Access in Brief: Students with Individualized Education Plans in Medicaid

Medicaid plays a significant role in supporting students with disabilities by financing health and related services delivered in school settings that help children access and benefit from special education. Under federal law, state Medicaid programs may reimburse for covered services provided to Medicaid-enrolled children when those services are medically necessary and included in a child's Individualized Education Program (IEP) or, for infants and toddlers (children under age three), an Individualized Family Service Plan (IFSP). These school-based Medicaid services commonly include speech-language therapy, occupational and physical therapy, behavioral health services, nursing services, and specialized transportation (MACPAC 2024). Together, Medicaid and the State Children's Health Insurance Program (CHIP) cover half of all children with special education plans, which was about 3.4 million kids in 2020 (Williams and Musumeci 2022).

The Individuals with Disabilities Education Act (IDEA) guarantees eligible children with disabilities the right to a free appropriate public education (FAPE) designed to meet their needs (20 U.S.C. § 1412 (a)(12)(A)). Under IDEA, states and local educational agencies (LEAs) must identify and provide the educational and related health services necessary for a child to achieve their educational goals, as documented in the student's IEP or IFSP to support their FAPE. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirement entitles all Medicaid-covered children, under the age of 21, who are enrolled through the categorically needy pathway, coverage of all medically necessary services, including those that improve health and daily functioning (42 U.S.C. § 1396d(r)). Most health-related services provided as part of an IEP or IFSP qualify as Medicaid-covered services. IDEA specifies that Medicaid must be billed for these services before school districts use local or state education funds for them, and that accessing Medicaid reimbursement may not result in cost-sharing for families or a reduction in the amount, duration, or scope of Medicaid services available to the child outside of school (IDEA, P.L. 101-476). To implement these services, all 50 states and the District of Columbia have a school-based services (SBS) program to reimburse LEAs for these Medicaid-covered services. When a child is eligible for services that are both educationally and medically necessary under their IEP or IFSP, federal law requires Medicaid to be the primary payor (34 C.F.R. § 300.154(d); 42 C.F.R. § 433.139).

A subset of students with disabilities is covered by both Medicaid and private insurance. Dual coverage can occur for several reasons. Some children qualify for Medicaid on the basis of disability rather than income, allowing them to retain private coverage through a parent or guardian while also enrolling in Medicaid (MACPAC 2025). In other cases, families may maintain private insurance to access broader provider networks or employer-sponsored benefits, while relying on Medicaid to cover services that private insurance may subject to higher cost-sharing, limit, or exclude, such as certain therapies or long-term services and supports (Validova et al. 2023). Medicaid coordinates benefits with other insurers as a secondary payer to all other payers. This means that if an insurer and Medicaid both provide coverage of a given benefit, the other payer is first responsible for making payment and Medicaid is responsible only for any balance covered under Medicaid payment rules. Medicaid is also responsible for payment of eligible services not covered by other insurers (CMS 2022).

Many children who receive Medicaid school-based services also receive similar services in the community, outside of the school setting. These community-based services focus on overall development and activities of daily living. For example, a school-based occupational therapist might focus on helping a student with physical disabilities transition between classrooms while wearing a backpack or carrying textbooks, and a community-based occupational therapist might work with this student on coordination and balance generally (for example, climbing stairs to access their personal home). Federal and state regulations emphasize that services provided

pursuant to an IEP or IFSP are not duplicative of services furnished in other settings and may not be used as a basis to deny medically necessary care outside of school. IDEA regulations expressly prohibit public agencies or insurers from reducing or denying services available outside the school setting on the grounds that a child is receiving similar services through special education in their school (34 C.F.R. § 300.154(b)(2)). State Medicaid agencies can coordinate with state education agencies, LEAs, and managed care organizations to ensure that Medicaid does not deny services that may be duplicative.

We conducted an analysis to examine how children with special education plans experience the Medicaid system. Using 2022 and 2023 data from the National Survey of Children's Health (NSCH), we examined differences in reported health status, access to care, and use of services between students with IEPs and IFSPs who are covered by Medicaid or CHIP, covered by both Medicaid and private coverage, and those with private coverage. We also stratified the results for Medicaid or CHIP-covered children with IEPs or IFSPS by race and ethnicity. These analyses are descriptive and do not adjust for socioeconomic or other factors that may also be associated with the differences or attempt to establish the reasons for these differences.

