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**MEMORANDUM**

DATE: May 7, 2012

TO: All Members of the Delaware State Senate  
and House of Representatives

FROM: Ms. Daniese McMullin-Powell, <sup>DMP/KH</sup>Chairperson  
State Council for Persons with Disabilities

RE: H.B. 303 [School Based Health Centers]

The State Council for Persons with Disabilities (SCPD) has reviewed H.B. 303 regarding School Based Health Centers (SBHCs). Consistent with the synopsis, SBHCs exist in twenty-eight (28) Delaware high schools. The Centers offer a wide array of diagnostic and treatment services to students. The bill is designed to implement a general Medicaid requirement that private insurance be billed for a covered service prior to billing to Medicaid. The bill disallows an SBHC from charging a student a co-pay or out-of-pocket fee. State-regulated health insurers would be required to reimburse SBHCs for the cost of services "as if those services were provided by a network provider". The amendments ostensibly address the sensitive issue of parental consent to reproductive services.

SCPD believes there is a significant oversight in the legislation. Public schools may incorporate SBHC services into an IEP or Section 504 Plan (e.g. counseling; medical evaluation; school health services). Federal law bars billing a parent's health insurance for services required for a free, appropriate public education ("FAPE") without parental consent. A parent cannot be forced to allow access to his/her insurance if such access could potentially result in a "financial loss". The attached HHS Policy Clarification [18 IDELR 558 (November, 1991)] summarizes the law:

Medicaid providers, including schools and their health care practitioners, must bill private plans first if a Medicaid recipient has private coverage for the relevant service. ...

Whether a school would actually choose to bill private insurers for services covered by more than one source of insurance would depend on the school's policies regarding health insurance billing and the potential for an associated cost to the family. Under Federal policy on use of parents' insurance proceeds, the requirements that a free, appropriate public education be provided "without charge" or "without cost" mean that an agency

may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children. Financial losses include, but are not limited to, the following:

- A decrease in available lifetime coverage or any other benefit under an insurance policy;
- An increase in premium under an insurance policy; or
- An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

At 561. See also attached OSERS Policy Letter to D.Rose, 18 IDELR 531 (September 19, 1991) [public agencies may not require parents to consent to filing of claim with private insurance or Medicaid]; and attached OSERS Policy Letter to G. Spinner, 18 IDELR 310 (November 13, 1991) [parents must give explicit consent to the filing of a claim by a public agency against their insurance policies to pay for required special education and related services where doing so poses a realistic threat of financial loss and be fully informed that refusal will not result in denial of services]. This policy applies to students covered by both the IDEA and Section 504 of the Rehabilitation Act. OSERS Policy Letter to G. Spinner, 18 IDELR 310, 311 (November 13, 1991). These policy interpretations are essentially reiterated in the relevant IDEA regulation, 34 C.F.R. 300.154.

Given the above considerations, SCPD recommends consideration of an amendment which would add the following subsection to the bill:

Insurer reimbursement to an SPHC for provision of services in fulfillment of an obligation under either the Individuals with Disabilities Education Act or Rehabilitation Act of 1973, codified at 20 U.S.C. 1400 and 29 U.S.C. 794 respectively, shall conform to any limitations established by such federal laws, including any requirement of parental consent and assurance of no adverse financial effect under a health insurance policy. The Division of Public Health, in consultation with the Department of Education, may issue regulations implementing this subsection.

Thank you for your consideration and please contact SCPD if you have any questions regarding our observations or recommendation on the proposed legislation.

cc: Ms. Rita Landgraf  
Ms. Deborah Gottschalk  
Ms. Mary Ann Mieczkowski  
Ms. Susan Haberstroh  
Mr. Brian Hartman, Esq.  
Governor's Advisory Council for Exceptional Citizens  
Developmental Disabilities Council

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Mr. Gerald A. Spinner  
Assistant Legal Adviser  
Illinois State Board of Education  
100 North First Street  
Springfield, IL 62777-0001

**Digest of Inquiry**  
[Date Not Provided]

- Does the purchase of an insurance policy by the parents of a child with disabilities constitute consent to a public agency's filing of a claim against that policy for the costs of special education or related services?

**Digest of Response**  
(November 13, 1991)

*Purchase of Insurance Does Not Constitute  
Consent to Claim Filing*

The parents of a child with disabilities must provide explicit consent to a public agency's filing of a claim against their insurance policy for the purposes of recovering the costs of special education or related services, when such a claim would pose a realistic threat of financial loss to the parents. The mere act of purchasing an insurance policy is not sufficient to this consent requirement. In addition, the state educational agency is responsible to inform the parents that their refusal to consent to the filing of a claim cannot result in the denial of services to their child.

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**Text of Response**

On April 26, 1991, Ms. Joy Rogers submitted a request to this Office for Secretarial review of the April 19, 1991 decision

of the Illinois State Board of Education (ISBE) to deny her complaint, which was filed with your agency pursuant to 34 CFR §§ 76.780-76.782. As the enclosed letter indicates, a decision has been reached to deny Ms. Rogers' request for Secretarial review. We are concerned, however, that ISBE's April 19, 1991 letter to Ms. Rogers may wrongly assume that a parent's purchase of an insurance policy constitutes consent to a public agency filing a claim against that policy to pay for required special education and related services. Specifically, the April 19, 1991 letter states that:

*As to the text of any notice given to parents requesting information and assuring them that services to their child will not be adversely [a]ffected should they refuse to consent to claims being filed against a private contract of insurance, two points must be noted. First, as the purchase of the contract of insurance is voluntary and is a contract under Illinois law which may be enforceable by a third party, consent to a third party's filing of a claim may have been waived by the purchaser at the time of purchase; this being very likely in a State not favoring exclusionary clauses against public sector service providers. Therefore, the seemingly widespread relief (sic) that a parent can preclude claims against a private contract of insurance simply by withholding consent to the filing of such claims is erroneous.*

April 19, 1991 letter from ISBE to Joy Rogers, at pages 2-3 (emphasis added).

The Notice of Interpretation published by the U.S. Department of Education on the use of insurance proceeds, however, very clearly states that:

Both Part B and Section 504 prohibit a public agency from requiring parents, where they would incur a financial loss, to use insurance proceeds to pay for services that must be provided to a handicapped child under the 'free appropriate public education' requirements of those statutes. The use of parents' insurance proceeds to pay for services in these circumstances must be voluntary on the part of the parents.

45 Fed. Reg. 86390 (December 30, 1980).

Consequently, parents must give explicit consent to the filing of a claim by a public agency against their insurance policies, to pay for required special education and related services, where doing so poses a realistic threat of financial loss. The mere act of a parent purchasing an insurance policy does not satisfy this requirement. Moreover, ISBE is required to ensure that parents are fully informed that a decision to refuse to submit a claim will not result in a denial of services that the child would otherwise be entitled to receive under Part B. In addition, TAMES of Flossmoor, Inc., is bound by the May 30, 1990 Letter of Findings issued by the U.S. Department of Education's Office for Civil Rights.

If you have any further questions on this issue, please do not hesitate to contact my Office.

Robert R. Davila  
Assistant Secretary

realistic threat of financial loss. Moreover, the school district may not condition the provision of special education services on parental consent to the filing of an insurance claim, including a claim to be filed with the State Medicaid agency.

*Use of Medicaid Funds Does Not Alleviate Part B Obligations*

Despite the use of Medicaid funds to pay for the costs of special education services, a school district remains obligated under Part B to provide special education and related services in conformity with a child's IEP, to place a child according to the placement and least restrictive environment requirements, and to provide the requisite due process rights and procedural safeguards.

