Draft Memorandum

To: Bruce Hunter, American Association of School Administrators

Fr: Sara Rosenbaum

Re: Federal Medicaid policy and health services in schools

Date: March 28, 2001

Introduction

This memorandum, prepared for the American Association of School Administrators (AASA) reviews issues that arise in the context of Medicaid payment for health services in schools. Specifically, AASA has requested an analysis that considers the impact of three specific Medicaid policies on the availability of Medicaid financing of health services furnished in and by schools:

- Medicaid as a secondary payer to other sources of health care financing;
- The prohibition against Medicaid payment for services that are available free of charge to community residents;
- Medicaid as a "payer of last resort."

This memorandum is designed to assist AASA formulate policy options for ensuring that to the maximum extent permitted under federal law, Medicaid is available to make health care available to children through schools. It is my understanding that in carrying out this task, AASA is responding to Congressional concerns regarding HCFA policies related to payment for school health services and the impact of these policies on poor children and children with disabilities. In its Report to Accompany the FY 2001 Labor/HHS appropriations legislation, the Conferees expressed the view that HCFA’s guidelines on Medicaid payments for health services in schools were “being developed without adequate input from interested parties and making it more difficult for schools to provide services to poor and disabled children.” The Conferees specifically required HCFA to consult with
“school practitioners and other groups” in the development of policy guidance regarding use of Medicaid funds to purchase services furnished in schools.

I have divided this analysis into the following sections:

1. An overview of Medicaid's goals and purposes in the context of pediatric health care.

2. A brief overview of other key programs aimed at assisting low income children and children with disabilities, specifically the Individuals With Disabilities Education Act and sources of funds for developing health clinics in school settings.

3. Specific issues in Medicaid policy: free care; Medicaid as a payer of last resort; and third party liability

1. An Overview of Medicaid and its Role in U.S. Child Health Policy

Medicaid, the largest of all federal means tested grant-in-aid programs, entitles states to open-ended federal financing to help meet the cost of administration of approved state plans. Under federal law, states have considerable discretion over Medicaid program design, including eligibility, benefits and coverage, participating provider qualifications and compensation, and program administration. Approved state programs receive federal financial contributions in accordance with a statutory formula.

The Medicaid program occupies a unique role in U.S. child health policy. In 1999, 19.6% of the nation’s 76.3 million children ages 18 and under (15 million children) were enrolled in Medicaid, making children more dependent on Medicaid than any other single age group. However, even this figure understates Medicaid’s importance for lower income children, whose access to health services in schools is probably the most essential. Among low income children with any insurance, approximately 60% are insured by Medicaid,1 making Medicaid the principal source of health insurance -- public or private -- for low income children. Furthermore, regardless of family income level, children with disabilities are significantly more likely than non-disabled children to be enrolled in Medicaid.2

Medicaid has had an enormous impact on children’s access to health care. As Figure 1 shows, poor children with Medicaid have receive virtually the same amount of health care as non-poor children with private health insurance (although their source of care is more likely to be a clinical setting).

1 Sara Rosenbaum et. al., The Role of Medicaid in Early Child Development Programs (Commonwealth Fund, 2001) [forthcoming].
Medicaid functions much like health insurance, in that it entitles eligible persons to coverage for defined medical benefits and services. But for purposes of this analysis, it is essential to understand that, particularly in the case of children, Medicaid operates according to unique rules and principles that differ from conventional insurance in key ways:

- First, within certain federal limitations applicable to group health insurance plans, insurers can impose preexisting condition exclusions and waiting periods on coverage. Medicaid prohibits the use of waiting periods and pre-existing condition exclusions, making the program the central means of payment for long term care and services for children and adults with serious and chronic health conditions who would be considered uninsurable in the private market. Medicaid is expressly designed to pay for care for chronically ill persons, including children with disabilities.

- Second, the scope of Medicaid coverage for children (known as Early and Periodic Screening Diagnosis and Treatment) is far broader than that found in a conventional insurance policy. The required classes of covered services range from complete coverage of preventive medical and dental care to virtually all classes of personal health care services for children with serious physical or emotional conditions. Table 1 displays the range of required Medicaid services for children.