In our analysis, we identified differences in population characteristics between students with Medicaid and CHIP and those with other sources of coverage. For example, children covered by Medicaid and CHIP were more likely to receive necessary mental health care services, were less likely to have out-of-pocket costs for treatment, and have adequate current insurance coverage compared to children with both Medicaid and private insurance and children with private insurance only.

Population Characteristics

Below, we compare the characteristics of students (age 0–17) with IEPs or IFSPs who had Medicaid or CHIP coverage to those covered by both Medicaid and private insurance and to those with private insurance only. We examined the differences in demographics and clinical conditions.

Demographics

Overall, of children with IEPs or IFSPs, 37.8 percent had Medicaid and CHIP coverage, 10.5 percent had both Medicaid and private insurance, and 47.6 percent had private insurance only, and there were statistically significant demographic differences between those who were Medicaid-covered and those who were covered by the other insurance types (Table 1). For example, Hispanic children were more likely to be covered by Medicaid and CHIP than Medicaid and private insurance or private insurance only. Additionally, white, non-Hispanic or Asian, non-Hispanic children were more likely to have private coverage than Medicaid or CHIP. There were also differences in family income. A higher proportion of Medicaid and CHIP-covered children had family income less than 100 percent of the federal poverty limit (FPL) compared to children with private insurance and children with both Medicaid and private insurance.

TABLE 1. Demographic and Socioeconomic Characteristics of Children with IEPs or IFSPs Age 0–17 by Insurance Type, CY 2022–2023

Demographic characteristics	Total	Medicaid and CHIP	Medicaid and Private	Private
Total children with IEPs or IFSPs		**37.8%**	**10.5%***	**47.6%***
Age				
0–5	**15.7%**	16.0	18.3	15.2
6–11	**40.8**	40.1	39.9	41.8
12–17	**43.5**	43.9	41.8	43.0
Sex				
Male	**63.5**	62.1	66.3	63.8
Female	**36.5**	37.9	33.7	36.2
Race and ethnicity				
Hispanic	**23.7**	30.8	18.0*	18.8*
White, non-Hispanic	**49.8**	38.0	48.7*	60.9*
Black, non-Hispanic	**15.9**	20.1	23.1	10.1*
Asian, non-Hispanic	**2.0**	0.9	1.8*	3.0*
Other, non-Hispanic	**8.5**	10.1	8.3	7.3*
Family income as percent of FPL				
Less than 100% FPL	**20.9**	40.6	22.2*	4.5*
100–199% FPL	**21.5**	33.9	21.9*	10.9*
200–399% FPL	**29.6**	20.0	33.2*	36.0*
400% FPL or higher	**28.0**	5.5	22.7*	48.6*

Notes: IEP is Individualized Education Plan. IFSP is Individualized Family Service Plan. CY is calendar year. CHIP is the State Children's Health Insurance Program. FPL is federal poverty level.

* Difference from Medicaid and CHIP only is statistically significant at the 0.05 level.

Source: SHADAC, 2025, analysis of 2022–2023 National Survey of Children's Health (NSCH).

Health status and reported conditions

There were differences in reported health status and prevalence of health conditions based on type of insurance coverage (Table 2). The majority of families with children with Medicaid and CHIP reported a favorable health status (69.9 percent reported very good or excellent health status and 23.2 percent reported their health status as good). However, families with private insurance were significantly more likely to report very good or excellent health status for their children (86.1 percent) compared to children with Medicaid and CHIP coverage. Families of those with Medicaid and CHIP coverage were significantly more likely to report fair or poor health status for their children (7.0 percent) compared to children with private insurance (2.4 percent). Families of children covered by Medicaid and CHIP were more likely to report a diagnosis of Autism Spectrum Disorder, developmental delay, epilepsy or seizure disorder, or intellectual disability compared to children with private insurance only. However, compared to children with both Medicaid and private insurance, families of children with Medicaid and CHIP coverage were less likely to report these same medical conditions.

