

**MEDICAID BILLINGS FOR IDEA SERVICES  
ANALYSIS AND POLICY IMPLICATIONS OF SITE VISIT RESULTS**

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## I. INTRODUCTION

States receive the bulk of federal funding for special education services through the Individuals with Disabilities Education Act (IDEA), formerly known as the Education for All Handicapped Children Act of 1975 (P.L. 94-142). The Act was intended to achieve four objectives (U.S. Department of Education, 1994):

- Assure a free appropriate public education for all children and youth with disabilities.
- Assure the rights of children and youth with disabilities are protected.
- Help states and localities provide for early intervention and education services for children with disabilities.
- Assess and assure the effectiveness of these efforts.

The IDEA legislation authorized several federal grant programs to states to help them meet these objectives. The principal granting program under IDEA is Part B, which provides funding for elementary and secondary education services for children ages five through 21, as well as pre-school grants for children ages three to five. In addition, states are required to utilize all other existing federal, state and local funds available for the education of "handicapped children", without diminishing their existing financial commitments to special education (P.L. 94-142). When the legislation was passed in 1975, the federal government was authorized to provide 40 percent of the average per-child costs for special education by 1982 (U.S. Department of Education, 1994).

During Fiscal Year 1993, the federal government provided \$2.053 billion to the states to help finance services authorized under Part B of IDEA (U.S. Department of Education, 1994). Federal per-child special education expenditures averaged \$411, or 8.3 percent of average Part B expenditures for each of the 4.9 million children who received Part B services that year. These resources fell far short of the cost to states of the federal entitlement for special education.

Although the federal resources available for special education services have not reached the maximum authorized Congressional commitment, the population receiving special education services has increased by 40 percent since 1976 (U.S. Department of Education, 1994). With limited federal funding for education and growth in eligible populations, states have been under pressure to seek out sources of special education financing beyond state and local tax bases; one such source is Medicaid. An amendment to IDEA, included in the Medicare Catastrophic Coverage Act of 1988, clarified that Medicaid funds could be used to pay for health-related services provided under IDEA. For health-related services provided under IDEA to be reimbursed by Medicaid, they must be: 1) provided by a participating Medicaid provider, 2) medically necessary, 3) included in the state's Medicaid plan, 4) provided to an individual eligible for Medicaid and 5) screened for any other third party payment that may be available for reimbursement.

Since 1988, states have been accessing Medicaid to help pay for health-related special education services. In this report, we present the findings of a study sponsored by the Office of the Assistant Secretary for Planning and Evaluation in the U.S. Department of Health and Human Services, undertaken to understand more about the nature and extent of State practices with respect to billing Medicaid for health-related services provided under IDEA. Specific aspects we investigated include:

- Eligible populations
- Services provided
- Financing and billing
- Related policy issues
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To complete the study we conducted site visits to Illinois, Louisiana, Massachusetts and Oklahoma. These states were selected because they represent a range of approaches states use to bill Medicaid for IDEA services. In addition, at the time they were selected, these states had the potential of supplying us with data about children living in the states who were receiving health-related services under IDEA , and the health services they received.

During our site visits, we interviewed key stakeholders in each state, including staff from the state Medicaid agency, state education agency, at least one local education authority (LEA), as well as others as

appropriate in each individual state. We asked informants questions using a semi-structured interview protocol, and we also collected documents to supplement the information we obtained in our interviews. We used our interview results and other documents to write case studies, one for each state, about Medicaid billings for IDEA services; the case studies are included with this document as appendices. In this report, we summarize our site visit findings and discuss the policy issues that arose from our analysis.

## **II. RESULTS FROM THE SAMPLE STATES**

### **A. Overview**

All four states that we selected for site visits have been billing Medicaid for health-related services under IDEA for several years. Louisiana began to bill Medicaid for health-related special education services in 1988, earlier than any of the other case study states. Nearly all of the school districts in that state (95 percent) currently participate in this initiative. Oklahoma began to bill Medicaid for IDEA services in 1990, while Illinois and Massachusetts allowed LEAs to begin billing Medicaid in 1992. In Oklahoma, only six percent of LEAs currently bill Medicaid for special education services, while 50 percent of the LEAs in Illinois and about 70 percent in Massachusetts bill.

