Final Needs Assessment

Program Summary

Nevada's School Health Services (SHS) program has played an integral role in ensuring that Medicaid-eligible students have access to critical health services within school settings. Since its inception, the program has evolved significantly, demonstrating the state's ongoing commitment to enhancing access to Medicaid-covered services and supporting the health and well-being of students. By positioning schools as essential health care hubs, the program fosters a holistic approach to supporting student health, which in turn promotes academic success.

The SHS program allows local education agencies (LEAs) to enroll as Medicaid providers, enabling schools to offer health services and receive Medicaid reimbursement for those services. This initiative is a vital component in supporting both the educational and the physical health needs of Nevada's students.

Key milestones in the development of Nevada's SHS program include the following:

- **2009:** Nevada secured federal approval for Medicaid reimbursement for services provided by Medicaid-participating providers in schools. Initially, coverage was limited to services outlined in a student's Individualized Education Program (IEP).
- **2019:** The program expanded through a State Plan Amendment, which included Early and Periodic Screening, Diagnostic, and Treatment services in school-based settings. This expansion broadened the scope to include preventive and medically necessary care for students.
- **2023:** Nevada updated the SHS program to better align with federal policies, further expanding eligible services and treatment modalities to include the following:
    - telehealth services
    - behavioral health services

These updates transformed Nevada's SHS program into a more comprehensive service delivery system, enabling LEAs to provide a full range of Medicaid-covered services to all eligible students.

Additionally, the SHS program is carved out of managed care, allowing LEAs to bypass third-party administrative hurdles and submit claims directly to the state. This streamlines

reimbursement processes, reduces operational complexity, and improves program efficiency. Another policy shift eliminating the requirement for local governments to fund the nonfederal share of Medicaid costs has alleviated financial burdens on LEAs, especially those in rural and under-resourced areas, enabling them to focus on delivering high-quality health services.

Although the SHS program has expanded significantly over the years and is now serving more students, several challenges remain, particularly in rural and Tribal communities. To inform the next phase of statewide program growth, the Nevada Division of Health Care Financing and Policy (DHCFP) conducted an online survey that informed the preliminary needs assessment submitted in spring 2024 as part of the Centers for Medicare and Medicaid Services expansion grant. Findings included from that preliminary assessment are listed below.

Preliminary Needs Assessment Findings

- **Limited participation by LEAs** emerged as a significant challenge, highlighting the need for targeted efforts to enhance engagement.
- **Administrative complexities and burdens** were also identified as obstacles creating additional challenges for schools attempting to implement these services and generate reimbursements effectively.
- **Cultural**, **language**, and **perceptual barriers** were noted as significant factors limiting equitable access to services for diverse student populations, underscoring the importance of culturally responsive approaches.
- **Workforce shortages** further compounded these issues, restricting schools' ability to connect students with qualified providers and emphasizing the need for workforce expansion and diversification.
- **A need for an electronic health record (EHR) and billing system that aligns with program requirements**, which is essential for improving efficiency and ensuring sustainable participation, was noted.

The preliminary needs assessment identified key challenges and opportunities, setting the stage for exploring strategies to support program expansion. Building on these initial findings, this report presents updated insights from the needs and infrastructure assessments, details the methodology and timeline used to refine them, and outlines strategic priorities to address identified barriers and infrastructure gaps.

Methodology and Timeline

The final needs and infrastructure assessments were developed through a comprehensive approach, integrating diverse data sources and stakeholder input to thoroughly examine the challenges and opportunities within the Nevada Medicaid SHS program. Key efforts included a statewide listening tour with LEAs, analyses of LEA enrollment and claims data, and a review of workforce data. Additionally, focus groups were conducted, and findings from all sources were presented and refined during a stakeholder engagement session. Representatives from all districts were invited to provide input, and all LEAs except one are represented by at least one input opportunity.

