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Individuals with Disabilities Education Act (IDEA) and Medicaid

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Summary

The Individuals with Disabilities Education Act (IDEA) — the centerpiece of federal legislation on educating children with disabilities — is an unusual statute because it not only provides funds to states and school districts but it also guarantees the rights of children with disabilities to a free appropriate public education (FAPE). IDEA requires that children with disabilities be provided with special education and related services so that they can benefit from their guaranteed public education. For some children, benefitting from, or even attending, school depends on health-related services. For example, a child dependent on a ventilator for life support could require in-school staff to ensure the proper operation of the equipment in order to attend school. For such a child, IDEA requires that necessary staff and services be provided.

While IDEA mandates special education and related services, it is not intended to pay for the total cost of this education and these services. One approach Congress has taken to ease the burden on states and school districts of fulfilling the requirements of IDEA is to allow the use of funds available under Medicaid, a federal-state entitlement program providing medical assistance to certain low-income individuals, to finance health services delivered to special education students who are enrolled in Medicaid. However, for various possible reasons, Medicaid funds appear to account for only a small proportion of expenditures for special education and related services. These reasons include: most IDEA children are not enrolled in Medicaid; federal privacy requirements may hinder identifying which IDEA children are participating in Medicaid; in-school health services may often be of relatively low cost; Medicaid financial requirements may reduce reimbursement to schools; and Medicaid's complexities may make many school districts unwilling or unable to access this funding source.

Relatively little is known about the interrelationship between IDEA and Medicaid. Thus a state-by-state study might be useful to Congress in determining whether to take legislative action. Depending on the outcome of such a study, various changes to Medicaid could be considered. To the extent that problems arise because of program complexity, improving technical assistance and outreach might be useful. To the extent that problems are related to Medicaid eligibility, expanding Medicaid eligibility to cover more children with disabilities could be examined. And to the extent that the problem is one of Medicaid financing, changing some of the rules that may adversely impact local educational agencies (LEAs) could be contemplated. Since some might oppose any changes to Medicaid that would result in increased state costs, other alternatives might be considered. For example, creating a funding relationship between IDEA and the State Children's Health Insurance Program (SCHIP) could be examined. In addition, federal privacy requirements might be amended to facilitate the identification of children with disabilities served under IDEA who are also enrolled in Medicaid. Finally, IDEA amendments could be considered, such as targeting some funding for children with disabilities who require expensive health-related services in order to attend school.

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Overview

The Individuals with Disabilities Education Act (IDEA) — the centerpiece of federal legislation on educating children with disabilities — defines how states and local educational agencies (LEAs) are to meet their obligations to serve these children and authorizes federal grants to states to help fund those obligations. Congress has been concerned about the financial burden that children with disabilities can impose on state and local systems of public education. Because IDEA requires that certain medical and health services be provided if they are necessary for a child with a disability to participate in and benefit from public education, one approach Congress has taken to ease the financial burden of serving children with disabilities is to allow use of funds available under Medicaid, a federal-state entitlement program providing medical assistance to certain low-income individuals, to finance health services to special education students who are covered by Medicaid.

This report begins with an overview of IDEA. It then discusses the distinction made in IDEA between medical services and health services. The report then summarizes the provisions in law that link Medicaid funding to IDEA. Next the report provides an overview of the complexities of Medicaid eligibility and covered services. Following that discussion, the report analyzes possible reasons why Medicaid appears to cover relatively little of IDEA health-related costs. Finally the report outlines possible legislative approaches with respect to Medicaid and IDEA.

Overview of IDEA. IDEA (P.L. 105-17) is an unusual, if not unique, federal statute in that it is both a civil rights statute and a grants statute. In addition to authorizing funding to provide special education[1] and related services for children with disabilities, IDEA requires that states accepting IDEA funds — and all currently do — must ensure certain procedures, rights, and services for children with disabilities and their parents. In general terms, these include:

- **Identifying, locating, and evaluating** all children with disabilities, regardless of the severity of their disability, to determine which children are eligible for special education and related services;
- Making available a **free appropriate public education** (FAPE) to all children with disabilities, generally between the ages of 3 and 21;

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[1] The Act defines "special education" as "specially designed instruction ... to meet unique needs of a child with a disability" (Section 602(25)).

- Ensuring that each child receiving services has an **individual education program (IEP)** spelling out the specific special education and related services to be provided to meet his or her needs; the parent must be a partner in planning and overseeing the child's special education and related services as a member of the **IEP team**;
- Educating children with disabilities, "to the maximum extent appropriate," **with children who are not disabled**; and
- Providing **procedural safeguards** to children with disabilities and their parents, including a right to a due process hearing, the right to appeal to federal district court and, in some cases, the right to receive attorneys' fees.[2]

In general, IDEA defines a 'child with a disability' as one who needs special education and related services because of a specified disability or disabilities. In its definition, the Act lists a series of disabilities, including mental retardation; hearing, visual, or speech impairments; autism; specific learning disabilities; and other health impairments (Section 602 (3)).

During the 1999-2000 school year, there were approximately 5.7 million school-age children (ages 6-21) served under the IDEA program across the 50 states, the District of Columbia (DC), and Puerto Rico. These children had a wide range of mild to severe disabling conditions that qualified them for IDEA. Children identified with specific learning disabilities were, by far, the largest single category of IDEA children, representing 50.5% of the total population. Another 19.2% had speech and language impairments. Nearly 11% were mentally retarded, and an additional 8.3% had emotional disturbances. The remainder of the IDEA population (about 11%) were classified as having hearing, orthopedic or visual impairments; developmental delay; autism; deaf-blindness; traumatic brain injury; other health impairments; or multiple disabilities.[3]

Although services for children with disabilities can be quite expensive, IDEA formulas do not distribute grants to states based on cost.[4] Instead most IDEA funds are distributed by formulas based on numbers of children with disabilities, total population in the age range served, and number of children from poor families in the

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[2] The various types of procedures include an opportunity for parents of a child with a disability to examine records and participate in meetings and obtain an independent educational evaluation of the child; prior written notice of a change or refusal to change a placement; an opportunity for mediation; and an opportunity to present complaints. For an overview of these and other IDEA provisions, see CRS Report RL31259, *Individuals with Disabilities Education Act: Statutory Provisions and Selected Issues*, by Nancy Lee Jones and Richard N. Apling.

[3] U.S. Department of Education (ED), *To Assure the Free Appropriate Public Education for All Children with Disabilities*. The Twenty-Third Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2001, Table AA2. (Hereafter cited as ED, *The Twenty-Third Annual Report*).

[4] Some states distribute state funds based on estimates of the varying costs for serving children with disabilities.

age range serviced. In addition, while IDEA provides for certain procedural rights and services, it is a discretionary program (its funding is subject to appropriations), not a mandatory program like Medicaid. Thus by saying that a service is required under IDEA, does not mean that IDEA funds necessarily pay for that service. Rather it means that the state and the school district must provide the service and pay for the service by whatever means available — be it IDEA funds from the federal government, state special education funds, local funds, or other federal programs, such as Medicaid.

IDEA and Related Medical and Health Services

As noted above, a basic tenet of the IDEA is that, as a condition of accepting IDEA funds, states and LEAs must provide free appropriate public education (FAPE) to children with disabilities. Guaranteeing FAPE involves the provision of special education — which must be specifically tailored to the needs of the individual child — and related services. The latter includes services necessary for children with disabilities to participate in and benefit from special education and public education in general and might involve, depending on the disability or disabilities, transportation, speech therapy, psychological services, physical therapy, interpretive services (for example, for hearing or visually impaired students), and health-related services.

IDEA law and regulations together with court interpretations make an important distinction between **medical services**, which — under IDEA — are those that only can be provided by a licensed physician, and **health services**, which are services provided by other health care providers, such as a school nurse or a physical therapist.[5] Under the FAPE requirement, the state and school districts must only provide **medical services** to the extent that such services deal with the diagnosis and evaluation of a child's disability. Other services provided by a physician need not be paid for by the state or the school district. On the other hand, **health services** that are necessary for the child to participate in and benefit from public education must be provided by the state or the school district.

