

Introduction

Oregon's School Based Health Services (SBHS) Medicaid program, also referred to as School Medicaid, allows an education agency (EA) to enroll as a School Medical Provider (SM) and leverage Medicaid for reimbursement for covered health services provided to Medicaid-enrolled children and young adults. This manual provides an overview of the SBHS Medicaid program and provides technical assistance for school business offices in support of a sustainable SBHS Medicaid program.

Purpose

The school business office is a critical component for EAs leveraging SBHS Medicaid. This document is intended for use by EAs who have already made the decision to implement a SBHS Medicaid program. Staff from ODE and OHA are available to provide support to agencies upon request.

Contact for Oregon Department of Education:

Jennifer Dundon
School Medicaid Operations & Policy Analyst
jennifer.dundon@ode.oregon.gov

Contact information for Oregon Health Authority:

Lasa Baxter
SBHS Medicaid Operations and Policy Analyst
lasa.baxter@oha.oregon.gov

Overview

The Oregon Health Authority (OHA) is Oregon's state Medicaid agency and has authority over and administers the state's SBHS Medicaid program and associated rules and regulations. OHA's Medicaid State Plan establishes how Oregon will adhere to Medicaid requirements in the Social Security Act and associated federal regulations. A Medicaid State Plan, and amendments to the plan, must be approved by the Centers for Medicare & Medicaid Services (CMS).

The Oregon Department of Education (ODE) is Oregon's state education agency and is primarily responsible for the state's supervision of Early Intervention/Early Childhood Special Education (EI/ECSE) programs, public elementary schools and public secondary schools. For the SBHS Medicaid program, ODE provides support to education agencies for efficient and sustainable Medicaid billing, alignment of education systems and processes in schools, interpreting education rules and regulations, and navigating the crossover between health and education.

ODE and OHA partner to provide training, technical assistance, guidance and resources for education agencies.

Program Summary

Medicaid is a state and federal partnership focused on funding health and medical services for enrolled beneficiaries. Oregon's SBHS Medicaid program, also referred to as School Medicaid, allows an EA to enroll as a school medical provider and leverage Medicaid for reimbursement for the cost of covered health services provided to Medicaid enrolled children and young adults. Participating in SBHS Medicaid reimbursement programs can be a great way of recouping costs. There are two programs in Oregon, administrative and direct:

- Medicaid Administrative Claiming (MAC) provides reimbursement for claimable activities related to the administration of Medicaid, such as referrals to medical, behavioral, vision or dental services, assisting a student/family with enrollment in the Oregon Health Plan (OHP), and coordination of Medicaid services to OHP enrolled providers.
- Direct service billing provides reimbursement for covered health services to Medicaid-enrolled children and young adults aged birth through 21.
- EAs may now choose to bill for covered health services provided pursuant to the Individuals with Disabilities Education Act (IDEA) and/or for covered health services provided outside of the IDEA. This requires separate enrollments with the OHA to ensure that billing for services pursuant to the IDEA is kept separate from billing for non-IDEA services. Please see OHA's provider enrollment guide for additional information on enrollment options.

Getting Started

If your EA is still determining whether to move forward with implementation, or is still in the beginning stages, please see the SBHS Medicaid Billing Startup Checklist, School Medicaid Cost-Benefit Analysis Tool, and School Medicaid Readiness Assessment Tool for information on how to get started.

