



ASHA
American
Speech-Language-Hearing
Association

August 1, 2023

The Honorable Miguel Cardona
Secretary
U.S. Department of Education
400 Maryland Ave, SW
Washington, DC 20202

Dear Secretary Cardona:

On behalf of the American Speech-Language-Hearing Association (ASHA), I write to provide comments regarding the notice of proposed rulemaking to “amend the IDEA Part B regulations to remove the requirement for public agencies to obtain parental consent prior to accessing for the first time a child’s public benefits or insurance (e.g., Medicaid, Children’s Health Insurance Program (CHIP)) to provide or pay for required IDEA Part B services.”

ASHA is the national professional, scientific, and credentialing association for 228,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Audiologists specialize in preventing and assessing hearing and balance disorders as well as providing audiologic treatment, including hearing aids. Speech-language pathologists (SLPs) identify, assess, and treat speech, language, swallowing and cognitive-communication disorders. Our mission is to make effective communication, a human right, accessible for all. Over half of ASHA’s members work in the schools.¹

ASHA appreciates the Department’s commitment to and careful consideration of the parental consent issue as it has developed over multiple reauthorizations of the Individuals with Disabilities Education Act (IDEA). Ensuring civil rights protections for children receiving services through an individualized education program (IEP) is paramount. **While the intent of this notice of proposed rulemaking is noble, we urge the Department *not* to finalize its proposal to remove the requirement for public agencies to obtain parental consent prior to accessing a child’s public benefits or insurance for the first time. Instead, ASHA recommends that the Department maintain the 2013 compromise language that allows parental consent to be provided initially and not each time an individual service is requested.**²

Health care decisions, whether in the doctor’s office or the billing department, are best left to the student, their parent(s), and their clinician. Thank you for the opportunity to outline ASHA’s specific concerns regarding proposed changes to this regulation. They touch on the negative impact on a student’s ability to receive the highest quality of services, parental consent, privacy concerns, unequal reimbursement, and the potential for clinical licensure risk. We appreciate the Department’s time and consideration.

Background

Since its passage in 1975, IDEA has made it clear through multiple iterations that parents and students should be at the heart of every decision throughout the IEP process. Parental consent is highlighted multiple times in both the statute and regulations.^{3,4,5} Consent is a bedrock principle to ensure the provision of civil rights, due process protections, and ensuring equitable

provision of services. Congress has further supported these principles through their explicit protection of fundamental rights such as parental consent in Section 607(b) and through ensuring basic rights are protected such as those “embodied in regulations in effect on July 20, 1983”, which includes parental consent.⁶ For instance, “The Secretary may not implement, or publish in final form, any regulation prescribed pursuant to this chapter that—(1) violates or contradicts any provision of this chapter; or (2) procedurally or substantively lessens the protections provided to children with disabilities under this chapter, as embodied in regulations in effect on July 20, 1983 (particularly as such protections related to parental consent to initial evaluation or initial placement in special education, least restrictive environment, related services, timelines, attendance of evaluation personnel at individualized education program meetings, or qualifications of personnel), except to the extent that such regulation reflects the clear and unequivocal intent of Congress in legislation.”

From that point, Congress and successive administrations have built on these protections and strengthened them to ensure maximum benefit for students achieving their education and functional goals, including access to health care services within and beyond the IEP construct. Health care supports available since IDEA first passed have evolved over time. It has been vital that key civil rights guardrails, like parental consent, that protect access to health care services inside and outside of the IEP construct have evolved and strengthened as well. Congress has made it clear that nothing can diminish the ability to receive public health services due to the requirements of IDEA. For instance, Section 640(c) of IDEA states “(c) REDUCTION OF OTHER BENEFITS.—Nothing in this part shall be construed to permit the State to reduce medical or other assistance available or to alter eligibility under title V of the Social Security Act (relating to maternal and child health) or title XIX of the Social Security Act (relating to medicaid for infants or toddlers with disabilities) within the State.”⁷ A free appropriate public education (FAPE) is ultimately an educational responsibility and the civil rights responsibility of schools. Such requirements cannot and must not be used as a rationale to diminish access to vital health care services conducted outside of the IEP construct.