The Supreme Court has upheld the distinction between medical and health services. Most recently the court held in *Cedar Rapids Community School District v. Garret F.*[6] that the school district, as part of its obligation to provide FAPE under IDEA, must provide ongoing school health services to Garret F., who is dependent on a ventilator for life support. Because maintenance of the ventilator and other health services were not dependent on a licensed physician but could be provided by a "responsible person," such as a school nurse, the Court, by a 7 to 2 majority, ruled

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[5] The Act specifically limits the definition of medical services to those with "diagnostic and evaluative purposes only." (Section 602(22)) ED regulations for IDEA elaborate on this definition: "Medical services means services provided by a licensed physician to determine a child's medically related disability that results in the child's need for special education and related services." (34 C.F.R. §300.24(b)(4)) The regulations add "school health services" to the definition of "related services" and define these services as those "provided by a qualified school nurse or other qualified person." (34 C.F.R. §300.24(b)(12))

[6] *Cedar Rapids Community School District v. Garret F.*, 526 U.S. 66 (1999).

that the services were covered by the definition of related services and must be provided in order that Garret F. could benefit from FAPE.[7]

Students like Garret F. can pose substantial financial burdens on school districts. Justice Thomas, in his dissenting opinion in *Garret F.*, noted that the school district would have to hire an additional employee to provide the one-to-one care Garret F. requires, which "will cost a minimum of $18,000 per year."[8] Unfortunately there are no current data on the overall amount LEAs spend on providing medical and health services to children with disabilities under IDEA. Expenditures for related services, of which medical and health services presumably account for a significant share, are substantial. For example, expenditures for staff providing related services for school-age children with disabilities under IDEA are estimated at about $7.5 billion.[9]

Currently there are no good data on the types of health service needs of school-aged children served under IDEA.[10] However, some studies do provide a glimpse into the health service needs of children with disabilities. Unfortunately varying definitions of what constitutes a disability make it difficult to apply the findings directly to the IDEA population. Elaine Maag, in a study of the supportive health services needs of children with disabilities, provides some useful data on the nature of these needs. Rather than the categorical definition of a child with a disability under IDEA, her definition was based on limitations in functioning in one or more of the following areas: mobility, self-care, communication, and learning. In addition, although she included children with mild, moderate, and severe limitations in mobility and self-care, she excluded children with mild communication or learning limitations. Based on this definition, she presented data representing an estimated population of nearly 4 million children with disabilities ages 5 to 17. Maag points out that supportive health services tend to be ongoing services and also "tend to be

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[7] For further information, see CRS Report RS20104, *Cedar Rapids Community School District v. Garret F.: the Individuals with Disabilities Education Act and Related Services*, by Nancy Lee Jones.

[8] *Cedar Rapids Community School District v. Garret F.*, 526 U.S. 66, 85 (1999) (Thomas dissenting). This is more than three times recent estimates of the national average additional expenditure for serving children with disabilities in public schools and apparently only accounts for the salary of a health-care attendant, not for additional special education and related services that Garret F. might require to ensure he receives FAPE. For the most recent data on the costs of special education, see Special Education Expenditure Project (SEEP), *What Are We Spending on Special Education Services in the United States, 1999-2000?*, Advance Report #1, March 2002. The report is available at [http://www.seep.org/]. (Hereafter cited as SEEP, *What Are We Spending?*)

[9] See SEEP, *What Are We Spending?*, Table B-1.

[10] ED in its most recent annual report to Congress on IDEA does provide national data on services provided under Part C of IDEA to infants and toddlers with disabilities and their families. Many of these services appear to be health related. For example, 14% of these infants and toddlers received audiology services,7% received nursing services, 39% received occupational therapy, and 38% received physical therapy. In addition many service providers are obviously health-care professionals and para-professionals, such as nurses, occupational therapists, and physical therapy assistant. (ED, *The Twenty-Third Annual Report*, Table III-13 and Table III-15).

unique to children with disabilities" as opposed to more traditional health services, such as "prescription drugs, annual doctor visits, or emergency care."[11]

Based on a population of children with disabilities ages 5 to 17 that excludes some more mildly disabled individuals, Maag estimated that about 40% of this population receives some type of supportive health service. Most prevalent among these services are communication services, such as speech therapy (received by an estimated 1.5 million). Next most prevalent are therapeutic services, such as physical and occupational therapy (about 850,000 recipients), followed by family services, for example, respite care (about 700,000) daily living services, perhaps provided by a personal care attendant (about 500,000) and medical services,[12] such as nursing services (about 200,000).

Many of these supportive health services are provided in the school, as well as at home and elsewhere, otherwise a child with a disability could not attend school and could not benefit from public education. For example, a paraplegic child, in order to attend school, might need a personal attendant to cope with daily living requirements, such as personal hygiene and biological functions. Under the FAPE requirement of IDEA, the school would be required to provide such support.

IDEA and Medicaid

Congress has been concerned about the financial burden that children with disabilities can impose on state and local systems of public education. One approach Congress has used to attempt to ease this burden is to authorize the use of funds under Medicaid, a federal-state entitlement program providing medical assistance to certain low-income individuals, to finance health services delivered to special education students who are eligible for Medicaid coverage.[13] Prior to 1988, Medicaid did not pay for coverable services that were listed in a child's IEP since special education funds were available to pay for these services, and because generally (with a few explicit exceptions) Medicaid is always the payer of last resort. Congress changed this connection between IDEA and Medicaid in 1988. Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended Medicaid (Title XIX of the Social Security Act) at Section 1903 as follows:

> c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a child with a disability

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[11] Elaine Maag, "Supportive Health Services Needs of Children with Disabilities," p. 2. Obtained from [http://aspe.hhs.gov/daltcp/reports/suphsnd.htm]. (Hereafter cited as Maag, *Health Services Needs*.) This study was based on data from the 1994 and 1995 waves of the National Health Interview Survey (NHIS).

[12] Recall that under IDEA medical services has a special meaning, i.e., services provided by a licensed physician. This limited definition of medical services can cause confusion in a broader discussion of health care financing, in which medical services might be provided by other professionals or even by para-professionals.

[13] For further information on Medicaid, see CRS Report RS20245, *Medicaid: A Fact Sheet*, by Jean Hearne.

> because such services are included in the child's individualized education program established pursuant to part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.[14]

Officials from the Centers for Medicare and Medicaid Services (CMS),[15] the federal agency that administers the Medicaid program,[16] have interpreted this provision to allow, but not require, state Medicaid agencies to pay for such services. According to these officials, most states have elected to do so.

IDEA requires states to establish interagency agreements to ensure that IDEA-eligible students receive the services to which they are entitled:

> Such agreement or mechanism shall include the following:
>
> (i) AGENCY FINANCIAL RESPONSIBILITY- An identification of, or a method for defining, the financial responsibility of each agency for providing services described in subparagraph (B)(i) to ensure a free appropriate public education to children with disabilities, provided that the financial responsibility of each public agency described in subparagraph (B), including the State Medicaid agency and other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or the State agency responsible for developing the child's IEP).[17]

Thus, for a disabled child who is enrolled in both IDEA and Medicaid, when necessary services are covered by a state Medicaid program, "the financial responsibility of ... the State Medicaid agency and other public insurers of children with disabilities, must precede the financial responsibility of the [school district] (or the State agency responsible for developing the child's IEP)."[18] Given CMS's interpretation of the 1988 amendment to Medicaid law, this IDEA requirement that

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[14] The 1997 IDEA Amendments redesignated Part H as Part C, the Infants and Toddlers with Disabilities program.

[15] Personal communication with Centers for Medicare and Medicaid Services officials, November 14, 2002.

[16] Prior to the current Bush Administration, this agency was called the Health Care Financing Administration or HCFA. In this report, we use both abbreviations (CMS and HCFA) as appropriate.

[17] Section 612(a)(12)(A). The committee reports accompanying the 1997 IDEA amendments (P.L. 105-17) elaborated on the relationship between Medicaid and IDEA:

> The committee places particular emphasis in the bill on the relationship between schools and the State Medicaid Agency in order to clarify that health services provided to children with disabilities who are Medicaid-eligible and meet the standards applicable to Medicaid, are not disqualified for reimbursement by Medicaid agencies because they are provided services in a school context in accordance with the child's IEP. S.Rept. 105-17, p. 12; H.Rept. 105-95, p. 92.

[18] 34 CFR §300.142(a)(1).

Medicaid be the first payer would apply only to those states that have elected to pay for services listed in IEPs.