There were also differences in the number of reported conditions by insurance type. Families of children covered by Medicaid and CHIP were less likely to report four or more conditions (i.e., co-occurring medical conditions) than those with both Medicaid and private insurance, but were more likely to report four or more conditions than

those with private coverage. Families of Medicaid and CHIP-covered children were also less likely to report one or two conditions than those with only private coverage.

TABLE 2. Health Status and Selected Reported Conditions of Children with IEPs or IFSPs Age 0–17 by Insurance Type, CY 2022–2023

Health measure	Medicaid and CHIP	Medicaid and Private	Private
Health status			
Very good or excellent	69.9%	67.7%	86.1%*
Good	23.2	25.3	11.4*
Fair or poor	7.0	6.9	2.4*
Reported conditions			
ADD or ADHD	45.8	46.0	41.6
Anxiety problems	31.8	32.6	28.5
Autism Spectrum Disorder	26.6	39.0*	19.9*
Behavioral or conduct problems	44.1	44.1	30.0*
Blindness or problems with seeing	6.4	5.2	2.9*
Brain injury, concussion, head injury	5.1	9.2*	5.5
Cerebral palsy	2.5	4.7	0.5*
Depression	17.4	13.5	11.3*
Developmental delay	47.9	61.6*	36.8*
Down syndrome	0.9	6.1*	1.1
Epilepsy or seizure disorder	4.0	10.2*	2.2*
Intellectual disability	11.8	21.9*	6.4*
Learning disability	57.3	60.0	45.3*
Speech or other language disorder	44.1	55.5*	41.2
Tourette syndrome	0.4	–	0.9*
Number of reported conditions			
No conditions	11.7	7.2*	11.2
1 condition	12.0	9.2	18.2*
2 conditions	12.0	10.2	20.5*
3 conditions	13.1	12.4	15.6
4 or more conditions	51.2	61.0*	34.6*

Notes: IEP is Individualized Education Plan. IFSP is Individualized Family Service Plan. CY is calendar year. CHIP is the State Children's Health Insurance Program. ADD is attention deficit disorder. ADHD is attention deficit hyperactivity disorder.

Reported conditions were selected as common causes for a student having an IEP or IFSP.

* Difference from Medicaid and CHIP only is statistically significant at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: SHADAC, 2025, analysis of 2022–2023 National Survey of Children's Health (NSCH).

Students with IEPs Health Care Access and Utilization

Among students with IEPs or IFSPs, there were barriers to obtaining various types of treatment, mental health treatment in particular, and care coordination based on insurance type.

Adequacy of health insurance coverage

Overall, 85.7 percent of Medicaid and CHIP-covered children had insurance coverage that adequately met their needs (Table 3). This is significantly greater than those covered by both Medicaid and private or only private insurance (66.5 percent and 54.4 percent, respectively). For example, families of children with Medicaid and CHIP were more likely to report that their current health insurance met their child's needs (93.8 percent) compared to those with private insurance (88.5 percent). Families of children with Medicaid and CHIP were also more likely to report reasonable out-of-pocket costs (91.3 percent) than children with private insurance (56.3 percent). A statistically significantly greater percentage of families with Medicaid and CHIP (65.8 percent) reported that their current insurance for mental health or behavioral health services was always adequate compared to families with private insurance (42.4 percent).

TABLE 3. Selected Health Insurance Measures of Children with IEPs or IFSPs Age 0–17 by Insurance Type, CY 2022–2023

Health Insurance Measure	Medicaid and CHIP	Medicaid and private	Private
Current insurance coverage			
Meet child's needs	93.8%	91.4%	88.5%*
Allows children to see needed providers	94.8	93.3	93.0
Current insurance out-of-pocket costs are reasonable	91.3	70.7*	56.3*
Current insurance coverage is adequate[1]	85.7	66.5*	54.4*
Current insurance for mental or behavioral health services[2]			
Always adequate	65.8	57.1	42.4*
Usually adequate	24.7	21.6	33.2*
Sometimes or never adequate	9.6	21.4*	24.5*

Notes: IEP is Individualized Education Plan. IFSP is Individualized Family Service Plan. CY is calendar year. CHIP is the State Children's Health Insurance Program.

