

INFANT & TODDLER CONNECTION OF VIRGINIA
SYSTEM OF PAYMENTS STAKEHOLDER

QUESTIONS AND COMMENTS ABOUT THE
CONSULTANT RECOMMENDATIONS

Question and Answer Document #4: 02/02/07



Members of the System of Payments Stakeholder Group are encouraged to share these Q&As with their regional folks and other constituents.

These responses represent what we know “now” and are always subject to continued inquiry and dialogue with key stakeholders at all levels. Additional questions or comments should be directed to the Consultants, SOLUTIONS Consulting Group, LLC by writing to Sue Mackey Andrews at sdmandrews@aol.com or calling 207-564-8245; fax: 207-564-7175. We make sure that these are forwarded to Mary Ann Discenza at DMHMRSAS and all responses are reviewed and approved by DMHMRSAS before any document is released. Thanks!

Phase I

Service Delivery Model:

First Bullet: Resurface Supports and Services document and widely distribute.

24. Comment. Recommend including a clear definition and explanation of Primary Service Provider Model. One perception of the Primary Service Model is that it means one service provider working with the child. Explanations from the consultants indicated that a Primary Service Provider Model implies that there may be one primary service provider but that other providers are also seeing the child for therapy and consultations. This has implications for funding as it is more costly to have multiple service providers and also to pay for consultations and team meeting to support the primary provider.

The primary coach approach to teaming is a family-centered process for supporting families of young children with disabilities in which one member of an identified multidisciplinary team is selected as the **team lead** who receives coaching from other team members, and uses coaching as the key intervention strategy to build the capacity of parents and other care providers to use everyday learning opportunities to promote child development. We cannot prescribe one model of service delivery for all children; Federal IDEA statute and regulations require that Part C services are individualized, and that the multidisciplinary team – of which the family is a member – is intricately involved in service planning, identification, delivery and evaluation.

While one provider may be the **team lead** with a family, if this model of services and supports is appropriate to respond to the child’s unique needs, there are other team members who participate in the IFSP process, and are responsible to provide information and guidance to the team lead (primary provider) and to the team.

Some recognition needs to be made in the reimbursement structure to ensure that the types of consultations and collateral contacts, including IFSP meetings, have the participation of all members of the child’s team. So, while this is a model that is appropriate to many children in Part C, it is not appropriate to all. The methods for reimbursement need to be constructed in

such a way that supports and promotes individualized planning and teaming regardless of whether the child and family have one primary provider or more.

Contrary to what is sometimes said about the primary provider model, it does NOT necessary “save” money and can often be – particularly in the early implementation of the model for an individual child and family – more expensive than the traditional multiple therapy provider model. This is because people have to work together to learn and earn trust, figure out the best way to communicate, and experience role release.

You are correct that service costs may increase by appropriately reimbursing for those practices that are valued by the Part C system in Virginia. Since we know through the SOP Stakeholder Group that this model is not supported by your current funding, this is making it difficult for the model to be properly implemented. We learned from stakeholders that the model is not “universal” and is only one of many practice approaches used at the local level.

Second Bullet: Training

25. Comment. Consider developing video or web-based training (including training manuals/handbooks) that will be available to all localities as new providers/staff enter the Part C system. The on-site training recommended could be very costly and have to be offered on an on-going basis to ensure new providers are trained in the Part C system. Consider requiring on-site training/technical assistance for areas in which there are identifiable problems. If on-site training is going to be required of all Part C personnel, funds need to be allocated to send private providers to this training. Also, include in plan procedures for training new Part C personnel. We will be recommending a BLEND of training approaches, based upon our experiences in other states. The use of web based modules is a great format, but we have found it needs to be augmented with effective supervision and some other method (e.g., regional networking meetings) that provide a chance for meeting face:face, talking about the implementation of new ways of doing EI, etc. These meetings usually are a format for regional updates from central office, administering needs assessments, and targeting TA specifically for local needs.