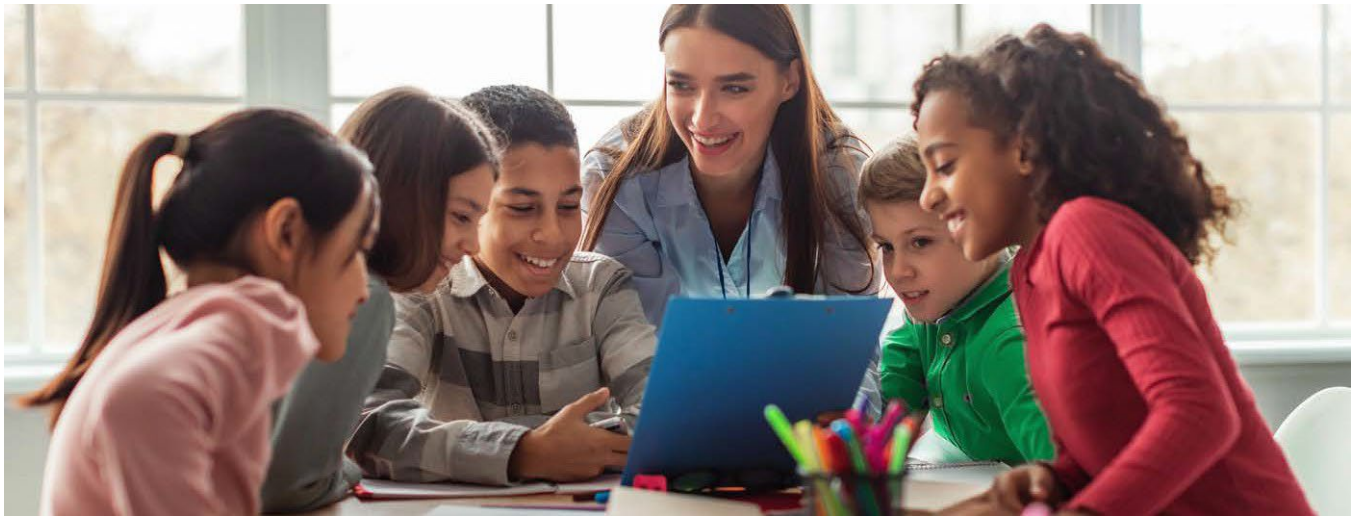
Identification of Key Partners

The school business office is integral to navigating SBHS Medicaid billing, but collaboration and communication with all key partners in the EA are also critical components. Key partners may vary by agency but may include:

- Superintendent
- Assistant Superintendent of Business and Operations
- Director of Student Services/Special Education
- Manager that supervises SBHS-Recognized Providers (RN, LPN, OT, PT, SLP, etc.)
- Chief Financial Officer (CFO)
- School Business/Finance Official
- Director of Human Resources
- Business office staff responsible for generating billable rates.
- Accounting Manager & Accountant responsible for reconciling general ledger and developing the internal controls
- Staff responsible for knowing student counts & IPOC information
- Transportation Manager (if billing for specialized transportation)
- Human Resources staff responsible for monitoring license status of SBHS-recognized providers
- SBHS-Recognized Providers
- Union Representative (to address workload concerns)
- Procurement/Contracts Manager
- Legal Representative – Education Agency Attorney
- Other Education Agencies involved in billing and/or service provision
- Electronic Data Interchange (EDI) submitter vendor billing agency (applicable if contracting with an outside vendor to submit billing)
- Medicaid Coordinator
- Medicaid Billing Clerk
- School Board

Identifying Billing Partnerships

- Per guidance from OHA, the school district responsible for providing a free appropriate public education (FAPE) must consent to allow another EA to bill on their behalf. If an EA is partnering with another EA for billing support, they will need to have an executed agreement to:
  - Define the billing relationship and flow of funds to avoid duplication of billing.
  - Clearly define service provision.
  - Establish training and communication protocols.
  - Identify software platform and/or integration of software platforms.
  - Ensure compliance with education and Medicaid rules and regulations, including but not limited to, requirements related to:
    - Written notification and parent/guardian consent
    - Practitioner recommendation
    - Fiscal and accounting requirements
    - Documentation of service provision
    - Data sharing and recordkeeping
    - Audit responsibilities
    - Payback in the event of an audit
    - Medicaid cost setting
    - Enrollment of billing and referring providers



EXAMPLES OF POTENTIAL PARTNERSHIPS BETWEEN EDUCATION AGENCIES:

1. An ESD and a school district bill for different services provided to the same student.

   The ESD bills for occupational therapy and physical therapy services that they provide, and the school district bills for services provided by their district nurse.

