The Ohio Council
Of Behavioral Health & Family Services Providers

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ODM CSI Medicaid School Program Rule Package Comments

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Thank you for the opportunity to provide feedback on the proposed rule amendments to Ohio Administrative Code Rules 5160-35-02, 5160-35-05, and 5160-35-06 related to the Medicaid School Program (MSP). We appreciate the Department's efforts to expand access to school-based services given the growing number of unmet physical and behavioral health needs students experience. We recognize the importance of aligning Medicaid reimbursement with the evolving needs of students and school systems.

As background, it's essential to understand community behavioral health centers (CBHC) have developed extensive partnership with school systems to meet the needs of students and educators. These partnerships allow students to access care during the school day and academic year but also provide continuity of care beyond the school day and when school is not in session. During the 2024-2025 school year, and Ohio Council survey of 82 of our member organization found that CBHCs were partnered with 692 districts, charter schools, private schools, and Educational Service Centers, reaching 3,850 school buildings statewide. Services offered include a full continuum of prevention, early intervention, treatment, crisis response, and family engagement services, with 97.7% providing clinical services and 83.5% delivering evidence-based prevention programs. Connecting students and their families to CBHCs is a best practice that both enables services to overcome academic barriers during the school day, but also supports students during the evenings, weekends, and over winter and summer breaks. Medicaid is the primary payer of behavioral health services through these partnerships under the Medicaid Community Behavioral Health Services authorized in Chapter 5160-27.

As this rule is developed, it's paramount that the MSP behavioral health services augment existing behavioral health partnerships in school and fill gaps. Given well documented behavioral health workforce shortages, we are concerned this may result in added workforce recruitment and retention challenges for existing CBHCs partnering with schools as it creates an incentive for schools to hire staff already working in their school building, offering both better working hours and higher wages. Further, CBHCs are required to have national accreditation for behavioral health services and OhioMHAS certification – neither of which is required for schools offering the same services. The lack of consistency in the regulatory environment is expected to have a negative impact on businesses already serving students in the 3, 850 school buildings described above.
Below are our specific comments on the Chapter 5160-35 rule package:

1. The proposed rules in Chapter 5160-35-05 (B) and (J) do not clearly address how MSP providers of behavioral health services should align with care a student may already be receiving from CBHCs or providers contracted by the district. Without clear expectations for coordination and documentation, students are at risk of fragmented care, conflicting treatment plans, and inconsistent service delivery. It may result in duplication of existing services and displacement of existing workforce without actually expanding care options or filling gaps. This is especially concerning for students who rely primarily on school-based services, as they may face gaps in care during evenings, weekends, breaks, and summer months when school is not in session. These disruptions can lead to

regression, increased risk of crisis, and disengagement from school. Clear guidance on how to coordinate and document services across providers would help ensure continuity of care, support consistent access to services year-round, and prevent duplicative billing. Aligning documentation expectations around medical necessity, service planning, and progress monitoring would further support shared care efforts and improve outcomes for students. Further, OAC 5160-27-03 and 5160-27-04 already require CBHCs to coordinate care with other providers and to document consultation, collaboration, and treatment planning across systems. Applying similar expectations to school-based MSP services would ensure consistency in care coordination, reduce risk of fragmented service delivery, and maintain Medicaid program integrity.

Recommendation: Revise 5160-35-05(B) and (J) to align coordination and documentation requirements with OAC 5160-27-03 and 5160-27-04, ensuring that school-based, district-contracted, and external providers deliver consistent, coordinated care and avoid duplicative or displacing services.

2. Students with more complex or intensive behavioral health needs may require care beyond what school-based or district-contracted providers can deliver. While the proposed rules expand allowable services in 5160-35-05, they do not outline a clear process for identifying when students should be referred to external behavioral health providers and limit care to the school day and academic calendar. The rule lacks defined referral pathways in sections 5160-35-05(J), which outlines plan of care requirements, and 5160-35-06 (E)(1), which addresses assessment and service determination. As a result, students may experience delays in accessing clinically appropriate care, which increases the risk of crisis escalation, school disruptions, and emergency interventions. This is especially concerning for students with co-occurring conditions, trauma histories, or those transitioning between levels of care. Establishing a structured referral process would help ensure timely access to the full continuum of behavioral health services, maintain continuity of treatment, and support students in the least restrictive environment.