The initiative to bill Medicaid for IDEA services originated with different parties in each of the states. In Illinois, the State Board of Education entered into a collaborative agreement with the Department of Public Assistance in order to develop a plan for billing Medicaid for IDEA services. In Louisiana, the Department of Health and Hospitals took on primary responsibility for billing, creating a provider billing manual and linking Medicaid billing for IDEA services to EPSDT screens. The Louisiana Office of Special Education Services has not formally collaborated with Medicaid. However, the office recently appointed a liaison to Medicaid in order to promote communication between the agencies. In Massachusetts, a university-based Institute provides routine consultation to state policymakers about how to maximize federal revenues. This Institute advised Massachusetts policymakers that federal Medicaid revenue could be obtained by billing for health-related services under IDEA. The Massachusetts Medicaid agency created a new Medicaid provider type, Municipal Medicaid Providers, to facilitate billing for IDEA services. Finally, the Oklahoma legislature established an Interagency Coordinating Council and charged the Council with identifying ways to improve service collaboration for children in the state while lowering direct state costs,

and increasing federal revenue to the state. The initiative to bill Medicaid for IDEA services originated in this group.

Each state developed its own method for LEAs to use to bill Medicaid and receive reimbursement for IDEA services. Illinois LEAs billing Medicaid for health-related services under IDEA are reimbursed according to a fee schedule. The state share for Medicaid reimbursement is drawn from the LEAs, and the federal matching payments are returned to the LEA for use only to supplement special education programs.

In Louisiana, too, LEAs are reimbursed according to a fee schedule, although the state share comes from the state Medicaid budget. After receiving federal matching payment, the state deposits Medicaid reimbursement directly to a health services fund in each of the participating parishes. Massachusetts schools bill Medicaid using a composite per-diem rate for children in each of several "prototype" categories that reflect various special education service modalities. The state share comes from the LEA budget, and the federal matching funds are returned to the town general fund without restrictions on their use. Finally, Oklahoma LEAs bill using a fee schedule, but schools may not bill for health-related services provided under IDEA until the child has had an EPSDT screen. The dollars for the state share are drawn from the LEA budget and the federal revenues are returned to the local school budget with the requirement that they will be used for health services.

As this overview suggests, the methods used to bill Medicaid for IDEA services vary from state to state. More specific details about each of the state programs we investigated are provided in the sections that follow, including a description of the populations served, the services provided and methods of financing special education services in each state.

## **B. Eligible Populations**

On average, about 10.3 percent of school-aged children in the U.S. receive special education services. (Brown, 1995). In the states we visited, the percentage of children receiving special education services ranges from about six percent in Louisiana to about 17 percent in Massachusetts, with Oklahoma and Illinois serving 11 and eight percent respectively. In this section of the analysis, we will provide information about how Medicaid-eligible children are identified for billing purposes in each state, and some of the issues associated with identifying these children.

In Illinois, about 260,469 children received special education services in 1994 because they exhibited one or more "exceptional characteristics" that "interfere with the student's education." About 12,000 of these children also received a Medicaid-reimbursed IDEA-related service in 1994. In order to bill Medicaid for IDEA services, an Illinois LEA must be able to identify a child as being Medicaid-eligible and also notify parents that the LEA may release certain information about the child to the Illinois Department of Public Assistance. One method for identifying children who are eligible for both Medicaid and special education would be to run a computer match of names using state special education and Medicaid recipient files. However, Illinois state officials have interpreted the federal Student Privacy Act as prohibiting this match in order to protect the confidentiality of children who receive special education services. Since the computer match has not been implemented in Illinois, school districts typically identify children as being Medicaid-eligible during the process of creating special education service plans called Individualized Education Programs (IEP). Because parents must sign the IEP to indicate their approval, school officials typically ask parents during IEP development for the child's Medicaid number and permission to bill Medicaid. Schools may also use the roster of children who receive free and reduced cost lunches to identify children who are likely to be eligible for Medicaid. Illinois interviewees suggested that this process of identifying children and obtaining parental consent is administratively cumbersome, and is thus a barrier to seeking Medicaid payment for health-related services under IDEA.

