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The Link Between Medicaid and the Individuals with Disabilities Education Act (IDEA): Recent History and Current Issues

Abstract

[From Summary] As a condition of accepting funds under IDEA, public schools must provide special education and related services necessary for children with disabilities to benefit from a public education. Generally, states can finance only a portion of these costs with federal IDEA funds. Medicaid, the federal-state program that finances medical and health services for the poor, can cover IDEA required health-related services for enrolled children as well as related administrative activities (e.g., outreach for Medicaid enrollment purposes, medical care coordination/monitoring). However, the link between IDEA and Medicaid has not been seamless. Despite written federal guidance, schools have a difficult time meeting the myriad complex reimbursement rules applicable to all Medicaid participating providers. According to federal investigations and congressional hearings, Medicaid payments to schools have sometimes been improper. The President's FY2007 budget proposal would prohibit federal Medicaid reimbursement for IDEA-related school-based administration and transportation costs. This report will be updated.

Keywords

disabilities, children, IDEA, Medicaid, public, education, federal, state, program, medical, health, service, school

Comments

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The Link Between Medicaid and the Individuals with Disabilities Education Act (IDEA): Recent History and Current Issues

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Summary

As a condition of accepting funds under IDEA, public schools must provide special education and related services necessary for children with disabilities to benefit from a public education. Generally, states can finance only a portion of these costs with federal IDEA funds. Medicaid, the federal-state program that finances medical and health services for the poor, can cover IDEA required health-related services for enrolled children as well as related administrative activities (e.g., outreach for Medicaid enrollment purposes, medical care coordination/monitoring). However, the link between IDEA and Medicaid has not been seamless. Despite written federal guidance, schools have a difficult time meeting the myriad complex reimbursement rules applicable to all Medicaid participating providers. According to federal investigations and congressional hearings, Medicaid payments to schools have sometimes been improper. The President's FY2007 budget proposal would prohibit federal Medicaid reimbursement for IDEA-related school-based administration and transportation costs. This report will be updated.

Under IDEA, public schools are required to provide children with disabilities with a free appropriate public education (FAPE), including special education and related services according to each child's individualized education plan (IEP) or individualized family service plan (IFSP). Related services are those services that enable a child to benefit from special education. States receive some federal aid under IDEA, but are otherwise responsible for the expense of special education and related services. One approach Congress has taken to ease the burden on states and school districts of fulfilling these IDEA requirements is to allow the use of funds available under Medicaid to finance health services delivered to the subset of special education students who are enrolled in the Medicaid program. Medicaid is a federal-state entitlement program providing a broad range of medical and health-related services to certain low-income individuals. Medicaid benefits commonly provided in school-based settings include, for example, physical, occupational and speech therapies, as well as diagnostic, preventive and rehabilitation services.

Recent History

Prior to 1988, Medicaid did not pay for coverable services that were listed in a child's IEP/IFSP 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 the financing relationship between IDEA and Medicaid in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). However, there is some controversy about the exact nature of this legislative change. IDEA requires states to establish interagency agreements to ensure that IDEA-eligible students receive the services to which they are entitled. These agreements must include an identification of the financial responsibility of all relevant agencies. IDEA regulations further stipulate that the financial responsibility of Medicaid and other public insurers *must* precede the financial responsibility of the local education agency (LEA) or the state agency responsible for developing the child's IEP. In other words, Medicaid is deemed to be the first payer. In contrast, according to officials with the Centers for Medicare and Medicaid Services (CMS) — the federal agency that administers the Medicaid program — the 1988 law *allows*, but does not require, state Medicaid agencies to pay for services included in an IEP/IFSP.¹ Thus, given CMS' interpretation of this law, the IDEA requirement that Medicaid be the first payer applies only to those states that have elected to pay for services listed in IEPs/IFSPs. According to CMS, most states do pay for these services.