**Text of Inquiry**

I am writing to inquire about two issues concerning the utilization of Medicaid funds to satisfy a public school's obligation to provide a free and appropriate education ("F.A.P.E.") under the Individual with Disabilities Education Act ("I.D.E.A."), 20 U.S.C. § 1400 *et seq.* First, may a public school require a parent or child to permit the school to access Medicaid to provide services required under F.A.P.E.? Second, does the accessing of Medicaid in any way alter the public school's obligations or rights under I.D.E.A.?

Thank you for your time and consideration.

**Text of Response**

This is in response to your letter in which you request clarification of the circumstances under which public agencies may access Medicaid payments to pay for the cost of required special education and related services.

In 1980, the Department published a Notice of Interpretation on Use of Insurance Proceeds (NOI), published at 45 *Fed. Reg.* 86390 (Dec. 30, 1980). A copy of the NOI, which also is applicable to use of Medicaid payments to pay for the cost of required special education and related services, is enclosed for your information. Your specific questions and the Department's responses follow.

1. May a public school require a parent or child to permit the school to access Medicaid to provide services required under [free appropriate public education (FAPE)]?

Part B of the Individuals with Disabilities Education Act (Part B) requires State educational agencies (SEAs) to assure that FAPE is available to all children with disabilities within specified age ranges. 20 U.S.C. § 1412. The term "free appropriate public education" means special education and related services which (A) have been provided at public expense, under public supervision and direction, and without charge, (B) meet the standards of the State educational agency, (C) include an appropriate preschool, elementary, or secondary school education in the State involved, and (D) are provided in conformity with the individualized education program required under sec-

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**Digest of Inquiry**  
(April 19, 1991)

- May a school district require a parent of a child with disabilities to file a Medicaid claim to recover the cost of special education services?
- Does the accessing of Medicaid to pay for special education services alter, in any way, a school district's obligations under Part B?

**Digest of Response**  
(September 19, 1991)

*School Districts May Use Medicaid as Funding Source*

A school district may access private insurance and Medicaid sources to pay for the cost of special education services; however, the use of a parent's insurance proceeds must be voluntary in circumstances where the parent would be likely to incur a

tion 614(a)(5). 20 U.S.C. § 1401(a)(18). Public agencies, however, in meeting their obligation to provide special education and related services without charge, "may use whatever State, local, Federal and private sources are available in the State to meet the requirements of this part." 34 CFR § 300.301(a). This regulation also provides that "[n]othing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or pay for services provided to a [child with a disability]." 34 CFR § 300.301(b).<sup>1</sup>

Based on the above regulations, it is permissible for school districts to access sources other than Part B funds to pay for the cost of required special education and related services for children with disabilities. However, in the NOI, the Department emphasizes that use of parents' insurance proceeds must be voluntary in circumstances where parents would incur a realistic threat of a financial loss. The NOI explains:

the requirements that a free appropriate public education be provided 'without charge' or 'without cost' . . . mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of [children with disabilities] would suffer a financial loss not incurred by similarly situated parents of [nondisabled] children. Financial losses include, but are not limited to, the following:

- (1) A decrease in available lifetime coverage or any other benefit under an insurance policy;
- (2) An increase in premiums under an insurance policy; or
- (3) An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

45 Fed. Reg. 86390 (December 30, 1980).

In addition, public agencies may not condition the provision of special education and related services on parental consent to the filing of an insurance claim. The Part B regulations provide that "[e]xcept for preplacement evaluation and initial placement consent may not be used as a condition of a benefit to a parent or child." 34 CFR § 300.504(b)(2). Thus, public agencies are not authorized to condition the provision of special education and related services to a child with a disability on a parent's willingness to consent to the filing of an insurance claim, including the filing of a claim with a State Medicaid agency. Therefore, parents may refuse to sign a consent form without jeopardizing receipt of services to their child.

2. Does the accessing of Medicaid in any way alter the public school's obligations or rights under [Part B]?

Under Part B, States and local school districts have an ongoing responsibility to provide FAPE to eligible children determined to have 1 or more of 13 specified disabilities. 20 U.S.C. 1412(2); 34 CFR §§ 300.121 and 300.2. Thus, regardless of whether Medicaid funds are accessed to pay the cost of required special education and related services for children with disabilities, the public agency responsible for educating each child must ensure that the services and program provided to the

child are at no cost to the child and the child's parents in accordance with the child's individualized education program (IEP), and that the other rights and procedural protections in Part B are extended to the child and the child's parents. These include the provision of special education and related services in conformity with an IEP developed and implemented in accordance with §§ 300.340-300.349; placement of the child in accordance with the placement and least restrictive environment requirements of §§ 300.550-300.554 and 300.533; and the provision of the due process rights and other procedural safeguards guaranteed by §§ 300.500, 300.502-300.514, 20 U.S.C. 1415(d)(4) and 20 U.S.C. 1415(e)(4).

I hope the above information has been helpful. If we can be of further assistance, please let me know.

Robert R. Davila  
Assistant Secretary

<sup>1</sup> A statutory amendment to Part B made by the Education of the Handicapped Act Amendments of 1986 recognizes the importance of Medicaid funds in paying the cost of required special education and related services for children eligible under both programs. See 20 U.S.C. § 1413(e). The Department's regulation implementing this statutory requirement provides:

This part may not be construed to permit a State to reduce medical and other assistance available to [children with disabilities], or to alter a [child with a disability's] eligibility, under Title V (Maternal and Child Health) or Title XIX (Medicaid) of the Social Security Act, to receive services that are also part of a free appropriate public education.

34 CFR § 300.601.

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## HHS Policy Clarification

Prepared for: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

In cooperation with: Health Care Financing Administration, U.S. Department of Health and Human Services, and the Office of Special Education and Rehabilitative Services, U.S. Department of Education

Prepared by: Lewin/ICF, a division of Health & Sciences International, and Fox Health Policy Consultants  
November 1991

The U.S. Department of Health and Human Services (HHS), in cooperation with HCFA and OSERS, issued a policy clarification on the use of Medicaid funds in the provision of health-related services under the IDEA. The purpose of the joint policy statement was to explain, in plain language, the extent to which services contained in an IEP under Part B can be reimbursed by Medicaid. The HHS guidance was intended to encourage state and local educational agencies to cooperate more closely with state Medicaid agencies in the provision and funding of special education and related services.

### Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies

#### Overview

Part B of the Individuals with Disabilities Education Act (IDEA) authorizes Federal funding to states in order to ensure that children with one or more of thirteen specified disabilities receive a free appropriate public education. The law was established by Public Law 94-142 and was formerly called the Education of the Handicapped Act. Under the law, school districts must prepare an Individualized Education Program (IEP) for each child eligible for services under Part B, specifying all special education and "related services" needed by the child. A state Medicaid program can pay for those "related services" that are specified in the Federal Medicaid statute and determined to be medically necessary by the state Medicaid agency.

Within Federal and state Medicaid program requirements regarding allowable services and providers, school districts can bill the Medicaid program for these health-related services when

provided to children enrolled in Medicaid. This is important because of the additional financing it offers to educational agencies. The Part B program requires states to provide all special education and related services to eligible students at no cost to parents, but many states find this difficult because they are constrained by limited education budgets.

This booklet is designed to help state and local education officials, Medicaid officials, and other interested parties understand the conditions under which the Medicaid program can pay for the related services required by an IEP. It also describes the extent to which state Medicaid eligibility, coverage, and reimbursement policies are governed by Federal law.<sup>1</sup>

The booklet is organized in a "Question and Answer" format. We strongly recommend that the reader review the complete range of questions and answers given the complexity of the issues presented. The remainder of this overview provides background information on the two relevant programs: the Assistance to States Program established under Part B of IDEA, and the Federal/state Medicaid program established under Title XIX of the Social Security Act. A list of the questions addressed by the booklet is provided in Exhibit 1.