About 74,000 children in Louisiana receive special education services through Part B of IDEA, although state officials were unable to provide us with information about how many of these children are eligible for Medicaid. This state has taken another approach to identifying those children receiving special education services who are also Medicaid-eligible. In Louisiana, the Department of Health and Hospitals provides the school system with computer tapes with the identification numbers of children who are Medicaid recipients. The schools can then match this tape with its own computer files containing information about special education eligibility. Interviewees reported that this method does not violate student privacy regulations because special education eligibility information is not provided to health care providers directly.

Massachusetts uses a system like Illinois's to identify children who are eligible for both Medicaid and special education services. About 130,030 Massachusetts children receive special education services, based on their inability to function at an age-appropriate level; about 15 percent of these children are also

Medicaid recipients. Interviewees explained that confidentiality concerns related to the Student Privacy Act prevented Massachusetts officials from running computer eligibility matches between the state Department of Education and the Medicaid agency. As a result, children who are eligible for Medicaid are identified during the process of completing each child's IEP. Parents are asked to sign a consent form during that process, giving the LEAs permission to bill Medicaid for IDEA services. Department of Education staff have asked for a federal opinion on whether the Student Privacy Act prevents state departments from sharing eligibility information in order to identify IDEA and Medicaid-eligible children.

Finally, Oklahoma provides Part B special education services to 70,809 children, about one-third of whom are Medicaid recipients. Schools receive enhanced state education funding if they are providing education services to children with special education needs, thus creating an incentive to identify members of this population. Similar to Illinois and Massachusetts, interviewees in Oklahoma raised concerns about confidentiality issues when discussing computerized matches between special education and Medicaid eligibility files. As a result, children are identified as Medicaid-eligible using other methods such as the process of developing the IEP or the roster of children receiving free and reduced cost lunches. In addition, Oklahoma was the only state in which Medicaid required that children receive an EPSDT screen, either through the LEA or from another provider, before LEAs can bill Medicaid for health related services under IDEA. Sometimes children are identified as requiring special education services through the EPSDT screening process. Oklahoma does not require parental consent to bill Medicaid for health-related IDEA services.

Our findings suggest that concerns about student privacy inhibit identification of Medicaid-eligible children who are receiving special education services. Three of the four states we visited identify eligible children using labor intensive processes, often requiring face-to-face contact with family members. Two of the states also require written parental consent to bill Medicaid for health-related IDEA services, which may further limit the population for whom Medicaid can be billed.

### **C. Services**

Medicaid must pay for medically necessary services provided under IDEA if the services are included in the state's Medicaid plan and if the services are delivered by providers that participate in the Medicaid program. In each of the states we visited LEAs bill Medicaid for a core group of health related

services under IDEA, which includes speech therapy, physical therapy and occupational therapy, among others. As might be expected, however, there is some variation among the states in the types of services provided and the ways these services are delivered. In this section, we describe the results we obtained about IDEA health-related services for which Medicaid is billed in each state.

Special education services in Illinois are provided along a continuum of program options, as specified in Illinois Administrative Code. The specified continuum of program options includes at least six modules, varying according to educational setting. LEAs can bill for the following health-related services under IDEA because they are included in the Illinois state Medicaid plan: physician services, nursing, occupational therapy, physical therapy, speech and language therapy, audiology, psychological services, psychiatric services, social work services, medical transportation, and EPSDT services. LEAs can bill Medicaid for a service only if the need for the service has been specified in the child's IEP. Services may be furnished providers employed by or under contract to the LEA.

Louisiana schools are authorized to bill Medicaid for the following health-related IDEA services: physical therapy, occupational therapy, speech therapy, and audiology. Schools can also bill for psychiatric rehabilitation services including psychological evaluation and therapy for a small number of children who have been diagnosed with a severe mental disorder that significantly impairs their social interactions or ability to learn. The schools and the Department of Health and Hospitals have requested federal permission to bill Medicaid for administrative case management services related to IDEA to receive reimbursement for the administrative costs of providing health-related services under IDEA. Although the federal regional office has denied this request, the state has implemented a demonstration using state Medicaid dollars to test the concept of billing for administrative case management services. Stakeholders in Louisiana suggested that the amounts LEAs could bill for administrative case management services related to IDEA may exceed the total amount currently billed for direct services.