- Third, Medicaid prohibits the use of premiums, copayments and deductibles in the case of children under 18.

- Fourth, Medicaid coverage rules for children are based on a unique pediatric standard of medical necessity that require states to take into account the need for health services that

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promote children’s growth and development.⁴ This is a far broader standard of coverage than that found in conventional insurance, which typically limits coverage to treatment needed to diagnose and treat an illness or injury, not aid in growth and development.

- Fifth, and of particular significance to this analysis, in a complete break with the conventions of commercial insurance, federal Medicaid law specifies the manner in which the Medicaid program must interact with and support the services of other agencies and programs involved in the care of children. Two types of programs and services are singled out for this special set of rules: pediatric services offered by public health agencies; and services for children available under the Individuals with Disabilities Education Act (discussed below).

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⁴ See 42 C.F.R. 438.210(a)(3)(iii) in which HCFA describes the standard of medical necessity as “the prevention, diagnosis, and treatment of health impairments, the ability to achieve age appropriate growth and development, and the ability to attain, maintain and or regain functional capacity.”
Table 1. Medicaid Coverage for Children (Early and Periodic Screening,
Diagnostic and Treatment Services)

- Screening services (age appropriate periodic schedules and as needed)
  - Comprehensive health and developmental history including mental and physical
development assessment
  - Comprehensive unclothed physical examination
  - Age appropriate immunizations
  - Laboratory tests including blood lead level assessments
  - Health education and anticipatory guidance

- Diagnostic services

- Treatment that is medically necessary and that requires the provision of any of the benefits and services
  that fall within the federal definition of “medical assistance”, including the following services
  - Physician services
  - Hospital services (outpatient and inpatient)
  - Federally qualified health center services
  - Rural health clinic services
  - Family planning services and supplies
  - Medical care or any other type of remedial care recognized under state law, furnished by
    licensed practitioners within the scope of their practice, as defined by state law
  - Home health care
  - Private duty nursing services
  - Dental services
  - Clinic services
  - Physical therapy and related services
  - Prescribed drugs
  - Dentures
  - Prosthetic devices
  - Other diagnostic, screening, preventive and rehabilitative services including any medical or
    remedial services (provided in a facility, a home, or other setting) recommended by a physician or
    other licensed practitioner for the maximum reduction of physical or mental disability and restoration
    of an individual to the best possible functional level
  - Services in an intermediate care facility for the mentally retarded and inpatient psychiatric
    services for individuals under age 21
  - Nurse midwife and certified pediatric nurse practitioner services to the extent that such
    services are authorized under state law
  - Case management services to help secure access to social, educational, health and other
    services.
  - Respiratory care
  - Personal care services
  - Any other medical or remedial care recognized by the Secretary of HHS

- Comprehensive vision services including eyeglasses
- Comprehensive preventive, restorative and emergency dental care beginning no later than age 3 or earlier if
  medically indicated
- Comprehensive hearing care, including hearing aids and speech therapy
- Transportation and scheduling assistance, and assistance in securing necessary non-Medicaid services

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5 Low income infants are disproportionately likely to be born to young mothers. The
EPSDT entitlement ends at age 21; therefore, EPSDT may be important both for a young
child and her young mother.

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Table 2 below summarizes the differences between Medicaid and conventional health insurance.