#### A. The Part B Program

The Federal entitlement program that governs services to children with one or more of thirteen specified physical or mental disabilities who by reason thereof require special education and related services is authorized under Part B of the Individuals with Disabilities Education Act.<sup>2</sup> The Part B program is administered by the Office of Special Education and Rehabilitative Services within the U.S. Department of Education. Grants are distributed to states, which then disburse most of the funds to local education agencies (e.g., school districts) to support their special education activities.

The grants under Part B are intended to assist states in assuring that children with specified disabilities receive a free appropriate public education as specified in the Act. A "free appropriate public education" is defined to include special education and related services at no cost to the parents.

- "Special education" is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability." It can include classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions to ensure that children with disabilities receive a free appropriate public education.

- "Related services" are defined as "transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education." These include several health-related services that must be available, including speech pathology, audiology, psychological services, physical and occupational therapy, early identification and assessment of disabilities, counseling services, school health services, social work services in school, and medical services for evaluation and diagnostic purposes only.<sup>3</sup>

Although states and localities fund the bulk of special education services, Federal Part B funds are an important supplement. To receive Part B funds, a state must submit a plan through its state education agency (SEA) detailing state policy for ensuring that children with specified disabilities have access to a free appropriate public education. The state application also must include an estimate of the total number of children with disabilities currently receiving and/or in need of special education and related services. The state must also provide estimates of the personnel and other resources necessary to meet the special education needs of children as specified by the Act. The distribution of funds among states is determined by a formula based on the number of children with disabilities age 3 through 21 receiving special education and related services within each state.

Once Part B monies have been approved, they are forwarded to the SEA for distribution to local education agencies (LEAs). LEAs generally are comprised of one or more local school districts. The LEAs receive funds only after they have submitted a program plan and been granted approval by the SEA. The LEAs are then expected to provide services to students with specified disabilities. State and local education agencies are prohibited from reducing their existing financial commitments to special education in response to the receipt of Part B funds.

For students with specified disabilities eligible for special education services under Part B, an Individualized Education Program (IEP) must be developed cooperatively by the school, the child's teacher, the child's parent or guardian, and others if deemed appropriate. Developed by the beginning of the school year, and reviewed (and if appropriate revised) at least annually, the IEP must detail specific special education and related services that are to be provided to the child. The LEA is responsible for assuring that all services included in the IEP are provided to the child and that education occurs in the "least restrictive environment," meaning that the child is educated with non-disabled peers to the maximum extent appropriate.

### B. The Medicaid Program

Medicaid is a nationwide Federal/state medical assistance program for selected low-income populations. The Medicaid program was established in 1965 as Title XIX of the Social Security Act. It is federally administered by the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (DHHS). While Congress and HCFA set broad Federal guidelines for the program, states have considerable flexibility in formulating eligibility, benefits, and reimbursement policies. Every state documents these policies in a state Medicaid plan which must be approved by HCFA.

The Medicaid program is funded by a combination of Federal and state dollars. The Federal Government "matches" state dollars as long as both the services and the eligible populations are within the parameters approved in the state plan. The level of the Federal match, known as Federal Financial Participation (FFP), is determined by a formula based on state per capita income. The minimum FFP in state expenditures for medical services is 50 percent of total program costs; the maximum FFP is 83 percent.

Medicaid is a "categorical," means-tested program. Individuals must fit into specific categories (e.g., dependent children) and must have income and resources below specified thresholds. Until recently, Medicaid eligibility was linked almost exclusively to eligibility for Federally funded cash assistance under two programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). AFDC and SSI are "categorical" programs. AFDC recipients live in families with a single or unemployed parent and SSI recipients are aged, blind, or disabled. States are also able to establish "Medically Needy" programs to cover individuals who meet the categorical eligibility criteria for cash assistance but not the income and resource eligibility criteria. Under a Medically Needy program, states may extend eligibility to individuals with family incomes up to 133 percent of the state's AFDC payment standard and also to individuals who incur health expenses which, when deducted from income, bring their net income below the medically needy level.

Recent Federal legislation has diminished the link between eligibility for cash assistance and Medicaid. Medicaid has been expanded to include many young children with family incomes and resources well above state eligibility standards for cash assistance. Moreover, many of these children qualify for Medicaid regardless of whether they have disabilities or are in single-parent families.

Medicaid covers a broad range of medical and remedial services. Federally allowable services include not only traditional medical services and remedial care, such as physicians' services and prescription drugs, but also several health and therapeutic interventions, such as occupational therapy. Some services are mandated by Federal law and must be provided by every state, while other services are provided at a state's discretion. One special program established for children is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under the EPSDT program, children must receive not only screening and diagnostic services, but also any medically necessary treatments that may not otherwise be available under a state's Medicaid plan but are allowable under Federal Medicaid law.

Medicaid services may be provided by a range of health professionals in a variety of settings, including a child's home or school. However, in defining service benefits, states have some latitude in specifying the types of providers and settings in which services must be provided in order to be reimbursable.

In general, state Medicaid programs pay participating providers for covered services on a per unit of service basis (such as a physician office visit). Within Federal guidelines, states have flexibility in determining reimbursement rates for particular services and providers. Providers generally bill Medicaid directly for payment for covered services provided to Medicaid recipients. States have the option of requiring nominal cost-sharing by Medicaid recipients for some services, meaning that the recipient pays a small "copayment" (e.g., \$2.00) to the provider for a given service.

In sum, states have considerable flexibility in defining Medicaid eligibility groups, benefits, provider participation requirements, and reimbursement levels within Federal guidelines. It is because of this flexibility that states can shape their programs to include reimbursement for health-related services



required under the Part B program, a process that can be facilitated through interagency agreements between the state's Medicaid agency and education agencies.

### C. Questions Addressed By The Handbook

Federal policy has established that education agencies can bill Medicaid for health-related services covered under the state's Medicaid program. However, there has been considerable confusion about Federal policy, and the various laws and regulations governing the billing and reimbursement process can be complicated and ambiguous. This booklet seeks to clarify the relevant Federal policies in response to the questions shown in Exhibit 1. (Exhibit 1 Omitted)

#### Questions and Answers

##### A. Idea Policy Regarding Medicaid Billing

###### 1. Does Federal Part B policy allow Medicaid billing for health-related services covered under a state's Medicaid program. . . .

Yes. Although Part B does not expressly require Medicaid billing for covered health-related services, Congress anticipated the use of Medicaid and other resources to finance health-related Part B services. The Senate Report accompanying the original act, P.L. 94-142, states that "the state education agency is responsible for assuring that funds for the education of handicapped children under other Federal laws will be utilized" and that "there are local and state funds and other Federal funds available to assist in this process."

Moreover, three statutory amendments to Part B, made in 1986 by P.L. 99-457, further support the use of Medicaid and other sources to finance IEP-related services. Under these amendments:

- States are prohibited from using Part B funds to satisfy a financial commitment for services that would have been paid for by other Federal, state, and local agencies but for the enactment of Part B and the listing of the services in an IEP;
- States are required to establish interagency agreements with appropriate state agencies to define the responsibility of each for providing or paying for a free appropriate public education and resolving disputes; and
- It is clarified that P.L. 94-142 cannot be construed as permitting a state to reduce medical or other available assistance, or to alter Title V Maternal and Child Health Block Grant or Medicaid eligibility with respect to the provision of a free appropriate public education.