Service delivery arrangements in Louisiana vary by type of service and LEA, and include the use of both salaried and contract providers. Interviewees indicated there are provider supply and salary issues. The state and local education funds available to pay special education provider salaries are limited; Medicaid funds enable the schools to supplement this base to bring salaries up to a competitive level.



However, some individuals indicated that, even with these “extra” funds, provider supply constraints limit the services that are specified in IEPs, particularly mental health services.

Massachusetts schools are authorized to bill Medicaid for a range of health-related IDEA services including speech therapy, occupational therapy, physical therapy, sensory training, mental health services, adaptive physical education, and diagnostic and treatment services. To receive Medicaid payment for health-related services provided under IDEA, LEAs must enroll as Municipal Medicaid Providers, a new class of providers created to facilitate Medicaid billing for IDEA services. Although, theoretically, other municipal providers such as ambulances could join this program, LEAs are currently the only type of Municipal Medicaid Provider. Children receive health-related IDEA services under one of nine special education service "prototypes" that have been specified in the state's enabling legislation. The prototypes vary primarily according to service delivery site and the amount of time a child spends in a regular classroom. Medicaid pays for health-related IDEA services using composite per-diem rates, that have been developed to match the legislatively required prototypes. Services are delivered by staff employed by the LEA, by a collaborative group of LEAs, or under contract to a single LEA or group of LEAs. Massachusetts stakeholders suggested that it is sometimes difficult to recruit and pay qualified therapists. In addition, LEAs have not yet billed Medicaid separately for services not included in the composite rate, such as private duty nursing, even though these services are included in the state plan. Finally, although health-related IDEA services are currently exempt from the state's growing Medicaid managed care program, some interviewees expressed concern about how, for Medicaid-eligible children enrolled in managed care and also receiving special education, these services will be coordinated in the future.

In Oklahoma, LEAs contract with Medicaid as EPSDT providers. In this capacity, they are authorized to provide EPSDT screens, as well as speech therapy, occupational therapy, physical therapy, audiological services and psychiatric and psychological services provided by licensed practitioners. Schools are required to submit a plan for service delivery to the Interagency Coordinating Council and the Medicaid agency; they may opt to provide services directly, collaboratively with other LEAs, or through contractual arrangements. LEAs choose different service delivery arrangements depending on provider supply and salary levels in the area. Interviewees suggested Oklahoma LEAs would like to be able to bill Medicaid for additional services, such as psychological services provided by certified school psychologists. Since the state plan specifies that mental health services must be provided by licensed providers, school

psychological services were not Medicaid billable. Medicaid staff in this state indicated they were concerned about the budgetary implications of including services provided by unlicensed mental health providers in the state plan: if these services were covered for all Medicaid recipients, the expense to the state could be enormous. The Department of Education asked the Attorney General for an opinion about this issue; the Attorney General ruled that for the purpose of providing school psychological services, certified school psychologists are equivalent to licensed psychologists in providing these services in the public schools. Therefore, LEAs may bill for and receive Medicaid reimbursement for services provided by certified school psychologists.

To bill Medicaid for health-related IDEA services in Oklahoma, a child must have had an EPSDT screen. These screens may be completed by "core skills trained" nurses in the schools or by pediatricians or other primary care providers. Although interviewees acknowledged that completing an EPSDT screen before creating an IEP reflects a holistic approach to service delivery for each child, they also stated that as a practical matter, the EPSDT screening requirement creates a barrier to the provision of IDEA services. In some areas, provider shortages may limit the number of children who receive EPSDT screens, thus limiting the LEAs ability to bill Medicaid for health-related services under IDEA. Like other states in our sample, Oklahoma has received HCFA approval of a Medicaid demonstration proposal, that will involve increased use of managed care. Stakeholders are currently negotiating how health-related services provided under IDEA will be delivered under the new managed care arrangements. Medicaid would prefer that managed care organizations provide the EPSDT screens, with the schools serving as "safety net" EPSDT providers. The state has imposed a moratorium against new billing for any additional services until the new managed care plan is developed.