### Table 2. Medicaid Versus Conventional Health Insurance

<table>
<thead>
<tr>
<th>Issue</th>
<th>Conventional Insurance</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-existing conditions and waiting periods</td>
<td>May be imposed with certain limits in the case of group plans</td>
<td>Prohibited</td>
</tr>
<tr>
<td>Benefits</td>
<td>Restricted to customary classes of “medical care” (e.g., physician, hospital, diagnostic, drugs, post-hospital rehabilitation, limited prevention)</td>
<td>Exceedingly broad, covering a full range of preventive medical and dental services for children, both acute and chronic care services, and case management, transportation, and patient support services</td>
</tr>
<tr>
<td>Coverage rules</td>
<td>Services needed to treat illness and injury</td>
<td>Services needed to prevent or ameliorate mental and physical conditions and promote child growth and development</td>
</tr>
<tr>
<td>Cost sharing</td>
<td>Premiums, deductibles and coinsurance are customary</td>
<td>Prohibited for children</td>
</tr>
<tr>
<td>Relations to other agencies</td>
<td>No interaction except at insurer discretion</td>
<td>Payment for services furnished by other agencies required, particularly in the case of health and special education services.</td>
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An important question is why Congress conceived a health care program of this breadth for children. The answer lies in the rationale for the original 1967 EPSDT amendments, which set many of the standards described above and whose goals and purposes have been underscored over the years by every federal court that has considered this issue. Simply stated, the purpose of the program was to identify, find, and assess all low income problems for the presence of physical and mental conditions and assure that they received all medically necessary care to prevent or ameliorate these conditions. Congress reaffirmed these goals as recently as 1989 and again in 1997 when it permitted states to use funds under the State Children’s Health Insurance Program to fashion coverage as broad as Medicaid for near-poor children.

The legislative history to the EPSDT program indicates close links to schools. Congress anticipated that much of EPSDT’s outreach and preventive health services would be carried out in the places that large numbers of low income children can be found such as schools, child care centers, Head Start programs, and other locations. State health and Medicaid agencies have throughout the life of the program been expected to mount broad outreach efforts to find children, assess their need for care, and enroll them in systems of comprehensive preventive care, broadly conceived. The entire history of the program is dotted with repeated efforts by successive Administrations to foster the most active possible efforts by states to identify,

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6 Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, 1997; 2001 Supplement) (Ch. 2(H)).

7 The definition of “child health assistance” under SCHIP is virtually identical to the definition of “medical assistance.” However, the SCHIP definition is optional with states. 42 U.S.C. §1397jj.

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assess, and preventively treat children. A review of 35 years of program history underscores the ongoing emphasis on EPSDT, beginning with the Johnson Administration and continuing through the Clinton Administration.

Finally, the heart of Medicaid is its goal of operating in a manner that fundamentally departs from conventional insurance norms, precisely in order to ensure that the American health care system has a means of addressing populations and services whose health care needs lie well beyond the outermost limits of market-based health insurance. Efforts to impose conventional insurance rules and limits on Medicaid or to interpret Medicaid to parrot insurance practices overlooks its basic differences from insurance.

In sum, Medicaid’s goals for children are unique in American social policy. These goals reflect low income children’s high level of need for the best possible and most accessible health care, given their greater levels of health risks and disabilities. The sheer breadth of Medicaid’s vision for children must be kept in mind when considering how to interpret and apply any limitations on Medicaid coverage and payment, as well as federal administrative practices and policies that affect how Medicaid operates in the case of children. The need to focus on Medicaid’s broad purposes is particularly great when considering its interaction with services available through or furnished by state and local education and health agencies, since it is in the area of interagency relations and intergovernmental relationships where Medicaid is unique compared to commercial insurance.

Despite these broad goals, Medicaid does impose certain requirements on states. Medicaid payments for medical assistance are limited to care and services that are medically necessary within the broad purposes of medical assistance coverage itself. In the case of children, Medicaid payments must be medically necessary to promote growth and development. Medicaid programs must be efficiently administered; this means that funds cannot be used to pay for services and activities that do not fall within the ambit of the statute. Furthermore, costs that are attributable to Medicaid administration must be reported to the federal government as such rather than as medical assistance, since federal financial participation rules are different. Finally, where a third party is legally liable for the coverage, any third party that is legally obligated to pay for medical assistance costs must be billed prior to billing Medicaid.

2. Medicaid’s Interaction with Other Programs Serving Children

As noted in the previous section, the federal Medicaid statute presumes a significant degree of interaction between Medicaid and other critical programs that serve enrolled children. Two of the most prominent examples of this “presumed interaction” can be found in the case of programs operated by state public health agencies and programs operated by school districts.