###### 2. Are there any Federal special education policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

The only Federal education policy that could restrict Medicaid payment for covered health services is the basic IDEA requirement that special education services be provided "at no cost to parents." The effect of this provision is that state or local education agencies must assume any costs the Medicaid agency

does not pay for so that no costs are imposed on the parents. For example, if the state Medicaid agency has elected to exercise its Federal option to impose nominal cost-sharing requirements on Medicaid recipients for services that include health-related services furnished by schools, the state or local education agency would be required to meet these copayment obligations for an eligible family.<sup>4</sup>

##### B. Medicaid Policy Regarding Payment For Health-Related Services

###### 1. What are the Federal Medicaid program requirements regarding reimbursement for health-related services?

The Federal Medicaid statute does not require that Medicaid programs reimburse schools for health-related services delivered to Medicaid-eligible children. However, the Medicare Catastrophic Coverage Act of 1988 (MCCA) amended the law to make clear that Medicaid funds are available to pay for health-related services.<sup>5</sup> The amendment states that nothing under the Medicaid statute is to be construed as prohibiting or restricting, or authorizing HCFA to prohibit or restrict, payment for services covered under a Medicaid state plan simply because they are furnished to a handicapped child pursuant to an individualized education program (IEP). The implication, as explained in the Conference Report, is that state education agencies are responsible for furnishing special instruction and educational services to children with disabilities, but that state Medicaid agencies are responsible for reimbursing health-related services provided to Medicaid-eligible children to the extent the state covers them under its Medicaid plan.

###### 2. Are there any Federal Medicaid policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

Under Federal law, the Medicaid program can only be billed for medically necessary services that are included in the state's Medicaid plan and provided by participating Medicaid providers. An exception to this is services provided under the EPSDT program (see Section C). In addition, except under circumstances described in Section F, Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay.

###### 3. What state Medicaid policies must be in place in order for schools to bill Medicaid for medically necessary health-related services?

In order for schools to be able to bill Medicaid, the state Medicaid program must cover the various health-related services a child may need (e.g., physical therapy) under one of the service categories in its Medicaid state plan. In addition, the state Medicaid agency needs to have qualifications for providers of health-related services that schools or their practitioners would be able to meet (see Section E for a discussion of provider qualifications). These policies need to be reflected in the state Medicaid plan (see section G). However, while the state Medicaid agency can establish qualifications which would allow schools or their practitioners to be providers, it may not specify schools or their practitioners as the sole providers of health-related services.

**4. If a Medicaid recipient also has private insurance, must the private plan be billed for health-related services?**

Yes. Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay. When individuals apply for Medicaid, they are required to inform the state Medicaid agency or any other health care coverage they have and permit the state Medicaid agency to pursue payment from these third-parties for covered services.

Medicaid providers, including schools and their health care practitioners, must bill private plans first if a Medicaid recipient has private coverage for the relevant service.<sup>6</sup> As a result, Medicaid reimbursement would not be available, or would be available only in a substantially reduced amount, for services to Medicaid-enrolled children who also have private health insurance coverage for health-related services.

Whether a school actually would choose to bill private insurers for services covered by more than one source of insurance would depend on the school's policies regarding health insurance billing and the potential for an associated cost to the family. Under Federal policy on use of parents' insurance proceeds, the requirements that a free appropriate public education be provided "without charge" or "without cost" mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children. Financial losses include, but are not limited to, the following:

- A decrease in available lifetime coverage or any other benefit under an insurance policy;
- An increase in premiums under an insurance policy; or
- An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.<sup>7</sup>

If such a cost would be incurred, a parent's use of insurance proceeds would have to be voluntary. If a school determined that private insurers could not be billed for dually insured services, then Medicaid could not be billed for these services either, and the state or local education agency would have to bear the costs which Medicaid and the third parties would have been obligated to pay.

**5. If providers bill a state Medicaid program for services to Medicaid recipients, must they also bill non-Medicaid children's parents or third-party payers for health-related services?**

No. This question often arises because of the Federal requirement that Medicaid payments are not available for services that are otherwise provided free of charge. Federal Medicaid policy is that all health-related services provided under Part B that are covered by a state's Medicaid program may be billed to Medicaid *regardless* of whether parents and third-party payers for non-Medicaid eligible children also are billed. (See Questions A.1 and B.1 above)

**C. Medicaid Coverage of Health-Related Services**

**1. Which health-related services are Federally allowable Medicaid services?**

The Medicaid statute establishes a broad scope of services including health-related services that may be furnished as part of a special education program and reimbursed. Part B services are potentially reimbursable if the State chooses to include them in its Medicaid plan.<sup>8</sup> These include: speech pathology services; occupational therapy; physical therapy; psychological services; school health social worker services; early identification, screening, and assessment services; and medical services for diagnostic or evaluative purposes.

The Federal Government requires that states cover certain Medicaid service categories and allows states the option of covering others.<sup>9</sup> The mandatory categories (i.e., those that are Federally required) include physician services, outpatient hospital services, and EPSDT. The optional categories include: physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders; medical and other remedial care provided by licensed practitioners (such as psychologists, social workers, and nurses); clinic services; diagnostic, screening, and rehabilitative services; nursing facility services (including services in institutions for the mentally retarded); and inpatient psychiatric services for individuals under age 21. Among these various Medicaid benefits, the rehabilitative services category—which carries no Federal requirements for physician prescription, provider qualifications, or setting limitations—is the most flexible.

Many Part B health-related services can be reimbursed under more than one Medicaid service category. The ancillary therapies, for example, can be reimbursed as therapies furnished by independent practitioners or as components of clinic or rehabilitative services.

While all medically necessary health-related services are potentially reimbursable, payment can only occur if the state Medicaid plan clearly covers the service. Thus, it is important that education agencies work closely with the state Medicaid agency to ensure that the scope of the appropriate benefit category is defined by the Medicaid plan so as to include health-related services that might be furnished in a school and to ensure that the provider qualifications in the plan are defined in a way which would permit schools to participate.

**2. What is meant by the Federal Medicaid requirement that a service be medically necessary?**

Medical necessity is a prerequisite for service payment under the Medicaid program. This stems from various provisions in the Medicaid statute that require states to safeguard against unnecessary utilization of care and services.

Federal law leaves the specification of medical necessity criteria for particular Medicaid services to the discretion of the state. There are a few services, though, including the ancillary therapies, for which physician referrals or prescriptions are Federally required as evidence of medical necessity. For instance, prescriptions are required for both physical and occupational therapy services and referral is necessary for speech pathology and audiology services. States then are free to establish more specific medical necessity criteria as they wish, and

to limit the coverage for services based on these criteria as well as on utilization control procedures. (State Medicaid coverage limits, of course, do not relieve a state of its responsibility for providing services to children under an IEP.)

### 3. What is the Medicaid EPSDT program for children?

Early and periodic screening, diagnosis, and treatment services—EPSDT—is a Federally required benefit for Medicaid-eligible children from birth to age 21. The EPSDT benefit is substantially different from other Medicaid benefits in that it obligates states to provide for all necessary Federally allowable Medicaid services regardless of the limitations in a particular state's Medicaid plan. To be in compliance with the Federal mandate for furnishing EPSDT, states are required to inform families of Medicaid-enrolled children about the benefits of preventive health care and the availability of EPSDT services, to assist with referrals and transportation to providers, and to arrange for provision of necessary diagnostic and treatment services, either directly or through referral.

EPSDT screening services include a comprehensive health and developmental screen (which includes a mental health assessment), a dental examination, a hearing examination, and a vision examination. These services are to be available in accordance with a state's periodicity schedule (or timetable), which must be established for each of the four components of the screening package and must meet reasonable standards of practice. These services are covered at other times as well, provided that the particular screening service is determined to be medically necessary.

Services for diagnosis and treatment include all Federally allowable Medicaid services. Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation of the child's health status and to provide diagnostic studies. Treatment services are covered whenever they are medically necessary to correct or ameliorate defects, physical or mental illnesses, or other conditions discovered (or found to have worsened) through an EPSDT screening. Both types of services are to be covered whether or not they are included in the state Medicaid plan and available to other Medicaid recipients.

