NC School Medicaid Toolkit

MCH Innovations Database

Assessment

Curricula

Strategy

Population of Focus
School-Based Workforce, Children

Location	Issue Area	Tool Type
North Carolina	Healthcare Financing and/or Insurance	Toolkit

Contact Information
La'Shanda Person, Rural Opportunity Institute, 252-216-4385, la'shanda@ruralopportunity.org

innovation hub
AMCHP | Explore. Build. Share.

I. Tool Description

The School Medicaid Toolkit is a digital resource designed to help public school staff understand and implement school-based Medicaid programs through clear, plain-language guidance. It translates complex regulatory, billing, and documentation requirements into practical, step-by-step instructions supported by checklists, process maps, templates, and guiding questions. The toolkit is organized for easy navigation and uses consistent formatting and visual structure to reduce cognitive load for users with varying levels of health and administrative literacy. By simplifying technical terminology and anticipating common points of confusion, it enables nurses, therapists, administrators, and support staff to confidently complete compliance tasks, document services accurately, and access available funding. Its accessible design supports districts with limited resources and limited prior experience, ultimately strengthening schools' ability to deliver and sustain essential student health services.

Objectives were to simplify Medicaid requirements, standardize school billing processes, and improve accurate participation. Health literacy was addressed through plain language, step-by-step guidance, visuals, and checklists to help non-experts understand requirements and implement them effectively.

The intended audience was school-based professionals and administrators, including school nurses, therapists, special education staff, Medicaid coordinators, billing personnel, and district leaders. It also supported support staff and compliance teams responsible for documentation and reporting, particularly in under-resourced school districts with limited prior Medicaid experience.

The project aimed to solve the challenge of complex and hard-to-understand Medicaid policies and billing requirements that prevented many schools—especially under-resourced districts—from accessing eligible funding for student health services. By improving clarity and usability of information, it addressed communication barriers, reduced administrative errors, and promoted access to healthcare resources for students.

II. Tool Purpose

The Medicaid Toolkit and Learning Collaborative were developed to strengthen schools' ability to access and implement Medicaid-funded mental health services for students. The focus of the tool is to simplify and operationalize complex Medicaid policies so that school districts can effectively leverage reimbursement to expand and sustain behavioral health supports. By translating federal and state Medicaid requirements into clear guidance, templates, workflows, and implementation steps, the Toolkit equips school leaders and staff with practical strategies to integrate mental health services within existing school systems.

This tool addresses a critical and well-documented need: schools often struggle to navigate Medicaid rules, documentation requirements, and billing processes, resulting in underutilized funding and limited access to services for students. Despite rising mental health needs among children and adolescents,

many districts—particularly rural and under-resourced ones—lack the infrastructure and technical expertise to claim eligible services. The complexity of Medicaid processes, including the Random Moment Time Study, provider qualifications, parental consent procedures, and documentation standards, can create administrative barriers that prevent schools from maximizing available funding. The Toolkit directly responds to these challenges by standardizing processes, building staff capacity, and reducing confusion around compliance.

The key population for this tool includes public school units (traditional and charter), district leaders, school-based mental health providers, and administrative staff responsible for Medicaid implementation. Ultimately, however, the primary beneficiaries are students and their families—especially those in high-need and rural communities—who gain increased access to school-based mental health services as a result of stronger district implementation. By strengthening the capacity of adults within the system, the tool creates a multiplier effect that benefits children and youth.

The Toolkit has contributed to removing barriers and supporting community wellness in several meaningful ways. First, it reduces financial barriers by helping districts draw down federal Medicaid funds to reinvest in expanded services. Second, it reduces knowledge barriers by providing clear, user-friendly guidance that demystifies complex policy requirements. Third, through the Learning Collaborative model, it strengthens peer support and shared problem-solving across districts, building a leadership pipeline of trained "Toolkit Champions" who sustain and spread best practices. By linking schools with state agencies and community partners, the tool also fosters stronger cross-sector connectivity, reinforcing a coordinated system of care rather than fragmented, crisis-driven responses.

The intended outcome of using this tool is sustainable expansion of high-quality, school-based mental health services embedded within a multi-tiered system of support. Districts are expected to increase their confidence and fidelity in implementing Medicaid processes, improve reimbursement rates, and reinvest funds into additional mental health staff and services. Ultimately, the long-term benefit is improved student well-being, increased access to timely supports, stronger school-community partnerships, and a system in which mental health services are accessible to all students regardless of geography or income.

