Medicaid in Schools

Medicaid pays for health and related services provided in schools when covered services are provided to Medicaid-enrolled children and adolescents, or when services are provided to a child through his or her individualized education plan (IEP) under the Individuals with Disabilities Education Act (IDEA, P.L. 101-476). As part of the activities necessary to administer the Medicaid state plan, states may also provide Medicaid payments to schools for Medicaid outreach and enrollment activities, as well as other eligible, school-based administrative activities. Medicaid spending on school-based services and Medicaid-related administrative services was estimated to be $4.5 billion in fiscal year (FY) 2016 (Appendix). This issue brief describes coverage of school-based services under Medicaid and how states pay for them.

School-Based Services

Schools are an important setting for providing health services to children with Medicaid coverage for two key reasons. First, schools are a convenient point of access for health and related services because children are in school for many hours a day, for approximately half the days of the year (CMS 1997). Second, IDEA requires public schools to provide all children with disabilities (generally between the ages of 3 to 21) with a free and appropriate public education.[1] This includes both education and related services, such as speech or physical therapy, which support a child's ability to learn. Most of the services provided to children in schools are covered by Medicaid, either under state plan authority or under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.[2] Schools may also receive Medicaid payment for related administrative activities.

To receive Medicaid payment for health and related services, schools, providers in schools, or school-based health centers must meet federal and state requirements for Medicaid providers (42 CFR 455.400-455.470, CMS 1997).

School-based services for children with disabilities

Since 1988, states have been able to draw down federal funds under Medicaid to pay for school-based health and related services required by IDEA, when provided to Medicaid-eligible children with disabilities.[3] Under IDEA, children with disabilities are eligible to receive educational and related services that will help them achieve their educational goals, as documented in each child's IEP, or for infants and toddlers (children under age three), the individualized family service plan (IFSP). These services must be provided in the school, although children may also receive similar services outside the school setting.

The IEP is a written plan developed by the school's IEP team that describes a plan for the child's education.[4] Every IEP is tailored to a child's specific circumstances and needs. Required components of an IEP include:

- an assessment of a child's academic and functional performance level;
- annual educational goals;
- the educational and related services that a school will provide to help a child reach his or her goals;
- any program modifications or accommodations for school personnel to help support the child participate or make progress in their education; and
- a plan to measure a child's progress toward annual goals (34 CFR 300.320).

The IFSP is similar to an IEP but focused on the needs of infants and toddlers. An IFSP team establishes the plan to provide early intervention services to meet the physical, cognitive, communication, social and emotional, and adaptive developmental needs of an infant or toddler with a disability (34 CFR 303.340-330.346). Examples of early intervention services include audiology, occupational therapy, physical therapy, and vision services (34 CFR 303.13).

State Medicaid programs may cover services included in a child's IEP or IFSP as long as (1) the services are listed in Section 1905(a) of the Social Security Act and are medically necessary; (2) all federal and state regulations are followed, including those specifying provider qualifications; and (3) the services are included in the state plan or available under EPSDT. Covered services may include, but are not limited to, physical therapy, occupational therapy, speech pathology or therapy services, psychological counseling, nursing, and eligible transportation services. Coverage of school-based services, including categories of service (e.g., speech, language and audiology services, or behavioral health services) and specific types of services (e.g., screening services or individual treatment) varies by state (Baller and Barry 2016). For example, most states and the District of Columbia include occupational or physical therapy in their coverage of school-based services. However, while most states cover evaluation and individual treatment services, fewer cover screening or group treatment (Baller and Barry 2016).

State Medicaid programs can also provide payment for evaluations to determine health-related needs for the purpose of an IEP or IFSP, if the assessment is conducted by a qualified Medicaid provider. Health-related services covered under an IEP or IFSP are subject to the state requirements on amount, duration, and scope; comparability; medically necessity; and prior authorization (CMS 1997). Medicaid is the primary payer for these services (§ 1903(c) of the Social Security Act, CMS 2014).

In fiscal year 2016, Medicaid spending on school-based services was estimated to be $3.3 billion (Appendix). While Medicaid spending for services provided in schools is a small proportion of overall program expenditures (about 0.5 percent in FY 2016), it provides a significant amount of funding for school-based services for children with disabilities.[5] Federal funding for IDEA was $13 billion in FY 2017 (OMB 2016). However, Medicaid is not a guaranteed source of funds for school-based services for children with disabilities and states and local education agencies are not required to participate in Medicaid, nor are they automatically eligible to receive Medicaid payment for Medicaid-covered services provided to Medicaid-eligible children. Under IDEA, local education agencies are required to provide necessary services identified in an IEP whether or not Medicaid funding is available.