Recent evidence suggests that Medicaid currently pays a small proportion of the overall excess cost of providing special education and related services to children with disabilities (i.e., those expenditures over and above the costs for educating children without disabilities). A recent national study for school year 1999-2000 indicated that Medicaid provided about $648 million for services to children with disabilities, representing about 1.8% of the estimated additional expenditure of $36 billion to provide special education and related services for such children.[19]

Overview of Medicaid Eligibility and Services

In order to explore the interrelationship between IDEA and Medicaid and to assess why Medicaid appears to pay for a relatively small proportion of the cost of servicing IDEA children, it is first necessary to discuss some of the complexities of Medicaid with respect to eligibility and services for children.

Relevance of Medicaid Benefits for IDEA Children. Although (as noted above) there are some data on health-related services provided to children with disabilities, no studies have been published describing the medical and support service needs of school-age IDEA children. In order to understand Medicaid's potential role in supporting eligible IDEA children in school, one must make a best guess of their service needs, defined from a Medicaid perspective, based on what is known about their disabling conditions, and what is known about the services used by disabled children in general.

Generally Medicaid finances a comprehensive array of both mandatory and optional, medical and health-related services. But it does not cover all the supportive services that many IDEA children may need while in school. Most notably, Medicaid probably has little to offer those children with learning disabilities who represent about one-half of the IDEA population. Medicaid does not cover the kinds of special educational services that many of these children require during the school day.

On the other hand, Medicaid does cover health services that are necessary for other children with disabilities to benefit from a free appropriate public education. For the purposes of IDEA, the most relevant Medicaid benefit is the **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program**. This program provides screening and preventive care to nearly all groups of Medicaid beneficiaries under the age of 21, as well as services necessary to correct health problems

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[19] See SEEP, *What Are We Spending?*, Table B-1. The estimates in this study are based on a stratified random sample designed to generalize to all students with disabilities in the 50 states and the District of Columbia. About 40% of the responding LEAs reported recovering any payments from Medicaid. This amount also represents a small proportion of Medicaid funding for school-age children (ages 6-18) in general, which is about $18 billion, according to the most recent data (FY1999). Thus Medicaid funding for school-based medical and health services for children with disabilities may represent less than 4% of all funding for eligible school-age children.

identified through screening. That is (with the exception to eligibility discussed below), states are required to provide all federally-allowed treatment to correct identified problems, even if the specific treatment needed is not otherwise covered under the state's Medicaid plan. For example, according to a HCFA guide "if the state does not cover an optional service under its [Medicaid] state plan, such as occupational therapy, the State would have to make medical assistance available for the service when furnished to a child eligible for EPSDT if occupational therapy is medically necessary."[20]

In addition to EPSDT, Medicaid covers a number of other services relevant to IDEA children with a wide range of disabilities. Durable medical equipment such as wheelchairs, ventilators, and prosthetic devices are also available through Medicaid. Medicaid covers the therapy services that may be needed by children with orthopedic impairments and speech disorders. It also covers vision-related screening and diagnostic services, and will pay for eyeglasses for children with visual impairments. Children with hearing disorders may receive audiology services and hearing aides. For IDEA children with developmental disabilities, emotional disturbances and those who are mentally retarded, certain non-medical supportive services, such as psychosocial rehabilitation and personal care services (e.g., assistance with daily activities and some medical services, when appropriate, provided by a professional attendant) may be covered under special Medicaid waiver programs. Other relevant services include psychologist and social worker services, prescribed drugs, and transportation.

Medicaid's Eligibility Rules for Children. Although Medicaid may pay for coverable medical, health, and support services that children with disabilities need to attend and benefit from school, IDEA children must meet specific financial[21] and non-financial eligibility rules, which vary widely from state to state, in order to receive these services. In addition, there are alternative routes for determining Medicaid eligibility, which influence the health services that are available. The complexity of Medicaid's eligibility rules, together with the difficulty educational agencies experience in navigating these rules, are likely to be primary reasons why Medicaid covers only a portion of IDEA-related costs for school-age children. In addition, as discussed below, some studies suggest that only about one-fourth of IDEA children are enrolled in Medicaid, most likely due in large part to Medicaid's financial restrictions.

Eligibility For Standard Medicaid Services. In analyzing the eligibility pathways into Medicaid for children who qualify for IDEA services, it is important to consider Medicaid eligibility groups that specifically target the disabled living in

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[20] *HCFA Medicaid Guide,* p. 10.

[21] With respect to financial eligibility criteria for Medicaid, both earned and unearned income are considered. For some eligibility categories, assets (e.g., savings accounts, savings bonds) may also be taken into account. States may base eligibility on gross income and assets, but in most cases, they apply what are known as income (and asset) disregards. That is, for certain categories of income, specific amounts may be disregarded or ignored in determining financial eligibility. The effect of these counting methods is to allow individuals with gross income and assets above the stated standards to qualify for Medicaid.

the community (rather than those who are institutionalized), as well as eligibility groups that target children in general, regardless of disability status as defined under Medicaid. **Table 1** provides a summary of the major Medicaid eligibility groups for school-age children. In brief, these are: the categorically needy — dependent children who qualify based on some measure of financial need or poverty status; the medically needy — dependent children who qualify based on modified measures of financial need plus medical costs; and two additional categories relevant to children with severe disabilities — the Katie Beckett option and the home and community-based waiver program. States are required to serve some of these groups under Medicaid (the mandatory groups in **Table 1**), and have the option to cover other groups (the optional groups in **Table 1**). In addition, the financial standards for each specific pathway vary widely across states. Finally, available services vary from category to category.

Categorically Needy. First, many children qualify for Medicaid via welfare-related pathways.[22] The income standards for this coverage category are typically well below the federal poverty level or FPL[23] — the median level nationwide is about 44% — but states can increase these standards. In FY1999, of the roughly 22.7 million Medicaid enrollees under age 21, nearly one-third (7.3 million) were eligible through welfare-related pathways. Second, states generally must cover blind and disabled recipients of Supplemental Security Income (SSI).[24]

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[22] In the mid-1990s, the Aid to Families with Dependent Children (AFDC) program was replaced by the Temporary Assistance for Needy Families (TANF) program. Unlike AFDC, TANF eligibility does not confer automatic Medicaid eligibility. However, Medicaid entitlement remains for families who meet the requirements of the former AFDC program as in effect on July 16, 1996. The old AFDC-related income standards are typically well below the federal poverty level (FPL) (the median level nationwide is about 44%), but states can modify them. Other mandatory and optional groups for which eligibility is tied to these old AFDC rules include children in welfare-to-work families who can qualify for up to 12 months of transitional Medicaid, and some foster care and adoption assistance children.

[23] In 2002, the poverty guideline in the 48 contiguous states and the District of Columbia for an individual is $8,860 and for a family of four is $18,100.

[24] States may use more restrictive eligibility standards for Medicaid than those used for SSI, if they were using those standards on January 1, 1972 (before implementation of SSI). In 2000, 11 states used more restrictive standards for Medicaid. For further information on SSI, see CRS Report 94-486, *Supplemental Security Income (SSI): A Fact Sheet*, by Carmen Solomon-Fears.

Table 1. Major Medicaid Eligibility Groups for School-Age Children[a] and Available Benefits

Eligibility group	Upper income standard	Other financial eligibility criteria		Institutional level of care required	Available benefits		
		Parents' income considered	Medical expenses deducted		Standard services[b]	Subset of standard services[c]	Standard plus waiver services[d]
Categorically needy groups							
Mandatory welfare-related groups	44% FPL (median level)	**X**	—	—	**X**	—	—
Mandatory SSI-related groups	74% FPL	**X**	—	—	**X**	—	—
Mandatory poverty-related groups (only if ineligible for two groups above)	133% FPL for < age 6; 100% FPL for ages 6-19	**X**	—	—	**X**	—	—
Optional medicaid expansions under SCHIP	200% FPL (or 50 percentage points above the applicable Medicaid level that exceeds 200% FPL)	**X**	—	—	**X**	—	—

Eligibility group	Upper income standard	Other financial eligibility criteria		Institutional level of care required	Available benefits		
		Parents' income considered	Medical expenses deducted		Standard services[b]	Subset of standard services[c]	Standard plus waiver services[d]
Medically needy group							
Optional medically needy group	55% FPL (median level)[e]	X	X	—	—	X[f]	—
Other eligibility groups							
Optional Katie Beckett group	Typically 221% FPL[g] or the medically needy standard	—	—	X	X	—	—
Optional HCB waiver group	Typically 221% FPL or the medically needy standard	—	—	X	—	—	X

[a] States can also add new coverage groups to their Medicaid programs via waivers of program rules (under Section 1115 of the Social Security Act), or extend coverage under existing eligibility categories by modifying income and resource standards for these groups (not shown). These options permit states to cover individuals at higher income levels, for example.

