American Speech-Language-Hearing Association
Empowering audiologists, speech-language pathologists, and supporting speech, language, and hearing scientists.
ASHA /Disclosures

• **FINANCIAL** - Dr. Coleman is a member and employee of the American Speech-Language-Hearing Association and receives a salary. She is receiving no honorarium for the Van Riper Lecture Series.

• **NONFINANCIAL** - Dr. Coleman has no nonfinancial relationships to the content of this presentation.
• Federal Policy and Legislation 8:30 – 9:00
• Medicaid 9:00 – 10:00
• Caseload/Workload 10:15 – 11:45
ASHA / Federal Policy and Implications SLPs in Schools

- Individuals with Disabilities Education Act (IDEA)
- Every Student Succeeds Act (ESSA)
- Section 504 of the Rehabilitation Act of 1973
- Americans with Disabilities Act (ADA)
The Individuals with Disabilities Education Act (IDEA) is a federal mandate under which more than 6.5 million children in our nation's schools are served.

IDEA preserves a free appropriate public education (FAPE) for children with disabilities, including students with communication disorders, in the least restrictive environment (LRE).

IDEA Parts

• Part A – General Provisions
• Part B – Assistance for Education of All Children with Disabilities
• Part C – Infants and Toddlers with Disabilities
• Part D – National Activities to Improve Education of Children with Disabilities
ASHA / Individuals with Disabilities Education Act (IDEA)

- IDEA Part B
  - 3 years old – 21 years old

- IDEA Part B, Section 619
  - Applies to children ages 3 years old to 5 years old
  - States may apply the term developmental delay to children 3 years old to 9 years old or any subset of that range, including children 3 years old to 5 years old

- IDEA Part C
  - Birth to 3 years old
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 1975</td>
<td>Education of All Handicapped Children (P.L. 94-142)</td>
</tr>
<tr>
<td>August 1986</td>
<td>Attorney fee provisions in law (P.L. 99-372)</td>
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<tr>
<td>October 1986</td>
<td>Part H (now Part C) established (P.L. 99-457)</td>
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<tr>
<td>October 1990</td>
<td>Renamed statute the Individuals with Disabilities Education Act (IDEA) (P.L. 101-476)</td>
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<tr>
<td>June 1997</td>
<td>Individuals with Disabilities Education Act of 1997 (IDEA 1997) enacted (P.L. 105-17)</td>
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<tr>
<td>March 1999</td>
<td>ED released the final regulations for Part B of IDEA 1997</td>
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<td>Date</td>
<td>Event</td>
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<tr>
<td>December 2004</td>
<td>Individual with Disabilities Education Improvement Act of 2004, which amended IDEA, enacted (P.L. 108-446)</td>
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<tr>
<td>June 2005</td>
<td>ED released notice of proposed rulemaking on IDEA 2004 (Part B and Part D)</td>
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<tr>
<td>August 2006</td>
<td>ED released IDEA Part B final regulations</td>
</tr>
<tr>
<td>December 2008</td>
<td>ED released IDEA Part B supplemental regulations</td>
</tr>
<tr>
<td>September 2011</td>
<td>ED released IDEA Part C final regulations</td>
</tr>
<tr>
<td>February 2013</td>
<td>ED released IDEA Part B final regulations on the use of public benefits or insurance</td>
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ASHA / Individuals with Disabilities Education Act (IDEA)

- Qualification for special education
  - Educational and functional impact-adverse affect on educational, functional, social, and/or developmental performance

- Individualized Education Program (IEP)
  - Legal document that captures individualized and well-defined objectives toward meeting educational goals for students eligible for special education services
• Children with Disabilities Enrolled By Their Parents in Private Schools
• Cochlear Implants
• Continuum of Service Delivery Options
• Culturally and Linguistically Diverse Students
• Early Intervening Services
• Identification of Specific Learning Disabilities
• Individualized Education Programs and Eligibility for Services (OSEP issues letter of guidance-2011 [PDF])
• Interpreting Services for the Deaf or Hard of Hearing
• Medicaid and Other Third Party Reimbursement
• Missed Sessions
• Personnel Qualifications
• Uses of Special Education Funds
• **Children with Disabilities Enrolled By Their Parents in Private Schools**
  
  **Overview**
  
  The current IDEA regulations, released in 2006, require the local educational agency (LEA) where the private school is **geographically located** to conduct a thorough Child Find, including evaluations and/or re-evaluations, and provide equitable services for parentally-placed private school children.

  **Implications for ASHA Members**
  
  - ASHA members should familiarize themselves as much as possible with state and federal statutes and regulations pertaining to parentally-placed private school children with disabilities.
  - Members should be aware of the private schools geographically located within their LEA(s) to ensure that appropriate services are being provided to parentally-placed private school children with disabilities.
  - Members should also be familiar with the procedures for providing services to these children.
**Cochlear Implants**

**Overview**
- Optimization of a cochlear implant (CI) (a.k.a., mapping a CI) is not a covered service under IDEA.
- A child with a CI is entitled to the related services that provide access to special education, as indicated in the child’s individualized education program (IEP).
- A public agency is responsible for the routine checking of the external components of a surgically implanted device in much the same manner as a public agency is responsible for the proper functioning of hearing aids.

**Implications for ASHA Members**
- ASHA members should ensure that the external CI components are functioning.
- Learn about the Act, regulations, and specific needs of children with CIs.
- Develop a plan for addressing a non-functioning CI processor.
- Share with teachers and other educators the learning potential for children with CIs and special considerations for the needs of children with a hearing loss.
- Advocate for increased audiologic support.
• **Continuum of Service Delivery Options**
  • Overview
    • The IEP Team is responsible for developing a child's IEP, including determining the anticipated frequency, location, and duration of the services.

• **Implications for ASHA Members**
  • Service delivery determination can not be made as a matter of local or state policy, and can not be predetermined or based solely on factors such as disability category or severity, availability of space or staff, budgetary considerations, or administrative convenience.
  • If members find themselves limited in service delivery options by local or state policies, they should engage in advocacy efforts, such as working with administrators or building teams for local change, or through their state associations for change at the state level.
Culturally and Linguistically Diverse Students

Overview

- Assessment and other evaluation materials should be administered "in the form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally."
- States are required to review race and ethnicity data to identify disproportionality (§300.646); revise policies, procedures, and practices; and the local education agency (LEA) will reserve the maximum amount of funds under §613(f) of the statute to provide early intervening services to children in the LEA (see final IDEA rules on significant disproportionality from January 9, 2017)

Implications for ASHA Members

- Review the child's language history to determine the language of assessment.
- SLP must use all available resources, including interpreters when necessary, to appropriately administer a non-English language evaluation.
• **Early Intervening Services**
  • Overview
    • A local education agency (LEA) may use not more than 15 percent of the Part B funds it receives to develop and implement coordinated, early intervening services for children who have not been identified as eligible under the act but who need additional academic and behavioral support to succeed in a general education environment (§300.226).