Services provided by school-based health centers

School-based health centers (SBHCs) provide a variety of health services beyond the first aid treatment provided by a school nurse; such services may include preventive care (e.g., immunizations), oral health care, behavioral health care, and diagnostic care such as routine screenings (HRSA 2017). They also may provide acute care services, such as treatment for asthma (HRSA 2017). Some school systems directly employ health professionals to provide these services. Other schools, often in partnership with community organizations, community health centers, hospitals, or local health departments, have established school-based health centers to provide health care services to students (HRSA 2017, SBHA 2017).[6] According to the 2013–2014 National School-Based Health Care Census, about 88 percent of the 2,315 school-based health centers in the United States have such an affiliation (SBHA 2017). The remainder are operated by local school systems (SBHA 2017).

SBHCs can receive Medicaid payment for state plan services provided to Medicaid-enrolled children, if the health center is enrolled as a Medicaid provider. In fee-for-service delivery systems, state Medicaid agencies provide SBHCs payment for services. In managed care delivery systems, SBHCs can contract with managed care organizations to be included in their provider networks. In 2013–2014, about 89 percent of school-based health centers billed state Medicaid agencies and about 78 percent billed Medicaid managed care organizations (SBHA 2017).

Administrative services

Schools also can receive Medicaid funding for qualifying school-based administrative activities that are considered necessary for the proper and efficient administration of the Medicaid state plan (CMS 2003). School-based administrative activities generally fall into two categories: outreach and enrollment, and efforts that support the provision of Medicaid-eligible services. Schools can receive federal matching funds for outreach to potentially eligible children and families and for making enrollment determinations, if this function has been delegated to the schools by the state Medicaid agency. Schools also can draw down federal funds for activities that can facilitate children's access to care, including care coordination, referrals, and transportation to and from school on a day a child receives a Medicaid-covered service. For example, some school staff coordinate care for children between the school and other public agencies (such as a state disability services agency) or health care provider. If a child's IEP includes transportation to and from Medicaid-eligible services, then the school is required to provide it and related costs can be claimed as administration or medical assistance. In FY 2016, estimated spending for Medicaid administrative services was $1.2 billion (Appendix).

Limitations on Medicaid payment for services provided in schools

Medicaid third-party liability rules apply to schools billing Medicaid for coverable health services and associated administrative costs (CMS 1997). That is, Medicaid will not pay for Medicaid coverable services provided to Medicaid enrollees if another third party (e.g., another health insurer or other federal or state program) is legally liable and responsible for providing and paying for the services. Schools, however, are not considered liable third parties for the purpose of federal Medicaid payment (CMS 2014). For services provided under IDEA, Medicaid is the primary payer (CMS 2014).

Until 2014, the free care policy, sometimes referred to as the free care rule, precluded Medicaid from paying for the costs of Medicaid-coverable services and activities that were generally available to all students without charge, and for which no other sources for payment were pursued (CMS 2014). For example, schools that provided free health screenings to all students could not seek payment for the screenings for children with Medicaid coverage. The free care policy included an exception for services provided to children as part of their IEP or IFSP. In December 2014, the Centers for Medicare & Medicaid Services (CMS) revised this policy to permit Medicaid payment for covered services to Medicaid beneficiaries under the approved state plan, regardless of whether there is any charge for the service to the beneficiary or the community at large (CMS 2014). As a result, federal financial participation (FFP) is available for Medicaid payments for care provided through providers that do not charge individuals for the service, as long as all other Medicaid requirements are met.

Program integrity

In the early- to mid-2000s, the U.S. Government Accountability Office (GAO) and the Health and Human Services Office of Inspector General (OIG) raised concerns about lack of oversight and improper Medicaid billing for school-based services (GAO 2000, OIG 2003). The GAO and OIG found that states had improperly billed Medicaid for school-based health and administrative services and that CMS was not providing proper oversight of states' billing practices. For example, some states lacked sufficient documentation to verify that services had been provided, or were billing for transportation services that were not eligible for Medicaid payment. The GAO also found states' use of contingency-fee consultants to maximize federal revenue for school-based services to be problematic, and policymakers raised concerns that these fees were inconsistent with CMS policy and were an inefficient use of federal Medicaid funds (GAO 2005). In response to these concerns, CMS updated guidance and now provides training for states, and states have updated their Medicaid state plans, policies, provider manuals, and rules accordingly. CMS issued an updated claiming guide for Medicaid school-based administrative activities in 2003 and has continued to provide guidance and training to states (CMS 2003). OIG continues to audit state Medicaid claiming for school-based services periodically and has found some improper claiming by states (OIG 2018, OIG 2017).