[1] The child's current insurance is considered adequate if the benefits usually or always meet the child's needs, the child is usually or always allowed to see needed providers, and there are either no out-of-pocket expenses, or the out-of-pocket expenses were usually or always reasonable.

[2] Estimates of current insurance for mental or behavioral health were only available and reported in the 2022 survey year.

* Difference from Medicaid and CHIP only is statistically significant at the 0.05 level.

Source: SHADAC, 2025, analysis of 2022–2023 National Survey of Children's Health (NSCH).

Obtaining behavioral health care and care coordination

Families of children with Medicaid and CHIP reported different experiences in access to care compared to those with private insurance (Table 4). For example, among those who needed mental health treatment or counseling in the past 12 months, a smaller share of children enrolled in Medicaid and CHIP received this treatment (79.9 percent) compared to those with private insurance (85.2 percent). However, a larger proportion of families of

children with Medicaid and CHIP reported having no difficulties in receiving this treatment (46.5 percent) compared to those with private insurance (39.4 percent).

There were also reported differences with care coordination by insurance type. For example, a smaller share of family members of children with Medicaid and CHIP reported needing extra help coordinating their child's health care in the last 12 months compared to children on both Medicaid and private insurance. Furthermore, Medicaid and CHIP-covered children were less likely to have a provider that communicates with the child's school or special education program compared to children with both Medicaid and private insurance.

Our findings suggest that families with Medicaid and CHIP-covered children spend more time coordinating health care per week, such as making appointments or locating services, compared to children with private insurance. For example, family members of children with Medicaid and CHIP were more likely to report spending 1 to 4 hours a week and over 11 hours a week coordinating care compared to those with privately insured children (35.6 percent compared to 28.7 percent and 9.6 percent compared to 3.3 percent, respectively). Further, family members of Medicaid and CHIP-covered children were less likely to report that the child did not need weekly health care coordination compared to privately insured children (66.5 percent compared to 71.3 percent).

TABLE 4. Selected Access Measures for Children with IEPs or IFSPs Age 0–17 by Insurance Type, CY 2022–2023

Access measures	Medicaid and CHIP	Medicaid and Private	Private
Mental health service use in the past 12 months[1]			
Received needed mental health treatment or counseling	79.9%	82.8%	85.2%*
Difficulties obtaining needed mental health treatment or counseling[2]			
No difficulties	46.5	39.0	39.4*
Somewhat difficult	29.1	34.8	33.6
Very difficult or not possible to obtain care	24.4	26.2	26.9
Difficulties obtaining needed specialist care[3]			
No difficulties	61.4	60.5	59.9
Somewhat difficult	24.1	29.7	28.9
Very difficult or not possible to obtain care	14.5	9.8	11.1
Care Coordination			
Received needed care coordination[4]	53.5	50.2	55.9
Family needed extra help coordinating child's health care in last 12 months	22.7	32.5*	21.5
Child receives effective care coordination	36.6	41.3	39.7
Provider communicates with child's school or special education program	29.9	40.2*	25.4*
Time spent coordinating health care			
Child does not need health care coordination on a weekly basis	66.5	50.8*	71.3*
Less than 1 hour per week	47.2	43.0	63.3*
1–4 hours per week	35.6	41.3	28.7*
5–10 hours per week	7.7	5.4	4.7
11 hours or more per week	9.6	10.4	3.3*

Notes: IEP is Individualized Education Plan. IFSP is Individualized Family Service Plan. CY is calendar year. CHIP is the State Children's Health Insurance Program.

[1] Denominator is children with special education plans who needed mental health services in the past 12 months.

[2] Denominator is children with special education plans who needed or received mental health treatment or counseling.

[3] Denominator is children with special education plans who needed or attended a specialist visit.

[4] Denominator is children with special education plans who needed care coordination.

* Difference from Medicaid and CHIP only is statistically significant at the 0.05 level.