Data Sources Informing the Final Assessments

1. **Annual School Survey (February–March 2024):** The DHCFP launched its first annual online survey to gather insights on challenges and potential solutions regarding the Medicaid SHS program. The survey received 21 responses representing 13 LEAs.
2. **Statewide School Listening Tour (March–May 2024):** The DHCFP conducted a listening tour with 14 LEAs statewide to understand their experiences and challenges in utilizing the Medicaid SHS program and delivering health services to students. WestEd analyzed session notes for common themes.
3. **SHS Program and Claims Data (October–November 2024):** WestEd matched publicly available data on Nevada's LEAs, including student enrollment numbers and eligibility for free-and-reduced-price lunches (FRL), with SHS program participation and claims data from fiscal year 2023–24 for LEAs actively billing the program.
4. **Focus Groups With LEAs (November 2024):** WestEd hosted two focus groups to explore LEAs' experiences with billing and EHR systems and to identify infrastructure needs for efficient claims submission. Participants from 10 LEAs were represented across the sessions.
5. **Focus Group With School Health Access (SHA) Steering Committee (November 2024):** WestEd gathered feedback from key Medicaid SHS program constituents, including state agency representatives, LEAs, and parents, to refine findings from the needs and infrastructure assessments.
6. **Stakeholder Feedback Session (December 2024):** WestEd presented initial findings from preliminary needs assessments and additional research to SHS program stakeholders. Breakout discussions helped further refine these findings by gathering feedback on challenges and potential solutions to barriers hindering SHS program participation. The session included 12 participants representing seven LEAs across the state.

These data sources were further enriched through regular meetings and information-gathering sessions with DHCFP staff, whose extensive knowledge and experience with SHS program operations and policy requirements provided valuable context and insights.

Updated Needs Assessment Findings

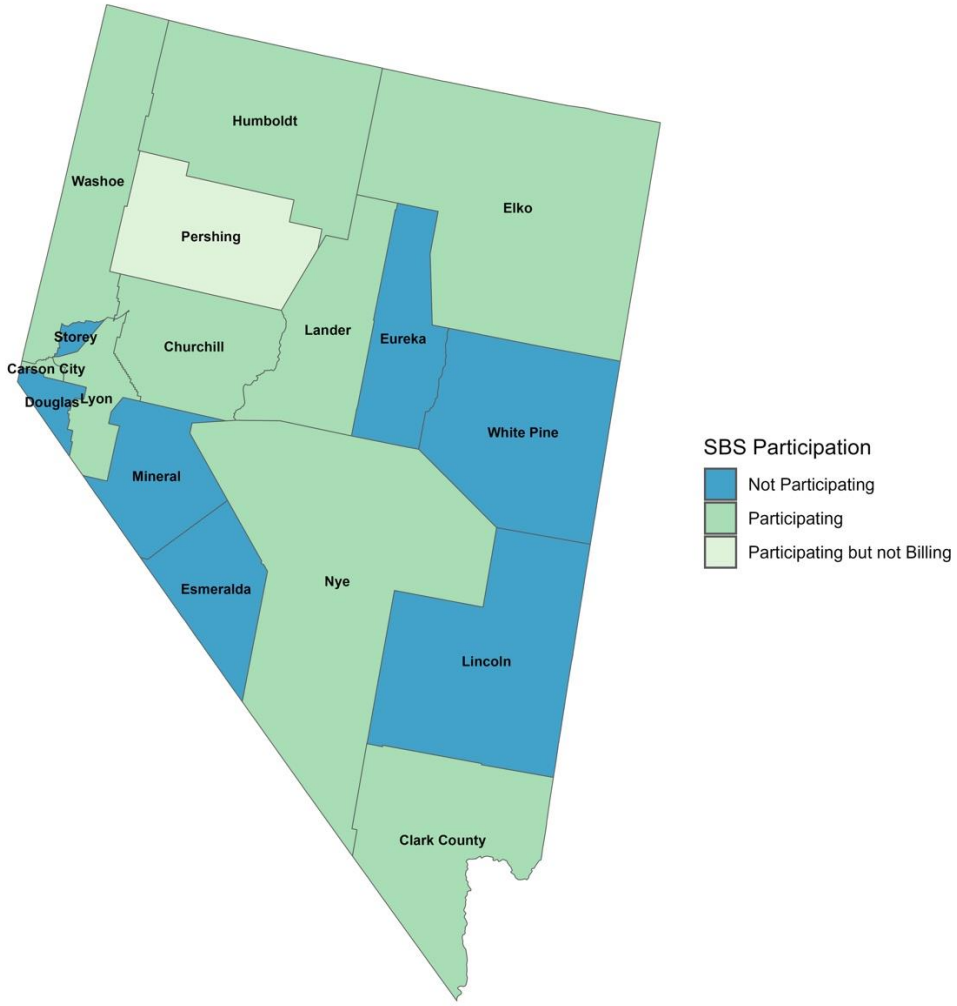
The updated needs assessment findings build upon insights from the preliminary assessment conducted last spring and incorporate additional research. Presented below is a comprehensive list of key findings followed by a detailed analysis of respective challenges and barriers to Nevada's SHS program.