[b] see **Tables 2 and 3**.

[c] see **Tables 2 and 3**.

[d] see examples under Other Eligibility Groups, below.

[e] The actual income criterion for this coverage group is 133 and one-third percent of AFDC payment standard on July 16, 1996 (as subsequently modified, if applicable). When this standard is expressed as a percentage of the federal poverty level, the median value nationwide is 55%.

[f] States may offer a subset of standard mandatory and optional services to the medically needy, but may choose to give this group access to the same set of benefits as other coverage groups (known as the "categorically needy").

[g] The actual income criterion for this coverage group is 300% of the SSI payment standard, known as the "300% rule." When this criterion is expressed as a percentage of the federal poverty level, it is equivalent to 221% FPL.

Nationwide, the upper income limit for this SSI-related pathway into Medicaid is 74% of the FPL. Such persons must also have countable assets valued at less than $2,000. For a child to qualify for SSI, and in most cases also Medicaid, he/she must be under 18 and have a medically determinable physical or mental impairment which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted (or can be expected to last) for a continuous period of not less than 12 months. Official counts of such Medicaid children are not available; however, in FY2001, there were approximately 865,700 children receiving SSI payments, all of whom were likely to be enrolled in Medicaid.[25]

Third, for children who do not qualify for Medicaid coverage via welfare-related or SSI-related pathways, there are additional poverty-related pathways into Medicaid for which the upper income standard is higher and varies by age. States must provide Medicaid to such children who are under 6 years of age living in families with income up to 133% FPL, and those ages 6 to 19 in families with income up to 100% of the FPL. In FY1999, roughly 8.7 million children representing 38% of Medicaid beneficiaries under age 21 were covered under these poverty-related groups.[26]

In addition, states may cover children in families with income up to 200% FPL (or 50 percentage points above the applicable Medicaid level that is at or greater than 200% FPL) through a Medicaid option under the State Children's Health Insurance Program (SCHIP). As of FY2001, 34 states and the District of Columbia had implemented this SCHIP option, covering 1.2 million children. To be eligible for this SCHIP option, children must be otherwise ineligible for Medicaid or other group health plans.

Children qualifying through the categorical needy groups have access to the mandatory services listed in the **first column of Table 2**. At the option of the state, they may also have access to all or a subset of services listed in **Table 3**.

Medically Needy. States may also offer "medically needy" coverage under Medicaid. The income standard for medically needy coverage can be up to one-third higher than the income standard for the applicable welfare- or SSI-related group in a given state. By in large, in those states that offer medically needy coverage (34 states including the District of Columbia as of November 2000), the income standards rarely exceed the poverty level. The median income level nationwide is 55% FPL. In FY1999, roughly 1.6 million children (about 7% of Medicaid beneficiaries under age 21) qualified for Medicaid as medically needy. Unlike all other eligibility categories under Medicaid, medical expenses can be considered in determining financial eligibility for this group. Children can meet the financial

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[25] See CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Lynn Stone for additional details.

[26] There is a hierarchical relationship among these three eligibility categories. That is, if a child qualifies for Medicaid under either a welfare-related group or an SSI-related group, that child must be enrolled in Medicaid under that category. Only those children who do *not* meet the financial and non-financial standards for the welfare-related or SSI-related groups *and* who do meet the age and financial standards for a poverty-related group can be enrolled in the applicable poverty-related group.

criteria for this coverage group by incurring medical expenses that when subtracted from income, result in an amount that is lower than the medically needy income standard. This eligibility category may be relevant to IDEA children with very large medical expenses who might otherwise not qualify for Medicaid.

Table 2. Standard Mandatory Medicaid Services for Categorically and Medically Needy Groups That Are Available to Persons Under Age 21

Categorically needy	Medically needy
- Inpatient hospital services - Outpatient hospital services - Rural health clinic services - federally qualified health center services - Other laboratory/x-ray services - Home health services - EPSDT - Family planning services - Physician services - Medical and surgical services of a dentist - Nurse midwife services - Certified pediatric and family nurse practitioner services - Pregnancy-related services and services for conditions that complicate pregnancy	- Prenatal and delivery services - Ambulatory services (for persons under age 18 and persons under 21 entitled to nursing facility care) - Home health services for persons entitled to nursing facility care - In states covering the medically needy in intermediate care facilities for the mentally retarded (ICF/MRs) or institutions for mental diseases (IMDs), broader requirements apply.[a]

[a] If a state covers IMD and ICF/MR services, it must cover for the medically needy either the same services as those which are mandatory for the categorically needy (except certified nurse practitioner services) or any seven of the categories of care and services in Medicaid law defining covered benefits.

Unlike all other coverage groups described here, the medically needy may have access to a more limited set of both mandatory (see **Table 2, column 2**) and optional benefits under Medicaid (see **Table 3**). Most notably, EPSDT is *not* a mandatory benefit for the medically needy, although states may choose to make this benefit available to this group. Thus, for IDEA children who qualify for Medicaid via the medically needy pathway, all or only some of the services outlined in their IEPs may be covered. Moreover, EPSDT may not be available to insure access to otherwise coverable Medicaid services.

Other Eligibility Groups. In addition to the medically needy option, there are two other optional pathways into Medicaid with more generous financial standards that may be particularly relevant to severely disabled children living in the community such as Garrett F. One is called the Katie Beckett option (so named after the ventilator-dependent child that was the impetus for the creation of this coverage group in the early 1980s) and the other is the home and community-based waiver program described below.

Table 3. Standard Optional Medicaid Services for Categorically and Medically Needy Groups That Are Available to Persons Under Age 21

- Other practitioners’ services (e.g., psychologists, social workers, optometrists)
- Private duty nursing
- Other clinic services
- Other dental services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Other diagnostic, screening, preventive and rehabilitative services
- Intermediate care facilities for the mentally retarded (ICF/MR) services
- Inpatient psychiatric hospital services
- Services in a religious non-medical health care institution
- Nursing facility services
- Emergency hospital services
- Personal care services
- Transportation services
- Tuberculosis-related services
- Hospice services
- Respiratory care services for ventilator dependent persons
- Primary care case management
- Home and community based care (1915(c) waiver programs)
- Other services approved by the Secretary of Health and Human Services

Note: States may offer an optional service to the categorically needy only, or to both the categorically needy and medically needy.

Under the Katie Beckett option, states may extend Medicaid to certain disabled children under 18 who are living at home and who would be eligible via the SSI pathway if they were institutionalized[27] for 30 or more days, as long as the cost of care at home is no more than institutional care. The law allows states to consider only the child’s income and resources when determining eligibility for this group. In the majority of these cases, the children meeting these criteria literally have no income of their own. They will be eligible for Medicaid via the Katie Beckett option even if their parents are in the upper-income category. For the subset of these children who have their own income, the applicable income standard is that which the state uses for determining Medicaid eligibility for institutional care — typically either what is known as the “300% rule” (i.e., 300% of the SSI payment standard, equivalent to 221% FPL), or the medically needy income standard (under which medical expenses can be taken into consideration). The Katie Beckett option may be applicable to severely disabled IDEA children from middle to upper-income families who might otherwise be ineligible for Medicaid. As of May, 2000, 20 states covered this optional eligibility category. There are no official counts of these children available. Katie Beckett children have access to all mandatory and optional Medicaid services covered in a state, including EPSDT.

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[27] Institutionalized means in a hospital, nursing facility or intermediate care facility for the mentally retarded.

States also have the option to cover persons needing home and community-based services (HCBS), if those individuals would otherwise require institutional care covered by Medicaid. These services are provided under special waiver programs authorized under Section 1915(c) of Medicaid law. Unlike the Katie Beckett option which requires that all such disabled children within a state be covered, HCBS waiver programs may be limited to specific geographic areas, and/or may target specific disabled groups and/or specific individuals within a group. Enrollment may be capped at a certain total number of participants.