### 4. What is the significance of the new Federal EPSDT mandate to furnish all medically necessary diagnostic and treatment services?

Federal law now requires states to provide reimbursement for any Federally allowable service found to be necessary to treat a condition discovered during an EPSDT screen, regardless of whether the service is included in the state Medicaid plan. Prior to this change, state Medicaid programs had the option to provide EPSDT-screened children an expanded package of Medicaid benefits but were not required to do so.

The new EPSDT mandate means that a broader scope of services and more generous coverage may be available to many Medicaid children. State Medicaid programs must now reimburse for diagnostic and medically necessary treatment services that otherwise are considered optional under Medicaid law. They also are prohibited from imposing limits on services that are not based on medical necessity requirements.

Recent HCFA preliminary instructions on EPSDT make clear, however, that states retain at least some of their usual limit-setting authority. Importantly, they remain responsible for setting medical necessity criteria for all EPSDT services. Using these criteria they also can limit both the scope of services—the nature of the intervention and the types of delivery settings for which reimbursement will be available—and the amount of service covered. Yet, any limitation imposed must be reasonable and related to medical necessity, and the benefit provided must be sufficient to achieve its purpose for EPSDT children.

### 5. Are health-related services included under the new EPSDT mandate?

Yes. Federally allowable Medicaid services mandated under EPSDT when medically necessary include, for example: clinic services; rehabilitative services; physical therapist services; occupational therapist services; speech pathology and audiology services; licensed psychologist and social worker services; and inpatient psychiatric facility services for individuals under age 21. Again, if a child is determined to need these services through an EPSDT screen, the services must be provided whether or not they are otherwise included in the state plan.

### 6. What is necessary for schools to bill for expanded EPSDT services?

To bill for a medically necessary EPSDT diagnostic and treatment services not otherwise covered under a state's Medicaid plan, a school must take steps to assure that:

- It or its health care practitioners, depending on the Medicaid service, is certified by the state as a Medicaid EPSDT provider;
- It can document the ongoing medical necessity of the health-related services it furnishes for conditions discovered or found to have worsened on the basis of a screening examination; and
- If required to do so by the state, it has obtained prior authorization for payment on a case-by-case basis.

#### D. Medicaid Eligibility and Enrollment

##### 1. Which children are eligible for Medicaid?

Medicaid coverage is currently required for all children under the age of six with family incomes below 133 percent of the Federal poverty level. States also must cover most children eligible for the two major Federally subsidized cash assistance programs: Supplemental Security Income (SSI), a program for the aged, blind, and disabled; and Aid to Families with Dependent Children (AFDC). Both programs are means-tested. The income eligibility standards for AFDC, which are established by the states, are generally much lower than the Federal poverty level. By the year 2002, states will be required to cover all school-age children (up to age 19) in families with incomes below 100 percent of poverty. Coverage of this group of children is being phased in one year at a time beginning with ages six and seven in July 1991.

State Medicaid programs have the option of covering some additional school-aged children who cannot qualify for either

SSI or AFDC. Financially eligible children in two-parent families, for example, may be unable to obtain AFDC but may nonetheless qualify for Medicaid in many states. Likewise, children with family incomes somewhat higher than the AFDC or SSI eligibility standards may qualify for Medicaid under the optional "Medically Needy" program. Adopting this program option allows states to set an income standard up to one-third higher than for the AFDC program and allows families to qualify for Medicaid when their income is below this medically needy standard or when they meet the medically needy standard by deducting incurred medical expenses from income.<sup>10</sup>

## 2. How do eligible children become enrolled in Medicaid?

Medicaid-eligible children cannot receive Medicaid benefits until they are formally enrolled in the program.<sup>11</sup> While most children receiving AFDC and SSI are automatically enrolled in Medicaid when their application for those programs is completed, children not receiving cash assistance must apply specifically for Medicaid coverage. Families, though, cannot be forced either to apply for or accept Medicaid benefits.

Families who want to have Medicaid coverage are Federally required to meet several specific eligibility criteria which must be documented and verified by the state through the enrollment process. States establish their own eligibility determination and enrollment procedures. In general, the process includes completing an application with information on family income and assets, other health insurance coverage, family size and composition, and other factors. The application process is usually conducted at local welfare or social service offices, although states are required (beginning July 1, 1991) to deploy outreach eligibility workers at other sites, such as hospitals or clinics. Once an application is submitted, the state has 45 days from the date of application to complete the eligibility determination (90 days for persons claiming disability as a reason for eligibility). When eligibility has been established, individuals must identify any other health care coverage they have and permit the state Medicaid agency to pursue payment from this third party coverage if it is legally obligated to pay for covered services. The family then is issued documentation (often a card) identifying their enrollment in Medicaid.

Importantly, establishment of eligibility is not permanent. Federal regulations require that states must conduct Medicaid eligibility redeterminations at least every 12 months. Redeterminations for AFDC recipients are conducted every six months. Redetermination generally entails verification of eligibility criteria—such as income, family composition, and age of children—and does not require reapplication.

### Is it a violation of Medicaid confidentiality requirements for local education agencies to require parents to provide information on the Medicaid enrollment status of children receiving health-related services?

No. Federal Medicaid regulations do not preclude providers or others from requiring parents to provide information on whether their children are enrolled in Medicaid. Under Part B, however, state and local education agencies are prohibited from requiring parents to identify whether their children are enrolled in Medicaid as a condition for receiving health-related services.

Education agencies may request this information from parents, but parents are under no obligation to provide it.

## 4. Can Medicaid enrollment information be furnished to education agencies by the state Medicaid program?

If the local education agency is a certified provider under the state's Medicaid plan, it may obtain information from the state Medicaid agency to verify the enrollment status of a particular child. It may not, however, request a comprehensive list of Medicaid-enrolled children. While Federal regulations require that the state Medicaid agency obtain permission from a family or individual for the release of any personal Medicaid-related information to an outside source, the Medicaid agency is permitted to release information without that consent if the information is necessary to verify enrollment.

## E. Provider Participation In The Medicaid Program

### 1. What Federal requirements must be met to become a provider of Medicaid services?

Federal law is specific about standards and certification procedures for hospitals and other inpatient care providers, but it leaves states considerable discretion in establishing Medicaid qualifications for individual practitioners and most other types of community-based providers. HCFA requires only that state provider standards be reasonable and objective with respect to the services covered. Because Federal law requires that Medicaid recipients have "freedom-of-choice" among providers—that is, the opportunity to choose among all health care providers who are qualified to participate—state Medicaid programs are expected to permit all qualified providers of Medicaid services to participate in the program.<sup>12</sup> The state Medicaid agency cannot specify a particular provider, such as schools, as the sole provider of Medicaid services.

All Medicaid providers, including schools or their practitioners, must abide by the Federal payment-of-claims provisions where third parties are involved. This means that, as a Medicaid provider, a school or its medical practitioner may be required to bill a private health insurance company first before billing Medicaid, unless the specific service meets one of the regulatory exceptions or the state has obtained a waiver of the cost avoidance requirements. If by billing the private insurer the school or its medical practitioner would be in violation of the IDEA requirement that services be provided at no cost to the parents, then the state or local education agencies must assume full financial responsibility for those services for which Medicaid would otherwise pay.

### 2. Is state licensure ever Federally required for providers of particular Medicaid Services?

Yes. Licensure is a Federal condition of participation for the services of physicians, dentists, and certain other practitioners such as psychologists, social workers, and nurses. Where they exist, state licensure requirements also apply to physical therapists. Otherwise, ancillary therapists are only Federally required to meet standards concerning education and professional certification.