   - Both education agencies are enrolled with OHA and submit claims using their respective Medicaid Provider ID numbers and receive reimbursement directly.
   - Both agencies develop cost rates for the services for which they are billing.

2. An ESD has an agreement with a school district to provide billing support (e.g., billing submission, training and technical supports, coordination) on behalf of the school district.

   - The district is enrolled with OHA and the ESD submits claims using the school district's Medicaid Provider ID number and receives reimbursement directly.
   - The school district develops cost rates that include the contracted cost for the services provided by the ESD.

3. A school district contracts and pays an ESD to provide covered health services, but the school district opts to bill.

   - The district is enrolled with OHA and submits claims using their Medicaid Provider ID number and receives reimbursement directly.
   - The school district develops cost rates that include the contracted cost for the services provided by the ESD.

4. An ESD has an agreement to provide a school district with medically qualified staff, documentation support, billing submission software, and staff training. The school district authorizes the ESD to submit claims on the ESDs Medicaid Provider ID Number.

   - The ESD is enrolled with OHA and submits claims using the school district's Medicaid Provider ID number and receives the reimbursement.
   - The ESD develops cost rates.
   - The ESD offsets the costs of providing the services to the school district.

Establish Internal Rules for Use of Funds

A major factor in operating a sustainable SBHS Medicaid program is using the Medicaid reimbursement to increase access to school health services, often through the addition of healthcare practitioner FTE. Transparent communication about how these funds are being used builds trust and buy-in from key partners, including staff, families, and the community. It helps them see how SBHS Medicaid directly benefits the students and the school.

Once the EA determines how funds will be utilized, a system for tracking the funds must be developed. Once spending options have been evaluated, it is recommended they be presented to the finance oversight committee, school board, or both for approval. Once approved, create the accounting structure and internal controls.

Create an Accounting Structure to Manage Assets, Liabilities, Revenue and Expenses

- EAs will need to create an accounting structure to properly account for assets, liabilities, revenue, and expenses. The account structure should be in alignment with the Oregon Program Budgeting and Accounting Manual (PBAM).
- EAs will need to create a structure that ensures that IDEA and non-IDEA match payments are tracked separately.
- Communicate with each department receiving Medicaid reimbursements to determine how they will spend the funds.
- Meet with all departments involved in claims/billing on a frequent basis to ensure that any issues are addressed, and operations are running smoothly.

Write up Internal Control Procedures for Single Annual Audit

Internal controls are methods put in place to ensure the integrity of financial and accounting information. EAs design internal controls for SBHS Medicaid billing like the internal controls developed for auditors. However, unlike an EA's typical internal controls, those developed for SBHS Medicaid billing will span multiple departments. A narrative is designed for auditors to be able to create a list of items eligible for testing (i.e., match expenses, revenue received, expenses, and cash). The typical model auditors use to evaluate school districts/ESDs is the COSO Framework, an internal control framework developed by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

The audit standards that cover SBHS Medicaid services, used by auditors to test report expenses on the annual single audit report, can be found in the Assistance Listing Number (ALN), formerly known as the Catalog of Federal Domestic Assistance (CFDA) Number: CFDA 93.778 Medical Assistance Program (Medicaid; Title XIX). Auditing requirements can be found in the Code of Federal Regulations at 2 CFR 200 Subpart F – Audit Requirements.

Managing the Utilization of Reimbursed Funds

SBHS Medicaid Billing Claims

Match Account Setup

SBHS Medicaid fee-for-service is a cost-sharing program. Education Agencies are required to put up local match funds to draw down federal reimbursement for covered services. The Federal Medical Assistance Percentage (FMAP) rates determine the local match rate. The FMAP is the federal government's share of expenditures for Medicaid and the Children's Health Insurance Program (CHIP). The FMAP changes annually on October 1st to correspond with the beginning of the federal fiscal year. The local match amount is a percentage of the total amount paid for claims submitted. The first time a match payment is made, the EA will have to decide which account to borrow funds from (match funds must be public, non-federal funds 42 CFR § 433.51).