1. Participation in the SHS program is uneven across Nevada's LEAs, with small, rural districts facing notable barriers.
2. Medicaid billing complexities limit SHS program participation and reimbursement.
3. Barriers to access and a lack of trust in school mental health services limit participation in rural and Tribal communities.

Participation in the SHS Program Is Uneven Across Nevada's LEAs, With Small, Rural Districts Facing Notable Barriers

Nevada is composed of 17 county school districts. Figure 1 visualizes those 17 districts and their participation in the SHS program. Of those 17 school districts, 7 are currently not participating in the SHS program (blue), 9 are participating and billing (green), and 1 is participating but not billing (light green).[1] For the purposes of the following analyses, Pershing County, which is participating in the SHS program but did not bill during the 2023–24 school year, is grouped with the nonparticipating districts.

Figure 1. Nevada County School Districts by SHS Program Participation



Note. Figure 1 is informed by data from DHCFP and the Nevada Department of Education. Data are fully described in Appendix A.

[1] Division of Health Care Financing and Policy. (August 2024). *Nevada Provider Type 60: School based services by county, from July 1, 2023 to June 30, 2024* [Data set]. Department of Health and Human Services.

Districts in blue and light green, which are either not participating or are enrolled but not billing, represent seven out of the eight smallest districts in Nevada by enrollment size. Together, these eight districts account for only 1.9 percent of the state's total student population and 1.2 percent of the total FRL[2] participation in the state.[3] Notably, all the nonparticipating districts are considered rural by the Census Bureau.

Lander County stands out as an exception to the trend of nonparticipation among small, rural districts in the SHS program. With 1,077 enrolled students, Lander is the seventh smallest district in the state and has recently enrolled in the SHS program, providing a valuable case study for identifying effective strategies to support program participation in small, rural districts.

The State Public Charter School Authority (SPCSA) operates as the LEA for all public charter schools in Nevada. Charter schools do not operate as independent LEAs and therefore cannot bill directly for school-based services. SPCSA and its authorized charter schools have very recently completed enrollment as a Medicaid provider but do not yet bill. Their students represent 12.8 percent of all students in Nevada and 8.0 percent of students on FRL in the state of Nevada.

Currently, billing in the SHS program accounts for services to only 3.7 percent of students statewide. Although this participation rate is low, the districts that are enrolled and billing represent 90.9 percent of all students eligible for FRL. If Pershing County (currently enrolled but not billing) were to begin billing and SPCSA were to enroll and begin billing, 98.9 percent of students eligible for FRL in Nevada would attend schools in districts participating in the SHS program. This presents a significant opportunity to expand SHS participation.

Within the participating districts, there is a wide variation in membership, claim volume, and revenue generation. For example, Lander County has only 18 enrolled members and generated approximately $12,000 in claim reimbursements for 2023–24. In contrast, Clark County, the largest district in Nevada, has 13,135 enrolled members and generated over $7.6 million in reimbursement during the same period.[4] This disparity is an important consideration for Nevada as it seeks to expand participation in the SHS program. Small districts face trade-offs between fixed administrative costs, regardless of student population size, and potential revenue benefits, which will be much lower for small districts and may not cover fixed administration costs.

Medicaid Billing Complexities Limit SHS Program Participation and Reimbursement

The complex billing processes and administrative burden associated with Medicaid reimbursement make it both difficult and time-consuming for districts to navigate and fully maximize billing

[2] FRL percentages are used in this report to identify the percentage of students in families with low incomes as a proxy for students who may be eligible for and/or enrolled in Medicaid.

[3] Nevada Department of Education. (n.d.). *SY 2023-2024 validation day student counts* [Data set]. Nevada Department of Education. Accessed October 15, 2024. https://doe.nv.gov/offices/office-of-assessment-data-and-accountability-management-adam/accountability/data-requests/enrollment-for-nevada-public-schools

[4] Division of Health Care Financing and Policy, 2023-24.

opportunities. Translating the broad range of health services provided in schools into a Medicaid reimbursement model is especially challenging because the methods of health care delivery in schools differ greatly from those in medical facilities. A key issue is the misalignment between the professional licensure of school-based providers and the requirements outlined in the Medicaid billing manual, even when those providers are qualified to deliver services in a school setting. Survey respondents noted difficulties in documenting services because claims must be matched with a student diagnosis. This becomes particularly problematic when a student has not yet been diagnosed with a disability but still requires services in the interim.