• Implications for ASHA Members
  • Be familiar with current information on spoken language and literacy research-based interventions/instruction.
  • Adapt to a more systemic approach to serving schools, including consultation and collaboration in general education classrooms.
  • Be open to change—change in how students are identified for intervention; how interventions are selected, designed, and implemented, etc..
  • Advocate for an expanded role in actively participating in the development and provision of services for students identified as eligible for early intervening services
Identification of Specific Learning Disabilities

- Overview
  - Procedures for Identifying Children with SLD
  - Team Determining SLD
  - Criteria for Determining SLD
  - Required Observation

- Implications for ASHA Members
  - Become familiar with RTI processes as a means of identifying children with disabilities.
  - Advocate for the use of RTI in the schools where they work.
  - Be familiar with your state's policies pertaining to RTI.
Individualized Education Programs and Eligibility for Services

• Overview
  • Change from "performance" to "academic achievement and functional performance"
  • Increased emphasis on "academic, nonacademic and extracurricular activities"
  • Elimination of the requirement of benchmarks or short-term objectives, except for children with disabilities who take alternate assessments aligned to alternate achievement standards
  • Absence or excusal from IEP team meetings.

• Implications for ASHA Members
  • Individualize evaluations to ensure student's academic, developmental, and functional needs in academic, non-academic, and extracurricular settings are assessed.
  • Continue to develop and monitor short-term to determine intervention effectiveness and student progress
  • Ensure that team members are not excessively excused from meetings and that the requirement for written input does not become an unreasonable burden or impede communication about students’ progress and needs
• **Interpreting Services for the Deaf or Hard of Hearing**

  • **Overview**
    - Additions of transcription services and services for children who are deaf-blind
    - The changes broaden the more typical thinking that interpreting is the provision of sign language only

  • **Implications for ASHA Members**
    - Expand assessment protocols for children who are deaf or hard of hearing to determine their ability to use different modalities for receptive communication.
    - Become familiar with the different transcription systems to help determine if the child who is deaf, hard of hearing, or deaf-blind can access them
**Missed Sessions**

**Overview**

- The Dept. of Education urged “public agencies to consider the impact of a provider's absence or a child's absence on the child's progress and performance and to determine how to ensure the continued provision of FAPE in order for the child to continue to progress and meet the annual goals of his or her IEP.
- Whether an interruption of services constitutes a denial of FAPE is an individual determination that must be made on a case-by-case basis."

**Implications for ASHA Members**

- Check your employment agreement regarding missed sessions.
- Check with your district about obtaining qualified providers for missed services through contracted agencies and summer employment.
- This is impacted by who is missing (student or clinician) and whether the need to make up sessions to be in compliance with IEP and/or for Medicaid reimbursement
- Schools could also consider maintaining a pool or list of qualified substitutes.
- Share ED's letter of clarification with your administrators and to request a meeting with the IEP team when the you feel that a substitute is needed.
**Personnel Qualifications**

**Overview**

- Provision that required state education personnel standards to meet the highest requirement for a profession or discipline in that state was removed.
- The statute and the regulations removed the option that state requirements could be waived on an emergency, temporary, or provisional basis.
- The final regulations allow the use of paraprofessionals and assistants, but require that they be appropriately trained and supervised.

**Implications for ASHA Members**

- Monitor local and state policies and practices regarding personnel standards to ensure that services are being provided by qualified personnel.
- Participate in state and local decision-making groups
- Because of the wide variability of teaching credentials from one state to another, it is imperative that personnel understand the requirements for their states.
• **Uses of Special Education Funds**
  • **Overview**
    • Supplementary aids and services
    • Early Intervening Services (EIS)
    • High Needs/Cost of Special Education and Related Services
    • Administrative Case Management
    • Other Funding

• **Implications for ASHA Members**
  • Advocate for increased funding for speech, language, and hearing services in schools/school districts
  • Work with other educators, parents, and students to provide testimony to your local school board and administrators
  • Work with your state association and lobby policy makers (e.g., governor)
  • Send an email to your U.S. representative or senator via ASHA’s Take Action website ([https://cqrcengage.com/asha/file/KcmpmFRkCPp/IDEAFunding2018.pdf](https://cqrcengage.com/asha/file/KcmpmFRkCPp/IDEAFunding2018.pdf)) about full funding of IDEA
• December 2008 - ED released IDEA Part B supplemental regulations

• The final regulations amend current Part B regulations as published in the August 14, 2006 Federal Register in the areas of:
  • parental consent for continued special education and related services;
  • non-attorney representation in due process hearings
  • State monitoring and enforcement
  • Positive efforts to employ and advance in employment individuals with disabilities
December 2008 - ED released IDEA Part B supplemental regulations

Parental consent for continued special education and related services

Overview
- Parents can unilaterally revoke consent for special education and related services
- Public agency must, within a reasonable time, discontinue all special education and related services to the child

Implications for ASHA Members
- Could impact members’ caseloads
- SLPs can be asked to consult or provide support to teachers or students in the classroom
- Be familiar with state requirements for ceasing and reinstating services
December 2008 - ED released IDEA Part B supplemental regulations

State Monitoring and Enforcement

Overview

Any non-compliance by LEAs identified by the State education agency (SEA) must be corrected no later than one year following identification of the non-compliance.

Implications for ASHA Members

ASHA members should be active participants in the development of efforts in their district to implement short or long-term solutions to the non-compliance of speech-language pathology or audiology service provisions.
December 2008 - ED released IDEA Part B supplemental regulations

Non-attorney representation in due process hearings

Overview

- The right to be represented by non-attorneys, has been revised to apply to any party to a hearing, not just parents.

Implications for ASHA Member

- Members may need to be prepared to provide more technical and disability information as related to a communication disorder to all parties involved.
February 2013 - ED released IDEA Part B final regulations on the use of public benefits or insurance

Parental Consent

Overview

- The final regulations require that:
  - the public agency must obtain parental consent prior to accessing a child's or parent's public benefits or insurance for the first time;
  - the public agency must provide written notification to the child's parents both prior to accessing a child's or parent's public benefits or insurance for the first time and annually thereafter.
- There is some variation on this by LEA and also if Medicaid is also involved, the requirement may vary.
- For more information see https://www.asha.org/Advocacy/federal/idea/IDEA-Part-B-Issue-Brief-Parental-Consent/}