### 3. May schools qualify as Medicaid providers and bill for health-related services?

Yes. Schools may be certified as Medicaid providers if they meet the state's provider qualifications (see Questions E.1 and E.2 above) for the appropriate covered service. Depending on the state, schools may qualify as rehabilitative service providers. They may also qualify, on the basis of their salaried and consultant practitioner staff, as providers of ancillary therapist, psychologist, social worker, and certain other practitioner services. Billing by schools or other facilities for the services of individual practitioners is permitted as long as it is a condition of employment or a service contract.

Federal Medicaid law otherwise requires that only providers who directly furnish Medicaid services may bill the Medicaid program. On a voluntary basis, direct providers may allow schools to bill for them. Medicaid providers, including schools, may elect to use a third party as a billing agent to prepare and submit Medicaid claims. Billing agents may charge providers a reasonable fee for their services if the amount is unrelated to the amount of Medicaid revenues collected, but they may not advance providers funds prior to the payment of Medicaid claims.

### 4. What are examples of provider qualifications that have been Federally approved for health-related services?

It is common and acceptable practice for states to establish Medicaid provider qualifications that reference the standards of applicable licensing agencies or boards. For certain types of services, though, particularly those not traditionally recognized by state licensure laws, Medicaid agencies generally develop their own provider standards and certification procedures. In many states, Medicaid plan amendments specifying provider qualifications for health-related services already have been approved by HCFA. These qualifications have addressed criteria such as education, training, experience and, depending on the service, supervisory capacity and participation in referral agreements.

### 5. What is the financial liability of Medicaid providers in cases where reimbursement is subsequently disallowed by HCFA?

HCFA's relationship is with the state Medicaid agency. In cases where HCFA disallows Federal funds for an already reimbursed service, it is the state Medicaid agency's decision whether to require that some or all of the Medicaid payment be returned by the provider.

## F. Medicaid Reimbursement Rates and Claims Submission

### 1. What are the Federal requirements governing Medicaid payments to providers?

Under Medicaid law, states have considerable freedom in developing their own methods and standards for Medicaid reimbursement rates. Only three general Federal requirements apply to all types of services. First, "methods and procedures" for making payments must be such as to assure that payments will be "consistent with efficiency, economy, and quality of

care." Second, payment rates must be sufficient to attract enough providers so that covered services will be as available to Medicaid recipients to the same extent as to the general population in the geographic area. Third, Medicaid providers must accept the amount reimbursed by Medicaid as payment in full.

A few other Federal rules apply to specific types of providers, but they are less likely to be relevant to health-related services. For example, payment for services furnished by organized health providers (such as clinics) must not exceed the amount that would have been paid for comparable services in comparable settings if provided to a Medicare beneficiary. Most Part B health-related services, however, are rarely comparable to services provided to a Medicare beneficiary.<sup>13</sup> Also, payment for ambulatory services provided by Federally qualified health centers (including community health centers and migrant health centers) must equal 100 percent of reasonable costs. This provision would be relevant in situations where a Federally qualified health center is rendering Part B services for the local education agency.

Importantly, states are permitted to establish separate classes of providers and pay them differentially. Publicly operated health care facilities and state-employed individual practitioners, for example, could be a class of providers paid by Medicaid at or near their full costs (provided that costs do not violate the guidelines and rules described above).<sup>14</sup> Facilities and practitioners that receive state funds (other than Medicaid) could be another class of providers. At the same time, other private agencies and practitioners could be a class of providers reimbursed through existing methodologies in the state, such as a percentage of their usual and customary charges.

### 2. What methods can states use to determine Medicaid payment rates for covered services?

With the exception of the requirements described above, there are no specific rules governing how states should develop Medicaid payment rates. State Medicaid agencies thus have established a variety of methodologies for determining reimbursement rates. The methodologies are detailed in their state Medicaid plans and generally vary by type of provider. For individual practitioners, Medicaid payment is usually the provider's actual charge for the service or a maximum payment amount established by the state, whichever is lower. Fixed fee schedules are the most common method for determining maximum payment amounts, although states may use other methods. For organized health providers, such as clinics, state Medicaid agencies generally determine payment rates using either cost-based reimbursement principles or fee schedules. Thus, it is possible in many states for particular classes of organized providers to have their full costs covered by the Medicaid payment, provided that the Federal guidelines described above are met.

### 3. How are Medicaid-covered services billed?

There are no specific Federal requirements establishing standard billing procedures for Medicaid services. Providers may send claims directly to the state Medicaid agency or its designated fiscal agency (i.e., an organization under contract with the Medicaid agency to complete claims processing) for

reimbursement. Claims generally must be submitted on a state standard form and must include pertinent information, such as a valid recipient number and a complete description of the services provided, in order to be processed in a timely manner.

#### 4. Who can bill for reimbursable services?

Any provider who is qualified under a state's Medicaid rules (see Section E) may bill Medicaid for medically necessary covered services provided to Medicaid recipients. Qualified Medicaid providers are usually issued a provider number that identifies them as such and must be included when filing claims.

As discussed earlier, Medicaid providers (including schools) may elect to use a third party as a billing agent to prepare and submit Medicaid claims. Billing agents may charge providers a reasonable fee for their services if the amount is unrelated to the amount of Medicaid revenues collected, but they may not advance providers funds prior to the payment of Medicaid claims.

#### 5. What kinds of records must be maintained by Medicaid providers?

Federal regulations require providers to keep any records necessary to establish the extent of services they provide to individual Medicaid recipients and information regarding payment for services requested by the state Medicaid agency. State Medicaid agencies generally specify a record and billing format that is compatible with their information and payments data systems. In addition, they often require providers to submit uniform cost reports as well as financial and statistical data.

#### 6. Must providers show evidence of billing other liable third parties prior to billing Medicaid?

If a provider is aware of another liable third party, then the provider must bill that third party and show evidence of billing (such as the denial of the claim) to the state Medicaid agency before Medicaid will remit payment. This practice, known as cost-avoidance, is required except if the specific service for which reimbursement is sought meets one of the regulatory exceptions or if the State has obtained a waiver of the cost avoidance requirements. Under these circumstances, the state Medicaid agency is permitted to pay for the service and subsequently seek to recover costs from liable third parties.

Federal regulations allow providers to obtain information on a Medicaid recipient's other insurance through access to the recipient's case file. However, if a provider is unaware of other third-party liability, or has no reason to believe that the services provided will be covered under the recipient's other insurance (as is likely to be the case with several health-related services for children), the provider may proceed to bill Medicaid.

### G. Medicaid State Plans

#### 1. What are the Federal requirements for state Medicaid plans?

To receive Federal matching funds, each state must have an approved state Medicaid plan that includes, among other items, descriptions of eligibility, benefits, reimbursement, and administrative policies. States provide the required information by filling out the HCFA-prepared "state plan pre-print" and furnishing necessary attachments.

Annual state Medicaid plan submissions are not required by HCFA, although state laws frequently dictate that Medicaid plans be prepared and reviewed each year. Similarly, public notice is not Federally required for state plan amendments (except for significant payment methodology changes), but is often mandated by states.

#### 2. How are state Medicaid plans revised?

State Medicaid plans may be revised at any time. Amendment requests are sent to the appropriate HCFA regional office, which has 90 days within which to approve the amendment, reject it, or request additional information. Regional offices have authority to approve or request additional information on plan amendments but do not have the authority to reject a state plan amendment. Only the HCFA Administrator can disapprove an amendment following consultation with the Secretary of DHHS. Moreover, if at the end of the 90-day period HCFA has not responded to the request, the amendment is deemed to be approved. If additional information is requested on a plan amendment, HCFA has a new 90-day period to approve or disapprove the amendments once the additional information is received.

#### 3. Who can submit Medicaid plan amendments?

Only the single state agency responsible for administration of the Medicaid plan can submit Medicaid plan amendments.