There was also recurring feedback among focus group participants, listening tour attendees, and survey respondents that documentation is a significant burden. The required documentation often forces school health providers into "double charting," meaning they must enter the same information into multiple platforms. This redundancy—documenting a service in educational records, medical records, and billing systems—significantly increases the administrative load on school-based providers, who already have demanding workloads. One participant from a listening tour shared that they were required to document the same service four times to meet the various reporting requirements, including educational, documentation, parental communication, and Medicaid billing compliance. This involved handwritten notes, entries into an IEP web-based platform, reports sent home to parents, and input into the Medicaid billing system software.

The lack of understanding among district staff regarding Medicaid billing procedures is also a core challenge. Participants in the focus groups and stakeholder session highlighted the challenges in referencing multiple resource documents for Medicaid reimbursement: the *Provider Type 60 Billing Guide* and the fee schedule. Ideally, these two documents work in tandem to facilitate accurate billing, with the fee schedule offering a comprehensive list of allowable CPT codes and rates for school-based providers and with the *Guide* providing supplemental information, including descriptions, service limitations, qualified provider types, and documentation tips for some but not all allowable services. Participants in focus groups and stakeholder sessions as well as survey responses all indicated a desire for one comprehensive resource to support claims submissions for allowable services.

Focus group participants shared that they feel expected to conduct in-depth research into codes, the limitations of codes, and ways to maximize reimbursement—a task that is not feasible given the lack of time and expertise. This complexity was reiterated in the stakeholder session, with one participant noting,

> *The guidance [for codes] is never clear. Providers have to read in between the lines. Sometimes the guidance is 'ask the billing company' and it still isn't clear. Sometimes there is a conflict or lack of consistency between state guidance and billing companies. They both say to ask the other one. Sometimes different districts working with different companies get different answers to the same question.*

Survey responses shared similar sentiments and indicated a need for a designated person in each district to assist with Medicaid billing questions. Respondents expressed uncertainty about how to navigate the billing process, emphasizing the importance of having a central resource for guidance. As shown in Table

1, the majority of survey respondents (71%) identified “billing issues” as the primary challenge. Focus group discussions reinforced this need, revealing confusion over which sources of information are accurate when they are in conflict. The lack of clear guidance further discourages districts from making claims, with focus group participants expressing concerns about recoupment of paid claims if documentation is not completed correctly.

During the November SHA Steering Committee meeting, committee members examined the preliminary finding, “Administrative complexity and burdens of participation present major challenges.” When asked to identify the most burdensome aspect of the program, steering committee members overwhelmingly emphasized the need to simplify administrative processes—especially those related to Medicaid billing and documentation. Similar to feedback from survey respondents and focus group participants, committee members saw clearer guidance and streamlined procedures as crucial for reducing the administrative burden on school staff, enabling more resources to be directed toward delivering services to students.

Committee members also noted that successful Medicaid billing in some districts relies heavily on established relationships with knowledgeable individuals who can navigate the complexities of the system. However, developing these relationships takes time, particularly given that Medicaid’s billing framework is designed for outpatient models, which are poorly aligned with school operations. To address these challenges, committee members recommended the creation of clear, adaptable guidance outlining best practices while allowing for flexibility to fit school environments. Such guidance would help districts maximize Medicaid billing opportunities while maintaining compliance, ultimately improving access to vital services for students.

Table 1. Survey Responses: “On behalf of your school district, what challenges are you currently facing regarding Nevada Medicaid and school health services?”

Challenges	Number of respondents	Percentage of respondents[1]
Billing issues—do not know how or do not have the capacity to bill Medicaid for services or another billing issue	15	71%
Policy issues—the Medicaid Services Manual and Billing Guide are too confusing and complicated to understand or another policy issue	9	43%
Communication issues—do not know who to contact to get help or another communication issue	6	29%

[1] The sum is greater than 100 percent because respondents were asked to select all that apply.

Data collected conveyed that billing challenges might be more pronounced in small, rural areas because these districts often have limited staff capacity to complete Medicaid billing procedures, including coding and claims management. These responsibilities require substantial time and resources, especially when documentation systems are not streamlined and require manual input. Hiring a coordinator

specifically for Medicaid billing is not always feasible or cost-effective, a sentiment echoed across focus groups, surveys, and listening tours. One survey respondent stated, “We do not have the staff to make it happen. We would need to add an additional staff member which is not feasible or cost effective at this time.”