Implications for ASHA Member

- Members should ensure that the IEP team obtains written approval from the parent allowing access to public insurance for every newly enrolled student for the first time and provide written notification to the child's parents both prior to accessing a child's or parent's public benefits or insurance for the first time and annually thereafter, in accordance with the final regulations.
- ASHA members can request that the consent on file be prominently displayed.
• Endrew F. v. Douglas County School District
  • The individualized education program (IEP) process should be driven by individualized processing.
  • Every child should have the chance to meet challenging objectives.
  • The individualized decision-making required in the IEP process "requires careful consideration of the child's present levels of achievement, disability, and potential for growth."
• ED Guidance on Access to SLP Services for Children with Autism
  • Recognized the importance of SLP services that may be appropriate for students with autism
  • Emphasized that school systems must ensure that SLPs and other appropriate professionals are part of the evaluation and IEP/IFSP teams for students with ASD
  • Stated that "ABA therapy is just one methodology used to address the needs of children with ASD, and remind States and local programs to ensure that decisions regarding services are made based on the unique needs of each individual child with a disability (and the child's family in the case of Part C of IDEA)."
ASHA / Individuals with Disabilities Education Act (IDEA)

- ASHA’s IDEA Webpage: [https://www.asha.org/advocacy/federal/idea/](https://www.asha.org/advocacy/federal/idea/)
• Originally passed in 1990
• Reauthorized in 2009
• Requires "access to buildings, facilities, and transportation, and includes the provision of auxiliary aides and services to individuals with vision or hearing impairments" (Moore & Montgomery, 2008).
• Deals with accessibility to public domains (including communication access) and "prohibits discrimination on the basis of disability in employment, programs, and services provided by state and local governments, goods and services provided by private companies, and in commercial facilities" (U.S. Department of Justice, 1999, in Moore & Montgomery, 2008).
• The reauthorization expands the conditions considered to be disabilities under the ADA.
• The provisions of the ADA are closely aligned to Section 504.
Section 504 of the Rehabilitation Act of 1973

- Has a broader definition of disability than IDEA of 2004.
- Section 504 of the Rehabilitation Act of 1973 is a federal civil rights law that prohibits discrimination against individuals with disabilities in programs and activities that receive federal financial assistance.
- Students who are determined eligible under Section 504 will have a Section 504 accommodation plan
• Group Activity
1. What do Federal laws require of a public school to meet the communication needs of students with hearing, vision, or speech disabilities?
2. Will the aids and services required be the same under both Federal laws?
3. Does the school have to give a student the aid or service the parents request?
4. What types of aids or services could be required for students?
5. Where can I get more information about the rights of students with hearing, vision, or speech disabilities?
6. What can a parent do if the school won’t give a child what the parent thinks is needed?
## Postsecondary education: ADA vs. 504 vs. IDEA

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<thead>
<tr>
<th>Context</th>
<th>ADA</th>
<th>504</th>
<th>IDEA</th>
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| Postsecondary Programs | • Title II covers state-funded programs (e.g., universities, career and technical education programs)  
                         • Title III covers private colleges and vocational programs | • Postsecondary programs that receive federal funding are covered by section 504 regulations | N/A        |
<p>| Admissions         | • It is illegal to have eligibility requirements that omit people with physical or mental disabilities. | • It is illegal to have eligibility requirements that omit people with physical or mental disabilities. | N/A        |</p>
<table>
<thead>
<tr>
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<th>ADA</th>
<th>504</th>
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</table>
| Documentation | • ADA’s definition of disability differs from IDEA’s definition; as such, all students who meet IDEA’s criteria for disability do not meet the ADA postsecondary accommodations criteria. | • N/A| • Schools are required to create a Summary of Performance (SOP) for each graduating student who received special education or a person who exits a special education program for 18-21-year-olds (IDEA, 2004)  
  • SOPs cover academic achievement, functional performance, and recommendations for meeting postsecondary goals |
| Private vs. public | • Title III-covers private colleges and vocational programs  
  • More lenient modification requirements for programs that fall under Title III | • Does not apply to programs that do not receive federal funding | • N/A |

**ASHA /• Postsecondary education: ADA vs. 504 vs. IDEA**
ASHA / Regulatory Reform Agenda

- In place for federal agencies
- The Regulatory Reform Agenda requires federal agencies to reduce regulatory burdens through regulatory reform
- Specifically, OSERS:
  - Phase I - Out of 169 documents reviewed, OSERS identified 72 out-of-date guidance documents for withdrawal related to IDEA and the Rehabilitation Act.
  - Phase II - reviewing more significant regulations/guidance that are more impactful. Expected to be complete in the fall of 2018.
• The nation’s national K-12 education law

• Law reauthorized the Elementary and Secondary Act (ESEA)

• Every Student Succeeds Act (ESSA) replaced No Child Left Behind (NCLB)

• ESSA allows for greater flexibility for states to create their own accountability systems, academic goals, reporting, and other requirements.
ESSA contains many new opportunities for ASHA’s school-based audiologists and speech-language pathologists (SLPs) to

- consult with state and local leaders when developing their state plan;
- access more professional learning opportunities;
- play a greater role in literacy in the early grades; and
- develop more comprehensive early intervening and multi-tiered systems of support (MTSS) for struggling students.
• State Plans
• Funding Analysis
• Alternate Achievement Standards for Students With the Most Significant Cognitive Disabilities (1%)
• Specialized Instructional Support Personnel (SISP)
• Literacy
• Early Intervening Services and Multi-Tiered Systems of Support
• Professional Learning
• Professional Accountability
• Dyslexia
• Early Childhood Grants
• Overview
  • The law requires that the state consults with various stakeholders, including those representing specialized instructional support personnel (SISP).
  • State associations and local ASHA members have the opportunity to play an important role in providing information to the states as they develop their plans related to professional development, literacy, and early intervening services and assessments of children with disabilities.
• Implications for ASHA Members
  • Contact the state association and encourage the leadership to contact the State Department of Education to express an interest in serving on the committee that will develop the state’s ESSA implementation plan.
  • Become familiar with the law (using this guide) to determine how they might be able to assist their district administration with interpretation and implementation of the state plan.
ASHA /ESSA: Funding Analysis

• Overview
  • ESSA permits states and local education agencies (LEAs) the flexibility to use funds from Title I as well as the Individuals with Disabilities Education Act (IDEA) to develop innovative, evidence-based approaches to assist struggling learners in general education with the use of SISP.
ASHA /ESSA: Funding Analysis

• Implications for ASHA Members
  • The new “allowable use” of funds for SISPs throughout ESSA will enable ASHA members at the state and local levels to advocate for and access better professional development opportunities and have a greater role in literacy instruction in their schools.
  • ESSA permits states and LEAs the flexibility to use both Title I and IDEA funding streams to develop innovative, evidence-based approaches to assist struggling learners in general education with the use of SISPs.
• **Overview**
  
  • If a state opts to develop a system for assessing students with the most severe cognitive abilities, that state cannot assess more than 1% of the total student population without meeting various requirements, including securing a waiver from the U.S. Secretary of Education and having the student’s individualized education program (IEP) designate that alternate standards will be used for that student.
• Implications for ASHA Members
  • Work with their state association to ensure that communication disorders are understood and addressed in decision making in regards to students with significant cognitive disabilities.
  • Participate on teams creating or selecting the alternative achievement standards and assessments.
ASHA / ESSA: Specialized Instructional Support Personnel