Since 1988, other complicated issues surrounding the relationship between IDEA, schools and Medicaid have arisen. While Congress made it clear that Medicaid funds can be used to pay for reimbursable school-based services rendered to IDEA children enrolled in Medicaid, at various points in time some Members have expressed concern that some of these Medicaid payments may be made improperly. In 1999 and 2000, the Senate Finance Committee asked the U.S. General Accounting Office (GAO; later renamed the Government Accountability Office) to examine Medicaid school-based services and held two hearings on this subject.² Three main concerns were identified in the GAO studies and accompanying testimony:

- Billing practices for school-based administrative services, coupled with uneven oversight of these practices by the Health Care Financing Administration (HCFA; now CMS), resulted in at least 2 of 17 states receiving improper payments.
- “Bundled” billing methods for school-based services used by seven states failed to account for variations in service needs among children and often lacked adequate documentation demonstrating that the benefits paid for were actually delivered in every case.³ However, both GAO and HCFA

¹ Personal communication with CMS officials, November 14, 2002.

² See *Medicaid Questionable Practices Boost Federal Payments for School-Based Services*. Testimony by William J. Scanlon before the Senate Finance Committee on June 17, 1999 (GAO/T-HEHS-99-148), and *Medicaid in Schools: Poor Oversight and Improper Payments Compromise Potential Benefit*. Testimony by Kathryn Allen before the Senate Finance Committee on April 5, 2000 (GAO/T-HEHS/OSI-00-87).

³ Bundled payments typically means a fixed rate is paid for a package of specific services made
(continued...)

believed that bundled rates, if proper assurances can be built into the approach, are the preferred method for LEAs to bill Medicaid.

- In some states, school districts received little of the reimbursements claimed for school-based services because state agencies and private contractors, hired by schools to assist in billing Medicaid, retained significant portions of federal payments. For example, seven states retained from 50% to 85% of total federal reimbursements for both health services and administrative activities. Some school districts paid private contractors contingency fees as high as 25% of federal payments for school-based administrative activities. In the worse case reported, schools were receiving as little as \$7.50 for every \$100 claimed for services and activities performed in support of Medicaid-eligible children.

In addition to these general school-based billing and reimbursement problems prevalent in a number of states, there are two other specific Medicaid financing issues that can affect the ability of LEAs to receive Medicaid payments for services provided to some IDEA children: (1) third party liability rules, and (2) financial arrangements under managed care. When private insurance is available for a Medicaid-enrolled child (e.g., family coverage through an employer), Medicaid must pay only the remainder of allowable costs for coverable services after the other coverage has been taken into account, even when such insurance actually pays nothing. Under the FAPE requirement of IDEA, LEAs cannot require parents with private family coverage to use that coverage to pay for IEP services required in school. Thus, LEAs may be caught in the middle between these two conflicting federal policies, and end up paying the portion of the costs that Medicaid cannot cover given its third party liability rules. There are no data showing how many Medicaid children also have private health insurance, but the likelihood of such dual coverage increases with family income.

Second, under managed care, states contract with managed care organizations (MCOs) to provide specified packages of services to Medicaid beneficiaries. Most managed care enrollees under Medicaid are families with children, and over time have increasingly included children with disabilities. Contracted benefits may include the services required by IDEA children. 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 such care may fall to either the LEA or the MCO, depending on the terms of any contractual relationship between the LEA and the managed care plan. When an LEA is not in the provider network of the plan, Medicaid reimbursement for IDEA-related services provided by the LEA may not be available.⁴ While there is no federal requirement that states establish relationships between LEAs and Medicaid MCOs, HCFA (now CMS) has encouraged states to promote such relationships.

³ (...continued)

available to children with a specific condition during a set period of time (e.g., a month). In a May 21, 1999 memorandum to state Medicaid directors, HCFA prohibited additional states from applying to use the bundled rate methodology.

⁴ 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).