Again, the reimbursement model that we are promoting includes a consideration of all provider responsibilities, including training, documentation, etc., to ensure that people participate. Training is expensive and should be linked to provider enrollment, performance and monitoring. Most states have Part C specific training requirements that are “over and above” licensure or certification. It is reasonable for the state to put forth these requirements only if there are provisions that ensure compliance.

Finance and Data

Continue to work with DMAS on current Medicaid support for Part C

26. Comment: The primary recommendation to access additional funding for the Part C system is to increase Medicaid revenue for Part C services. To ensure this revenue, there needs to be an adequate supply of Medicaid providers. Otherwise, Part C funds will still be used to pay for these services. Will the Medicaid support for Part C include active recruitment of providers (including by MCO’s) for all Part C services as well as a reimbursement rate that covers provider costs for providing Part C services? This is critical to ensuring private therapists are willing to contract with the MCOs. Also, is there any consideration of negotiating a Medicaid

reimbursement rate that includes the associated costs instead of using Part C funds to pay these costs?

Yes to all of those excellent points.

Third Bullet: General Revenue and Service Data

27. Comment: Please confirm if the general revenue and service data for General Assembly reporting purposes will be provided in aggregate.

The General Assembly report does require service data specifically; it asks specifically for total revenue, total expenses, total number of children served and services provided.. The data will be collected in the format used in the prior reporting year but will eliminate the Box C option and must specify the detail by type of revenue. In addition, it must reflect the total cost for that Local lead Agency including any effort that is sub-contracted.

Collecting detailed service information is an opportunity to expand data collection to meet most of the reporting requirements of the system and to provide a level of programmatic information about Virginia's system that could be used for sound decision making. There is no other more universal data collection process that could satisfy so many issues within the system. While it is unclear whether this can occur for 7/1/2007, it is the direction that appears to make the most sense for the overall program accountability and equity for children and families within the system. The interim plan to collect needed data, effective 7/1/07, will be through an Excel spreadsheet that the Consultants will provide to us. Expanding data collection to meet reporting requirements will be part of Phase II of ITOTS and will involve a stakeholder group.

Sixth Bullet: Revise MCO contracts

28. Comments: Recommend including in the MCO contracts a streamlined process for pre-authorization with authorization period to coincide with 6 month and annual IFSP reviews. Include retroactive pre-authorization for Part C services. Part C clients frequently move between Medicaid and Medicaid MCO's or do not get renewal paperwork in on time. Even with careful monitoring of Medicaid status and billings, there is probably some loss of Medicaid revenue due to difficulties in obtaining timely information on Medicaid status.

The proposal that we are developing could provide Medicaid reimbursement "outside" of the managed care network. We have yet to get to this level of detail in our dialogues with DMAS. In this new configuration, there is no prior authorization as that would be inconsistent with the Federal regulations for Part C and the obligation of the team to determine services, frequencies, etc. The IFSP would serve as the authorization document to meet "medical necessity" and there needs to be more formal linkages with the primary medical home as a result of this recommendation.

Seventh Bullet: Associated Costs

29. Comments: Identify specific items included in associated costs. For example, some localities require attendance at meetings that is included in the associated costs. Other localities pay for attendance at meetings at the hourly rate. In addition, the associated costs in an area requiring significant travel are likely to be higher than in a small geographic area. On the other hand, urban areas may have a higher cost of living/higher salaries which require a higher reimbursement rate. May want to clearly specify what costs are covered in the reimbursement

rate vs. costs covered in the associated cost rate. As mentioned above, may also want to include associated costs in a Medicaid reimbursement rate rather than as a Part C cost.

Under the reimbursement model that we are advancing, the rate(s) for services (no matter how configured) would be the same statewide and used consistently by all LLAs. The kind of discretion that you are talking about above, that we know exists now, would no longer happen.

The Cost Study did not indicate appreciably higher costs in some selected areas of the Commonwealth and this will have to be examined more closely when this study is updated, as it is the guiding tool for rate determination.

Family Cost Participation

30. First Bullet. Please explain what is meant by “Assistive Policy Procedure”.

That should read “Assistive Technology Services and Devices Procedure.” Thanks for catching.