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8 Ironically perhaps, it was the health status of young draftees during the Viet Nam war that brought the magnitude of low income children’s health problems into view for the Johnson Administration.
Health agencies and entities and agencies that receive health agency funding: The Medicaid statute requires state Medicaid agencies to enter into "cooperative agreements with the state agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State, looking toward maximum utilization of such services in the provision of medical assistance under the plan * * * ."\(^9\)

Furthermore, state Medicaid agencies must enter into agreements with agencies, institutions and organizations that receive funds under Title V of the Social Security Act (the Maternal and Child Health Services Block Grant) and must "make such provision as may be appropriate for reimbursing such agency, institution or organization for the cost of any such care and services furnished [a Medicaid enrollee] for which payment would otherwise be made to the State under section 1903 * * * ."\(^10\) In other words, state Medicaid agencies must in accordance with federal regulations utilize entities that receive funds under Title V as providers in their medical assistance plans and must pay these agencies for care and services furnished to Medicaid beneficiaries that are recognized under the federal definition of medical assistance.

Federal regulations that implement these statutory provisions provide that state agencies must have relations with Title V grantees and specify that "federal financial participation is available in expenditures for Medicaid services provided to recipients through an arrangement under this title."\(^11\) The regulations thus assume Medicaid payment for covered services furnished by Title V grantees.

Schools and special education programs: The Medicaid statute also expressly presumes interaction between special education and early intervention programs under the IDEA and Medicaid. Specifically, the statute presumes Medicaid payment for covered medical assistance services that are furnished to a "handicapped" child under Parts B or H of the IDEA and clarifies that:

"Nothing in this title\(^12\) should be construed * * * as authorizing the Secretary to prohibit or restrict payment for medical assistance" because such services are included in an individualized education plan or family service plan.\(^13\)

This clause could not be clearer. The phrase "nothing in this title" means nothing in the Medicaid act. Thus, no other provision of federal Medicaid law should be read as authorizing the Secretary to restrict Medicaid payment for covered Medicaid services when furnished by qualified Medicaid providers to Medicaid-enrolled children who also receive special education services. Whether the issue is the "free care" exclusion, the "educational" exclusion, or Medicaid's "third party liability" provisions, the law is clear: nothing should be read as interfering with Medicaid payment for covered services in the case of children who also receive IDEA education services.

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\(^9\) §1902(a)(11) of the Social Security Act.

\(^10\) Id.

\(^11\) 42 C.F.R. §431.615.

\(^12\) i.e., the Medicaid statute

\(^13\) §1903(c) of the Social Security Act.

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The logic behind this presumed interaction between Medicaid and other programs is obvious. Low income and disabled children tend to be eligible for a variety of programs that have been designed to the maximum extent possible to work in tandem with one another. The very fabric and structure of the statute shows that underlying the two areas of “presumed interaction” discussed above are certain longstanding assumptions on the part of both Congress and the states:

- As a general matter, states are the part of the federal/state partnership that bears responsibility by and large for developing and assuring sources of health care for poor families. The federal side of the deal is that federal Medicaid funds will be available to pay for covered care when it is furnished to Medicaid enrollees by participating providers. Thus, for example, public health agencies fund many activities such as school clinics or public health nursing programs that are designed to get basic health care to low income and underserved children who in turn are eligible for Medicaid. School systems themselves may of course decide to support school clinics and school nurses as well. As long as these clinics and nurses become qualified Medicaid providers, the covered services they furnish to Medicaid-enrolled children should be governed by the same principles as apply under Title V-assisted programs.

- It is Medicaid’s overall contextual mission where child health is concerned to purchase covered health care as accessibly as possible. Where the provider is a public entity (e.g., a public health agency, a school, or a private non-profit clinic located in a school), the allocation of responsibilities is that one agency develops a service delivery system, and Medicaid buys covered health services from the provider. This is the essence of the Medicaid statute’s Title V and health agency provisions. It reflects states’ longstanding efforts to develop health services for poor children and families because of low provider participation and geographic isolation from “mainstream” sources of health care.