- Overview
  - ESSA renamed the category of school-based qualified professionals, which includes audiologists and SLPs, from pupil services personnel to specialized instructional support personnel.
Implications for ASHA Members

- Members can use ASHA’s website to educate school administrators about the role of audiologists and SLPs in ESSA.
- Members can explain that the term specialized instructional support personnel reflects the wide range of providers who provide academic support to students in the classroom.
ASHA / ESSA: Literacy

• Overview
  • U.S. Secretary of Education can award competitive grants to states to develop, enhance, and implement comprehensive literacy instruction plans to improve literacy instruction for students who are at risk.
• Implications for ASHA Members
  • Members can share with administrators and staff their knowledge of early literacy and how school-based SLPs are an integral part of a team working on literacy goals.
  • State associations and members serving on ESSA implementation teams can develop information to share regarding the important role that SLPs play in early literacy.
• Overview
  • ESSA explicitly grants states and LEAs the flexibility to use the funding they receive through the law to be, “coordinated with similar activities and services carried out under the Individuals with Disabilities Education Act.”
ASHA / ESSA: Early Intervening Services and MTSS

• Implications for ASHA Members
  • Members can explain the importance of providing speech-language pathology services to struggling students in general education.
  • Members can describe the importance of a comprehensive team, including audiologists, SLPs, and other SISPs and providers, in meeting the needs of students in general education.
  • Members are encouraged to inform administrators that although ESSA allows for the flexibility in funding CEIS services, SISP services in general education should be provided through tapping a combination of funds or ESSA funds rather than through using IDEA funds.
ASHA / ESSA: Professional Learning

• Overview
  • ESSA, Title II, Preparing, Training, and Recruiting High-Quality Teachers, Principals, or Other School Leaders, is the primary section for professional learning and training opportunities for educators in the regular education space
• Implications for ASHA Members
  • Members can explain the importance of providing speech-language pathology services to struggling students in general education.
  • With new opportunities to be engaged in specialized professional learning, members can advocate to participate in professional learning activities that further their ability to provide high-quality services to students in general education.
  • Members can offer to provide training to staff about the important role that SLPs play in early literacy development.
Overview

- In ESSA, Title I, Section 1111, State Plans, requires states to “make public any methods or criteria the State is using to measure teacher, principal, or other school leader effectiveness.”
- In ESSA, the term effectiveness replaces the term highly qualified that was used in NCLB.
ASHA / ESSA: Professional Accountability

• Implications for ASHA Members
  • Members can advocate for evaluation processes that reflect the roles and responsibilities of audiologists and SLPs (e.g., PACE).
  • If the district/state is unable to adopt the PACE, then members can provide components of the PACE resource that could be used in the evaluation process (e.g., PACE Observation Form; PACE Matrix).
  • Members can provide administrators with resources that contain information about the roles and responsibilities of audiologists and SLPs in the schools.
• Overview
  • Title II, Section 2244, Technical Assistance and National Evaluation, requires the U.S. Secretary of Education to establish “a comprehensive center on students at risk of not attaining full literacy skills due to a disability.”
ASHA / ESSA: Dyslexia

• Implications for ASHA Members
  • Members can provide information and resources to their administrators on reading and literacy development.
  • Members can advocate to be part of the team working with students who have reading disabilities.
  • Members can provide education and training to other educators and administrators on the distinct roles of school-based SLPs treating students with reading disabilities.
  • Members can help parents and staff understand the impact that communication disorders may have on the development of reading skills.
Overview

Title IX, Section 9212, Preschool Development Grants, of the ESSA authorizes the Secretary of Health and Human Services (HHS) to offer grants to states “to develop, update, or implement a strategic plan that facilitates collaboration and coordination among existing programs of early childhood care and education in a mixed delivery system across the State designed to prepare low-income and disadvantaged children to enter kindergarten and to improve transitions from such system into the local educational agency or elementary school that enrolls such children.”
• Implications for ASHA Members
  • Members can encourage their state association to have an active presence with
    the State Department of Education and Health so that they can be aware of
    grants and other opportunities to work collaboratively with other SISPs.
  • Members can seek opportunities to work with funding system administrators to
    advocate for better access and coordination of care.
ASHA / ESSA: Resources

- Every Student Succeeds Act: Key Issues for ASHA Members -
  https://www.asha.org/uploadedFiles/Every-Student-Succeeds-Act-Key-Issues.pdf
ASHA / Medicaid

- What is Medicaid?
- Medicaid vs. IDEA
- Medicaid in Schools
- ASHA People and Material Resources
Medicaid Basics

- Enacted in 1965 as part of Title XIX of the Social Security Act
- Partnership program funded jointly between the States and Federal Government
- Beneficiaries include low-income families and children, pregnant women, the elderly, people with disabilities
- 35,781,107 children receive health care through Medicaid and CHIP
- Schools began billing Medicaid in 1987
**ASHA / Medicaid Roles**

**Federal Role**
- Establishes broad guidelines, minimum standards, and qualifications
- Oversight of the State Medicaid plans
- Processes plan amendments and waiver requests
- Ensures program integrity

**State Role**
- Administers the program
- Determines eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets payment rates
The Medicaid program is NOT the same in all states

- The Federal Government does not decide what all Medicaid programs look like
- States have flexibility to design their own Medicaid programs within federal guidelines
- Each state’s plan—and subsequent amendments to the plan—must be reviewed and approved by the federal government in order for a state to receive federal matching funds.
- The state plan is the funding agreement between the state Medicaid agency and the federal government.
• Children in low income families receive important screenings and treatment under Medicaid’s Early Periodic Screening Diagnostic and Treatment (EPSDT) program, so that health problems are diagnosed and treated as early as possible.

• This is particularly important for children who are more likely to experience developmental delays due to challenges such as poor nutrition or exposure to lead-based paint.

• Medicaid EPSDT helps catch such developmental delays, connects children to the appropriate treatment.
• Authority to function autonomously within the scope of practice of a human services profession is signified when members of that profession:
  • are a point of entry for services that fall within its scope of practice;
  • select the appropriate candidates for those services;
  • determine appropriate diagnostic methodology and suitable approaches to and throughout the duration of treatment;
  • effect referrals for services to be provided by other speech-language pathologists and audiologists as well as by members of other professions
• The determination made on a case-by-case basis, taking into account the particular needs of the child.
• States are permitted (but not required) to set parameters that apply to the determination of medical necessity in individual cases, but those parameters may not contradict or be more restrictive than the federal statutory requirement.
• Stedman’s medical dictionary – “interruption, cessation, or disorder of body function.”
• Impaired speech and language, loss of hearing, and swallowing difficulties – reflect loss of body functions
• Disorders with neurological basis – head injury, Parkinson’s disease, stroke, autism, cerebral palsy
• Developmental conditions/impairments – differ from the normal condition
• Developmental conditions – indicates an abnormal state of function – SLP treatment are as medically necessary as for someone who has suffered a stroke
• Part A – General Provisions
• Part B – Assistance for Education of All Children with Disabilities
• Part C – Infants and Toddlers with Disabilities
• Part D – National Activities to Improve Education of Children with Disabilities
**EPSDT**

- Medicaid covered services included in the IEP may be provided in, and reimbursed to, schools. Needs in physical, cognitive, communication, adaptive, and social and emotional development, for children from birth to age 3.
- Schools are particularly appropriate places to provide medical, vision, and hearing screenings; vaccinations; some dental care; and behavioral health services.