Education agencies may submit funds via paper check or through an electronic funds transfer (EFT). See OHA's Automated Clearing House Setup document for information on how to set up electronic transactions. Once local match is received and processed by Medicaid, federal funds are released for payment Medicaid returns the local match funds along with the federal reimbursement. Education agencies submit local match payments for SBHS direct services billing using the MMIS Local Match Leveraging Form OHP 3049 and form MSC 1419 for MAC Local Match Leveraging.

Local match received and processed by 5:00 p.m. Wednesday is available for claims processed during the following weekend's financial process. If funds are not available during the financial process, claims go pending until local match funds are received and processed. If funds are available during the financial process, the match payment is automatically calculated, and claims are paid in the order received/processed. The Medicaid Management Information System (MMIS) will only process and pay claims for which the entire local match is available; it will not pay partial claims (See Medicaid Leveraging Process for Public Education Entities for further information).

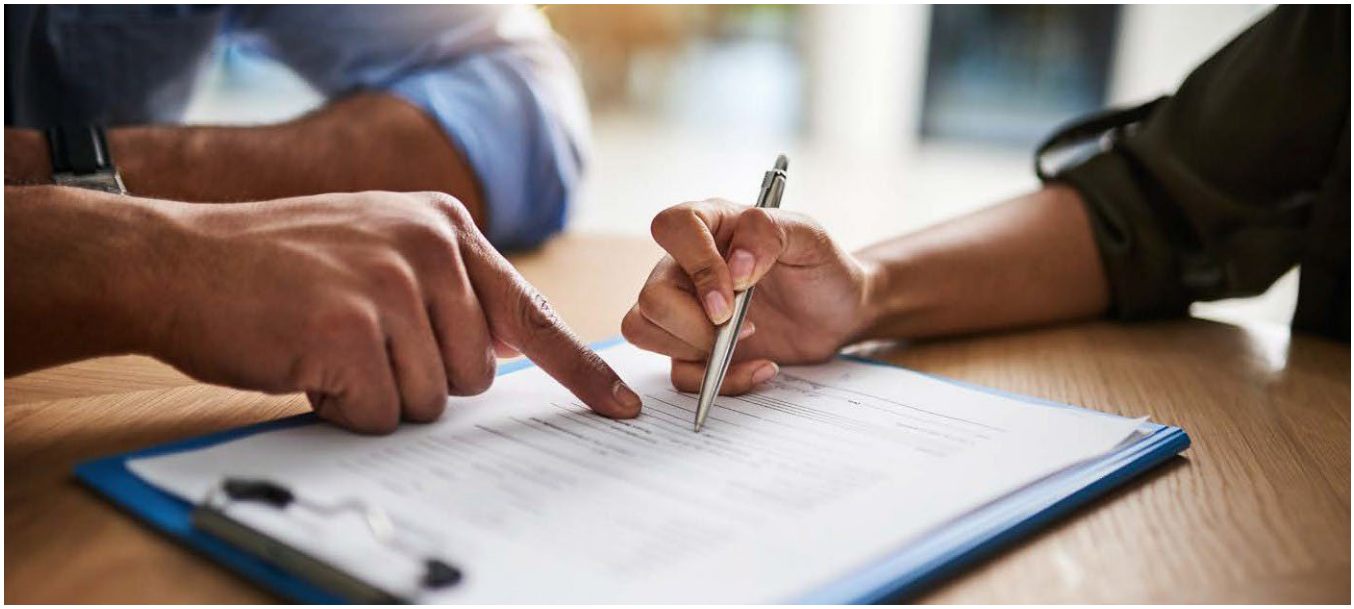
PLEASE NOTE: Medicaid match funds should be tracked for Individuals with Disabilities Education Act (IDEA) Maintenance of Effort (MOE) purposes. Funds used as Medicaid match for services provided pursuant to the IDEA may be included in a school district's MOE calculation. However, the federal reimbursement, even if expended on IDEA Part B services, is not considered state or local funds for the purposes of MOE and must be excluded from the calculation. 34 CFR 300.154(g)(2).