Participants in focus groups and the stakeholder session also requested training on coding and the limitations of codes, particularly for frequent IEP activities and accommodations. Some suggested the creation of a specialized role—an expert coder—whose job would be to research medical codes and their limitations and ensure they align with services for compliance purposes, optimizing reimbursement. This expert knowledge would help alleviate the administrative burden on existing staff. As one participant phrased it, “The state should hire a billing code expert to provide guidance to all LEAs on which disciplines can use which codes.” During the stakeholder session, this idea was independently brought up in all three breakout rooms.

Barriers to Access and a Lack of Trust in School Mental Health Services Limit Participation in Rural and Tribal Communities

One preliminary finding highlighted that cultural, language, and perceptual considerations posed challenges to participation in some regions. SHA Steering Committee members provided additional insight, emphasizing that rural and Tribal communities in Nevada face significant barriers to accessing school-based mental health services. They explained that these challenges are driven by geographic isolation, limited resources, and cultural dynamics, with a widespread lack of trust in the school mental health system further hindering participation. During the November SHA Steering Committee meeting, participants explored these issues in greater detail, underscoring how the issues limit students’ access to essential services.

Another key barrier identified by the committee is the lack of diversity within the mental health workforce in rural and Tribal communities, where providers are often predominantly White, which does not reflect the total student populations served. The limited availability of personnel to assist with Medicaid enrollment compounds this mismatch and prevents many eligible children from accessing services. Additionally, misconceptions about the scope of school mental health services, especially in rural areas, create confusion and contribute to reluctance in utilizing available supports. Committee members suggested the creation of targeted educational materials to clarify these services and address misunderstandings in the community.

The lack of trust in school mental health providers was also highlighted as a significant concern, particularly impacting access to services for Native American populations. The irregular onsite availability of providers exacerbates these trust issues. However, successful models in some districts have included cultural engagement and community outreach as strategies for building trust. These approaches were cited as valuable for other areas facing similar challenges. Despite the potential benefits of telehealth in addressing access issues, its underutilization in rural areas due to mistrust also came up as a key concern.

In addition to these cultural and trust-related barriers, the committee also discussed the high workloads of school mental health professionals. This issue is especially prevalent in rural districts, where limited resources have led some districts to contract services rather than hire in-house staff. This reflects the broader systemic challenges faced by these areas, which strain the ability to provide consistent, high-quality care.

Final Infrastructure Needs Assessment

The following updated infrastructure assessment findings build upon insights from the preliminary assessment, incorporating additional research and stakeholder input. This section provides a comprehensive overview of two key findings, an in-depth analysis of each, and a review of Nevada's compliance with state and federal regulations.

Updated Infrastructure Needs Assessment Findings

1. Workforce shortages, especially in rural areas, restrict Medicaid program capacity and increase administrative strain.
2. Successful adoption of a common EHR system requires district involvement, tailored design, and comprehensive staff training.

Workforce Shortages, Especially in Rural Areas, Restrict Medicaid Program Capacity and Increase Administrative Strain

Workforce shortages, particularly in rural, Tribal, and remote areas, were identified as a significant barrier to effective Medicaid program participation. Data collected from surveys, focus groups, and SHA Steering Committee discussions highlighted that limited access to qualified providers directly restricts schools' ability to deliver necessary services and increases the administrative strain associated with Medicaid participation.

Survey respondents reported that the scarcity of qualified mental health professionals in rural and Tribal regions prevents many schools from meeting the demands of students eligible for Medicaid. Many of these districts rely on a small pool of service providers, which limits the number of children who can be served and significantly strains the resources available. This shortage of qualified staff often results in extended waiting times for services and, in some cases, a lack of available services altogether. Focus group participants echoed these concerns, emphasizing the difficulty in recruiting and retaining providers who not only are qualified but also understand the unique needs of rural and Tribal communities.

The steering committee further discussed how the lack of qualified personnel exacerbates the administrative burden on school districts. Without sufficient staff, districts face increased challenges in navigating the Medicaid billing process, which requires specialized knowledge. Many school districts rely on external billing agents, but the absence of consistent, in-house expertise increases the risk of errors and delays in processing claims. Additionally, survey data revealed that some districts are unable to fully utilize Medicaid funding due to this lack of personnel qualified to complete the necessary

documentation to submit claims. In some cases, districts may even be hesitant to pursue Medicaid billing at all, fearing the potential for recoupment or administrative errors as noted during some stops along the statewide listening tour.