**IDEA**

- Requires that every child with a disability have available a free appropriate public education that includes special education and related services.
- Part B requires the development and implementation of an individualized education program (IEP) that addresses the unique needs of each child with a disability ages 3 through 21.
- These services are provided pursuant to an Individualized Family Service Plan (IFSP).
- Part C covers early intervention services.
IDEA

• Ensures the protection of the confidentiality of any personally identifiable data
• Rights under the Family Educational Rights and Privacy Act (FERPA) of 1974

Medicaid

• Individuals providing Medicaid services are required to comply with the Health Insurance Portability and Accountability Act (HIPAA)
IDEA
• Local Educational Agency (LEA) where the school is located to conduct thorough Child Find
• LEA responsible for paying for equitable services provided to a parentally-placed private school child

Medicaid
• There are no federal regulations that require school systems to bill the Medicaid program
• There may be restrictions on providing services in schools and private under Medicaid at the same time
School districts rely on Medicaid to help provide school-based health care such as vaccinations, vision and hearing screenings, and mental health care.

School districts also use Medicaid funding to help pay for medically necessary special education services under the Individuals with Disabilities Education Act (IDEA).

- IDEA was written to cover up to 40% of special education funding
- IDEA currently funded at 15.7%
- Medicaid helps to bridge the gap
• Section 1903 (c) of Section 411 of the Medicaid Catastrophic Coverage Act:
  • amended allows Medicaid coverage of health related services to children under Individuals with Disabilities Education Act (IDEA).

• Section 1903(a) of the Social Security Act:
  • requires Medicaid to pay for covered services in an IEP
School-Based Services

- Centers for Medicare and Medicaid Services (CMS) recognizes school providers, as long as all Medicaid requirements for the provision and reimbursement of Medicaid services are followed

- Medicaid qualified provider

- IEP/IFSP included services are covered
Some states have changed the requirements so that a physician’s signature is needed for billing Medicaid in the schools (vs. the IEP serving as statement of Medical Necessity).

Overlap of school provided vs. private provider of services.
• Importance of billing and funding positions
• Making up the gap for IDEA and budgets
• Provides for technology (real-time billing, reduction in paperwork, connection with technology)
• Need for streamlining of information between districts as well as across states
• Timely access to care
Importance of School Medicaid Programs

- Population of Medicaid recipients: Monetary access to services limited – knowledge of advocacy is limited – schools can help advocacy efforts/access to care
- Impacts on workload/caseload
- Medicaid money received from billing can be used for people, staffing, equipment
- Reduction of caseload = better care for students
It is important to know and understand what is being required in your state.

While some states may require school-based providers to obtain and use their individual NPI numbers when billing for services rendered, other states allow school-based providers to bill under the facility (e.g., school district or facility) identifier.

School-based professionals should consult with state and local administration to determine if an individual NPI number is required. The decision of whether you must have an NPI number or "unique identifier number" will be made by your individual state's health care authority.
A “speech pathologist” is an individual who meets one of the following conditions: (Section 440.110(c))

- CCC-SLP
- Completed equivalent education requirements and work experience for the certificate
- Completed academic program-acquiring supervised work experience (CF)
• Varies by state
  • Varies by setting – more common in schools than in other health care settings

• Varies by state licensure board – some states have temporary or provisional licensure status for CFs who may be able to provide services to Medicaid clients
• Current Medicaid rules governing audiology and speech-language pathology services also permit States the flexibility to provide audiology and SLP services by, or under the direction of, a qualified audiologist or SLP.

• This flexibility is recognized and widely used by States to provide audiology and SLP services to Medicaid-eligible children under IDEA in school-based settings.

• Existing regulations at § 440.110(c) define requirements.
ASHA /SLPAs

- Can SLPAs treat?
- Can they bill- independent billing – or does the SLP bill?
- In what setting?
- What level of supervision is needed?
• For each requirement, there is state variability
  – For example:
    • Paraprofessionals may be acceptable as a provider in the schools, but that doesn’t necessarily mean that Medicaid can be billed for the service.

• A good rule of thumb is to go with the most stringent requirement and then you cover the majority of payers.
• Medicaid Committee -
  https://www.asha.org/About/governance/committees/CommitteeSmartForms/Medicaid-Committee/

• School Finance Committee –
  https://www.asha.org/About/governance/committees/CommitteeSmartForms/School-Finance-Committee/
• Medicaid Coverage of Speech-Language Pathologists and Audiologists -
  https://www.asha.org/practice/reimbursement/medicaid/

  – Highlights
  • Medicaid Toolkit
  • Medicaid Coverage Policies
  • School-Based Services
  • Frequently Asked Questions
  • Medicaid Overview
ASHA / • Student/Patient Confidentiality & Privacy

• FERPA
  • Family Educational Rights and Privacy Act (FERPA) (1974)
  • This federal law that addresses student records, including who can have access to these records.
  • The law ensures that parents/guardians have an opportunity to have the records amended and provides families some control over the disclosure of information from the records.

• PPRA
  • The Protection of Pupil Rights Amendment (PPRA) (1978)
  • Parents have the right of written consent before their children are required to participate in any federally funded survey, analysis or evaluation dealing with information such as political affiliations or religious beliefs
• HIPAA
  • Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  • The law that pertains to protected health information (PHI).
  • In most cases, HIPAA privacy rules do not apply to public schools
  • Private school: could be HIPAA or FERPA
• COPPA
  • Children’s Online Privacy Protection Act (COPPA) (1998)
  • A federal student privacy law regulated by the Federal Trade Commission that requires operators of commercial websites, online services, and mobile apps to notify parents and obtain their consent before collecting any personal information on children under the age of 13.
  • The aim of COPPA is to give parents more control over what information is collected from their children online.
• Sometimes both HIPAA and FERPA apply.

• FERPA is usually stricter, but if Medicaid is involved HIPAA is required.
• **Group Activity**
  – Put a push pin in your state that represents your caseload number
### ASHA 2018 SLP Schools Survey: Survey Summary Report

#### Question 4:
What are your greatest challenges as a school-based professional? **Select all that apply.** (Percentages) Responses were in alphabetical order on survey instrument.