If your education agency is billing for both IDEA and non-IDEA services, you will need to ensure that match payments made for non-IDEA services are not included in IDEA MOE. Please refer to the PBAM for guidance on how to account for MOE.

Remittance Advice (RA)

The MMIS automatically generates an RA on a weekly basis for the weeks during which any claims are submitted and/or pended. An RA is not generated if no claims are submitted and/or pended during the previous week. The RA lists all claims processed and/or pended during the most recent financial cycle. Paid, denied, and adjusted claims are detailed claim-by-claim. Pended claims are listed in the Leverage Claims Payable – Not Paid section, with the local match due claim-by-claim and the total is calculated and listed.

Automatically generated RAs are mailed to the district at the mailing address on file in the MMIS, unless the district has requested to stop receiving a paper RA. Current and past RAs are also accessible through the MMIS Provider Web Portal at any time (See Accessing the Online RA for more information).



State Denial of Claims

The RA details paid, denied, and adjusted claims, including reason codes for each. In many instances, the education agency will be able to correct the claim and resubmit/adjust for reimbursement.

To correct a claim reimbursed for services provided to a Medicaid-eligible student, the SM provider must resubmit a claim for services denied or request an adjustment for services paid. The process for resubmitting a claim is the same as initial submission. Adjustments can be requested for claims that are paid when something on the claim is inaccurate (e.g. an incorrect rate was billed, or the diagnosis code was incorrect). The district may adjust a claim through the MMIS Provider Web Portal or on the Individual Adjustment Request form.

Examples of denied claims that cannot be corrected include a claim submitted for a child who is not eligible for Medicaid on the date of service, or a claim that is submitted more than 12 months after the date of service. Please see OHA's guidance on adjusting and resubmitting claims for additional information.

If an EA receives an Early and Periodic Screening Diagnostic Treatment (EPSDT) letter regarding claims denial, the letter indicates an opportunity for the EA to submit supporting documentation to be reviewed for potential payment for services that fall outside of current rules/guidelines (see EPSDT Provider Guide).

Reconcile General Ledger

The school business office is responsible for the transparency and accountability of EA funds. It is best practice to create a system of checks and balances to ensure no one person is responsible for the entire SBHS Medicaid reimbursement and accounting process. It is recommended the EA reconcile the general ledger (GL) accounts that are associated with SBHS Medicaid activity monthly. When reconciling the GL, remember to include reconciliation of the SBHS Medicaid Remittance Advice (RA). Billing frequency and expedience will affect the timing of reimbursement and the reconciliation process. There will be a timing difference on the reconciliation.

PLEASE NOTE: EAs may bill up to 12 months from the date of service. However, delayed billing may put the EA at higher risk for errors and/or reimbursement loss. Complications that may arise with delayed billing include:

- A SBHS-recognized provider leaves employment and supporting documentation is not signed or complete.
- A claim was denied that requires a SBHS-recognized provider to make a change to rebill the services.
- The federal match rate may be lower as claims are paid based on the current FMAP rate, which changes every October.

Develop Annual Medicaid Cost-Based Rates

EAs must meet OHA's federally approved financial reporting requirements for calculating cost-based rates. This cost methodology is based on prior year audited and reconciled costs utilizing financial data from ODE's audit report and financial data collection process. EAs report previous fiscal year audited costs, by discipline, using the Medicaid Cost Calculation Worksheet. Previous fiscal year costs are used to set rates for the current calendar year. (i.e. 2023-2024 fiscal year costs submitted by January 31, 2025, determine unique Medicaid rates for each discipline for calendar year 2025). Instructions for developing Medicaid costs are detailed in the Medicaid Cost Calculation Instructions.

Use ODE Upload Report to Develop Cost-Based Rates

To streamline development of annual SBHS Medicaid cost-based rates the EA may want to gear the chart of accounts toward SBHS-recognized providers' objectives by using codes outlined in the PBAM, allowing the district to sort, filter, and extract costs from the ODE Consolidated Collections annual upload report more easily.