Medicaid Financing for School-Based Services

As noted above, FFP is available for both health services and for administrative activities provided by schools. In many states, local education agencies, which are units of local governments, contribute to financing of the non-federal share of Medicaid spending for school-based services provided under IDEA.[7]

Certified public expenditures

Certified public expenditures (CPE) are most commonly used by local education agencies to contribute the non-federal share of Medicaid school-based services and related administrative service expenditures.[8] CPE is a statutorily recognized Medicaid financing approach by which a governmental entity, including a governmental provider (e.g., local education agency), incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (§1903(w)(6) of the Social Security Act, 42 CFR 433.51). The governmental entity certifies that the funds expended are public funds used to support the full cost of

providing the Medicaid-covered service or the administrative activity. Based on this certification, the state is able to claim the federal share of these costs.

CPE-based financing must recognize actual costs incurred. CMS requires providers to use a CMS-approved cost reporting methodology to document the actual cost of providing the services, typically determined through a CMS-approved statistically valid time study, periodic cost reporting, and reconciliation of any interim payments to actual incurred cost. For qualifying school-based administrative activities, the amount of time that school staff members spend on Medicaid-related activities is typically determined based on time studies; local education agencies then certify to the state that the full cost of these activities is spent by the schools on Medicaid services.

Intergovernmental transfers

An intergovernmental transfer (IGT) is a transfer of funds from another governmental entity (e.g., a county or other state agency) to the Medicaid agency before a Medicaid payment is made. When these funds are used as the non-federal share of a Medicaid expenditure, they are eligible for federal matching funds. In some states, a local education agency will submit claims for services provided in schools to the Medicaid agency, which will calculate the non-federal share. The locality then transfers that amount to the state so that federal matching funds can be claimed. The claims then will be paid by the Medicaid agency, with the full amount (federal and non-federal share) paid to the local education agency that provided the service.

Endnotes

[1] A child with a disability is defined as a child who has been evaluated as having autism, deaf-blindness, deafness, developmental delays, or emotional disturbance that adversely affects a child's educational performance, hearing impairment, intellectual disabilities, multiple disabilities, orthopedic impairment, specific learning disability, speech or language impairment, traumatic brain injury, or visual impairment (34 CFR 300.8).

[2] All children under age 21 enrolled in Medicaid through the categorically needy pathway are entitled to the EPSDT benefit, which requires states to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan.

[3] The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) added Section 1903(c) to the Medicaid statute, which allows state Medicaid agencies to pay for services listed in a child's individualized education program (IEP) or individualized family service plan (IFSP) if the child is enrolled in Medicaid.

[4] An IEP team includes the child (when appropriate), the parents of a child, at least one regular education teacher, at least one special education teacher, the child's case manager, a specialist who can interpret testing and evaluation results, and other individuals at the discretion of the child's parents (34 CFR 300.321).

[5] Total federal and state Medicaid spending in FY 2016 was $576 billion (MACPAC 2017).

[6] Under such an arrangement, the clinic staff are employed by the partner organization rather than the school system.

[7] Because schools are public providers of primarily non-medical services, and because, in general, third-party payers other than Medicaid do not cover services provided in the schools, states must demonstrate that rates paid for school-based services are no higher than the actual cost of providing the medical services. A state may pay providers the Medicare rate or

the state plan fee-for-service rate applicable to the services treated as school based services without demonstrating cost (CMS 2018).

[8] A CPE equals 100 percent of a total computable Medicaid expenditure, including the federal and non-federal share of the cost.

References

Baller, J.B., and C. L. Barry. State variation in school-based disability services financed by Medicaid. *Journal of Disability Policy Studies* 27, no. 3: 148-157. http://journals.sagepub.com/doi/abs/10.1177/1044207316637545.

Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2018. E-mail to MACPAC staff, March 21.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2014. Letter from Cindy Mann to state Medicaid directors regarding "Medicaid payment for services provided without charge (free care)". December 15, 2014. Baltimore, MD: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2003. *Medicaid school-based administrative claiming guide*. Baltimore, MD: CMS. https://www.cms.gov/research-statistics-data-and-systems/computer-data-and-systems/medicaidbudgetexpendsystem/downloads/schoolhealthsvcs.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 1997. *Medicaid and school health: A technical assistance guide*. Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/school_based_user_guide.pdf.

Cieslicki, M., Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2017. E-mail to MACPAC staff, April 18, 2017.