As the Supreme Court referenced in cases such as *Antonio Independent School District v. Rodriquez*, education is fundamentally a state right.^{8,9} If a state educates one child, it must educate all. Children with disabilities are general education students first. The first purpose of IDEA is “to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living...”¹⁰ It's imperative to ensure that any regulatory changes cement the civil rights protections of children with disabilities and the equitable provision of services beyond the IEP construct. Children live their lives and access health care outside of an IEP construct. This includes the provision of health care services outside the school to ensure equitable access, individualized and unique self-determination goals to support education, functional outcomes, employment, and independent living outside of a school setting as students transition through their educational career and throughout adulthood.

When the Department issued its initial regulations on these issues in 2006, they were meant to ensure alignment with the Family Educational Rights and Privacy Act (FERPA); build on the parental consent provisions of IDEA for items such as initial evaluation and services to ensure it was clear that parents and students were the ones who consented to services and the allocation of resources both inside and outside of the school setting (e.g., provision of Medicaid services); and align with statutory provisions in Section 612(a)(12) and 640(c) of IDEA.^{11,12,13} Eventually, Section 300.154(d)(2)(iii) of the Department's regulations further ensured that a public agency, “May not use a child's benefits under a public benefit or insurance program if that use would—

(A) Decrease available lifetime coverage or any other insured benefit; (B) Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school; (C) Increase premiums or lead to the discontinuation of benefits or insurance; or (D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures...¹⁴ The current requirements of Section 300.154(d)(iv)(B) that, “specifies that the parent understands and agrees that the public agency may access the parent’s or child’s public benefits or insurance to pay for services under part 300,” are a vital civil rights guardrail.¹⁵ They ensure the protections provided against undue harm, such as the ones afforded in Section 640(c), are implemented with fidelity to minimize unintended negative consequences for students who need to access health care services beyond the IEP construct and throughout their lives.¹⁶

We feel the Department struck the appropriate balance in 2013 when they revised their regulations from 2006 clarifying that the requirement for parental consent could be provided initially and not every single time a specific individual service was requested.¹⁷ This compromise balanced a smooth provision of services while still ensuring a student’s civil rights protections were respected, and that informed consent, understanding, and agreement for services were maintained. Since this program provides services for students, it is imperative that the parent and/or the student have the ultimate ability to provide consent to ensure that the allocation of limited health care services outside of the IEP construct are not negatively impacted. ASHA asserts that it is the parent and/or student who is in the best position to decide the holistic needs of the student beyond the health care services afforded by an IEP.

Negative Impact on Services

This proposed rule will eliminate the requirement, which “specifies that the parent understands and agrees that the public agency may access the parent’s or child’s public benefits or insurance to pay for services” and “remove the requirement for public agencies to obtain parental consent prior to accessing for the first time a child’s public benefits or insurance (e.g., Medicaid, Children’s Health Insurance Program (CHIP)).”^{18,19} ASHA strongly contends that removal of this requirement is problematic. If parents do not have to consent for Medicaid to be billed in the school, they cannot opt-out of such billing even when the school may not be the best setting for their child due to any number of reasons, such as a need for a different service delivery model than what is available in the school (e.g., individual versus group therapy); lack of capacity for the appropriate number and/or length of sessions; or the desire to choose a provider who can best meet the child’s individualized needs, regardless of setting.

Allowing a school district to unilaterally authorize billing for Medicaid without full knowledge of the child’s complementary needs outside of a school setting will negatively impact a child’s ability to receive the highest quality comprehensive services possible. For instance, a school district could unknowingly provide and bill for small group speech-language therapy sessions that could consequently hinder a student’s ability to receive one-on-one speech-language pathology services outside of the school setting. Without parental consent, families may have restricted access to holistic audiology, mental health, speech-language pathology services, or other services that their child needs. The educational agency should not limit students’ allocation to health care resources outside of the IDEA construct without informed consent of their parent(s).

ASHA has heard from many of our members and the families they serve about the difficulties Medicaid billing for school-based services create for the provision of services outside of schools, as illustrated in the following examples.