31. Third Bullet. Please explain what is meant by using “negotiated” contract rate for billing families for FCP/ATP. We understand there have been some differences in how families have been billed. The current ATP configuration will stay in place for Phase I, clarification on this issue would be helpful so there are consistent guidelines and procedures.

A major impetus for bringing the SOP Stakeholders Group together was the differences in local areas in terms of which “rate” was being used as the base for assigning family payments. Some used the “negotiated” rate that had been established between the LLA and provider; others were using their “full cost rate.” This resulted in major inequities for families and providers. As an interim measure, we are recommending that the “negotiated” rate (between the LLA and provider for contract purposes) is the rate that is used by providers when they are billing family cost/ability to pay. This will be more clear in the final report.

Fourth Bullet. Collect and report FCP/ATP

32. Comment. Recommend developing procedures for data collection that is consistent throughout the state. Consider including as many items as possible on ITOTS. For example, the number of families who received a financial assessment could be included in ITOTS. FCP/ATP could be a reason on ITOTS that is entered when families decline services. Need to consider how data on the # of families who are referred to a collection agency will be collected. Referral to collection may happen several months after a case is closed. Is the amount billed and collected requested aggregate?

The second wave of ITOTS improvements is still being discussed, so we know that we can't use ITOTS for the purpose of collecting the data that we know are immediate information needs.

LLAs will have the option of using a spreadsheet or a text file with a record layout specification until we can make the ITOTS data system work for this data capturing need.

Phase 2:

Service Delivery Model.

33. First Bullet: Agree strongly with the recommendation to examine the service coordination model and caseloads. With increase in monitoring and responsibilities of the SC for prior notice, transition, and assisting families in accessing multiple resources, there is a strong need to identify a maximum caseload for service coordination. At the same time, also recommend looking at the

cost and funding of a service coordination model that has an appropriate caseload and meets the needs of the Part C system.

We agree and are working on this.

Medicaid Utilization:

First Bullet:

34. Comment: Coverage of these EI services by Medicaid would greatly increase revenue for localities whose Part C caseload includes a significant number of children with Medicaid. Funding allocation needs to consider mix of Medicaid and non-Medicaid clients. Adequate funding needs to be assured to pay for all the services not covered by insurance (service coordination, teaming, screening and intake etc) for non-Medicaid clients.

The allocation formula would succeed in doing just this – ensuring parity and equity re: the allocation of Federal and state resources (as required by Federal regulations). We know that insurance doesn't pay for all services, so this variable would be adjusted to reflect something less than 100% consideration.

Finance and Data:

35. Third Bullet: Please explain in more detail what is included in the “expanded and comprehensive training initiative”.

As we understand, training provided by the Part C system has historically focused on service coordinators. Federal regulations require that training and technical assistance be provided to all system participants, including referral sources and family members. When we use the term “expand and comprehensive” we are referencing our recommendations to broaden the audience for training to include all practitioners, link training to Part C enrollment and the ability to bill Medicaid under the new configuration, and that the training topics would be expanded to include practice issues as well as effective supervision. Oftentimes, these training initiatives are done collaboratively with other early childhood providers, child welfare, etc., and the state’s “trade” organizations including physical therapy, occupational therapy, speech/language therapy so that the Part C training also meets their continued licensure requirement.

The Part C system is currently planning, in collaboration with the Integrated Training Collaborative, to expand training for all practitioners around areas identified above and topics such as autism, etc.

Family Cost Participation:

36. In general, it would be helpful to have more information about the recommendations regarding the Family Cost Participation. Will this be available in the report with an opportunity for comment as the details are made available?

There will be considerably more detail in our final report, expanding upon much of what we have talked about in the past SOP Stakeholders meetings.

37. First Bullet: Conversation about fees often takes place at intake—if different personnel, need to consider when in the intake process this conversation about ATP and FCP takes place and whether this happens in the home or family is required come to office.