- Federal interpretation of Medicaid should to the maximum extent foster the integration of publicly developed and supported services into state Medicaid operations, with maximum use of community health providers.

- It is up to states to design provider qualification standards and select their qualified providers. This includes contracting with health providers - whether organized by health agencies or schools - who are located in schools or who serve children through schools, and who are in an ideal purpose to carry out Medicaid’s pediatric goals.

- Children who receive special education services should receive all of the medical assistance to which they are entitled.

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14 The one possible exception to this rule is the federal community health centers program, the central federal commitment to developing and supporting health services in poor communities. Many health centers operate school clinics. As with state-supported health providers, federal Medicaid policy covers and pays for services of federally qualified health centers. It is irrelevant for Medicaid payment purposes that health centers do in fact receive limited operating funds. Under HHS policy these operating funds are “last dollar” to Medicaid, and health centers are treated as participating providers.
In the case of school health services, these assumptions are reflected in Medicaid and School Health: A Technical Assistance Guide, which was issued by HCFA in 1997. This Manual was designed to encourage the use of schools in health care delivery to Medicaid-enrolled children in recognition of the importance of this aspect of school systems.

3. Specific Issues in Medicaid Policy: Free Care, Medicaid as a Payer of Last Resort, and Third Party Liability

In analyzing specific provisions of law in a statute as complex as Medicaid, it is important to read provisions not only for the text of what they say, but also in the context of the entire program. Furthermore, where, as in the case of Medicaid, the law contemplates interactions with other laws, it is important to consider these other laws as well, since Congress does not write one law to be placed in contradiction with another. In this case the two most important laws are the IDEA and the Title V Maternal and Child Health Services Block Grant, which in many states may offer a source of funding for the support of health services to children in schools.

Title V: As noted, the Medicaid statute itself contemplates reimbursement of Title V providers that participate in Medicaid. Similarly, the Title V statute assumes that agencies will take steps to ensure that their funded providers coordinate with Medicaid, assisting in the enrollment of eligible individuals, applying Medicaid funds toward the care of children with special needs prior to using Title V funds, and furnishing EPSDT services to eligible children enrolled in Medicaid. requires that agencies assure that their for covered health services furnished to Medicaid enrollees. The availability of Medicaid funding to Title V assisted providers and entities thus is assumed in the Title V statute.

The IDEA: The IDEA even more forcefully assumes the availability of Medicaid funding to pay for health services in the case of children receiving IDEA education and related services. The IDEA classifies medical care necessary to permit a child to obtain a free and appropriate public education to be “related services.” However, under the IDEA, federal funds are not available for payment of related services that are medical services. As a result, the IDEA expressly provides that:

“if any public agency other than an educational agency is otherwise obligated under Federal law or assigned responsibility to provide or pay for any services that are also considered special education or related services that are necessary for ensuring a free appropriate public education for children with disabilities within the state, such public agency shall fulfill that obligation.”

The IDEA further provides that:

15 The Manual can be found at HCFA’s website (www.hcfa.gov/medicaid).
17 IDEA §§602 (22).
18 IDEA §602(a)(12)(B).
“Nothing in this title permits a state to reduce medical and other assistance available *** under Titles V and XIX of the Social Security Act with respect to the provision of a free appropriate public education for children with disabilities *** 19.

Implementing regulations contemplate that education agencies will make full use of Medicaid and any private insurance that might be available. 20

Thus, in reading the free care, payer of last resort, and third party liability provisions of the Medicaid statute, these provisions must be read in the context of:

(a) other provisions of the statute, most specifically those provisions that Medicaid’s presumed interactions with special education programs serving Medicaid-enrolled children and health providers funded in whole or in part by Title V and other federal grant programs such as community health centers;

(b) The broader purpose of Medicaid in the case of children (i.e., to pay for necessary medical assistance to promote growth and development and prevent or ameliorate disabilities and conditions); and

(c) Other federal laws with which Medicaid is supposed to interact (in this case, the IDEA that instructs education agencies to bill Medicaid and private insurance when available and Title V, which presumes Medicaid participation by Title V providers).