   Recommendation: Add language to 5160-35-05(J) to include referral to external behavioral health providers as a component of the school services plan of care when student needs exceed the capacity of the school-based team. Also revise 5160-35-06(E)(1) to establish criteria for referral when assessments identify behavioral health needs outside the scope of school-based services. These changes would help ensure timely and appropriate referrals to community providers and prevent service gaps for students with complex care needs.

3. The proposed rule 5160-35-05 (B)(3) states that School Services Plans of Care and related documentation are not medical records and are governed by FERPA. While HIPAA is referenced, it does not apply to education records maintained by schools or their agents. Further, explicitly stating a school services plan of care is not a medical record implies it does not contain protected health information and would not be subject to HIPAA. This distinction raises significant confidentiality concerns, as it appears to be contradictory and FERPA permits broader internal access than HIPAA, increasing the risk that sensitive behavioral health information such as therapy notes or crisis related details could be accessed by nonclinical staff. These concerns are especially significant for students receiving trauma informed care, substance use treatment, or suicide risk interventions, particularly when multiple providers operate under different privacy standards. Further, CBHCs operating in schools are required to follow HIPAA, licensed health and behavioral health practitioners are also subject to HIPAA, and this is another example of the unequal regulatory environment created by this rule. Additional guidance is needed to ensure that schools and providers apply consistent and appropriate privacy protections when documenting and sharing protected health information.

Recommendation: Provide guidance to protect the confidentiality of behavioral health records in schools, including limits on access and best practices for FERPA and HIPAA alignment.

4. The proposed rule in 5160-35-05(C)(6)(b) expands the list of allowable behavioral health providers under the MSP to include dependently licensed professionals such as trainees, interns, and conditional license holders. The rule requires these providers to operate under supervision in accordance with their respective licensing boards, which is appropriate and necessary. However, the practical implementation of this expansion in school settings may be challenging. Unlike community behavioral health settings, many schools may not employ or contract directly with independently licensed staff, leaving trainees without consistent access to qualified clinical supervision. This can lead to variation in service quality, gaps in documentation and treatment planning, and potential compliance risks under Medicaid. Ensuring that supervision requirements are met in school-based environments, particularly when behavioral health services are being reimbursed through Medicaid, will be critical to program integrity, student safety, and clinical effectiveness and a consistent regulatory environment for businesses that offer the same services to a school.

   Recommendation: Add language to explicitly require MSP providers delivering behavioral health services to ensure access to independently licensed clinicians who can provide appropriate supervision to dependently licensed staff, either through direct employment, contract, or formal partnership.

5. The School Services Plan of Care defined in 5160-35-05(J) lacks sufficient clinical structure and alignment with Medicaid behavioral health treatment planning standards. While comment #3 outlines related privacy and record-keeping concerns, this issue centers on the absence of requirements that ensure clinically appropriate, individualized treatment planning. Under OAC 5160-27-04, community behavioral health providers must develop medically necessary, goal-driven plans with qualified staff and documentation protocols. No similar expectations are applied to MSP providers in this section. By defining the School Services Plan of Care as "not a medical record" and subject to FERPA, the rule risks establishing a separate, less accountable framework for Medicaid-reimbursed services delivered in schools. Without clearly defined clinical elements or alignment with community standards, the Plan of Care could vary widely across providers and schools—leading to gaps in treatment quality, coordination failures, and audit vulnerability. Aligning this framework with existing Medicaid requirements is essential for maintaining program integrity, supporting cross-system coordination, and ensuring that all students receive consistent, appropriate care.

   Recommendation: Revise 5160-35-05(J) to align the School Services Plan of Care with Medicaid treatment planning standards outlined in OAC 5160-27-04, including individualized planning, documentation of medical necessity, progress monitoring, and qualified provider involvement. Clarify how the plan should interface with external provider care plans to promote coordination and continuity of care.

Thank you for the opportunity to share these comments. We look forward to continued partnership to develop these rules in a manner that extends MSP to more students and fills gaps in care. If you would like to discuss our comments further, please don't hesitate to contact me at lampl@theohiocouncil.org.