The committee also highlighted how these workforce shortages disproportionately affect rural and remote areas, where travel limitations and the lower availability of qualified professionals further complicate the delivery of services. Some committee members pointed out that Medicaid billing processes are designed around an outpatient model, which does not always align with the way services are provided in schools. This misalignment places additional strain on already overburdened districts, making it more difficult to access Medicaid funding that is critical for delivering mental health and other support services to students.

Overall, workforce shortages, particularly in underserved rural and Tribal areas, create a compounded challenge for schools trying to implement Medicaid programs. The lack of qualified staff not only limits service provision but also creates a significant administrative burden that hinders districts' ability to maximize Medicaid funding and meet the needs of eligible students.

Successful Adoption of a Common EHR System Requires District Input, Tailored Design, and Comprehensive Staff Training, and Many LEAs Lack Resources to Invest in Suitable Systems

Preliminary findings on the challenges involved with school districts' EHRs and Medicaid billing systems led the research team to conduct focus groups with the objective of determining how this challenge can be alleviated. The focus groups were asked questions about their current billing and documentation systems, any integration experiences with multiple systems, valuable and desired features, documentation and billing platform barriers and challenges, and considerations for a common statewide billing system.

One unique asset in Nevada is that all county school districts use the same student information system (SIS), Infinite Campus. Using one system allows for standardized recording and reporting of data and reduced complexity when a student transfers from one district to another in the state. However, SIS, health documentation, and billing platforms do not always operate easily together; focus group participants shared that inefficient data transfer and ineffective validation processes create significant administrative burdens. This sentiment was echoed across all other conducted engagements: the survey, listening tour, and stakeholder session.

Technology systems designed to document services and submit claims to Medicaid often complicate the process and create redundant steps rather than simplifying processes for providers and administrative staff. With limited staff capacity, many districts do not have the technological expertise or staff available to invest the significant time required for customizing the platforms to interact with each other. LEAs currently have a complex array of documentation and billing options that they must navigate on their own, which many find overwhelming. For example, the SIS is used along with separate EHRs for different practitioner types (such as school nurses using one platform and occupational therapists using another), all of which may or may not easily share data with a selected billing system. One focus group participant stated,

I think that's one of our barriers is some folks being reluctant to have to deal with the integration issue and having multiple vendors. So maybe some of the challenges with [integration], but also some of the contractual challenges like having multiple vendors under contract for similar products.

One potential solution would be the implementation of a common statewide billing platform capable of seamlessly handling documentation and Medicaid billing claims. This was suggested by multiple survey respondents who were interested in a "one-stop shop." Two focus groups shared differing views on this, with opinions varying in large part due to district size. One focus group was reluctant about a statewide EHR and billing system given that many participants represented school districts that had already invested heavily in their current systems. Participants in this focus group expressed concern about getting practitioner buy-in to learn a new system. The other focus group was in support of a statewide EHR and billing system, even suggesting that it should be mandatory. Despite the short-term challenges, the participants noted the benefits of not only internal efficiency but also district-to-district compatibility.

Members of the focus groups emphasized that if a common system were to be implemented, any statewide platform change would need to be developed with great care, including direct district involvement beginning from the early stages of selection and development and comprehensive in-depth training and ongoing assistance.

Nevada Is in Compliance With Regulatory Requirements

Based on a review of Nevada DHCFP policies and practices, the state is in compliance with the regulatory requirements outlined in the Notice of Award. Specific requirements are detailed below.

IDEA Regulatory Requirements: The Nevada Department of Education (NDE) and the DHCFP collaborate on several initiatives to ensure coordination when noneducational public agencies, such as Medicaid and Children's Health Insurance Program (CHIP), fund services that are also considered special education and related services. These efforts include collaboration on updated guidance, NDE participation in the SHA Steering Committee, and regular monthly meetings between the agencies.

Other Regulatory Requirements: The DHCFP ensures compliance with Medicaid and CHIP services for non-IDEA services by issuing updated guidance and drafting an updated program manual with explicit compliance information for expanding services beyond those included in IDEA. The DHCFP continues to work with LEA providers and billing vendors to ensure timely and accurate billing submissions.