We know that families often want to know, right off at the beginning of their engagement with the Part C system, “what is this going to cost me.” We need to be responsive to their need to

know this information, and also responsible not to let funding (or the lack thereof) “drive” the family’s participation or ultimate agreement for individual services. We will recommend that the actual administration of the FCP paperwork with families is not performed until AFTER eligibility is determined. We know that this may present a problem for some localities who “couple” the eligibility meeting with the IFSP meeting. It just doesn’t make sense to administer this activity with families until we know their child is eligible. The family, at this point, has engaged in the system and understands more from the evaluation for eligibility process about their child’s needs, etc.

The determination of who does this process should be a local decision. The recommendation in our report deals with the need for the person (whoever it is) to be properly trained and competent in the administration of the FCP protocol. Having families come to an office may be appropriate in some cases, but typically this service is a “linked” service performed with preparation for the IFSP. We know that the service pathway in Virginia is different, and will provide a protocol that is easy to administer and understand, and has some flexibility to recognize the variability of the service pathway in the Commonwealth.

Fourth Bullet: Family Fee reconstructed to incorporate EI service component

38. Comment. Request more information on this recommendation (will there be more detail in the report?).

This reference is more towards how families would be charged, and reflects our recommendation that services be clustered into functional categories:

- Screening and Intake
- Evaluation/Assessment
- IFSP Teaming
- Early Intervention Services
- Service Coordination

Families would only experience cost participation for Early Intervention Services, which would be inclusive of all required Part C services, as the other functional categories are to be provided “at no cost.” **We would like some feedback from the field about the degree to which Medicaid and private insurance is used to pay for “testing” (evaluation/assessment services) for a child to determine eligibility. Thanks.**

39. Fifth Bullet: If localities are required to make major changes in billing practices this could have significant costs. For example, our contractors are currently responsible for billing the family cap. If the LLA were responsible for billing the family cap, there would be increased Part C systems management costs. Recommend that costs to the Part C system are identified with the different options for billing the family fee. This may vary by locality.

We know that the priority is to make sure that this process is implemented consistently, and that each family’s rights are protected (e.g., ensuring the “inability to pay”). We will provide options but our primary recommendation is that this function is centralized either within the LLA or regionally, across several LLAs.

Interagency Agreements:

40. Comment. Other agencies are willing to work with the Part C system to coordinate services and ensure children are referred to the system. However, our experience has been that other agencies have not had funding or actual staff positions available to allocate to Part C.

As we talk about interagency collaboration, we are seeking more partnerships with those agencies, programs and services which typically serve this population and how these services will “couple” with the Part C services, not duplicate, etc. Part C was established to identify and utilize existing resources, such as Early Head Start, Head Start, Title V/CSHCN, etc. While other agencies may not have funds allocated specifically to Part C, they do provide services that could be considered Part C or supportive to Part C – including the provision of training, data collection, Child Find, etc. Local interagency agreements confirm these contributions and permit the LLAs and others to include these resources in planning and service delivery. There are over 40 funding/program resources from the federal/state level that could contribute to Part C; some in very substantial ways.

Child Find:

41. Second Bullet, No. 3. Recommend that this data be obtained as much as possible through ITOTS reports. This would ensure more statewide consistency in the data.

We concur.

Data:

42. Second Bullet—Data needs (a). Same comment as under Family Cost Participation

Not sure what this refers to?

43. In addition, data is requested on the “Amount Billed” and the “Amount Collected”. When a provider has a contracted rate with an insurance network, the provider may bill the full rate for the service, but only the contracted rate will be collected. Please clarify whether the data requested is the billing rate or the contracted rate?

The initial effort to collect data is focused on the Federal and state report requirements. We will discuss this comment in more detail as we prepare the final report.

Second Bullet—Data needs (b). Tracking of delivered services.

44. Request more information about how individual data will be used at the State level.

1) Data on “practioner” is identified as an item to be reported. Is the actual name of the “practioner” need to be listed for each child and service? If yes, how will this be used to assess resources and supports for Part C services?