As of 2000, 49 states and the District of Columbia had at least one HCBS waiver program in place. (Arizona provides similar benefits through separate waiver authority.) Many have multiple programs, some of which specifically target disabled children. Official counts of children participating in these waiver programs are unavailable. In 1997 (the most recent available data), over three-quarters of spending under HCBS waivers was for persons with mental retardation or developmental disabilities.[28]

The financial standards for HCBS waiver programs are the same as those applicable to the Katie Beckett option (i.e., states typically use the 300% rule or the medically needy standard, and parents' income may be disregarded; see above discussion and **Table 1**). Thus, as with the Katie Beckett category, the HCBS waiver option may be applicable to IDEA children in middle- to upper-income families who might otherwise not qualify for Medicaid. In addition, HCBS waiver programs may offer support services that may be available only through such waivers (described below).

A common misconception about the institutional requirement for HCBS waivers is that a severe level of medical need or functional limitation must be present. There is no federal requirement or definition here. In fact, states are not required to use only medical, or even any medical, service criteria to determine eligibility for institutional care, and hence HCBS waiver programs. States may use medical and nursing needs as well as functional assessments in determining eligibility for HCBS. Functional measures may include, for example, the need for assistance with eating/drinking, toileting, mobility, and medication management; and/or the presence of cognitive impairments or behavioral problems. To qualify for HCBS waivers, an applicant may be required to display a certain minimum number of these functional limitations, or to meet a certain score on a functional assessment tool to be eligible.[29]

In addition to the standard Medicaid benefits offered by a state, other services which could be important to some IDEA children in the school setting may be available through HCBS waiver programs that might not otherwise be covered under Medicaid. These include, for example, personal care (e.g., assistance with

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[28] For more information on HCBs waivers, see CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.

[29] G. Smith, et al., *Understanding Medicaid Home and Community Services: A Primer*, Washington, DC, George Washington University, Center for Health Policy Research, Oct. 2000.

eating/drinking, toileting, medication management, or ventilators as in the case of Garrett F.); transportation; case management; psychosocial rehabilitation and clinic services for persons with chronic mental illness; and home health aides or personal attendants. Habilitation services (those services designed to assist individuals with self-help, socialization and adaptive skills) for persons with mental retardation or developmental disabilities may also be covered. However, the special education and related services available through IDEA are specifically *excluded* from coverage as habilitation services under these waiver programs. (Vocational rehabilitation is similarly excluded.)[30]

Possible Reasons Why Medicaid Appears to Cover Relatively Little of IDEA Health-Related Costs

As noted above, recent data indicate that Medicaid covers only a small share of the excess cost for providing special education and related services for children with disabilities. Although data limitations prevent definitive determination of Medicaid's limited role with respect to IDEA, possible reasons include:

- Many IDEA children may not be eligible for Medicaid,
- LEAs may not be identifying all IDEA children who are enrolled in Medicaid,
- The in-school services covered by Medicaid for IDEA children may be relatively low cost,
- Certain Medicaid financial requirements may reduce Medicaid reimbursements for LEAs, and
- Medicaid's billing procedures are complex, and as a result many LEAs may be unwilling or unable to access this funding source.

Many Children with Disabilities May Not Be Eligible for Medicaid. Although there is no current direct information on the number of IDEA children who are eligible for Medicaid, it is likely that most are not eligible, and that is one reason Medicaid does not cover more IDEA-related health care costs. The most recent IDEA-relevant national data are from an SRI study for school year 1985-1986 for children ages 13 to 21 in special education, which reported that about 22% were covered by Medicaid or by "similar coverage."[31] There are no more recent IDEA-specific data, in part, because different federal agencies collect different types of survey data about Medicaid recipients and about children with disabilities served by IDEA. Among other difficulties, these agencies use different definitions of who is disabled.

The National Center for Health Statistics (NCHS) uses a broad definition of disability in its National Health Interview Survey (NHIS). In this survey, an individual is classified as having a disability if he or she:

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[30] Section 1915(c)(5)(C) of the Social Security Act.

[31] National Longitudinal Study of Special Education, *Youth with Disabilities: How Are We Doing?* SRI International, Menlo Park, CA, September 1991, Table 2-16, p. 2-26.

- has a specific physical, functional, or mental/emotional disability or limiting condition;
- has significant difficulty performing daily self-maintenance activities;
- uses special equipment or devices such as a wheelchair or breathing aid;
- is limited in a major or other life activity due to physical, mental, or emotional problems;
- receives income or insurance based on disability; or
- has other indicators of disability such as poor overall health status, use of specialized programs or services, or other behavioral indicators of disability or developmental delay.[32]

Based on this definition and using NHIS data, the Economic and Social Research Institute (ESRI), a private research group, estimated that there are 8,960,000 individuals with disabilities ages 5 to 17.[33]

The NHIS definition is broader than the definition of a child with a disability under IDEA, which, as noted above, uses disability categories, such as mental retardation, hearing impairment, orthopedic impairment, autism, and specific learning disability.[34] Based on this definition and using state-provided data, ED reports that there were 5,383,000 children with disabilities ages 6 to 17 served under IDEA Part B in school year 1999-2000.[35] Clearly the broader definition of disability used in the NHIS classifies many more school-age children as disabled than states report being served under IDEA.

According to the ESRI analysis of NHIS data, approximately 28% of individuals with disabilities ages 5 to 17 are covered by Medicaid.[36] Unfortunately because the NHIS definition of disability differs significantly from the IDEA definition, this percentage can provide only a rough guideline as to what percentage of children with disabilities under IDEA are Medicaid-eligible.

The *enrollment* figures provided by the SRI and ESRI studies indicate that only about one-fourth of all IDEA children are covered by Medicaid. This 25% estimate probably represents a lower boundary for the overall proportion of IDEA children

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[32] Jack A. Meyer, and Pamela J. Zeller, *Profiles of Disability: Employment and Health Coverage*, Report prepared by the Economic and Social Research Institute for the Kaiser Commission on Medicaid and the Uninsured, Sept. 1999, p. 2. (Hereafter cited as Meyer and Zeller, *Profiles of Disability*).

[33] The ESRI analyses are based on the April 1999 Disability Supplement to the 1994 National Health Interview Survey.

[34] See Section 602(3) of IDEA for the full definition.

[35] ED, *Twenty-Third Annual Report*, Table AA1.

[36] Meyer and Zeller, *Profiles of Disability*, Figure 6, p. 10. In addition, 58% of this group is covered by private insurance, and 11% are uninsured. No determination of insurance coverage was made for the remaining 3%. Medicaid coverage was higher (42% with 7% uninsured) for infants, toddlers, and preschoolers with disabilities (ages birth to 4).

who are actually *eligible* for Medicaid, including both those enrolled and those eligible but not enrolled. Because there are no income data available for IDEA children, there is no way to adjust this 25% figure to more accurately estimate the proportion of Medicaid-eligible IDEA children.

Medicaid only pays for services delivered to children actually enrolled in the program. For the three-quarters of IDEA children not enrolled in Medicaid, their health services are being paid by other means — probably in large part by state and local special education funding.

LEAs May Not Be Identifying All IDEA Children Who Are Enrolled in Medicaid. It is possible that federal privacy guarantees may inhibit the identification of IDEA children who are covered by Medicaid. The Family Educational Rights and Privacy Act (FERPA)[37] provides parents and students with certain rights to examine educational records and limits access to such records by parties outside the schools. The U.S. Department of Education (ED) has made it clear that identifying a child as eligible for IDEA means disclosing information contained on the child's IEP, which ED interprets as an "educational record" for the purpose of FERPA. In addition, IDEA explicitly references FERPA and specifically charges the Secretary of Education "to assure the protection of the confidentiality of any personally identifiable data, information and records collected or maintained by the Secretary and by State and local educational agencies pursuant to the provisions of [IDEA]."[38]

Concerns about violating FERPA requirements apparently make some states reluctant to use computer matching to identify IDEA students who are also enrolled in Medicaid. In case studies of Medicaid billing for IDEA in four states, this was found to be true in three of the four study states. In at least one of these states, interviewees suggested that trying to determine Medicaid eligibility during the process of creating the IEP instead of using computer matching was "a barrier to maximizing Medicaid billings for IDEA services."[39]

In a similar instance, ED has expressed concern that states have sought IDEA eligibility information to determine eligibility for the Supplementary Security Income (SSI) program. In a letter to the Commissioner of the Social Security Administration, ED warned:

> Under FERPA and its implementing regulations at 34 CFR Part 99 and the confidentiality of information requirements of IDEA at 34 CFR §§300.560-300.577, educational agencies are generally prohibited from releasing personally identifiable information in education records without prior written consent of the parent or eligible student, except in statutorily specified circumstances. 20

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[37] 20 U.S.C. 1232g.