Free care The 1997 HCFA school health manual expressly addresses the non-applicability of the prohibition against Medicaid payment for free care in the school health context. The Manual states:

An important requirement related to billing for Medicaid covered school based services is the issue of “free care.” From the outset of the Medicaid program, a principle basic to public assistance has applied to Title XIX, in that Medicaid funds may not be used to pay for services that are available without charge to everyone in the community. Free care, or services provided without charge, are services for which there is no beneficiary liability and for which there is no Medicaid liability. ** Providers of Medicaid services must have the authority to charge for their services and utilize this authority before Medicaid will make payment. ** Schools may employ certain methods to ensure the care is not considered free, allowing Medicaid to be billed. The services would not be considered free if the following conditions are met. The provider: (1) establishes a fee schedule for the services provided (it could be sliding scale to accommodate individuals with low income; (2) ascertains whether every individual served by the provider has any third party benefits,

19 IDEA §612 (c)
20 34 C.F.R. §§300.142(a) – (f).

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and (c) bills the beneficiary and/or any third party for reimbursable services.21

The Manual then goes on to note two important exceptions to the free care prohibition:

For purposes of the provision of school-based health services there are two exceptions to the free care rule, described below.

(1) IDEA. Section 1903(c) prohibits the Secretary from refusing to pay or otherwise limiting payment for services provided to children with disabilities. * * * Under these circumstances Medicaid is the primary payer to the Department of Education. As such, Medicaid covered services provided under an IEP or IFSP are exempt from the free care rule. * * * However, the requirement to bill all liable third parties would still apply.

(2) Title V. Another exception to the free care policy which relates to school based health services includes services provided by Title V of the Social Security Act. * * * Medicaid-covered services provided by Title V are exempt from both the free care rule and the policy of Medicaid as the payer of last resort.22

Thus, where school based services are concerned school operated or school-located clinics funded in whole or in part with Title V funds (federal or state contributions) would be exempt from the free care rule. In addition, Medicaid covered services furnished to children receiving special education services are exempt from the free care rule. For school clinics financed with other funds (e.g., local or state education funds), HCFA regulations provide that as long as the school services operate with a fee schedule and billing system for both Medicaid and other legally liable third parties, no free care problems exist.

Medicaid as a payer of last resort and third party liability Medicaid policy requires that Medicaid be the payer of last resort and that other sources of third party liability be billed in the case of covered services. 23 In the case of Title V, as the above excerpt from the Manual makes clear, the statutory provisions of both Medicaid and Title V make Medicaid “first dollar” to Title V (Title V funds are extremely limited in relation to Medicaid). Thus, there is no “last resort” violation when Medicaid pays, nor is there a third party liability, since Title V effectively is not considered a legally liable third party.

Similarly, where medical services are concerned, the IDEA is not a legally liable third party, since the IDEA prohibits use of federal funds to pay for medical care. Moreover, the provisions in the above excerpt regarding the requirement that Medicaid pay for covered medical assistance services that are enumerated in an IEP or IFSP effectively negate both any “last resort” or third party liability problem.

22 Id., p. 44.

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The Manual gives exhaustive treatment to the twin problems of TPL and payer of last resort, with extensive instructions to states regarding how both issues can be avoided in a school health context:

There are exceptions to the provisions of Medicaid as the payer of last resort which allow Medicaid to be the primary payer to another federal or federally funded program for services covered under Medicaid when specifically required by federal law. One such exception is Title V as mentioned earlier in the discussion of free care. In addition, §1903(c) of the Act permits and exception to the TPL requirements in that, for Medicaid covered services listed on a Medicaid eligible child’s IEP/IFSP, Medicaid will pay primary to the IDEA. This means that Medicaid will pay prior to DOE for Medicaid covered services listed in a child’s IEP/IFSP. * * * This exception does not provide any exemption from pursuing OTHER liable third party payers such as private insurance. Medicaid is still secondary to all other sources of payment. Neither IDEA nor Medicaid was changed in any way by Congress that would relieve the Medicaid program of actively pursuing any liability of third parties, including private insurance, in order to minimize Medicaid outlays. [stet].