### H. Certification Of The State's Share Of Medicaid Program Costs

#### 1. What kinds of funds may be used to provide a state's share of Medicaid program costs?

Federal law provides that both public and private donated funds may be considered as the state's share of Medicaid program costs. There are certain conditions, though, that apply to each source of funds.

Public funds used to claim Federal Financial Participation (FFP) must be funds that are appropriated directly to the state or local Medicaid agency, are transferred to the Medicaid agency from another public agency, or are certified by a contributing public agency as eligible state-match expenditures under the Medicaid program. Public funds may not be Federal funds, such as IDEA funds, that are otherwise provided for the state's use. Nor may they be state funds already obligated as state matching funds for another Federal program.<sup>15</sup>

Privately donated funds used to claim FFP must be funds that are transferred to the state or local Medicaid agency and are under its administrative control. Such funds may revert to a donor's facility only at the discretion of the Medicaid agency and only if the donor is a non-profit organization.<sup>16</sup>

#### 2. What is required for state and local education agencies to certify their contribution?

There are no Federal requirements regarding certification of the state Medicaid match by schools and other contributing public agencies. Federal policies concerning the receipt of FFP pertain only to state Medicaid agencies, which are required to document allowable Medicaid expenditures for broad service categories in the HCFA-prepared "state Medicaid expenditure report" form. States are expected to generate the requisite data

for this report on the basis of their own expenditure reporting systems.

<sup>1</sup> Several states have been subject to court decisions in this area. However, since courts have limited jurisdiction and since Medicaid and education policies differ across states, these decisions may not apply generally to all states. Consequently, we do not discuss these legal cases in the booklet.

<sup>2</sup> This booklet does not address Part H of IDEA, which provides for services to infants and toddlers with disabilities. As with Part B services, Medicaid can be billed for health-related services under Part H. We did not cover Part H Medicaid funding in this booklet, however, because it is subject to fewer complex requirements than Part B and has already been covered in such documents as "The Role of Medicaid and EPSDT in Financing Early Intervention and Preschool Special Education Services" prepared by Fox Health Policy Consultants with funding from the Bureau of Maternal and Child Health, Department of Health and Human Services (DHHS).

<sup>3</sup> In certain instances, some of the services in this list could be furnished for educational or vocational purposes rather than for health purposes. Such services would not be reimbursable by Medicaid. The remainder of this booklet addresses health-related services provided for medical or remedial purposes.

<sup>4</sup> In addition, Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is legally obligated to pay. While Medicaid can be billed for covered health-related services provided to an eligible Medicaid recipient, to the extent that Medicaid copayment or third-party liability rules apply, the state or local education agency (or the third party) would have to bear those costs. Third party liability is discussed in greater detail in Section F.

<sup>5</sup> Shortly before the Medicaid statute was amended, the First Circuit Court of Appeals in the case of *Massachusetts vs. Secretary of HHS*, 816 F.2d 796 (1st Cir. 1987) upheld a Federal District Court decision prohibiting the denial of Federal Medicaid funds for an otherwise covered service solely on the basis that the service was provided pursuant to the state special education law and included in a child's IEP. The Court had held that the Massachusetts Department of Education was not liable as a first-party payer under Medicaid law. It also had held that the inclusion of a service in an IEP did not automatically establish the service as educational, rather than medical, in nature. The Supreme Court affirmed the jurisdiction of the Federal District Court to make such a determination in *Bowen vs. Massachusetts*, 487 U.S. 879 (1988).

<sup>6</sup> There are some exceptions to the usual requirement that state Medicaid agencies refuse to make payment until other liable third parties are billed. Final regulations published January 16, 1990 require states to pay claims first and then seek reimbursement from other liable third parties for several specific services, including preventive pediatric services such as EPSDT and services provided to a child where an absent parent is under court order to provide medical support.

<sup>7</sup> 45 *Federal Register* 86390 (December 30, 1980).

<sup>8</sup> The reader should note that these reimbursable services do *not* include educational and vocational services.

<sup>9</sup> The Federal requirement applies only to services provided to categorically eligible recipients (i.e., those receiving cash assistance and pregnant women and young children). States are permitted to provide more limited coverage of ambulatory services to medically needy recipients.

<sup>10</sup> There are several other categories of eligible children, some of which include a large proportion of children in need of special education. These are primarily adopted children, and children in foster care covered under provisions of Title IV-E of the Social Security Act, and (at the state's option), children with disabilities living at home who otherwise would be eligible for Medicaid only if they were institutionalized.

<sup>11</sup> HCFA uses the term "eligible" to denote individuals who are enrolled in Medicaid. For purposes of clarity, we define eligible individuals as persons who meet Medicaid eligibility criteria regardless of whether they have applied for the program, and we use the term "enrolled" to denote those persons who have completed the application process and have been issued a Medicaid card.

<sup>12</sup> If a family chooses to receive health-related services from providers that are not affiliated with a school, they would be expected to pay any applicable copayments specified by the state Medicaid agency.

<sup>13</sup> For example, occupational therapy may be provided to overcome sensory integration or motor planning deficits among children, but may be used to address problems associated with physical inactivity and inability to perform self-care among the elderly.

<sup>14</sup> Cost principles for state and local government entities are set forth in the U.S. Office of Management and Budget (OMB) Circular A-87.

<sup>15</sup> Public funds may be derived from both general tax revenue and provider-specific tax revenues. However, as specified in an interim final rule (implementing statutory provisions) issued on September 12, 1991 and clarified on October 31, 1991, FFP is not available for that portion of states' payment to facilities for costs attributable to a provider-specific tax. The issue of using provider-specific taxes as the state share of Medicaid program costs has been the subject of controversy.

<sup>16</sup> The issue of using voluntary private contributions to finance a state's share of Medicaid program costs has also been controversial. HCFA's September 12, 1991 interim final rule and the October 31, 1991 clarification require that donations from providers be offset from Medicaid expenditures before calculating the Federal share. Currently, however, there is a Congressionally mandated moratorium on issuing final regulations until January 1, 1992.

an decided in a due process hearing involving the same parties—

- (i) The due process hearing decision binding on that issue; and
  - (ii) The SEA must inform the complainant to that effect.
- (3) A complaint alleging a public agency's failure to implement a due process hearing decision must be solved by the SEA.

Approved by the Office of Management and Budget under control numbers 1820-0030 and 1820-0600)

Authority: 20 U.S.C. 1221e-3)

### 300.153 Filing a complaint.

(a) An organization or individual may file a signed written complaint under the procedures described in §§ 300.151 through 300.152.

(b) The complaint must include—

(1) A statement that a public agency has violated a requirement of Part B of the Act or of this part;

(2) The facts on which the statement is based;

(3) The signature and contact information for the complainant; and

(4) If alleging violations with respect to a specific child—

(i) The name and address of the residence of the child;

(ii) The name of the school the child is attending;

(iii) In the case of a homeless child or youth (within the meaning of section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), available contact information for the child, and the name of the school the child is attending;

(iv) A description of the nature of the problem of the child, including facts relating to the problem; and

(v) A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

(c) The complaint must allege a violation that occurred not more than one year prior to the date that the complaint is received in accordance with § 300.151.

(d) The party filing the complaint must forward a copy of the complaint to the LEA or public agency serving the child at the same time the party files the complaint with the SEA.

(Approved by the Office of Management and Budget under control numbers 1820-0030 and 1820-0600)

(Authority: 20 U.S.C. 1221e-3)

### Methods of Ensuring Services

#### § 300.154 Methods of ensuring services.

(a) *Establishing responsibility for services.* The Chief Executive Officer of a State or designee of that officer must

ensure that an interagency agreement or other mechanism for interagency coordination is in effect between each noneducational public agency described in paragraph (b) of this section and the SEA, in order to ensure that all services described in paragraph (b)(1) of this section that are needed to ensure FAPE are provided, including the provision of these services during the pendency of any dispute under paragraph (a)(3) of this section. The agreement or mechanism must include the following:

(1) An identification of, or a method for defining, the financial responsibility of each agency for providing services described in paragraph (b)(1) of this section to ensure FAPE to children with disabilities. The financial responsibility of each noneducational public agency described in paragraph (b) of this section, including the State Medicaid agency and other public insurers of children with disabilities, must precede the financial responsibility of the LEA (or the State agency responsible for developing the child's IEP).