Practitioner could be the agency, individual provider or primary discipline of the provider. We need to think this through more clearly and all of the implications about the level of detail.

These data referenced in the DRAFT Recommendations are not used to access reimbursement but merely to provide detailed service data.

45. Do the “services provided” include multiple areas that a primary provider may be addressing (i.e. PT addressing outcomes related to gross motor, fine motor, and cognition) and the practitioner is the type of service provider?

For the interim data collection, the service as defined in the IFSP would be recorded. We anticipate that this is DT, SPL, OP, PT, etc.

46. Location of services is entered into ITOTS at entry and verified yearly. Is this data needed on a quarterly basis to quantify resources and supports or could the state use the ITOTS and verified data?

If this relates to the detailed delivered service information, it is an important piece of information that would be than checked against the IFSP. It would not be prudent to assume that they are the same.

47. Request more detail on the specific funding or supports data that is requested. In particular, we were not sure what type of “supports” data will need to be collected and reported.

One example of a support could be that service coordination is provided by a nurse from the state’s Title V/CSHCN program. No funds would be exchanged for this service; Title V would pay for this service for dually enrolled children when the team recommends this.

The data collection is necessary but will require significant time and cost for data entry into a common spreadsheet as different providers have different accounting systems. Recommend that local systems are only required to submit data that is essential for the quantification of resources and supports.

48. Comment: A long term recommendation is to “Accept transactions in the 837 EDI format”. Our finance office indicated that this is not currently used for private pay and will require significant effort and resources to implement for all Part C clients.

This is one of those areas which needs more development discussion.

Service Payment

49. Please describe the procedure for backing out children/services that are funded with non-part C money. Also, if associated costs are paid, Part C money is used to fund all children to some extent.

The current reimbursement practices of the LLAs often pay an additional amount above Medicaid and private insurance to cover associated costs. Under a realigned reimbursement structure, this would no long happen. Medicaid and perhaps other state managed reimbursements, such as that through the MCOs, would be common rates that would also be the Part C rates. Associated costs would be included in the rate.

This proposal is to develop a new methodology to distribute the Federal and state Part C funds which encourages and promotes the use of available third party resources. Thus, the percentage of children enrolled in MCOs, in Medicaid, and those with private insurance would each have some influence in the formula for Federal and state fund allocation.

50. Recommend exploring more fully the data on Medicaid revenue for Part C services. If a locality is already maximizing Medicaid revenue, the allocation should not be based on the assumption that Medicaid revenue has not been maximized.

The approach to developing an allocation method makes no assumptions of what localities have been doing in the past.

51. A high percentage of children with private insurance does not guarantee payment for the services. We have found that speech therapy is rarely covered, and private insurance does not cover special instruction.

This is an area needing more study, which we anticipate will be achieved through the data collection in Phase 1. Private insurance would not be given a 100% weight in the allocation formula for just this reason. This comment does promote the need to collect data and have a conversation with the state insurance commission, and to figure out a way to make the insurance legislation work to include all Part C services, etc.

52. In thinking about moving EI services to EPSDT, we have concern that the rate of reimbursement will change from what it is now to a lower rate because of the potential reimbursement to individual therapists and not rehab agencies. Currently our medicaid rate is cost-based and is helpful to trying to cover costs. Va Premier's rate is very different. Just food for thought.

A new rate for Part C services would be created including what are now called associated costs. This rate would be based upon the updated Cost Study.

53. That was very insightful. In reading it, it states that income information should be gathered for each referral. Right now, families don't have to provide income information if they want to use their insurance or pay full fee if it doesn't cover. Has this been brought up? Also, getting income at referral or intake before we even know if the child is eligible may be hard to come by. Thanks for all your work on this and keeping us informed.

The primary reason for collecting family income (which can be done in any number of ways (which are not intrusive to families) is not for the assignment of family fee. It is essential that the Part C system understand the general demographics of those families and children referred and enrolled into the system. Family income provides one piece of data that can be useful in accessing some Federal resources that rely upon this as a key eligibility.