- In Colorado, the state Medicaid agency mandated that outpatient providers share a copy of their patient's IEP and then denied coverage of outpatient services based on that information.
- In Alabama, Georgia, Pennsylvania, Virginia, and South Carolina, therapy services billed on the same day as school-based services are often deemed "duplicative" and denied, even if addressing different goals or using different service delivery models (e.g., individual versus group therapy).
- National Imaging Associates (NIA), a large, multistate utilization management company employed by multiple managed care organizations (MCOs) issued an updated policy in July 2023, that requires outpatient providers to prove they are not duplicating services offered in school, shortly after the revised Centers for Medicare & Medicaid Services' (CMS) claiming guide, which encourages increased Medicaid billing by schools, was released.²⁰
- During North Carolina Medicaid's recent transition to managed care, advocates included language in the managed care contracts that ensured MCOs could not deny services based on alleged "duplication" in schools. However, once claims were submitted for outpatient services, MCOs *still* tried to deny care based on school-based services and advocates had to, again, point to language in the state contract.

It is important to note that these are all examples of existing problems for care coordination with parental consent *in place*.

In another stark example, Kate Wicar explained to ASHA how her son, Isaiah, was denied Medicaid covered speech-language pathology services in the outpatient setting because the Colorado Medicaid agency noticed he was receiving services in the schools when they received claims for services offered in both the school and outpatient setting. Kate had been told verbally at Isaiah's IEP meeting that her signing the consent to bill Medicaid form was "a formality" and it wouldn't affect coverage outside of the school. Nothing could have been further from the truth. Kate fought these denials of outpatient coverage through the agency all the way to the Fair Hearing level. The Administrative Law Judge (ALJ) ruled in Isaiah's favor, and coverage of Isaiah's outpatient services should have been restored. Unfortunately, the Medicaid agency appealed and asked for a lengthy time extension to file the appeal on top of it, delaying restoration of those critical speech-language pathology services. In the meantime, ASHA staff and Colorado Speech-Language-Hearing Association members met with the Medicaid agency and after months of meetings discussing the challenges families like Isaiah's faced, the agency agreed to change their policy to allow for billing of speech-language pathology services in both settings. Even with that policy change by the agency, the agency *still* doggedly appealed Isaiah's case through the ALJ, claiming that his services were duplicated by school-based Medicaid billing. In this case, even agency policy changes were not enough to solve the coverage issues outside of the school.

Upon second appeal, the ALJ again ruled in Isaiah's favor and ordered the agency to cover services outside of the school setting. The entire process took more than 18 months and for those 18 months Isaiah was not getting the services he needed and was falling farther behind in his communication skills. Kids in social settings refused to play with him because they could not understand him, leading to social isolation and frustration. Although Isaiah continued to receive services in the school, they were limited. He was unable to get the frequent one-on-one speech therapy he desperately needed because the school-based speech-language pathologist simply didn't have the capacity to carry out that many services. The SLP agreed that Isaiah needed more services than they could provide. Kate followed the well-intentioned, if misguided, advice

of the school representatives about signing the paperwork “formality” and because of it, her son lost vital services in a critical window of development.

Some stakeholders may view these coverage challenges outside the schools as merely an issue of MCO program administration or faulty implementation of IDEA requirements. While ASHA does not question difficulties with program management, as illustrated by the multiple examples already discussed, we assert that this is an issue of preserving parental consent for important reasons, including ensuring children have access to the comprehensive services they need in and outside of the schools. The point remains that parents and students should be able to determine the best setting for services, especially considering the challenging program administration patterns across states.

If services offered outside of school are not covered because of billing for related services in schools, families will be responsible for paying for those services or the child will simply not receive them; this is the exact situation that the IDEA regulations are supposed to prevent. For instance, IDEA prohibits scenarios that would, “Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school,” as outlined in Section 300.154(d)(2)(iii)(B).²¹ Parents should be able to decide if billing for services for their child in the schools will do more harm than good and withhold consent for billing in the schools if they so choose. If schools are given unobstructed authority to bill without parental consent or the opportunity for parents to withdraw it, parents will be forced to weather the kind of difficulties described above without an avenue for redress. It is not difficult to see why parents may not offer consent to bill Medicaid in the school if these are the challenges they face.

In addition to keeping parental consent, ASHA also recommends that the Department encourage state agencies to ensure that consent forms clearly disclose that billing Medicaid for services in school may affect services received outside of school. We’ve reviewed examples of some current consent forms that make statements such as, “I understand that Medicaid reimbursement provided by the school district will not affect any other Medicaid services for which my child is eligible.”²² However, ASHA contends that a school district simply cannot guarantee the actions of third-party insurance companies or Medicaid state agencies. Stating that receiving services in the schools will not affect services outside the schools is an aspirational goal. ASHA members have shared scores of examples of how services within school walls have created barriers to care outside of them, like the ones we outlined above. Therefore, it is imperative for parents to understand that services in the schools affect services outside of them and to have the opportunity to evaluate and decide where and how their child receives services.