Analyses limited to respondents who met the following criterion:

- CCC-SLP

<table>
<thead>
<tr>
<th>Challenge</th>
<th>All Facility Types (n = 2,170)</th>
<th>Special Day/Residential (n ≥ 83)</th>
<th>Preschool (n ≥ 279)</th>
<th>Elementary (n ≥ 1,195)</th>
<th>Secondary (n ≥ 278)</th>
<th>Admin. Office (n ≥ 49)</th>
<th>Combination (n ≥ 163)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large amount of paperwork</td>
<td>79.2</td>
<td>67.9</td>
<td>78.9</td>
<td>81.9</td>
<td>71.0</td>
<td>79.6</td>
<td>78.0</td>
</tr>
<tr>
<td>High workload/caseload size</td>
<td>71.2</td>
<td>56.0</td>
<td>73.2</td>
<td>73.6</td>
<td>62.4</td>
<td>75.5</td>
<td>71.8</td>
</tr>
<tr>
<td>Limited time for collaboration</td>
<td>53.5</td>
<td>36.1</td>
<td>43.6</td>
<td>55.9</td>
<td>51.3</td>
<td>62.0</td>
<td>62.0</td>
</tr>
<tr>
<td>Budget constraints</td>
<td>46.9</td>
<td>26.5</td>
<td>50.9</td>
<td>45.7</td>
<td>46.2</td>
<td>46.0</td>
<td>53.0</td>
</tr>
<tr>
<td>Incorporating optimal service delivery models</td>
<td>43.6</td>
<td>34.5</td>
<td>42.9</td>
<td>45.5</td>
<td>45.5</td>
<td>60.0</td>
<td>36.6</td>
</tr>
</tbody>
</table>

**Statistical significance:** $\chi^2(5) = 23.5$, $p = .000$, Cramer’s $V = .107$

**Conclusion:** There is adequate evidence from the data to say that the responses vary by facility type.

**Statistical significance:** $\chi^2(5) = 24.5$, $p = .000$, Cramer’s $V = .109$

**Conclusion:** There is adequate evidence from the data to say that the responses vary by facility type.

**Statistical significance:** $\chi^2(5) = 30.5$, $p = .000$, Cramer’s $V = .122$

**Conclusion:** There is adequate evidence from the data to say that the responses vary by facility type.

**Statistical significance:** $\chi^2(5) = 18.7$, $p = .002$, Cramer’s $V = .095$

**Conclusion:** There is adequate evidence from the data to say that the responses vary by facility type.

**Statistical significance:** $\chi^2(5) = 13.3$, $p = .021$, Cramer’s $V = .080$

**Conclusion:** There is adequate evidence from the data to say that the responses vary by facility type.
• **Caseload** refers to the number of students with Individualized Education Programs (IEPs), Individualized Family Service Plans (IFSPs), and 504 plans served by school-based speech-language pathologists (SLPs) and other professionals through direct and/or indirect service delivery options.

• **Workload** refers to all activities required and performed by school-based SLPs.

• The **total number of workload activities** required and performed by school-based SLPs should be taken into account when establishing caseloads.
Median caseload sizes ranged from 3-145, with the median caseload being 48.

The largest median caseload of 76 was in Indiana and smallest, 30, was in New York.

Supervision of students and SLP: the majority said workload increased (46.3%), but caseload decreased (35.9%).

28% of SLPs reported no role in MTSS/RTI or preferral.
<table>
<thead>
<tr>
<th>State</th>
<th>Caseload</th>
<th>State</th>
<th>Caseload</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama (AL)</td>
<td>Montana (MT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alaska (AK)</td>
<td>Nebraska (NE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arizona (AZ)</td>
<td>Nevada (NV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arkansas (AR)</td>
<td>New Hampshire (NH)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>California (CA)</td>
<td>New Jersey (NJ)</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Colorado (CO)</td>
<td>New Mexico (NM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connecticut (CT)</td>
<td>New York (NY)</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Delaware (DE)</td>
<td>North Carolina (NC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District of Columbia (DC)</td>
<td>North Dakota (ND)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Florida (FL)</td>
<td>Ohio (OH)</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>Georgia (GA)</td>
<td>Oklahoma (OK)</td>
<td></td>
<td>50</td>
</tr>
<tr>
<td>Hawaii (HI)</td>
<td>Oregon (OR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Idaho (ID)</td>
<td>Pennsylvania (PA)</td>
<td></td>
<td>54</td>
</tr>
<tr>
<td>Illinois (IL)</td>
<td>Rhode Island (RI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana (IN)</td>
<td>South Carolina (SC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa (IA)</td>
<td>South Dakota (SD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kansas (KS)</td>
<td>Tennessee (TN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kentucky (KY)</td>
<td>Texas (TX)</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>Louisiana (LA)</td>
<td>Utah (UT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maine (ME)</td>
<td>Vermont (VT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maryland (MD)</td>
<td>Virginia (VA)</td>
<td></td>
<td>49</td>
</tr>
<tr>
<td>Massachusetts (MA)</td>
<td>Washington (WA)</td>
<td></td>
<td>48</td>
</tr>
<tr>
<td>Michigan (MI)</td>
<td>West Virginia (WV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minnesota (MN)</td>
<td>Wisconsin (WI)</td>
<td></td>
<td>40</td>
</tr>
<tr>
<td>Mississippi (MS)</td>
<td>Wyoming (WY)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missouri (MO)</td>
<td>42</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. n = 1,231 for the 23 states with reportable data. Blank cells indicate that fewer than 25 respondents provided data.
Figure 2: Median Caseload Size, by Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Median Caseload Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>40</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>35</td>
</tr>
<tr>
<td>E. N. Central</td>
<td>43</td>
</tr>
<tr>
<td>W. N. Central</td>
<td>43</td>
</tr>
<tr>
<td>E. S. Central</td>
<td>50</td>
</tr>
<tr>
<td>W. S. Central</td>
<td>57</td>
</tr>
<tr>
<td>Mountain</td>
<td>50</td>
</tr>
<tr>
<td>Pacific</td>
<td>52</td>
</tr>
</tbody>
</table>

Note. $n = 1,539$. A list of states assigned to each area can be found in the Appendix.
Barriers to Working With a Manageable Caseload Size

- 28% Lack of administration support
- 27% Shortage of SLPs in my area
- 23% Other barriers (e.g., funding)
- 13% District policy
- 9% State policy

n = 343
Factors that Impact Caseload/Workload

• School funding

• Paperwork/documentation
### Federal Appropriations for IDEA Part B, Section 611 (children ages 3–21)