Developing Cost-Based Rates for each Medical Discipline

The OHA Medicaid Cost Calculation Worksheet for developing annual Medicaid cost calculations includes a tab for each of the following disciplines:

- Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Nurse Practitioner (NP), Unregulated Assistive Person (UAP)
- Occupational Therapist (OT)/Certified Occupational Therapist Assistant (COTA)
- Physical Therapist (PT)/Licensed Physical Therapist Assistant (LPTA)
- Speech Language Pathologist (SLP)/Speech Language Therapist Assistant (SLPA)
- Audiologist
- Licensed Psychologist/ Psychologist Associate/Psychology Technician
- Licensed Psychiatrist
- Licensed Professional Counselor (LPC)/Licensed Professional Counselor Associate (LPCA)
- Licensed Clinical Social Worker (LCSW)/Licensed Clinical Social Work Associate (CSWA)
- Licensed Marriage and Family Therapist (LMFT)/Licensed Marriage and Family Associate (LMFTA)
- TSPC-Licensed School Psychologists, School Social Workers, and School Counselors
- Medical Doctor, Doctor of Osteopathic Medicine, Doctor of Podiatric Medicine
- Licensed Dentist, Expanded Practice Dental Hygienist, Licensed Dental Therapist
- Licensed Dietitian

EAs only need to submit costs for disciplines they intend to bill. It is common practice for EAs who are just beginning to bill Medicaid to select one or two disciplines that yield high rates of return first.

FOR EXAMPLE: An EA provides daily covered services for a student requiring a 1:1 nurse, which incurs a high cost. The EA may choose to begin billing nursing services and then expand to include other services once they have a system in place.

There are direct costs and administrative costs for each discipline. Both are used to calculate hourly costs for each medical discipline. Administrative costs may include actual audited salaries, benefits, and cost (not included in the ODE indirect rate) of management and clerical staff that perform work in support of SBHS-recognized providers. The allocation of prorated costs may require calculating the percentage of time spent providing support services for SBHS-recognized providers attributable to each discipline.

FOR EXAMPLE: A manager only supervises occupational and physical therapists (OT and PT, respectively). The percentage allocated to the OT and/or PT costs is based on the total percentage of full-time equivalent employees (FTE) supervised for each discipline. If there are five full-time OTs and five full-time PTs, 50% of the manager's salary and benefits is allocated to the OT rate and 50% is allocated to the PT rate; if there are seven full-time OTs and three full-time PTs, 70% of the manager's salary and benefits is allocated to the OT rate and 30% is allocated to the PT rate.

Develop Transportation Cost-Based Rates

Transportation to and from school may be claimed as a Medicaid service if the child is Medicaid-eligible and receives a Medicaid-covered service when both are specified in the child's IEP/IFSP and occur on the same date. Reimbursement rates are derived from the EA's prior-year actual audited costs for IDEA special education transportation and are based on a per-trip rate. All special education trips, whether billable to Medicaid or not, must be used in calculating the per-trip cost. Do not include percentages of costs that are unrelated to special education transportation. Complete instructions are detailed in the Medicaid Cost Calculation Instructions.

Review Cost-Based Rates

EAs should review cost-based rates for accuracy prior to submission. Some common indicators of errors include:

- Cost-based rates are very high or low compared to statewide averages. (This may be due to under or over reporting the number of paid work hours in the cost calculation worksheet or an incorrect entry of ODE's state-approved indirect rate.)
- Delegated health care cost-based rates exceed those of their licensed supervising nursing staff.
- Cost-based rates exceed 100% of combined shared costs between disciplines.

The EA should ensure there are multiple levels of review on the proposed rates to ensure all areas have been evaluated for reasonableness and compliance with state guidelines. If you are utilizing an ESD for services, coordinate with the ESD to obtain their costs for billing along with your own costs. Medicaid cost-based rate worksheets should be submitted to Lasa Baxter at OHA (lasa. baxter@oha.oregon.gov) for review and acceptance.