ASHA believes it’s important to consider that each Medicaid program has a finite budget in every state. Given that fact, the idea that funding increased services in schools by eliminating the parental consent requirement will not affect payment for services outside of the schools is fiscally implausible. State Medicaid programs are losing more money every quarter as they incrementally lose the 6.2% federal matching boost they had during the pandemic.²³ Approximately, 21.2 million people joined the Medicaid program between February 2020 and December 2022, and while some of these people are now being removed since the continuous enrollment requirement has expired, the program remains one of the largest health insurance programs for children available. Suggesting that increasing the number of school-based services billed to Medicaid by removing parental consent will not affect funding for the same level of services outside the school does not comport with the dire fiscal reality many state Medicaid programs are facing. Because of this proposed rule’s impact on services to children,

the 2013 changes (noted above) appropriately balance reducing unnecessary paperwork burden with the civil rights protections of children regarding how to best allocate public health care resources within and beyond the IEP process.²⁴

Parental Consent Opportunities in the IEP Process are Not Interchangeable

Parental consent is a foundational civil rights guardrail for IDEA. This is no less true in the decision for whom limited public benefits, such as Medicaid, are allocated. It is the parent and/or student who is in the best position to understand both the acute and long-term audiology and speech-language pathology needs of their child to ensure success. It is the right of parents and students to have access to services provided across educational and medical settings to receive the full scope of interventions and assessments to habilitate disabilities.

While we understand that there are other components of parental consent involved in IDEA, they are different in kind than what is offered currently. For instance, under Section 615(d)(2) discussing procedural safeguards, 1) prior written notice, 2) parental consent, and 3) access to educational records are listed separately.^{25,26,27}

FERPA is primarily about consent for the disclosure of personally identifiable information as it pertains to educational records. FERPA does not primarily speak to consent for matters pertaining to accessing IEP services or understanding and agreeing to billing for services such as Medicaid and the impact of such consent on the ability of a child to access future non-IDEA Medicaid health care services. Consent for the *disclosure* of information is different than consent for evaluation or provision of services. This is part of the reason the requirements of FERPA are different than the consent for a child to be evaluated for IDEA eligibility under Section 34 CFR 300.300(a) and consent for a child to receive special education services under IDEA Section 34 CFR 300.300(b).^{28,29}

Furthermore, the consent for Medicaid approved providers to bill for IEP services per Section 34 CFR 300.154(d)(2)(iv) is a guardrail to help ensure the provisions of Section 640(c) are followed to the maximum extent practicable that, “Nothing in this part shall be construed to permit the State to reduce medical or other assistance available or to alter eligibility under title V of the Social Security Act (relating to maternal and child health) or title XIX of the Social Security Act (relating to medicaid for infants or toddlers with disabilities) within the State.”^{30,31,32} While there is some overlap, each consent provision affords a unique and materially different statutorily based safeguard to ensure the maximum provision of services without incurring unintended harm to the child. **As a result, ASHA recommends maintaining the current language that, “specifies that the parent understands and agrees that the public agency may access the parent’s or child’s public benefits or insurance to pay for services under part 300.”³³**

This current requirement is a key safeguard to help ensure that IEP services cannot diminish other Medicaid reimbursable services and that services are delivered at no cost to the child’s family. If this language is removed, we know that these changes will have a negative impact on a child’s ability to access Medicaid health care services outside of the IEP construct. **ASHA strongly urges the Department to maintain the current interpretation of parental consent established by the Obama-Biden Administration.**³⁴ We believe this appropriately strikes the right balance between reducing an unnecessary paperwork burden and ensuring basic civil rights protections and access to health care services.