[38] 20 U.S.C. 1417(c).

[39] S. Bachman, and S. Flanagan, *Medicaid Billings for IDEA Services: Analysis and Policy Implications of Site Visit Results*, Prepared for the Office of the Assistant Secretary of Health and Human Services, Interim Final Report (no date), p. 5. (Hereafter cited as Bachman and Flanagan, *Medicaid Billings for IDEA Services*.)

> U.S.C. §1232g(b)(1) and (d); see also 34 CFR §§99.30-31 and 34 CFR §300.571(a) and (b)(1)(i).
>
> Based on the information we have received, it does not appear that any of FERPA's exceptions to the prior written consent provision would permit the nonconsensual disclosure by school districts of personally identifiable information from education records regarding children who may be eligible for SSI childhood disability benefits.[40]

Medicaid confidentiality requirements also must be considered. Medicaid law requires that state Medicaid agencies restrict the use and disclosure of information concerning Medicaid applicants and enrollees to purposes directly related to plan administration. Such purposes include establishing eligibility. A state Medicaid agency cannot submit a list of beneficiaries to other agencies, but LEAs can obtain information on which school children are dually covered under IDEA and Medicaid in one of two ways. States have established automated data systems for certified Medicaid providers. LEAs that are certified Medicaid providers can access on-line confidential Medicaid eligibility files to determine which IDEA children are enrolled in Medicaid (by entering a child's full name, date of birth and/or social security number, for example) and for other information pertinent to billing (e.g., to determine scope of covered benefits for a child). If this automated option is unavailable to an LEA, Medicaid agencies may compare a list of **all** children compiled by an education agency against Medicaid files, and in return, provide information concerning which children on the education agency's list are already enrolled in Medicaid. The LEA can then identify those children enrolled in Medicaid who are also served by IDEA. Some Medicaid agencies and school systems have taken additional steps to resolve confidentiality requirements. For example, some Medicaid agencies have modified application forms to obtain parental consent to release information (e.g., information regarding education records necessary for claiming Medicaid reimbursement for health-related educational services). In other states, some schools seek parental permission to bill Medicaid for special education students, which in turn permits information sharing.[41]

Computer matching of education and Medicaid records would assist LEAs in obtaining Medicaid reimbursements for children who are covered under both IDEA and Medicaid. But this strategy would not resolve the problem that some IDEA children may be eligible but not enrolled in Medicaid. Such children will not be included in Medicaid eligibility files. Other outreach and enrollment facilitation strategies would be required to address this circumstance.

Many Medicaid In-School Services May Be Low Cost. Just as there are no data on how many IDEA children are eligible for Medicaid, there is also no information on precisely what in-school services Medicaid covers for eligible IDEA

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[40] Letter from Judith Heumann, Assistance Secretary, Office of Special Education and Rehabilitative Services, to Mr. Kenneth Apfel, Commissioner, Social Security Administration, July 20, 2000.

[41] Health Care Financing Administration, *Medicaid and School Health: A Technical Assistance Guide*, August 1997. (Hereafter cited as *HCFA Medicaid Guide*.)

children. However, in general, Medicaid in-school services for children may be relatively low cost.

When children receive Medicaid financed services in school, state-level expenditures for these services tend to be low. GAO conducted an analysis of Medicaid claims from the late 1990s for school-based services in 47 states and the District of Columbia and found that 31 of 47 states spent less than $100 per Medicaid-eligible child on school-based services.[42] If these general findings can be applied to spending on Medicaid-enrolled children under IDEA, they suggest that the services received may be relatively low cost, which could help explain the small contribution Medicaid makes to IDEA's excess cost. Even if true, however, it is important to remember that health-related services for some children with disabilities, for example, Garrett F. discussed above, are substantial.

Medicaid Financing Issues May Reduce LEA Reimbursements. Two Medicaid financing issues may affect LEAs ability to bill Medicaid, and may contribute to the trend in limited Medicaid spending for IDEA-related services — Medicaid's third party liability rules and financial arrangements under Medicaid managed care.

One issue is Medicaid's third-party liability rules when private insurance is available to cover IDEA-related service costs. IDEA regulations permit the use of private insurance for FAPE-required services; however, parents' fully informed consent must be obtained and that consent must be obtained each time private insurance is to be accessed.[43] Comments accompanying the final IDEA regulations explain the need for fully informed parental consent.

> Parents who permit use of their private insurance often experience unanticipated financial consequences ... consent must fully inform parents that they could incur financial consequences from the use of their private insurance .... In addition, parents need to be informed that their refusal to permit a public agency to access their private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.[44]

At the same time, there are specific third-party liability rules under Medicaid that can complicate the financing of school-based services to IDEA children with both Medicaid and private insurance coverage. There are no official data showing

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[42] In addition, GAO found considerable variation in average payments across states, ranging from $820 per Medicaid-eligible child in Maryland to about 5 cents per Medicaid-eligible child in Mississippi. See *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefits*. Testimony by Kathryn G. Allen before the Senate Committee on Finance, April 5, 2000, (GAO/T-HEHS/OSI-00-87), p. 5. (Hereafter cited as *GAO April 5, 2000, testimony*.) About one-half of all states reported data to GAO for state fiscal year 1999. Most of the remaining states reported data for state fiscal year 1998, federal fiscal year 1998 or calendar year 1998. Three states reported data for periods before July 1997.

[43] 34 CFR §300.142(f).

[44] 64 F.R. 12567, March 12,1999.

how many Medicaid children are also covered by private insurance. But the likelihood of such dual coverage increases with family income. When private insurance is available, Medicaid must pay only the remainder of allowable costs for coverable services after other third party coverage such as employer-based insurance has been taken into account, even when such insurance actually pays nothing. However, under IDEA, LEAs cannot require parents with private family coverage to use that coverage to pay for IEP services required in school. The implications of these seemingly conflicting program policies is that LEAs may be caught in the middle, and could end up paying the portion of costs that Medicaid cannot cover given its third party liability rules.

The second financing issue concerns Medicaid managed care and how these arrangements may affect the availability of Medicaid payments to schools for IDEA-related services. Under Medicaid managed care, state Medicaid agencies contract with managed care organizations (MCOs; for example, Blue Cross/Blue Shield, Kaiser Foundation Health Plan, Humana Family Health Plan) to provide a specified set of benefits to enrolled beneficiaries. These MCOs are frequently reimbursed on the basis of a pre-determined monthly fee (called a capitation rate) for each enrolled Medicaid beneficiary. In FY1998 (the latest available data), of the roughly 18.3 million Medicaid children, nearly 57% were enrolled in prepaid health plans, and Medicaid managed care has continued to grow since that time.[45] Contracted benefits may include the services required by IDEA children to benefit from public education. When an IDEA child is eligible for Medicaid and enrolled in a Medicaid managed care plan, control over the delivery of those services, and hence, reimbursement for those services may fall to either the LEA or the health plan, depending on the terms of any contractual relationship between the LEA and the MCO. When an LEA is not in the "provider network" of the MCO, Medicaid reimbursement for IDEA-related services provided by the LEA may not be available.[46]

While there is no federal requirement that states establish relationships between LEAs and managed care organizations, HCFA (now CMS) has encouraged states to promote such relationships. The policy goal is to insure that the provision of Medicaid covered services can be coordinated between schools and MCOs so that children receive necessary care and such care is not duplicated. For example, to achieve this goal, some state laws require such coordination (e.g., MCOs must include LEAs in their provider networks and reimburse them for school-based services). Other states exclude school-based services from managed care contracts.[47]

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[45] Preliminary data for FY1999 (the latest official statistics available) indicate that the largest single expenditure category for Medicaid children ages 6 to 18 ($5.3 billion or 28% of total spending for this group) was for premium payments to managed care organizations — the extent to which such payments cover school-based services is not known.

[46] S. Bachman, and S. Flanagan, *Medicaid Billings for IDEA Services: Analysis and Policy Implications of Site Visit Result*. Prepared for the Office of the Assistant Secretary of Health and Human Services, Interim Final Report (no date). (Hereafter cited as Bachman and Flanagan, *Medicaid Billings IDEA Services*.)