<table>
<thead>
<tr>
<th>Fiscal year</th>
<th>Children served (in thousands)</th>
<th>Appropriation (in thousands of dollars)</th>
<th>Federal share per child served (dollars)</th>
<th>Percentage of APPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>4,236</td>
<td>1,431,737</td>
<td>338</td>
<td>9%</td>
</tr>
<tr>
<td>1989</td>
<td>4,347</td>
<td>1,475,449</td>
<td>339</td>
<td>8%</td>
</tr>
<tr>
<td>1990</td>
<td>4,419</td>
<td>1,542,810</td>
<td>349</td>
<td>8%</td>
</tr>
<tr>
<td>1991</td>
<td>4,567</td>
<td>1,864,186</td>
<td>406</td>
<td>9%</td>
</tr>
<tr>
<td>1992</td>
<td>4,727</td>
<td>1,976,096</td>
<td>418</td>
<td>8%</td>
</tr>
<tr>
<td>1993</td>
<td>4,896</td>
<td>2,052,728</td>
<td>419</td>
<td>8%</td>
</tr>
<tr>
<td>1994</td>
<td>5,101</td>
<td>2,149,686</td>
<td>421</td>
<td>8%</td>
</tr>
<tr>
<td>1995</td>
<td>5,467</td>
<td>2,322,915</td>
<td>425</td>
<td>8%</td>
</tr>
<tr>
<td>1996</td>
<td>5,629</td>
<td>2,323,837</td>
<td>413</td>
<td>7%</td>
</tr>
<tr>
<td>1997</td>
<td>5,806</td>
<td>3,107,522</td>
<td>535</td>
<td>9%</td>
</tr>
<tr>
<td>1998</td>
<td>5,978</td>
<td>3,807,700</td>
<td>636</td>
<td>11%</td>
</tr>
<tr>
<td>1999</td>
<td>6,133</td>
<td>4,310,700</td>
<td>701</td>
<td>11%</td>
</tr>
<tr>
<td>2000</td>
<td>6,274</td>
<td>4,988,686</td>
<td>793</td>
<td>12%</td>
</tr>
<tr>
<td>2001</td>
<td>6,381</td>
<td>6,339,685</td>
<td>991</td>
<td>14%</td>
</tr>
<tr>
<td>2002</td>
<td>6,483</td>
<td>7,528,533</td>
<td>1,159</td>
<td>15%</td>
</tr>
<tr>
<td>2003</td>
<td>6,611</td>
<td>8,874,398</td>
<td>1,340</td>
<td>17%</td>
</tr>
<tr>
<td>2004</td>
<td>6,723</td>
<td>10,068,106</td>
<td>1,495</td>
<td>18%</td>
</tr>
<tr>
<td>2005</td>
<td>6,820</td>
<td>10,589,746</td>
<td>1,558</td>
<td>18%</td>
</tr>
<tr>
<td>2006</td>
<td>6,814</td>
<td>10,582,961</td>
<td>1,551</td>
<td>18%</td>
</tr>
<tr>
<td>2007</td>
<td>6,796</td>
<td>10,782,961</td>
<td>1,584</td>
<td>17%</td>
</tr>
<tr>
<td>2008</td>
<td>6,718</td>
<td>10,947,511</td>
<td>1,609</td>
<td>17%</td>
</tr>
<tr>
<td>2009</td>
<td>6,599</td>
<td>22,805,211*</td>
<td>3,453</td>
<td>33%</td>
</tr>
<tr>
<td>2010</td>
<td>6,614</td>
<td>11,505,211</td>
<td>1,736</td>
<td>16%</td>
</tr>
<tr>
<td>2011</td>
<td>6,552</td>
<td>11,465,960</td>
<td>1,745</td>
<td>16%</td>
</tr>
<tr>
<td>2012</td>
<td>6,543</td>
<td>11,577,856</td>
<td>1,766</td>
<td>16%</td>
</tr>
<tr>
<td>2013</td>
<td>6,574</td>
<td>10,974,866**</td>
<td>1,674</td>
<td>15%</td>
</tr>
<tr>
<td>2014</td>
<td>6,593</td>
<td>11,472,848</td>
<td>1,743</td>
<td>16%</td>
</tr>
<tr>
<td>2015</td>
<td>6,691</td>
<td>11,497,848</td>
<td>1,717</td>
<td>16%</td>
</tr>
<tr>
<td>2016</td>
<td>6,691</td>
<td>11,912,848</td>
<td>1,777</td>
<td>16%</td>
</tr>
<tr>
<td>2017</td>
<td>6,814</td>
<td>12,002,848</td>
<td>1,761</td>
<td>16%</td>
</tr>
</tbody>
</table>

*2009 includes funds made available under the ARRA (P.L. 111–15).

**2013 reflects the impact of sequestration required under the Budget Control Act of 2011.

### TABLE 1
Federal Expenditures by Program in 2017 and Change in Expenditures from 2016

<table>
<thead>
<tr>
<th>Program</th>
<th>2017</th>
<th>Change from 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Health</td>
<td>111.9</td>
<td>1.5</td>
</tr>
<tr>
<td>Medicaid</td>
<td>89.9</td>
<td>*</td>
</tr>
<tr>
<td>CHIP</td>
<td>15.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Vaccines for children</td>
<td>4.4</td>
<td>*</td>
</tr>
<tr>
<td>Other health</td>
<td>2.1</td>
<td>*</td>
</tr>
<tr>
<td>2. Nutrition</td>
<td>50.0</td>
<td>-2.1</td>
</tr>
<tr>
<td>SNAP (formerly Food Stamps)</td>
<td>30.6</td>
<td>-1.8</td>
</tr>
<tr>
<td>Child nutrition</td>
<td>22.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Special Supplemental food (WIC)</td>
<td>5.0</td>
<td>-0.3</td>
</tr>
<tr>
<td>3. Income Security</td>
<td>54.3</td>
<td>-2.0</td>
</tr>
<tr>
<td>Social Security</td>
<td>20.8</td>
<td>-0.4</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families</td>
<td>12.8</td>
<td>0.1</td>
</tr>
<tr>
<td>Supplemental Security Income</td>
<td>10.5</td>
<td>-1.4</td>
</tr>
<tr>
<td>Veterans benefits</td>
<td>6.8</td>
<td>-0.2</td>
</tr>
<tr>
<td>Child support enforcement</td>
<td>4.1</td>
<td>-0.1</td>
</tr>
<tr>
<td>Other income security</td>
<td>-0.6</td>
<td>*</td>
</tr>
<tr>
<td>4. Education</td>
<td>41.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Education for the Disadvantaged (Title I, Part A)</td>
<td>16.2</td>
<td>0.4</td>
</tr>
<tr>
<td>Special education/IDEA</td>
<td>12.7</td>
<td>-0.1</td>
</tr>
<tr>
<td>School improvement</td>
<td>4.4</td>
<td>*</td>
</tr>
<tr>
<td>Indian education</td>
<td>1.2</td>
<td>*</td>
</tr>
<tr>
<td>Innovation and improvement</td>
<td>1.3</td>
<td>*</td>
</tr>
<tr>
<td>Impact Aid</td>
<td>1.5</td>
<td>0.2</td>
</tr>
<tr>
<td>Dependents’ schools abroad</td>
<td>1.2</td>
<td>*</td>
</tr>
<tr>
<td>Other education</td>
<td>3.1</td>
<td>0.3</td>
</tr>
</tbody>
</table>