[The Manual then describes TPL procedures applicable to schools that seek to obtain Medicaid funds for their services and describes how Medicaid agencies can be used to carry out TPL recovery tasks for school systems. The Manual also clarifies the third party obligation of school systems when parents refuse to consent to billing their insurers and explains how payment is coordinated between school districts and Medicaid in cases in which private insurance is not recovered].

Conclusion and Recommendations

The Medicaid program establishes broad benefits for children and contemplates that these benefits will be received in locations that are the most accessible possible. Schools are just such an accessible location. Whether in the context of basic health care for low income children or extended services for children with disabilities, the results of this analysis underscore that the provisions of the statute, including its thrust and aims in the area of child health, support the broadest possible interpretation of law where school health is concerned. HCFA’s own 1997 Manual suggests such a broad reading.

Medicaid’s free care, payer of last resort, and third party liability policies do not in any way undermine these conclusions. When school clinics are supported with Title V funds, Medicaid funds must be made available for covered services without regard to otherwise applicable free care or payer of last resort prohibitions. According to HCFA’s guidance, school clinics supported with non-Title V funds also can receive Medicaid funding by

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maintaining third party billing and fee schedule policies. Under such circumstances, services are not considered “free” to the community.

In addition, federal special education laws envision access to Medicaid along with other forms of insurance. The IDEA calls for the provision of not only education but also educationally related services for children with disabilities in order to ensure their free appropriate public education. At the same time, however, the IDEA funds only the most limited diagnostic medical services and clearly envisions the broadest possible access to both Medicaid and other forms of health insurance. Thus, federal Medicaid and education policy envisions a close collaboration between the two programs, with Medicaid funds applied whenever available to advance the goal of mainstreaming.

In light of both the express statutory provisions of Medicaid, the IDEA, Title V, and other Public Health Service Act programs that help anchor health services for children in schools, I would recommend adoption of the following broad policies, either as a matter of statutory reform or agency guidance and clarification:

- A reaffirmation of and slight expansion of §1903(c), to clarify that Medicaid must pay for any covered service (whether medical or administrative) that is (a) considered educationally related under the IDEA or (b) is furnished pursuant to an express IEP or IFSP. This revision of 1903(c) would eliminate the need to distinguish between covered medical assistance and covered administrative services when determining the allowability of activities. There are many types of activities that relate to the management of a child in special education that could be considered either management of his educational needs or his health services. Most of the services that schools would claim under Medicaid are medical assistance services, but where a school is performing a Medicaid administrative service that furthers the efficient operation of the system (scheduling, transportation, prior authorization, etc.) these also should be billable to Medicaid, since they are legitimate Medicaid expenses that further Medicaid’s goals for children.

- Second, I would amend the Medicaid statute to clarify that states that use managed care arrangements must make provision (whether through “carve outs or contractual requirements) for ensuring that (a) Title V assisted providers that furnish care in schools are paid for the covered services they furnish and (b) services that fall within the scope of the (expanded) reach of §1903(c) are paid for.

- Congress also might consider a new optional eligibility/service category known as a school health service, covered at an enhanced matching rate, that allows a state to blend medical and administrative activities into a single per-student payment rate that could be paid for each eligible child during a school year (year-round of course in the case of children who are on a full-year cycle). Payments could be made for any child who was enrolled in school at the beginning of the academic year and who was enrolled in Medicaid as of that date. The payment could be set at differential rates, depending on whether the rate was meant to cover preventive services offered by a primary school health clinic or advanced services that were educationally related.
and/or part of an IEP. The rate could include both medical and administrative costs, including transportation. What would be new about this option is the blended nature of the coverage, the enhanced rate, and a mini-guaranteed coverage provision that would ensure payment for the academic year, even if the child experienced a lapse in coverage. The purpose of this new option would be to foster the most active use possible of schools and school services for basic and enhanced services for children.