[47] *Medicaid and School Health: A Technical Assistance Guide*, Aug. 1997.

Challenges for Schools Participating in Medicaid.

In order for LEAs providing IDEA-related services to qualify for reimbursement under Medicaid, four conditions must be met: (1) the child receiving the service must be enrolled in Medicaid, (2) the service must be covered in the state Medicaid plan or authorized in federal Medicaid statute, (3) the service must be listed in the child's IEP, and (4) the LEA (or school district) must be authorized by the state as a qualified Medicaid provider. More generally, with the exception of the IEP requirement, these same conditions must be met by all other Medicaid providers (such as, hospitals) seeking Medicaid payments for school-based services delivered to any Medicaid-enrolled child. However, other Medicaid providers are likely to have considerably more experience with Medicaid's (and other insurers') processes and procedures for successfully claiming reimbursement. Ensuring that these conditions are met is a more daunting prospect for LEAs that otherwise seldom if ever interact with health insurers including Medicaid.[48]

While Congress has authorized the use of Medicaid funds for covered health services for eligible children with disabilities, and HCFA encouraged the establishment of relationships between the program and schools, HCFA pointed out that

> There are, however, challenges in the collaboration between the Medicaid program and the schools. Federal Medicaid requirements are complex and the implementation of Medicaid varies by state. Because many schools are unaccustomed to these requirements and the complexity of operating in the "medical services world," understanding and negotiating Medicaid in order to receive reimbursement often has the effect of placing a considerable administrative burden on schools.[49]

The wide variability among state Medicaid programs makes it difficult, if not impossible, for the federal government to provide uniform guidance to LEAs on how to participate in this program. Although HCFA has published a lengthy guide on Medicaid for schools,[50] the guide frequently advises schools and school districts to seek assistance from their state Medicaid office because of the variability in state programs.

Selected Legislative Approaches

Faced with growing budget deficits, many states reduced Medicaid spending in both state fiscal year 2002 and the current state fiscal year 2003. Further reductions in 2003 and 2004 could be on the horizon for some states. This state fiscal situation creates a difficult environment for proposals that could lead to increased Medicaid costs for states. Nonetheless, there is continuing interest in approaches that would increase funding of school-based medical and health services for children with

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[48] As previously noted, only about 40% of LEAs surveyed by SEEP reported recovering any funds from Medicaid for in-school health services for children with disabilities under IDEA. SEEP, *What Are We Spending?*, p. 17.

[49] *Medicaid and School Health: A Technical Assistance Guide*, Aug. 1997, p. 2.

[50] *HCFA Medicaid Guide*, p. 5.

disabilities. If Congress desires to increase Medicaid funding for this group, various changes to the program might be considered. To the extent that the problem is seen as one of program complexity, improved technical assistance and outreach could be considered. To the extent that the problem is seen as one of eligibility, expanding Medicaid eligibility to cover more children with disabilities could be contemplated. And to the extent that the problem is seen as one of Medicaid financing, changes could be made to some of the rules that may adversely impact LEAs. These options are outlined below. Before considering significant changes to Medicaid (because so little is known about how Medicaid currently provides services to children with disabilities), a state-by-state study might be utilized to determine (1) the number and proportion of IDEA children at various income levels and the number and proportion of those with private insurance coverage, (2) the number and proportion of IDEA children who are eligible for Medicaid under current rules, and the subset also covered by private insurance, (3) the proportion of Medicaid-eligible IDEA children actually enrolled in the program, and the proportion enrolled in Medicaid managed care plans, (4) the types of school-based, health-related services these children require, (5) a description of which of these required services are currently covered by Medicaid, (6) trends in the use of school-based services among these children, and (7) Medicaid costs associated with these services.

Because some might oppose any changes to Medicaid that would result in increased costs to states, other policy alternatives might be considered. The State Children's Health Insurance Program (SCHIP), which builds on Medicaid, might be considered as another potential means of financing the health-related costs for children with disabilities. Policy changes to SCHIP, in addition to changes in Medicaid, could increase the funding available to finance these health-related services, which in turn could free up IDEA funds to cover school-based health-related services for children with disabilities not otherwise eligible for SCHIP or Medicaid. Finally, changes to IDEA itself could be considered to target some funding for high-cost medical and health services for children with disabilities.[51]

With respect to Medicaid and SCHIP, many of the possible legislative actions outlined here would increase spending to some degree. In most state budgets, Medicaid is second in size after elementary and secondary education costs. Although state finances experienced a substantial boom in the second half of the 1990s, the current economic recession has placed a severe strain on the majority of states. While children in general are not an expensive coverage group under Medicaid, legislative changes at the federal level, like those described in this report, must nonetheless take into consideration the current budget crisis states are now facing.

Changes to Medicaid. Congress has allowed Medicaid to finance covered school-based services delivered to children who are dually covered by IDEA and Medicaid. School-based billing problems have been the subject of recent Senate hearings because of concerns about fraud, waste and abuse. These hearings did identify a number of situations where Medicaid payments for school-based services

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[51] Of course, Congress could choose not to change Medicaid, SCHIP, or IDEA, and could continue to pursue its present course of increasing IDEA funding.

were made inappropriately.[52] Why did this happen? Some of these problems may stem at least in part from LEAs' lack of understanding about Medicaid's reimbursement rules, which are likely to be particularly incomprehensible to institutions that are in the business of education, not medical care. Also, for some LEAs, the administrative resources necessary to regularly, successfully, and appropriately bill Medicaid may be limited.

To facilitate schools' participation in Medicaid on behalf of IDEA children, new policies to remedy some of these problems may be helpful. For example, state Medicaid agencies could be required or encouraged (through higher federal matching rates, for example)[53] to provide direct outreach and technical assistance to state and local educational agencies. Another strategy to facilitate coordination between IDEA and Medicaid, which was included in the President's FY2003 Budget Proposal, is that CMS will complete and publish guidance for school-based administrative claiming, medical service claiming, and claiming reimbursement for transportation services.[54]

Policies such as these could help LEAs make increased use of Medicaid to finance additional IDEA-related costs. But these types of indirect policy changes may not substantially reduce the overall health care-related financial burden on state and local education agencies for special education students. Extending Medicaid eligibility to additional IDEA children is a more direct strategy for providing financial relief to these education agencies.

It is likely that some, perhaps many, special education students in higher income families do not qualify for Medicaid under current law. Although there are no reliable data that indicate the proportion of IDEA children currently eligible for Medicaid, as noted earlier, as many as three-fourths of children in special education are not enrolled in the program. Given the lack of detailed information on family income in particular, this enrollment level may be appropriate. In addition, during this time of fiscal stress, states may not be interested in further Medicaid eligibility expansions. However, IDEA children, especially those with intensive service needs, may be costly for some schools to serve, and may otherwise create substantial

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[52] See *Medicaid Questionable Practices Boost Federal Payments for School-Based Services*. Testimony by William J. Scanlon before the Senate Committee on Finance, June 17, 1999, (GAO/T-HEHS-99-148), and *GAO April 5, 2000 testimony*.

[53] Such outreach and technical assistance would be considered to be administrative services under Medicaid. Administrative services are usually matched at 50%, including outreach and interagency coordination, but some types of administrative expenses are matched at 75% (e.g., training of the state agency's skilled professional medical personnel) and 90% (e.g., development of mechanized claims processing and retrieval systems). Still other administrative services are fully funded by the federal government (e.g., operation of the immigration status verification system to establish Medicaid eligibility).

[54] U.S. Department of Health and Human Services, *FY2003 Budget in Brief*. (no date) The President's Budget Proposal also states that CMS will begin work on creating a regulation to ban contingency fee arrangements in accessing Medicaid funds to pay for school-based health services.

financial hardships for their families. There have been some legislative proposals to extend Medicaid coverage to such children.

The bill that received the most attention in the 107th Congress was the Family Opportunity Act (FOA) of 2001 (S. 321 and H.R. 600), introduced in the House and Senate in early 2001. On September 9, 2002, a substitute version of the Senate bill was reported out of the Senate Committee on Finance and was placed on the Senate Legislative Calendar. No further action was taken. The key provision in this bill would add a new optional eligibility group for disabled children to the Medicaid statute. The new group would include children under 18 years of age who meet the disability definition for children under the Supplemental Security Income (SSI) program, and whose family income is above the financial standards for SSI but not more than 250% of the FPL. States would be permitted to exceed the 250% FPL maximum, but federal financial participation would not be available for coverage of disabled children in families with income above that level. While the income level under FOA would potentially reach more IDEA children, the SSI definition of disability differs from the disability definition under IDEA, which could make some IDEA children ineligible under FOA, despite the higher income standard.