III. Tool Design

The Medicaid Toolkit and Learning Collaborative were designed through a cross-sector collaboration that brought together expertise in education, public health, Medicaid policy, and implementation science. Core contributors included state education leaders, Medicaid policy experts, school district practitioners, and technical assistance partners with deep experience in school-based mental health systems. District administrators, school finance officers, and mental health providers also informed the design through feedback loops, ensuring that the tool reflected on-the-ground realities rather than solely policy-level interpretation. This collaborative development model ensured that the tool was both technically accurate and operationally feasible.

Concern for community wellbeing was embedded from the outset. The design team recognized that schools are often the most accessible point of contact for children and families experiencing mental health challenges, particularly in rural and under-resourced communities. As such, the tool was intentionally crafted to reduce systemic barriers that limit access to care. Rather than focusing narrowly on billing compliance, the Toolkit framed Medicaid as a mechanism to expand equitable access to supports. The Learning Collaborative component was incorporated to promote peer learning, reduce isolation among district leaders, and strengthen community connectivity across schools, local agencies, and state partners. In this way, community wellness was not treated as an outcome alone, but as a guiding design priority.

The design of the tool was informed by multiple frameworks and evidence bases. It aligned with Multi-Tiered Systems of Support (MTSS) to ensure that Medicaid-funded services could be embedded across promotion, prevention, and intervention tiers. Implementation science principles guided the structure of the Learning Collaborative, emphasizing coaching, continuous quality improvement, data-informed decision-making, and iterative refinement. Federal and state Medicaid statutes, billing manuals, and compliance standards provided the regulatory foundation, while research on school mental health and sustainable financing models informed the practical guidance. The tool also drew from adult learning theory, recognizing that district leaders benefit from applied practice, peer exchange, and scaffolded supports rather than static written guidance alone.

Several core principles shaped the design: access for all, sustainability, clarity, and capacity-building. Limited resources drove the focus on expanding access in high-need districts. Sustainability emphasized building internal district expertise rather than reliance on external consultants. Clarity guided the translation of complex policy into plain language tools, templates, and workflows. Capacity-building ensured that staff were not only compliant but confident and skilled in implementing Medicaid processes. The tool also reflected a systems-level perspective, prioritizing integrated, proactive supports over fragmented, crisis-driven approaches.

The design process occurred over approximately 12–18 months. Initial phases included policy analysis and stakeholder engagement, followed by drafting, piloting with a cohort of districts, and iterative revision based on feedback and implementation data. The Learning Collaborative was launched alongside the Toolkit to test and refine materials in real time. This phased and responsive development approach ensured that the final product was grounded in policy accuracy, practitioner experience, and a sustained commitment to community wellness.

**The Medicaid Toolkit emerged from a previous AMCHP Replication Grant project that implemented and adapted NC Project AWARE/ACTIVATE—recognized by AMCHP as a Best Practice—within the HOPE Alternative Learning Program.*

IV. Tool Use

The Medicaid Toolkit and Learning Collaborative are designed to be used as both a practical implementation guide and a structured capacity-building resource for school districts seeking to strengthen their Medicaid-funded mental health services. District teams use the Toolkit as a step-by-

step reference to understand eligibility requirements, establish compliant documentation processes, assign staff roles, implement the Random Moment Time Study, and develop workflows for billing and reimbursement. The materials include guidance documents, templates, checklists, sample forms, and process maps that districts can adapt to their local context.

The tool is typically administered at the district level by a designated "Toolkit Champion" or implementation lead. This individual may be a finance officer, school mental health coordinator, Medicaid billing specialist, or district administrator responsible for program oversight. In many districts, the work is supported by a small cross-functional team that includes representatives from finance, student services, and school leadership. Through the Learning Collaborative, district teams also receive structured coaching and peer support to guide implementation and troubleshoot challenges.

The time required to use the Toolkit depends on the district's starting point. Initial review and planning may take several weeks as leaders assess current practices and identify gaps. Full implementation of Medicaid processes typically occurs over the course of a school year, with incremental steps introduced and refined over time. The Learning Collaborative model often spans an academic year, providing ongoing touchpoints, coaching sessions, and opportunities for shared learning. While implementation requires sustained effort, the Toolkit is designed to integrate into existing district systems rather than operate as a standalone initiative.