Federal Medicaid Administrative Match

The DHCFP is not utilizing the Cooperative Agreement funding as a match for Medicaid funds because this is not permitted. Below are the investments made using the Cooperative Agreement funds, some of which may be eligible for future matching with federal Medicaid administrative funding provided they are funded with state resources:

- **Contract with vendor to support start-up efforts**—not eligible due to the short-term nature of the investment
- **Contract with vendor to develop statewide EHR option**—eligible, and the DHCFP plans to request State General Funds during the 2027 Legislative Session to access federal matching funds

The DHCFP will explore the possibility of using state funds in the future to leverage federal Medicaid administrative match funds to sustain these investments beyond the Cooperative Agreement. However, this would be contingent on securing additional funding from the Nevada Legislature.

Priorities to Address Needs and Infrastructure Findings

To address the barriers described in the updated assessment findings, the DHCFP intends to expand program participation, LEA engagement, and efficient and effective billing for Medicaid services in school settings through the following priorities.

Engage LEA Stakeholders Through Public Workshops and Annual School Surveys

To ensure that the SHS program meets the diverse needs of Nevada's LEAs, the DHCFP will prioritize ongoing engagement with stakeholders. In-person listening sessions and virtual public workshops will provide a platform for LEAs to share their experiences, challenges, and recommendations, creating a collaborative space for program improvement. Annual surveys will serve as a vital tool to capture feedback on program operations, resource accessibility, and areas needing additional support.

These engagement efforts have the following aims:

- **Increase Awareness:** Educate LEAs on Medicaid program opportunities, requirements, and benefits to encourage broader participation.
- **Inform Guidance:** Tailor program policies, tools, and resources to the unique operational and demographic realities of Nevada's urban, rural, and Tribal LEAs.
- **Foster Collaboration and Build Relationships:** Build trust and partnership between the DHCFP, LEAs, and other stakeholders to ensure shared ownership of program outcomes.

Develop a School Health Access Resource Center and Steering Committee

Establishing a centralized SHA Resource Center will provide Nevada's LEAs with a one-stop source for essential program information, training, and technical assistance. This hub will offer user-friendly resources such as how-to guides, webinars, and materials designed to address the nuances of Medicaid participation in school settings. The hub will also include links to relevant resources hosted by other agencies, including the NDE.

Key components of this initiative include the following:

- **SHA Steering Committee Formation:** A diverse group of stakeholders—including LEA representatives, DHCFP staff, health care providers, and community advocates—will guide the Resource Center's development and ongoing updates to ensure relevance and accessibility.
- **Revised SHS Program Manual:** The manual will be updated to reflect current program requirements, best practices, and practical guidance, empowering LEAs to navigate Medicaid participation more effectively.
- **Expanded Technical Support:** On-demand support through the Resource Center will help address complex Medicaid billing questions and operational challenges, reducing administrative strain on schools.

Procure and Pilot a State-Option School Billing System/Electronic Health Record

To streamline Medicaid billing and improve claims accuracy, the DHCFP will pursue the development and implementation of a state-option school billing system or EHR solution. This initiative aims to overcome inefficiencies in current billing practices and align data collection with state and federal reporting requirements.

Specific focus areas include the following:

- **Efficient Claims Submission:** automating and standardizing the billing process to reduce administrative burdens and errors
- **Pilot Implementation:** launching the system in selected districts to refine functionality, gather user feedback, and ensure scalability statewide
- **Comprehensive Training:** providing LEA staff with detailed training to ensure successful adoption and integration into existing workflows

By expanding stakeholder engagement, developing robust resources, and modernizing systems, the DHCFP aims to create a sustainable framework that enhances Medicaid participation and ensures equitable access to essential services for all students. These efforts reflect Nevada's commitment to improving health outcomes and operational efficiency in school settings, laying a strong foundation for long-term program success.

Appendix A

Figure 1 is a map of school districts in Nevada color coded by SHS program participation. This map displays the following data:

School district	SHS participation
Carson City	Participating
Churchill County	Participating
Clark County	Participating
Douglas County	Not participating
Elko County	Participating
Esmeralda County	Not participating
Eureka County	Not participating
Humboldt County	Participating
Lander County	Participating
Lincoln County	Not participating
Lyon County	Participating
Mineral County	Not participating
Nye County	Participating
Pershing County	Participating but did not bill in 2023–24
Storey County	Not participating
Washoe County	Participating
White Pine County	Not participating