Health Resources & Services Administration (HRSA), U.S. Department of Health and Human Services. 2017. School-based health centers. Rockville, MD: HRSA. https://www.hrsa.gov/our-stories/school-health-centers/index.html.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2017. Exhibit 10: Medicaid enrollment and total spending levels and annual growth, FYs 1966 – 2016. Washington, DC: MACPAC. https://www.macpac.gov/publication/medicaid-enrollment-and-total-spending-levels-and-annual-growth/.

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2018. Active work plan items. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000281.asp.

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2017. Appendix A: Related Office of Inspector General reports. In *New Jersey claimed hundreds of millions in unallowable or unsupported Medicaid school-based reimbursement*. Washington, DC: OIG. https://oig.hhs.gov/oas/reports/region2/21501010.pdf.

Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2003. *Medicaid payments for school-based health services, Holyoke, Massachusetts—July 1999 through June 2000*. Washington, DC: OIG. https://oig.hhs.gov/oas/reports/region1/10200004.pdf.

Office of Management and Budget (OMB), Executive Office of the President. 2016. *President's FY 2017 budget request for the U.S. Department of Education*. Washington, DC: OMB. https://www2.ed.gov/about/overview/budget/budget17/17action.pdf.

School Based Health Alliance (SBHA). 2017. *2013–14 Census of school-based health centers: Methodology, key report data details, and acknowledgements*. Washington, DC: SBHA. http://www.sbh4all.org/wp-content/uploads/2015/02/2013-14-Census-Data-and-Methods.pdf

U.S. Government Accountability Office (GAO). 2005. *Medicaid financing: States' use of contingency-fee consultants to maximize federal reimbursements highlights need for improved federal oversight*. Washington, DC: GAO. http://www.gao.gov/products/GAO-05-748.

U.S. Government Accountability Office (GAO). 2000. *Medicaid in schools: Poor oversight and improper payments compromise potential benefit*. Washington, DC: GAO. http://www.gao.gov/products/T-HEHS/OSI-00-87.

Appendix

TABLE 1. Medicaid Spending for School-Based Services and Administration, by State, for Fiscal Year 2016

State	School-based services	School-based administration
Alabama	$0	$38,193,833
Alaska	2,627,452	0
Arizona	77,934,860	8,898,997
Arkansas	36,558,373	40,755,439
California	212,266,364	70,909,250
Colorado	74,268,064	9,121,380
Connecticut	38,486,237	4,563,841
Delaware	6,538,031	0
District of Columbia	83,383,770	0
Florida	9,124,639	259,460,994
Georgia	29,891,999	24,381,491
Hawaii	481,562	0
Idaho	37,126,054	0
Illinois	171,454,993	84,866,020
Indiana	10,613,096	8,402,214
Iowa	104,441,037	0
Kansas	25,878,182	11,967,951
Kentucky	21,007,242	17,238,810
Louisiana	0	0
Maine	43,753,424	0
Maryland	78,444,393	0
Massachusetts	96,096,636	89,630,096
Michigan	235,957,682	16,565,676
Minnesota	90,451,033	13,665,502
Mississippi	3,457,709	9,310,990
Missouri	0	58,713,391
Montana	56,298,664	3,227,939
Nebraska	5,158,748	18,817,697
Nevada	16,748,091	0
Hampshire	52,311,025	0
New Jersey	242,904,181	0
New Mexico	15,503,780	22,270,275
New York	261,796,456	0
North Carolina	74,463,193	31,491,347

TABLE 1. (continued)

North Dakota	$930,685	$0
Ohio	224,592,347	7,599,104
Oklahoma	583,530	0
Oregon	5,275,024	232,397
Pennsylvania	171,933,616	47,662,040
Rhode Island	37,235,812	18,093,906
South Carolina	25,006,945	11,939,479
South Dakota	3,044,990	3,949,835
Tennessee	0	0
Texas	367,589,403	136,568,158
Utah	27,480,388	13,323,938
Vermont	6,998	0
Virginia	49,471,488	14,169,783
Washington	10,401,480	80,146,535
West Virginia	7,913,361	0
Wisconsin	148,716,314	20,960,062
Wyoming	0	0
National total	**$3,295,609,351**	**$1,197,098,370**

Notes: For CMS-64 reporting, states are instructed to report school-based services (see section 1903(c) of the Social Security Act (the Act)) that include medical assistance for covered services (see section 1905(a) of the Act) furnished to a child with a disability because such services are included in the child's individualized educational program (IEP) established pursuant to Part B of the Individuals with Disabilities Education Act, or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan (IFSP). However, some states may report non-IEP or IFSP services (Cieslicki 2017).
Source: CMS-64 financial management report net expenditures, as of June 23, 2017.