(2) The conditions, terms, and procedures under which an LEA must be reimbursed by other agencies.

(3) Procedures for resolving interagency disputes (including procedures under which LEAs may initiate proceedings) under the agreement or other mechanism to secure reimbursement from other agencies or otherwise implement the provisions of the agreement or mechanism.

(4) Policies and procedures for agencies to determine and identify the interagency coordination responsibilities of each agency to promote the coordination and timely and appropriate delivery of services described in paragraph (b)(1) of this section.

(b) *Obligation of noneducational public agencies.* (1)(i) If any public agency other than an educational agency is otherwise obligated under Federal or State law, or assigned responsibility under State policy or pursuant to paragraph (a) of this section, to provide or pay for any services that are also considered special education or related services (such as, but not limited to, services described in § 300.5 relating to assistive technology devices, § 300.6 relating to assistive technology services, § 300.34 relating to related services, § 300.41 relating to supplementary aids and services, and § 300.42 relating to transition services) that are necessary for ensuring FAPE to children with disabilities within the State, the public agency must fulfill that obligation or responsibility, either directly or through contract or other arrangement pursuant to paragraph (a) of this section or an

agreement pursuant to paragraph (c) of this section.

(ii) A noneducational public agency described in paragraph (b)(1)(i) of this section may not disqualify an eligible service for Medicaid reimbursement because that service is provided in a school context.

(2) If a public agency other than an educational agency fails to provide or pay for the special education and related services described in paragraph (b)(1) of this section, the LEA (or State agency responsible for developing the child's IEP) must provide or pay for these services to the child in a timely manner. The LEA or State agency is authorized to claim reimbursement for the services from the noneducational public agency that failed to provide or pay for these services and that agency must reimburse the LEA or State agency in accordance with the terms of the interagency agreement or other mechanism described in paragraph (a) of this section.

(c) *Special rule.* The requirements of paragraph (a) of this section may be met through—

(1) State statute or regulation;

(2) Signed agreements between respective agency officials that clearly identify the responsibilities of each agency relating to the provision of services; or

(3) Other appropriate written methods as determined by the Chief Executive Officer of the State or designee of that officer and approved by the Secretary.

(d) *Children with disabilities who are covered by public benefits or insurance.*

(1) A public agency may use the Medicaid or other public benefits or insurance programs in which a child participates to provide or pay for services required under this part, as permitted under the public benefits or insurance program, except as provided in paragraph (d)(2) of this section.

(2) With regard to services required to provide FAPE to an eligible child under this part, the public agency—

(i) May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE under Part B of the Act;

(ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parents otherwise would be required to pay;

(iii) May not use a child's benefits under a public benefits or insurance program if that use would—



(A) Decrease available lifetime coverage or any other insured benefit;

(B) Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;

(C) Increase premiums or lead to the discontinuation of benefits or insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures; and

(iv)(A) Must obtain parental consent, consistent with § 300.9, each time that access to public benefits or insurance is sought; and

(B) Notify parents that the parents' refusal to allow access to their public benefits or insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(e) *Children with disabilities who are covered by private insurance.* (1) With regard to services required to provide FAPE to an eligible child under this part, a public agency may access the parents' private insurance proceeds only if the parents provide consent consistent with § 300.9.

(2) Each time the public agency proposes to access the parents' private insurance proceeds, the agency must—

(i) Obtain parental consent in accordance with paragraph (e)(1) of this section; and

(ii) Inform the parents that their refusal to permit the 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.

(f) *Use of Part B funds.* (1) If a public agency is unable to obtain parental consent to use the parents' private insurance, or public benefits or insurance when the parents would incur a cost for a specified service required under this part, to ensure FAPE the public agency may use its Part B funds to pay for the service.

(2) To avoid financial cost to parents who otherwise would consent to use private insurance, or public benefits or insurance if the parents would incur a cost, the public agency may use its Part B funds to pay the cost that the parents otherwise would have to pay to use the parents' benefits or insurance (e.g., the deductible or co-pay amounts).

(g) *Proceeds from public benefits or insurance or private insurance.* (1) Proceeds from public benefits or insurance or private insurance will not

be treated as program income for purposes of 34 CFR 80.25.

(2) If a public agency spends reimbursements from Federal funds (e.g., Medicaid) for services under this part, those funds will not be considered "State or local" funds for purposes of the maintenance of effort provisions in §§ 300.163 and 300.203.

(h) *Construction.* Nothing in this part should be construed to alter the requirements imposed on a State Medicaid agency, or any other agency administering a public benefits or insurance program by Federal statute, regulations or policy under title XIX, or title XXI of the Social Security Act, 42 U.S.C. 1396 through 1396v and 42 U.S.C. 1397aa through 1397jj, or any other public benefits or insurance program.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(12) and (e))

#### Additional Eligibility Requirements

##### § 300.155 Hearings relating to LEA eligibility.

The SEA must not make any final determination that an LEA is not eligible for assistance under Part B of the Act without first giving the LEA reasonable notice and an opportunity for a hearing under 34 CFR 76.401(d).

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(13))

##### § 300.156 Personnel qualifications.

(a) *General.* The SEA must establish and maintain qualifications to ensure that personnel necessary to carry out the purposes of this part are appropriately and adequately prepared and trained, including that those personnel have the content knowledge and skills to serve children with disabilities.

(b) *Related services personnel and paraprofessionals.* The qualifications under paragraph (a) of this section must include qualifications for related services personnel and paraprofessionals that—

(1) Are consistent with any State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services; and

(2) Ensure that related services personnel who deliver services in their discipline or profession—

(i) Meet the requirements of paragraph (b)(1) of this section; and

(ii) Have not had certification or licensure requirements waived on an

emergency, temporary, or provisional basis; and

(iii) Allow paraprofessionals and assistants who are appropriately trained and supervised, in accordance with State law, regulation, or written policy in meeting the requirements of this part to be used to assist in the provision of special education and related services under this part to children with disabilities.

(c) *Qualifications for special education teachers.* The qualifications described in paragraph (a) of this section must ensure that each person employed as a public school special education teacher in the State who teaches in an elementary school, middle school, or secondary school is highly qualified as a special education teacher by the deadline established in section 1119(a)(2) of the ESEA.

(d) *Policy.* In implementing this section, a State must adopt a policy that includes a requirement that LEAs in the State take measurable steps to recruit, hire, train, and retain highly qualified personnel to provide special education and related services under this part to children with disabilities.

(e) *Rule of construction.* Notwithstanding any other individual right of action that a parent or student may maintain under this part, nothing in this part shall be construed to create a right of action on behalf of an individual student or a class of students for the failure of a particular SEA or LEA employee to be highly qualified, or to prevent a parent from filing a complaint about staff qualifications with the SEA as provided for under this part.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(14))

##### § 300.157 Performance goals and indicators.

The State must—

(a) Have in effect established goals for the performance of children with disabilities in the State that—

(1) Promote the purposes of this part, as stated in § 300.1;

(2) Are the same as the State's objectives for progress by children in its definition of adequate yearly progress, including the State's objectives for progress by children with disabilities, under section 1111(b)(2)(C) of the ESEA, 20 U.S.C. 6311;

(3) Address graduation rates and dropout rates, as well as such other factors as the State may determine; and

(4) Are consistent, to the extent appropriate, with any other goals and academic standards for children established by the State;