Source: SHADAC, 2025, analysis of 2022–2023 National Survey of Children's Health (NSCH).

Health care utilization

There were reported differences with cost of care between those who were Medicaid or CHIP-covered compared to those with other insurance types (Table 5). For example, families of children with Medicaid and CHIP reported significantly lower out-of-pocket costs compared to those with Medicaid and private coverage and those with private coverage.

TABLE 5. Selected Health Care Utilization Measures for Children with IEPs or IFSPs Age 0–17 by Insurance Type, CY 2022–2023

Utilization measures	Medicaid and CHIP	Medicaid and Private	Private
Unmet need in the past 12 months			
Needed, but did not receive care	9.1%	12.5%	7.0%
Reasons for not receiving needed services[1]			
Not eligible	18.6	31.0	14.3
Not available in area	45.7	38.1	36.7
Problems getting an appointment	71.4	68.5	67.2
Transportation or child care problems	16.4	–	12.8
Office wasn't open when care needed	13.3	–	14.1
Issues related to cost	34.3	37.3	45.7
Cost in the past 12 months			
Problems paying for any of child's medical or health care bills	24.5	30.7	20.6
Out-of-pocket health care costs in the past 12 months			
$0	79.3	35.1*	6.7*
$1–$249	12.5	20.5*	19.5*
$250–$499	3.7	13.0*	19.2*
$500–$999	2.7	12.0*	18.2*
$1,000–$5,000	1.5	14.4*	27.6*
More than $5,000	–	5.0*	8.9*

Notes: IEP is Individualized Education Plan. IFSP is Individualized Family Service Plan. CY is calendar year. CHIP is the State Children's Health Insurance Program.

[1] Denominator is children with special education plans who needed but did not receive needed services.

* Difference from Medicaid and CHIP only is statistically significant at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: SHADAC, 2025, analysis of 2022–2023 National Survey of Children's Health (NSCH).

Access and utilization among Medicaid-covered students, by race and ethnicity

We estimated access and utilization among Medicaid and CHIP-covered children with IEPs and IFSPs by racial and ethnic groups (Table 6). There were differences in access and utilization in obtaining health care services, including mental health care and counseling, across racial and ethnic groups. For example, of those in need of mental health treatment and counseling, a smaller share of Asian non-Hispanic children (50.2 percent) received treatment compared to their white non-Hispanic counterparts (79.2 percent). In contrast, other, non-Hispanic children were more likely (92.5 percent) than white non-Hispanic children to receive necessary mental health treatment and counseling (79.2 percent). While Black, non-Hispanic families of Medicaid and CHIP-covered children were more likely (77.0 percent) to report no difficulties obtaining needed specialist care compared to white, non-Hispanic children (62.2 percent), other, families of non-Hispanic children were less likely to report no difficulties (46.2 percent).

There were also reported differences with care coordination across racial and ethnic groups. White, non-Hispanic children were more likely to receive needed and effective care coordination compared to Asian non-Hispanic and Hispanic children. Asian, non-Hispanic (39.3 percent) were more likely to need extra help coordinating their child's health care in the last 12 months compared to white, non-Hispanic children (20.1 percent). Hispanic children were less likely (22.5 percent) to have providers who communicated regularly with the child's school or special education program compared to their white counterparts (35.4 percent).

TABLE 6. Selected Access and Utilization Measures for Medicaid and CHIP-covered Children with IEPs or IFSPs Age 0–17 by Race and Ethnicity, CY 2022–2023

Access and utilization measures	Total	White, non-Hispanic	Black, non-Hispanic	Asian non-Hispanic	Hispanic	Other, non-Hispanic
Total (Medicaid-covered children with IEP/IFSP)	**37.8%**	**28.7%**	**48.3%***	**17.8%***	**49.5%***	**44.5%***
Unmet need in the past 12 months						
Needed, but did not receive care	**9.1**	9.9	7.2	–	9.3	8.4
Mental health service use in the past 12 months[1]						
Received needed mental health treatment or counseling	**79.9**	79.2	74.6	50.2*	80.3	92.5*
Difficulties obtaining needed mental health treatment or counseling[2]						
No difficulties	**46.5**	41.1	51.3	–	49.6	48.3
Somewhat difficult	**29.1**	35.6	27.4	–	25.0	21.9*
Very difficult or not possible to obtain care	**24.4**	23.4	21.3	38.3	25.4	29.8
Difficulties obtaining needed specialist care[3]						
No difficulties	**61.4**	62.2	77.0*	44.3	56.8	46.2*
Somewhat difficult	**24.1**	23.1	–	–	28.1	36.4
Very difficult or not possible to obtain care	**14.5**	14.7	–	–	15.1	17.4