To help schools obtain Medicaid reimbursement for health care services and related administrative activities, HCFA and later CMS issued two manuals, *Medicaid and School Health: A Technical Assistance Guide* (August 1997) and *Medicaid School-Based Administrative Claiming Guide* (May 2003). Prior to the 2003 release, on two occasions, Congress urged the Administration to revise early drafts of the latter guide.⁵ The 2003 guide represents a consolidation of existing requirements for administrative claiming, and drew on the input from education community on the two earlier draft versions released in 2000 and 2002. The usefulness of these guides has been questioned by some in the education community.⁶

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 seeking Medicaid payments for school-based services delivered to a Medicaid-enrolled child. However, traditional Medicaid providers are likely to have considerably more experience with Medicaid's (and other insurers') processes and procedures for successfully operating and obtaining reimbursement in a "medical services world." Ensuring that these conditions are met is a more daunting prospect for LEAs that otherwise seldom if ever interact with health insurers including Medicaid. Although the two Medicaid guides were intended to bridge this gap for the education community, because of the wide variability in state Medicaid programs, schools and school districts have been advised to seek assistance from their state Medicaid offices.

Current Issues

Nationwide, estimated Medicaid expenditures for school-based services totaled about \$2.9 billion in FY2005 (latest data available). Roughly \$2.1 billion of these expenditures were for Medicaid benefits provided in schools and about \$834 million was spent for school-based administrative activities.⁷

In the President's FY2007 budget proposal, the Bush Administration noted that Medicaid claims for services provided in school settings have been prone to abuse and overpayments, especially with respect to transportation and administrative activities. As

⁵ See Sec. 321, H.Rept. 106-577 for the Concurrent Resolution on the Budget for Fiscal Year 2001, and page 153 of H. Rept 106-1033 for the Omnibus Consolidated and Emergency Supplemental Appropriations for Fiscal Year 2001.

⁶ See, for example, Travis Hicks: "Special Ed advocates oppose new Medicaid guidance. (Cuts in Medicaid funding for health services professional for special education students)." *Education Daily*, Feb. 6, 2003.

⁷ Source: CMS, Form-64. These data are reported by states on a voluntary basis and may be incomplete. Also, these data may include claims from prior periods. Some services can be claimed as either administrative expenses or as a benefit (e.g., case management, transportation).

of March 2006, the HHS Office of Inspector General (OIG) had completed reviews of school-based claims in 18 states. Based on this and other research, both the HHS OIG and GAO have reached similar conclusions.⁸

For transportation services, examples of inappropriate Medicaid billing include (1) no verification that transportation was in fact provided; (2) a Medicaid-covered school health service other than transportation was not provided on the day that transportation was billed; and (3) child/family plans did not include a recommendation for transportation services, or there was no IEP or IFSP.

School districts may perform administrative functions for Medicaid purposes, such as outreach, eligibility intake, information and referrals, health service coordination and monitoring, and interagency coordination. Examples of inappropriate Medicaid billing include (1) payments based on inaccurate time studies used to allocate the cost of these administrative activities across funding sources including Medicaid; (2) expenditures for school employees who do not perform Medicaid administrative activities; (3) expenditures for operating costs such as nursing supplies, non-Medicaid outreach supplies, and education-related expenditures; (4) expenditures for personnel funded by other federal programs; and (5) payments for personnel who render only direct medical services.

The President's FY2007 budget would, through administrative action rather than legislation, prohibit federal reimbursement for IDEA-related school-based administration and transportation costs. HHS estimates that this proposal would save \$615 million in FY2007, and \$3.645 billion over the FY2007-FY2011 period. CBO does not provide alternative cost estimates for administrative proposals in the President's budget.

For more detailed background information on the relationship between IDEA and Medicaid, see CRS Report RL31722, *Individuals with Disabilities Education Act (IDEA) and Medicaid*, by Richard Apling and Elicia Herz.

⁸ See, for example, HHS OIG, *Review of Medicaid Transportation Claims Made by the New York City Department of Education*, A-02-03-01023, Sept. 2005; HHS OIG, *Audit of LaPorte Consortium's Administrative Costs Claimed for Medicaid School-Based Services*, A-06-02-00051, Jan. 2006; GAO, *Medicaid in Schools: Improper Payments Demand Improvements in HCFA Oversight*, GAO/HES/OSI-00-69, Apr. 2000, and *Medicaid: States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight*. Testimony by Kathryn Allen before the Senate Finance Committee, June 28, 2005 (GAO-05-836T).