| 5. Early Education and Care                  | 14.9 | 0.4              |
| Head Start (including Early Head Start)      | 8.9  | 0.1              |
| Child Care and Development Fund             | 5.7  | 0.3              |
| Other early education and care               | 0.3  | *                |
| 6. Social Services                          | 10.1 | -0.3             |
| Foster care                                 | 4.9  | *                |
| Adoption assistance                          | 2.5  | -0.1             |
| Other social services                        | 2.7  | -0.2             |
| 7. Housing                                  | 9.5  | 0.2              |
| Section 8 low-income housing assistance      | 7.7  | 0.3              |
| Low-rent public housing                     | 1.0  | *                |
| Other housing                               | 0.7  | *                |
| 8. Training                                 | 1.2  | -0.1             |
| 9. Refundable Portions of Tax Credits        | 74.0 | -2.9             |
| Earned income tax credit                     | 53.1 | -1.6             |
| Child tax credit                            | 19.4 | -1.1             |
| Premium tax credit                          | 0.6  | -0.2             |
| Other refundable tax credits                 | 0.8  | *                |
| 10. Tax Reductions                          | 106.2| 1.3              |
| Dependent exemption                         | 37.8 | 0.2              |
| Exclusion for employer-sponsored health insurance | 22.9 | 0.9              |
| Child tax credit (nonrefundable portion)     | 29.9 | -0.3             |
| Earned income tax credit (nonrefundable portion) | 7.0  | *                |
| Dependent care credit                       | 3.3  | *                |
| Other tax reductions                        | 5.3  | 0.4              |

| TOTAL EXPENDITURES ON CHILDREN | 481.5 | -3.4 |
| OUTLAYS SUBTOTAL (1–9)         | 375.3 | -4.6 |
ASHA / Caseload/Workload

What would happen if schools lose their Medicaid dollars?

School districts receive $4 billion in Medicaid reimbursement annually. These dollars are used to support professionals in schools who provide services to special education students in accordance with their IEP as well as to provide basic health services for all students such as asthma and diabetes management as well as mental health services. You can read more about how districts use Medicaid dollars at aasa.org/medicaidcuts.

In December 2017, AASA asked school districts what would happen if they lost their Medicaid reimbursement due to a change in Medicaid’s structure at the federal level.

THESE ARE THEIR RESPONSES

- **57%** will have difficulty meeting special education mandates in state and federal law without Medicaid funds.
- **36%** will be forced to reduce mental health services and providers without Medicaid funding.
- **32%** will be unable to intervene early in identifying and addressing health needs for students without Medicaid funds.
- **29%** will have to cut general education positions and programs to compensate for Medicaid dollars.
- **26%** will have to ask their community to raise local revenue to compensate for lost Medicaid dollars.
- **25%** will have to eliminate staff positions that address student health needs.
- **25%** will have to limit or end efforts to enroll children in Medicaid/CHIP programs.
- **16%** will be unable to provide services and programs for opioid impacted students.

Data gathered from a survey of 500 superintendents and school leaders in 46 states.
### Table 2: Types of Burdens Associated with Administrative Tasks under the Individuals with Disabilities Education Act (IDEA), as Identified by GAO Focus Group Participants

<table>
<thead>
<tr>
<th>Administrative Tasks</th>
<th>Complicated&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Time-intensive&lt;sup&gt;b&lt;/sup&gt;</th>
<th>Paperwork-intensive&lt;sup&gt;c&lt;/sup&gt;</th>
<th>Resource-intensive&lt;sup&gt;d&lt;/sup&gt;</th>
<th>Duplicative&lt;sup&gt;e&lt;/sup&gt;</th>
<th>Vague&lt;sup&gt;f&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing individualized education program (IEP) documents&lt;sup&gt;g&lt;/sup&gt;</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Focusing too much on compliance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Meeting state or local special education requirements</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Using technology</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Engaging in child find or determining eligibility</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Monitoring or reporting student progress</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ensuring due process</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Documenting behavioral problems</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Implementing IEPs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparing State Performance Plan/Annual Performance Report&lt;sup&gt;h&lt;/sup&gt;</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Source: GAO analysis of focus group comments. | GAO-16-25

Note: A checkmark indicates, for the tasks cited as particularly burdensome in table 1, the nature of the burden as described by one or more focus group participants.
ASHA /Impact of large caseloads

- Constrained service delivery options
- Inability to engage consistently or periodically in collaboration or interprofessional practice
- Recruitment and retention of SLPs
- Supervision of student clinicians, CFs, SLPAs, classroom aids
- Professional development and leadership opportunities
- May result in increased mediations and due process hearings
- Increased paperwork and documentation
ASHA /Workload Factors

School SLP Workload Activities

- Professional Influences: Increase in scope of practice
- Caseload: Number of students served
- IDEA Mandates: FAPE, LRE
- School Policies & Expectations: Data collection, third party billing
- State and Local Budgets
- Unfunded Mandates: No waiting lists
- Student Factors: Expanding range & severity of disabilities
- State and Local Regulations: Eligibility and dismissal criteria
- State Certification Requirements
Why doesn’t ASHA recommend a caseload number?

• In the past, ASHA did recommend a caseload number; some states saw the recommendation as a minimum caseload size and others said there was not research to support the caseload number proposed.

• A specific caseload number does not take into account the variation in needs of students receiving speech-language services.

• Caseload number is only one factor that impacts workload. Others include direct services, indirect services, duty, etc.

• Therefore, determination of caseload via workload analysis and assignment of SLPs based on workload vs. caseload is recommended.
• Contract Language
• Expansion of MTSS
• IEP Factors
• Staffing.
• Telepractice
• Use of SLPAs
• Use of Technology
• Use of Staff Specialists
• Weighted Caseloads
ASHA /Scheduling Strategies

- 3:1 Model
- Cyclical Schedule (e.g., block scheduling)
- Flex Schedule
- Receding Schedule
- Weekly Schedule
• Pull-Out (small group or one-on-one)
• Classroom Based
• Community Based
• Combined Service Delivery Models
• Service Delivery in Nonacademic and Extracurricular Settings
• Group Activity
  – Case Examples
  – Resources
Activity

- Participants will need to have caseload and workload data to participate; see the Implementation Guide: A Workload Analysis Approach for Establishing Speech-Language Caseload Standards in Schools for more details.
ASHA / Take Home Message

- Federal Policy
- Medicaid
- Caseload/Workload
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