Access and utilization measures	Total	White, non-Hispanic	Black, non-Hispanic	Asian non-Hispanic	Hispanic	Other, non-Hispanic
Care Coordination						
Received needed care coordination[4]	**53.5**	58.1	56.0	36.8*	44.5*	56.2
Family needed extra help coordinating child's health care in last 12 months	**22.7**	20.1	24.2	39.3*	24.3	23.8
Child receives effective care coordination	**36.6**	42.6	36.8	25.3*	27.6*	42.1
Provider communicates with child's school or special education program	**29.9**	35.4	29.2	39.9	22.5*	30.7

Notes: CHIP is the State Children's Health Insurance Program. IEP is Individualized Education Plan. IFSP is Individualized Family Service Plan. CY is calendar year. Families who report their child's race as American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or multi-race are grouped as "Other, non-Hispanic".

[1] Denominator is Medicaid and CHIP-covered children with special education plans who needed mental health services in the past 12 months.

[2] Denominator is Medicaid and CHIP-covered children with special education plans who needed or received mental health treatment or counseling.

[3] Denominator is Medicaid and CHIP-covered children with special education plans who needed or attended a specialist visit.

[4] Denominator is Medicaid and CHIP-covered children with special education plans who needed care coordination.

* Difference from white, non-Hispanic children is statistically significant at the 0.05 level.

– Estimate not reported due to too small of a sample size or is unreliable because it has a relative standard error greater than or equal to 30 percent.

Source: SHADAC, 2025, analysis of 2022–2023 National Survey of Children's Health (NSCH).

Data and Methods

Data for this report are from the 2022 and 2023 National Survey on Children's Health. The Maternal and Child Health Bureau (MCHB) of the Health Resources & Services Administration in the U.S. Department of Health and Human Services funds and directs the NSCH. Respondents are the parents or guardians of randomly selected children from all 50 states and the District of Columbia. The survey provides national and state-level estimates on measures related to the health of children ages 0–17. For more information on the NSCH, see https://mchb.hrsa.gov/data/national-surveys.

The analysis identified whether a child had a special education plan or early intervention plan (IEP or IFSP). Families were asked whether their child has ever had an IEP or IFSP. If respondents answered yes, they were asked whether the child is currently receiving services under one of these plans. For this analysis, special emphasis is placed on factors related to the well-being of children. These factors include access to and quality of health care, as well as school and after-school experiences.

Insurance coverage

Our analyses used the constructed insurance variable, which is based on self-reported information, in the NSCH codebook (CAHMI 2025). Medicaid coverage was defined as those reporting having “Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability.” Private insurance coverage was defined as insurance provided through an employer or purchased directly from an insurance company; or TRICARE or other military health care. Private health insurance coverage excludes plans that pay for only one type of service, such as accidents or dental care. Medicaid or CHIP, with no private insurance, is defined as Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability. Medicaid and CHIP also include persons covered by other state-sponsored health plans. For children, Medicaid and CHIP coverage is combined, as analysis has shown that respondents cannot accurately distinguish between the two sources of coverage.

Race and ethnicity

Survey respondents self-identify their race and ethnicity. Race is defined as follows: white-only, non-Hispanic; Black-only, non-Hispanic; Asian-only, non-Hispanic; other, non-Hispanic. Families are grouped as “Other, non-Hispanic” if they report their child’s race as American Indian or Alaska Native; Native Hawaiian or Pacific Islander; or multi-race. U.S. Census Bureau does not recommend using national population estimates for any other race categories. Individuals of Hispanic origin can be of any race.

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