In addition to the three types of consent listed above, the Department has made the important distinction between the concepts of *consent* and *agree* in regulatory discussion, specifically

noting that, “the meaning of the terms ‘agree’ or ‘agreement’ is not the same as ‘consent.’”³⁵ The regulatory discussion further clarified the distinction between ‘agrees’ and ‘consent.’ The proposed changes to Section 300.154(d)(2)(iv)(B) specifically remove the ‘understands and agrees’ standard in addition to ‘consent.’³⁶ While there is some overlap, these consent provisions are distinct concepts based on the Department’s historic interpretation outlined in part in the previous regulatory discussion of these issues and the statutory provisions outlined by Congress. **ASHA urges the Department to continue to require all three types of consent because each serves a distinct and specific purpose.**

Furthermore, while Medicaid funding can be a helpful source for supporting schools, it is a bonus, and not the main source of funding. The Department’s focus should be on ensuring the full funding of IDEA. Siphoning limited funds from Medicaid to fund the civil rights obligations afforded under IDEA is an untenable solution. FAPE is ultimately the responsibility of the state education agency through IDEA and education is a protected state right. CMS has stated that it lacks the statutory and/or regulatory authority to compel the money that is generated by Medicaid billing to return to the special education departments. Children need robust funding in *both* educational and non-educational settings. There is already insufficient health care funding for children, and it seems less than optimal to incentivize taking more money away from one source of revenue as opposed to ensuring that there is a vote on the full funding of IDEA first. Medicaid cannot compensate for a lack of federal funding for essential programs, especially when getting the funds from Medicaid does not guarantee they will be used for children receiving special education services.

The Department recently announced that most states fell short of their basic civil rights obligations to provide FAPE.³⁷ **ASHA suggests that the Department focus on finding new sources of revenue—including advocating for full funding of IDEA—and ensuring the current requirements of IDEA are met before making such changes that could have negative consequences on a child’s ability to access audiology and speech-language pathology services, and other vital special education services, regardless of setting.** The educational agency should not be in a position to take away the ability for a parent to affirmatively consent, understand, and agree to services that have an impact beyond the IEP construct.

Privacy Concerns

ASHA appreciates that the proposed rule maintains both FERPA requirements regarding parental consent for disclosure as well as parental consent for evaluation and services under IDEA. These privacy guardrails are essential in the school setting. However, by removing parental consent for accessing services that could have a negative impact on the provision of health care services beyond the IEP construct, this proposed rule allows the school district to make decisions regarding how a student’s most personal health care records are shared with educational agencies and their personnel (contract and non-contract) that a parent and/or student may not want to share with them. For example, children receiving mental health may not want to discuss their family mental health issues in a group or school setting, or students who stutter or have other articulation issues may not feel as comfortable receiving speech-language pathology services at school in close proximity to their peers.

Parents and/or students are the only individuals that have a comprehensive understanding of the impact of sharing personal health information with other agencies and individuals. As more data, including meta data, is shared, it increases the chances of an unauthorized disclosure of a student’s most personal health care information.

Removal of Parental Consent Does Not Provide Equal Treatment of Children with and without Disabilities

The proposed rule emphasizes that removing the requirement for parental consent to bill Medicaid will ensure equal treatment of Medicaid eligible children with disabilities and Medicaid eligible children without disabilities because the latter group does not require parental consent to bill Medicaid.

Parental consent to bill Medicaid is a best practice that should be afforded to both children with and without disabilities. For example, the parents of a Medicaid eligible student who needs mental health services to support classroom interactions—but does not have an IEP—would still be best suited to determine where the child receives services and with whom. The school provider may not have a) the specific expertise required for the child’s needs (as all mental health providers are not interchangeable), b) sufficient availability for the needed number of sessions, c) capacity to provide the optimal mode of service for the child (e.g., group versus individual therapy), or d) a previously established therapeutic relationship like the student may have with an external provider.

As established, parents of Medicaid eligible children who are not able to consent are stripped of their right to determine the best setting for their child to receive services. ASHA understands the role that schools play in providing access to vital services for children with Medicaid, and that some children will not receive services outside of the school. However, this doesn’t mean that parents are not in the best position to elect whether or not they receive those services, especially when school-based billing could interrupt or terminate care in other settings.

In addition, there are material differences between a child with a disability and a child without a disability. When a child with a disability and an IEP has their services billed to Medicaid, the state agency (or the MCO) gains access to the IEP, which gives them additional health and education information beyond what a Medicaid eligible child without a disability would have to provide. This raises significant concerns regarding privacy as well as inequitable coverage of related services for children with a disability. As established earlier in our comments, the additional health and education information obtained by the state agency can be used to deny coverage of critical services outside of the school. Parents should be supported in their decisions to access a range of health care services for their children. Instead, the proposal creates a potential barrier to seeking services by creating this added privacy concern and potential risk for denials for children with disabilities.