Although some aspects of IDEA service delivery vary among the case study states (e.g. Oklahoma's choice to make LEAs EPSDT providers vs. Massachusetts' decision to create a new class of Medicaid providers), there are also a number of consistent themes. For example, all states provide a core group of health-related IDEA services, but would like to bill for more services, such as private duty nursing, or mental health services. All states provide services directly or through contractual arrangements and have also experienced difficulty recruiting and meeting the salary requirements of some types of providers, particularly therapists. All states are in the process of determining how IDEA services will be financed and delivered as more Medicaid recipients are enrolled in managed care plans.

## D. Financing and Billing

Special education services are financed by a combination of local, state and federal education dollars; as described above, most of the federal dollars are granted to the states through IDEA. Limitations in all three sources of education funding have created an incentive for schools to access additional sources of funding, including Medicaid, in order to meet the growing expenses associated with the provision of special education services. In this section of the report, we discuss how each of the case study states finances special education services and the methods they have chosen to bill Medicaid for IDEA services.

Illinois spent a total of \$486,660,500 for special education in 1994. About 10 percent of this amount derived from federal revenues, about one-third from state appropriations, and the remainder from local sources. Illinois began to supplement its special education budget with Medicaid dollars in 1991; Medicaid paid a total of about \$4.3 million for health-related services under IDEA in 1994. The Medicaid agency reimburses LEAs based on the lesser of charges or fees established by a fee schedule. The Medicaid agency reimburses fee-for-service claims each quarter to an Illinois State Board of Education Treasury account, and sends remittance advice (billing invoice) to the LEAs. Based on a report from the Medicaid agency, the Board of Education sends checks from the Treasury account to each LEA in the amount of the federal portion of the Medicaid reimbursement. LEAs may use these funds only to supplement other funding sources for all special education services. The Board of Education provides LEAs with a list of other insurers that might reimburse for IDEA services, but interviewees suggested third-party reimbursement is not often received for IDEA services. Some school districts in Illinois, including Chicago, rely on consulting firms to help them bill Medicaid for IDEA services.

As in Illinois, special education services in Louisiana are financed by a combination of state, local and federal education funding, with a total budget of more than \$400 million. Louisiana began to bill Medicaid for IDEA services in 1988, and billed more than \$4 million in 1994. To receive Medicaid reimbursement, the LEAs submit claims to the Medicaid agency electronically and receive full state and federal reimbursement directly from the Medicaid agency. Medicaid is billed a rate per service type and unit of time according to a payment schedule established by the Department of Health and Hospitals. Medicaid funds go into a general health services budget in the local parish without restrictions about

whether they will be used to pay for special education services for Medicaid-eligible children. However, the provider manual states that parishes should place a priority on using IDEA revenues to expand the special education health-related service provision. Some interviewees suggested that such "earmarking" of funds is technically not legal under the Medicaid program. Stakeholders are currently considering the option of having the parishes, rather than the state, provide the state share to draw down federal matching dollars. The Louisiana Department of Health and Human Services hires contractors to pursue third-party payments for IDEA services; however, most third-party payers do not cover IDEA related services.

Massachusetts spent nearly \$1 billion for special education services in 1994. About sixty percent of this amount came from local sources, about \$5.5 million from Medicaid and the remainder from state appropriations. Massachusetts is the only one among our case study states to have adopted per diem, composite Medicaid rates for health-related IDEA services. To create these rates, a sample of IEPs in each of the prototypes was reviewed to determine the number and type of services ordered for each child. Rates were applied to the services provided, and an average expenditure for children in each prototype was created. Through negotiations with HCFA and key stakeholders in the state, these average expenditures were used to create the per diem rates. To bill for services, local schools certify that a Medicaid-eligible child attended school on a given day, received services in a given prototype, and received health-related IDEA services. The local expenditures are certified by the state as the state Medicaid share, and are then used to draw down federal revenue. Federal Medicaid matching funds are returned to the town without restriction as to how they can be used. Stakeholders suggested this method was adopted to make it easy for LEAs to bill Medicaid; even so, a number of consulting firms have become active in billing Medicaid for IDEA services in Massachusetts. Interviewees reported that there is virtually no effort in Massachusetts to claim additional third-party payments for IDEA services, partially because private payers do not think the blended rate methodology is specific enough for billing purposes. HCFA has completed three audits of LEA billing practices and found only minor problems in the way LEAs are implementing the per diem rates.