A more inclusive and targeted approach might be to create a new categorical group under Medicaid comprised of IDEA children who are not otherwise eligible for the program. Coverage of this new group could be made mandatory or optional for states, and could include an income standard (e.g., IDEA children living in families with income at or below 300% of FPL). Some members of Congress, and some state legislatures, might be reluctant to support such a proposal, since it would create a new eligibility group that may include some high-cost individuals all of whom would be entitled to the full range of covered Medicaid benefits. To address such concerns, legislation creating such a new categorical group could also limit covered benefits to school-based, IDEA-related health and medical services.[55]

Finally, our analysis identified two Medicaid financing issues that may reduce LEA reimbursements — Medicaid's third party liability rules when private insurance is available to cover IDEA-related service costs, and financial arrangements under Medicaid managed care. An exemption to Medicaid's third party liability rules could be established in the case of LEA's billing for school-based Medicaid services delivered to IDEA children enrolled in Medicaid who also have private insurance (or other third party liability coverage). Under IDEA rules, schools cannot require families to use their private insurance (when available) to cover the cost of IDEA-related services. But Medicaid law requires that Medicaid pay only the net amount applicable after other available third party coverage is considered, even when such coverage pays nothing. With an exemption to current Medicaid law, LEAs could receive the full amount of allowable payments for Medicaid covered services, rather than the net amount applicable after other third party coverage is taken into account.

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[55] There is a precedence for offering a limited benefit package to specific categorically needy groups. For example, the group comprised of pregnant women with incomes up to 133% of FPL is restricted to pregnancy-related services only (through 60 days postpartum). Similarly, states may offer to certain low-income tuberculosis (TB) infected individuals only TB-related ambulatory services and TB-related drugs.

However, allowing such an exemption for LEAs only may be viewed as unfair to other Medicaid providers that deliver school-based services to IDEA children.

In addition, state Medicaid agencies could be required to establish explicit relationships between Medicaid managed care organizations and LEAs for the purpose of providing school-based, IDEA-related services. To meet this requirement, states could be given several options, such as: (1) require MCOs to include LEAs in their provider networks and reimburse such LEAs for school-based services delivered to IDEA children enrolled in these Medicaid managed care plans, (2) exclude IDEA-related services from MCO contracts, eliminating possible service duplication and facilitating LEAs' access to Medicaid reimbursement outside the managed care context and/or (3) devise an alternative plan which must be approved by the Secretary of HHS to establish explicit relationships between MCOs and LEAs. States may choose different options for MCOs serving different geographic regions and Medicaid populations. State Medicaid agencies would need to inform education agencies of these decisions and LEAs wishing to receive Medicaid payments would need to work within the rules established for their region as well.

Changes to SCHIP and IDEA. Another potential means of financing the health-related costs of special education students is through the State Children's Health Insurance Program (SCHIP).[56] SCHIP allows states to cover uninsured children under age 19 in families with incomes that are above applicable Medicaid financial standards. As of FY2001, the upper income eligibility limit under SCHIP had reached 350% of the FPL (in one state). Nearly one-half (24) of the states and the District of Columbia had established upper income limits at 200% of the FPL. Another 13 states exceeded 200% of the FPL. The remaining 14 states set maximum income limits below 200% of the FPL.

States may choose from among three benefit options when designing their SCHIP programs. They may expand Medicaid, create a new "separate state" insurance program that must met minimum benefit requirements, or devise a combination of both approaches. All 50 states, the District of Columbia, and five territories have SCHIP programs in operation. As of early 2002, 21 are Medicaid expansions, 16 are separate state programs, and 19 use a combination approach. Approximately 4.6 million children were enrolled in SCHIP during FY2001. Over 3.4 million were served by separate state SCHIP programs, and 1.2 million were enrolled in SCHIP Medicaid expansions.

States implementing Medicaid expansions under SCHIP create a new optional coverage group under Medicaid. Such Medicaid expansions must provide all mandatory Medicaid benefits and covered optional services to these SCHIP children, but payments for services provided to Medicaid expansion children under SCHIP are matched at a higher federal matching rate.[57] In addition, the nominal cost-sharing

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[56] For general background information on SCHIP, see CRS Report RL30473, *State Children's Health Insurance Program: A Brief Overview*, by Elicia J. Herz and Peter Kraut.

[57] Like Medicaid, SCHIP is a federal-state matching program. While the Medicaid federal matching rate for benefits ranges from 50% to 76% in FY2002, the federal matching rate (continued...)

rules under Medicaid apply to Medicaid expansions under SCHIP. Most importantly, the funding relationship between IDEA and Medicaid described above applies to Medicaid expansions under SCHIP.

In contrast, there is nothing in the SCHIP statute or regulations that establishes a funding relationship between the IDEA program and separate state SCHIP programs. To establish such a relationship, both the SCHIP and IDEA statute would need to be amended. Such amendments could be modeled after that used to create the funding link between Medicaid and IDEA. A SCHIP and IDEA funding link could be made mandatory or optional for states.

With respect to IDEA, two SCHIP benefit issues are important to highlight. First, guaranteed access to all federally allowed, medically necessary treatment under the EPSDT provision in Medicaid does not apply to separate SCHIP programs. Second, existing benefits under separate SCHIP programs may not include relevant school-based services required by IDEA children. There are no recent data delineating the specific benefits covered and limits applied to those benefits under SCHIP. Adding an EPSDT-like mandate to SCHIP is likely to receive limited political support. However, adding an optional benefit specifically for school-based, IDEA-related services could be considered.

FERPA Amendment. Changes to FERPA might be considered so that limitations on releasing educational records does not prevent or inhibit school districts and state departments of education from sharing data on the status of children with disabilities with Medicaid agencies. As noted above, this Act restricts entities receiving federal funds from releasing "educational records" except to parents and students and under other specified circumstances. Except in specified cases, the permission of the parent or of the student must be obtained to release records. Examples of exceptions are release of records to another school district to which a student is transferring and release of information in connection with a student's application for financial aid. From time to time Congress amends FERPA to take into account a reasonable need to share student information. For example, in 1992 Congress excluded from the definition of educational records law enforcement records kept by a law enforcement unit (such as, the campus police) attached to an educational agency or institution. Thus such records can be shared (with another law enforcement agency, for example) without permission. In addition, FERPA could be amended to permit school districts or state educational agencies to share educational records with the state Medicaid agency for the purpose of identifying children with disabilities who are eligible for Medicaid.

IDEA Funding. Changes to IDEA might also be considered. One approach to relieve the financial burden on states and school districts for providing special education and related services (including the costs of health services) is to increase federal funding for IDEA; and the Congress has been doing this. Since FY1996

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[57] (...continued)
under SCHIP ranges from 65% to 83% across states. In both programs, these matching rates are set such that states with lower per capita incomes receive the higher federal matching rates (and vise versa for states with higher per capita incomes).

funding for school-age children with disabilities under IDEA has more than tripled — from $2.3 billion to $7.5 billion for FY2002. In addition, the President has requested an additional $1 billion in funding for FY2003. Finally some Members have advocated "fully funding" IDEA by providing states their maximum authorized grants under the Act. This would currently require more than an $11 billion increase to approximately $18.8 billion for FY2003.

In addition to increases in overall funding, Congress might consider setting aside (or requiring states to set aside) funds for LEAs facing extremely high special education costs (for example, as the LEA faced in the *Garret F.* case discussed above). One difficulty in this approach is determining which children's costs would be considered and how much funding would be required.

One approach that Congress has considered and enacted deals with certain LEAs educating children of parents in the military. As a supplement to funding under the Impact Aid Program, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398, Section 363) authorized the Secretary of Defense to make payments on behalf of certain children with severe disabilities. The determination of severity is based on the cost of a child's educational and related services. If the LEA is paying for services by another provider (for example, a private school placement), the cost must be "five times the national or State average per pupil expenditure (whichever is lower)." If the LEA serves the child directly, the cost must be at least "three times the State average per pupil expenditure." Payments would be determined after taking into account state, IDEA, and other funds for the child's education and related services.