The tool is available in multiple formats to support usability and accessibility. The primary component is a comprehensive written Toolkit that serves as a reference manual. Accompanying materials include one-page summaries, editable templates, slide decks, training materials, and virtual learning sessions. The Learning Collaborative is delivered through a combination of live virtual meetings, coaching calls, and shared resource platforms, allowing districts across geographic regions to participate.

Outcomes and results are measured through both implementation metrics and service impact indicators. Districts track improvements in Medicaid program processes, confidence in completing required activities such as the Random Moment Time Study, and fidelity to documentation standards. Financial outcomes include increased Medicaid reimbursement that can be reinvested in student supports. Most importantly, districts monitor student-level outcomes such as the number of students receiving mental health services and perceived impact on student well-being. Results are typically shared through progress reports, data dashboards, end-of-year summaries, and cohort-wide reflection sessions, enabling districts to see both their individual progress and collective growth across participating sites.

Overall, the Toolkit is used as an ongoing systems-strengthening resource that builds district capacity, improves compliance, expands access to services, and supports sustainable community wellness.

V. Tool Testing & Evaluation

The Medicaid Toolkit and Learning Collaborative were tested through an initial pilot cohort model and refined using continuous quality improvement (CQI) practices. During the first year of implementation, participating districts engaged in structured feedback cycles that included surveys, coaching reflections,

implementation check-ins, and end-of-year debrief sessions. Data on process implementation—such as documentation fidelity, completion of required Medicaid activities, and confidence in completing the Random Moment Time Study—were collected at baseline and again at the end of the year. Feedback from district leaders led to revisions that simplified language, clarified workflow steps, added visual process maps, and expanded practical examples. Templates were refined to reduce administrative burden, and training sessions were adjusted to include more applied practice and peer problem-solving. This iterative design ensured the tool evolved in direct response to user experience.

In the initial cohort, districts implemented the model at varying levels of intensity, including high-touch districts that fully implemented the model and additional districts receiving lighter-touch support. District implementation teams—including finance officers, student services leaders, and mental health providers—reported increased clarity and confidence in navigating Medicaid requirements. All high-touch districts demonstrated improvement across Medicaid program processes, with notable gains in responding to the Random Moment Time Study and in documentation compliance. Participants consistently described the Learning Collaborative as reducing isolation, increasing problem-solving capacity, and strengthening cross-department collaboration.

Evaluation has included both process and outcome measures. Baseline-to-end-of-year comparisons demonstrated increases in district confidence across all measured Medicaid processes and stronger fidelity in implementation. Districts also reported perceived improvements in student well-being, attendance, and school climate. Financial tracking showed increased Medicaid reimbursement, which districts reinvested into expanded school-based mental health services.

Corona Insights serves as the external evaluator for the Medicaid Learning Collaborative project. A one-page fact sheet summarizing results from Medicaid Learning Collaborative Cohort 1 is linked.

While the evaluation has primarily relied on structured data collection and district reporting, results have been documented through formal summaries and dissemination products. The model has not yet undergone a randomized independent evaluation; however, outcome data, implementation metrics, and consistent cross-district trends provide strong evidence that the approach is achieving its intended goals of improving process fidelity and expanding access to services.

Unexpected positive outcomes included the development of a leadership pipeline within districts and stronger cross-sector collaboration between education and health agencies. Early implementation also highlighted challenges, including initial administrative burden and the need for sustained leadership commitment to maintain gains.

Overall, the Medicaid Toolkit—which serves as the foundation for the Medicaid Learning Collaborative—strengthened school capacity and expanded student access to mental health services in rural North Carolina. High-touch districts increased confidence across all ten Medicaid program processes, with Random Moment Time Study response rates rising from 50% to 89%. A threefold increase in students receiving school-based mental health services was observed over one academic year, with a median of 129 students served in high-touch districts and 42 in low-touch districts during the 2024–25 school year. All high-touch districts reported positive impacts on student well-being, and schools also noted early improvements in attendance, disciplinary incidents, and academic engagement.

VI. Accessing the Tool and Intellectual Property

To request a copy of the toolkit, please send an email to mlc@ruralopportunity.org.

You will receive the toolkit via email 24 to 72 hours of submitting your request.

When citing or referencing this document, please refer to the toolkit itself, which identifies the owners of the current version.

For any questions about citing sources or using the toolkit, reach out directly to mlc@ruralopportunity.org.