Oklahoma's special education budget was about \$200 million in 1994, approximately \$29 million of which derived from federal dollars. Medicaid reimbursement was a small proportion of this amount; only about \$250,000 was billed to Medicaid in 1994. As we described, LEAs bill Medicaid according to a fee schedule, as EPSDT providers. As in most of the states we visited, LEA dollars are used as the state share to draw down federal Medicaid matching dollars. These federal revenues are returned to the LEAs with the

stipulation that they be used for school health services. Stakeholders suggested there was no other third-party reimbursement being claimed, for reasons similar to those provided by interviewees in other states: private insurers do not usually cover health-related IDEA services, few recipients have access to third-party coverage, and attempts to access third-party reimbursement may result in increased out-of-pocket expenditures for families, which is prohibited under IDEA. Although there are computer programs available to LEAs to facilitate billing, as well as some consulting support, we found the LEA representatives did not necessarily understand that they had contracted with Medicaid as EPSDT providers.

Our findings illustrate the variety of methods states use to bill Medicaid for IDEA services, and the varying extent to which they access Medicaid dollars. All states but Louisiana use local dollars as the state Medicaid share. Louisiana is also the only state to direct both state and federal Medicaid dollars back to the parishes. All states but Massachusetts use a fee schedule for billing purposes. Massachusetts is also the only state to allow the federal funds received through Medicaid billing to be used for unrestricted purposes. Consulting firms have become involved in billing Medicaid for IDEA services in nearly every state, and often receive a percentage of the amount billed as remuneration for their activities. Finally, there is little if any third-party billing for health-related services provided under IDEA in any of the states we visited.

### **III. POLICY ISSUES**

Our findings suggest a number of issues that state and federal policymakers should consider as they examine the role Medicaid plays in financing special education services. In this section of the report, we identify these key issues and related policy implications. Topics addressed include: student privacy concerns, provider supply, the link between IDEA service delivery and EPSDT, IDEA service delivery in the context of managed care, billing practices, state objectives in billing Medicaid for IDEA services, and the federal role in setting policy about state practices in billing Medicaid for IDEA services. Each of these issues is discussed below.

Lack of clarity about whether student confidentiality is violated by computer matches between Medicaid and special education have prevented some states from conducting such computer matches. Moreover, states may require LEAs to obtain parental permission to bill Medicaid for special education services. Both of these activities are barriers to billing Medicaid for IDEA services, since they limit the

population of children on whose behalf Medicaid can be billed. States are not consistent in their interpretation of federal regulations about whether computer matches are prohibited or whether parental consent to bill Medicaid for IDEA services is required. Louisiana has conducted such computer eligibility matches, and Oklahoma does not require parental approval to bill Medicaid for IDEA services. The Massachusetts Department of Education has asked the Attorney General for an opinion on this issue. More consistent processes for identifying children who are eligible for both special education and Medicaid would result from a single federal interpretation of the requirements of the Student Privacy Act.

Policy issues related to the delivery of IDEA services also arose during our site visits. One general concern is the supply of providers of health-related IDEA services and the salaries LEAs must offer to attract and retain these providers. The availability of Medicaid revenues has helped LEAs to meet provider salary demands and thus ease provider supply constraints. Education stakeholders report that even though Medicaid revenues supplement special education revenue, these fees do not cover LEA provider costs, regardless of whether providers were hired directly by the school systems or paid through a contractual arrangement.

Another service delivery issue is the link between EPSDT and IDEA services. In Oklahoma, this link was the most explicit, since LEAs contract with the state Medicaid agency as EPSDT providers and cannot bill Medicaid for health-related IDEA services until a child has had an EPSDT screen. In Louisiana, schools can bill Medicaid for EPSDT services, but children are not required to have a screen before Medicaid will pay for health-related IDEA services. Most importantly, since EPSDT may allow providers to order other medically necessary services regardless of whether these services are specified in the state plan, the link to EPSDT may allow LEAs to arrange for a wide range of services for children with disabilities.