As stated by now Vice President Kamala Harris when running for office in 2020, “There is a big difference between equality and equity.” Equality gives everyone the same thing, while equity gives them what they need to be on the same level playing field. ASHA contends that removing parental consent does not similarly situate Medicaid eligible children with a disability and Medicaid children without a disability, as the rule suggests, and does not promote equity, which is what schools should be attempting to achieve.

Caps on Services

With the ongoing fiscal pressures state governments face, there have been pushes to limit funding, such as implementing lifetime caps, that could harm coverage of services for Medicaid eligible children.³⁸ For example, states such as Kansas have recently requested lifetime caps on Medicaid coverage in certain circumstances, illustrating the active political movement to impose lifetime caps on individuals with disabilities. Since Medicaid agencies often follow each other’s policies, the negative effects of implementing such a policy would likely be widespread,

especially given there were already scarcity concerns before the Affordable Care Act became law.

As another example, North Carolina's Medicaid program uses a waiver that has budget limits and caps services based on the number of hours of care provided for medically needy children, including those with autism. This waiver would be extremely problematic for a family who could no longer opt-out of billing Medicaid in the schools because they would be forced to receive services in the schools to avoid exceeding the cap on the number of service hours afforded to their child through the Medicaid waiver. This demonstrates that there are still ways Medicaid enrolled children are denied coverage for health care services, even in a health system that has the coverage guardrails, which the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit affords (e.g., no caps on services provided).³⁹

Given these examples of proposed and existing caps on services, it is imperative that parental consent to bill Medicaid for school-based services remain in place. Educational agencies generally have a more limited and/or more acute view of a student's situation, and as such, ASHA respectfully argues that parents and/or students are in the best position to make decisions that may have a lifetime impact inside and outside of school.

Unequal Reimbursement and Potential for Clinical Licensure Risk

Concerns regarding appropriate billing not only impact a child's ability to receive services but may also impact a clinician's ability to maintain their license. CMS holds individual clinicians accountable for any issues that may arise due to incorrect interpretations of practice from supervisors, school districts, or state officials. Removing a key protection for parents could make clinicians legally liable for potential injury by CMS and through Supreme Court interpretations that have impact beyond the IEP/IDEA construct. The recent Supreme Court case regarding *Perez v. Sturgis Public Schools* and the intersection of IDEA and the Americans with Disabilities Act (ADA) illustrates this point.⁴⁰

In this case, there was the question of whether the provision of relief under IDEA precluded being able to seek relief under the ADA. The Court touched on how IDEA primarily focuses on schools and achieving educational and functional goals through the IEP process, while the ADA is more broadly an antidiscrimination statute covering individuals in and out of the school context and in public and private settings. Compensatory financial damages are available under the ADA but not IDEA. Compensatory damages can entail financial relief if a party is found to be in violation of the law. Since the type of relief may be different between aspects of the two laws, the Supreme Court ruled unanimously that IDEA does not forfeit an individual's ability to seek relief through other disability statutes for relief that are outside the scope of IDEA in this context. The administrative procedures (e.g., procedural safeguards) under IDEA focus on relief in terms of the provision of FAPE. This is a different type of relief than what the ADA provides. Since the proposed rule would allow the school to make clinical decisions that impact a child's ability to receive health care services beyond the IEP construct, this new Supreme Court decision could potentially allow for greater clinical and school district legal liability.

Treating school-based audiology, mental health, and speech-language pathology services differently than health care services outside of the school setting could also have a disparate impact on students of lower socioeconomic status and/or English Language Learners and cause material harm to the student. For instance, an individual of lower socioeconomic status may be treated differently because of the type of personal information that can be automatically shared (e.g., IEP) with Medicaid compared to an individual who bills under private insurance and isn't

required to divulge this information. There may also be disproportionate ramifications for English Language Learners if consenting to billing for Medicaid services under an IEP is not explicit and provided in an individual's native language.