Sustainability

Develop SBHS Medicaid Billing Processes and Procedures for Business Office

Established policies and procedures are critical to sustainable SBHS Medicaid billing. Elements that should be included in developing processes and procedures for the business office:

- **Annual Cost-Based Rate Calculations.** Develop a process to ensure SBHS Medicaid billing cost-based rates are completed each year and submitted to OHA for review and acceptance (due annually by January 31). Ensure internal review processes are in place. If the EA is using a third-party submitter, be sure to submit cost-based rates that have been reviewed and accepted by OHA to the third-party agency so they may bill on the EA's behalf.
- **Match Payments.** Establish a process for tracking match payments. If billing for multiple areas (EI/ECSE, School Age IDEA, Non-IDEA) ensure separate billing provider enrollments have been completed which will align with separate match payments for each billing provider ID (program type) ensuring IDEA Maintenance of Effort (MOE) requirements are not impacted. Please see School Based Health Services: Provider Enrollment Instructions for more information.
- **Reconcile Accounts.** Establish a reconciliation process for the Medicaid remittance advice (RA) for all services billed, including denied, paid, and payable-not-paid services and ensuring reconciliation for all enrollments.

Frequently Asked Questions (FAQs)

Must school districts deduct Medicaid reimbursements from High Cost Disability Fund (HCD) and State Transportation Grant (STG) Applications?

School districts are not required to deduct Medicaid reimbursements from HCD and STG applications from the 19-20 school year forward.

Do I need to report Medicaid reimbursement on the Schedule of Expenditures of Federal Awards (SEFA)?

You will only report the expenses, not the reimbursements. See: 29 CFR 99.205 Chapter XI: Schedule of Expenditures of Federal Awards (SEFA) Contents.

Cost-Based Rate Calculation FAQs

OHA provided a webinar on the cost-based rate calculation process.
The webinar and FAQ have been posted on OHA's website for reference.

How often do I need to complete Medicaid billing rates?

They are due annually on January 31st.

Can I bill with a rate that has been rejected?

No. You will need to work with OHA to determine why the rate was rejected. You will then make necessary updates and resubmit the new rate for review and acceptance. You can only use accepted cost-based rates for billing.

What if there are no actual audited costs for the discipline or function from the previous school year?

If the EA does not have audited costs for the medical discipline from the prior year, an hourly cost may be determined based on current actuals paid to year-to-date. Upon submitting cost-based rate calculation worksheets, it should be noted on the worksheet for each applicable discipline which costs are based on current year actual costs year-to-date.

How does a district determine the total number of trips when they do not have any history from the prior year for calculating the cost of transportation for the first time?

For the period of one year only the district is allowed to use an alternate methodology to determine the total number of trips to be entered on line 4 of the transportation cost worksheet. The alternate methodology uses the total number of school days in session multiplied by the total number of potential daily trips (two) multiplied by the total number of Medicaid enrolled students receiving specialized transportation as specified in their IEP/IFSP on an adapted vehicle (e.g. wheelchair lift, ramp, or harness system)

FOR EXAMPLE: 165 days in session x 2 daily trips x 12 Medicaid eligible students receiving transportation as a related service on the IEP/IFSP = 3,960 (total # of trips).

Our EA has an ODE approved FINALIZED indirect rate for the previous year but does not have an ODE approved FINALIZED indirect rate for the current year. Do we have to report a current ODE approved FINALIZED indirect rate in the cost calculations?

Yes. However, an EA is not required to report an ODE approved finalized indirect rate in the cost-based rate calculation worksheet. Including the current year finalized indirect rate is optional. If an EA does not have an ODE state approved FINALIZED indirect rate for the current year, they must leave the cost rate cell blank.

PLEASE NOTE: EAs may not use an ODE state approved FINALIZED indirect rate from a prior year. ODE state approved FINALIZED indirect rates applied in the cost calculation worksheets must be for the current year.

OREGON
DEPARTMENT OF
EDUCATION

Oregon achieves . . . together!