Finally, concerns expressed about the impact of Medicaid managed care on delivery of services prescribed for children under IDEA will only grow in importance as states increase Medicaid enrollment in prepaid health plans. Because the interface between the LEAs and managed care plans is still being negotiated, the control over delivery of IDEA services may rest either within the health plan or within the schools. Regardless of the locus of control, however, schools will still be obligated to provide a free appropriate public education to children with disabilities. Without control over the Medicaid dollars that

might be available to finance these services, schools may be at risk for continuing responsibility for service provision. One solution to this problem is to carve out IDEA services from the capitation rates, even though primary care practitioners may still want to control service delivery decisions in this context.

As described above, states have chosen different methods to bill Medicaid for IDEA-related services, and different ways of using the federal revenues that result from these practices. Although HCFA has not identified major issues in the audits of Massachusetts' per diem composite rates, this strategy may not make the most sense as states move into increasing use of managed care plans. Massachusetts interviewees suggested managed care plans "did not like" the lack of specificity afforded by the composite rates. The variety of ways that even our limited sample of states allocate federal matching dollars suggests that some federal policy pertaining to the use of federal Medicaid revenues may be desirable. At the least, it may be worthwhile to consider some standards for the use of federal dollars, such as the requirement that federal revenues accessed for IDEA related services be used to finance special education or other health related services.

Another issue that arose during our site visits is the concern that standard Medicaid billing practices may not lend themselves to billing for IDEA services. Medicaid claims are typically paid for services delivered in a "medical" model, in which patients receive individual, medically necessary treatments. However, special education services are most often delivered using an integrated therapy model, in which an individual participates in group activities, often in a regular classroom setting. Some of the representatives from education agencies suggested the traditional Medicaid model of billing should be revamped to accommodate billing for services provided in a group setting.

In addition to these issues, there are two larger policy questions related to Medicaid billing for IDEA services that should be addressed. First, the states we visited had varying objectives in billing Medicaid for IDEA services. Massachusetts, for example, began to bill Medicaid for IDEA services as just one more initiative to maximize federal revenue into the state. In contrast, one reason Oklahoma began to bill Medicaid for IDEA services was to increase EPSDT screening rates, and to provide more comprehensive services to children with disabilities. We believe, however, that most states are billing Medicaid for IDEA services in order to maximize the flow of federal revenues into the states, rather than

specifically to improve the health status of children with disabilities. Indeed, the federal Medicaid revenues received may not be used to finance school-based or health services at all.

In the future, it seems likely that Medicaid resources will be constrained, either by federal block grants to the states, limits in growth on per capita Medicaid spending or by increased use of managed care plans. It is not clear how well LEAs will compete for these dollars against the demands of other larger providers such as hospitals or long-term care facilities. Currently, some states are billing Medicaid for significant sums related to the delivery of IDEA services. Since other sources of special education funding are constrained, LEAs are also beginning to depend on Medicaid revenues to provide a "free appropriate public education" to a large and growing population of children with disabilities. If Medicaid dollars are transferred from special education to more traditional providers, the delivery of special education services may suffer. At the same time, there may not be adequate state, local and federal resources to support the current array of health and other services for Medicaid recipients who receive special education services. Health and education policymakers at both the state and federal level should begin to place these multiple and competing demands for constrained resources in some order of priority.

Finally, the theme of variation in state practices for billing Medicaid for IDEA services was evident throughout our research. There was also variation at the federal regional office level in terms of how differing state approaches would be tolerated. Federal policymakers need to create more explicit guidelines for states about the methods they may use to bill Medicaid for IDEA services, particularly around the issues of protection of student privacy and uses of federal revenues.



## References

Brown, Scott. US Department of Education, Office of Special Education Programs. Personal Conversation. August 4, 1995.

U.S. Department of Education. To Assure The Free Appropriate Public Education of All Children with Disabilities. Sixteenth Annual Report to Congress on the Implementation of the Individuals With Disabilities Education Act. 1994