Parents and/or students are in the best position to make decisions regarding how limited health care dollars are allocated. It should not be the decision of a billing office that may not have all of the information related to both the student's acute and long-term hearing, speech-language, or mental health needs. For instance, in states such as South Carolina, services outside of a school setting are reimbursed at a lower rate. For example, a therapy re-evaluation is reimbursed at \$61.68 per unit in school, but for outpatient, it is \$54.59 per unit. Group therapy is reimbursed at \$12.47 per unit in school, but for outpatient, it is \$11.60 per unit.⁴¹ Those differences may seem small but add up tremendously over time, especially given the overhead costs for an outpatient provider that are not seen by the provider in the schools. South Carolina is not alone, with higher rates of payment for school-based provider services in Nevada, Michigan, and other states. Given Medicaid's limited funding in many states, it is imperative that parents and/or students are the ones making holistic decisions for services such as audiology, speech-language pathology, and mental health services. Disparate rates based on settings, as outlined above, make parental consent even more critical to protecting how and where their Medicaid coverage is spent, especially when they have limited means to pay out-of-pocket for needed services.

Furthermore, removing parental consent to bill Medicaid also removes another quality/fraud check on billing by schools. Under the new system of billing announced in the recently released CMS billing guide, schools are subject to even fewer program integrity/fraud checks and balances (e.g., lack of prior authorization for school-based services that are often required outside of the schools). For instance, Medicaid agencies in states (e.g., Washington) where schools aren't required to bill under a fee-for-service model, could be forced to deal with potential duplication of services by disparately focusing on outpatient providers, who are subject to much more rigorous prior authorization and other documentation requirements, as illustrated in our earlier examples such as those from the NIA.

Conclusion

More IDEA funding is a shared goal. This goal can best be achieved by actively pursuing IDEA full funding and through CMS ensuring school-based Medicaid funding that is billed by audiologists and SLPs are returned to those programs that generated the Medicaid funding (e.g., special education). Compared to the last reauthorization of IDEA, the IDEA full funding amount as a percentage of the full funding amount is less not more.⁴² ASHA shares the goal of streamlining redundant paperwork. However, to truly address the issue of paperwork burden and the ever-increasing workload and caseload requirements for audiologists and SLPs, it is imperative that any proposed regulatory changes ensure new funding supports special education services, such as audiology and speech-language pathology. Also, any final rule must ensure equitable treatment for all students and providers regardless of setting. ASHA looks forward to working with the Administration on increasing funding for these vital services while balancing the need to ensure the provision of vital civil rights guardrails against any unintended consequences for children with disabilities and the school-based and clinical providers who support them.

Thank you for the opportunity to provide these comments and lend our members' expertise to help further inform the Department's deliberative process. If you or your staff have any questions regarding Medicaid, please contact Caroline Bergner, JD, ASHA's director of health

care policy for Medicaid, at bergner@asha.org, and for questions regarding FERPA and IDEA, please contact Bill Knudsen, ASHA's director of education policy, at bknudsen@asha.org.

Sincerely,



Robert M. Augustine, PhD, CCC-SLP
2023 ASHA President

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- ¹ American Speech-Language-Hearing Association. (2022). *2022 Member & Affiliate Profile. Annual Demographic and Employment Data*. <https://www.asha.org/siteassets/surveys/2022-member-affiliate-profile.pdf>.
- ² Federal Register. Vol. 78, No. 31. (2013 Feb. 14). *Rules and Regulations*. https://sites.ed.gov/idea/files/20130214-Part_B-final_regulations.pdf.
- ³ Individuals with Disabilities Education Improvement Act of 2004. <https://www.congress.gov/108/plaws/publ446/PLAW-108publ446.pdf>.
- ⁴ Federal Register. Vol. 71, No. 156. (2006 Aug. 14). *Rules and Regulations*. <https://www.govinfo.gov/content/pkg/FR-2006-08-14/pdf/06-6656.pdf>.
- ⁵ Federal Register. Vol. 78, No. 31. (2013 Feb. 14). *Rules and Regulations*. https://sites.ed.gov/idea/files/20130214-Part_B-final_regulations.pdf.
- ⁶ Individuals with Disabilities Education Improvement Act of 2004, Section 607(b). <https://www.congress.gov/108/plaws/publ446/PLAW-108publ446.pdf>.
- ⁷ Individuals with Disabilities Education Improvement Act of 2004, Section 640(c). <https://www.congress.gov/108/plaws/publ446/PLAW-108publ446.pdf>.
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