

**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!

54. Comment: There is a significant concern that the system will be changed radically without adequate explanation about the reason to do so. Some thought that the initial concerns were that 1) the distribution of Part C funds was inequitable and based on old system, 2) family fees were not being assessed or collected equitably across the state and families were declining services, and 3) the system used by localities to identify what they would pay private therapy providers was very complicated and some therapy groups felt that their payments were not adequate. There was interest in being able to generate revenue to pay for special instruction through Medicaid and their HMOs, but that seems to have changed into another system of billing for activities such as intake.

55. Is part of the plan or projection that the amount of fees collected from parents would increase over the amount currently collected?

That is impossible to know as we don't know the amount of fees current collected.

55. Regarding the question raised in #17, I don't believe that the reason that families don't come right out and say that they are declining services or some services because of the cost is related to training. I believe it is because in Virginia people often "try to keep up appearances". It is also, in some settings, considered "impolite" to talk about financial matters with strangers.

It seems that these comments relate to “cultural” differences, which are part of the training for Part C including training related to administering any information collection – financial included. The way in which the whole discussion of family cost is conducted influences the family’s responses. Our recommendation to conduct this process after a child is determined eligible will hopefully reduce some of the concerns expressed above related to talking about these matters with strangers. It is rare in our world today that anyone can conduct personal business without sharing certain forms of personal information, including income. Our experience has been that if families know what the purpose of the information collection is, they are more likely to participate, be honest and not see the question(s) as intrusive.

56. I still am puzzled and unsure of how to explain the need to collect financial information from every family enrolled in Part C. This will be different from what families do with the school systems and different if they bypass the Part C system and just go and get therapy at the regional hospital where it would be free if on Medicaid or they would just pay their copay. Financial information is collected for the purpose of identifying the potential for other resources that could support Part C. One state, having collected family income information before they even initiated family fees, was able to access over \$23 million dollars in TANF funds to support some Part C services. Schools do have this income information as it is part of the free/reduced lunch data, which are often used as a proxy for poverty.

57. Regarding question #19, it would be more typical to wait 4-6 months to find out what some insurance copays will be. Some deny everything at first and then it has to be re-submitted. We don't stop trying for a year but that is not a typical length of time. Some reasonable public policy has to be developed that is fair and equitable for families throughout the Commonwealth re: family cost participation. Families often think that their insurance will cover a service for their child, only to find out later that this isn't accurate. They should know this information and be able, as informed consumers, to figure out if they want to change their carrier or talk with their employer about the policy that is provided for them. In most instances, employees are paying for some portion of their insurance coverage and need to make informed decisions about how they use their resources.

During Phase 1, we will need to find out more information about the insurance billings, timelines, compensation, etc. One question recently that came to mind was – what use has the Virginia Insurance Legislation been to families? Have any families exceeded the \$5,000 annual cap? How do LLAs “track” the utilization of insurance to even know if the cap is being approached or exceeded? Who does this?

Families also shouldn't be expected to initiate services under the expectation that their insurance will pay, only to find out 4-6 months later that it didn't and there be an expectation that their fee would be retroactive. Financing Part C is a partnership with many entities – families included.

58. One of the system managers in our region questioned how a family could be billed for a month that they don't actually receive services other than service coordination. This is one approach used by some states where the family fee isn't collected based upon service, but upon the general enrollment in the Part C system. The analogy could be that we pay our insurance premiums every month, but don't typically use the insurance every month.

59. The concern about the data collected from DMAS so far is that such a small amount is available (310 children out of 9,673). That seems like a small percentage from which to draw conclusions and make decisions. It is reassuring that you will work with the LLAs to verify what you do have. However, it would be important to convene stakeholders as a group to review the data and the conclusions drawn from it.

As a general rule it would take about 370 randomly selected records against a total population of 10,000 records to have a 95% confidence level that the results are representative. In this case the 310 is probably a decent number, however, the records were not randomly selected nor do we have complete data for all 310 children since we believe that the MCO data is not included. The

information should be fairly indicative for 220 children who were billed for case management services since that is covered under straight Medicaid as opposed to managed care. What is striking in the information is very small dollar amounts that have been billed, not all of which can be attributable to Part C IFSP services and the variance on all the numbers. Those two factors add to the confidence that even asking for more information will not likely change the results.

It is our intent to continue to work with the information to better understand the implications and to do some verification with the LLAs. .

One example: a high percentage of revenue for Medicaid children on the existing data is for case management. It would be important to note that this “revenue” that has been generated may not actually reflect revenue into the Part C system, since in many localities it is separate. In addition, identifying a percentage comparison of Medicaid revenue for case management (71%) to Medicaid revenue for outpatient rehab (29%) may be skewed. The Medicaid revenue for case management likely includes children covered by straight Medicaid and the Medicaid HMOs, while Medicaid revenue for outpatient rehab is probably only be for children with straight Medicaid.

Irrespective of how LLAs may make decisions regarding the classification of revenue, if a service is covered by another source the Part C system is obligated not to supplant those dollars. The Part C system is more broad than the LLAs and includes the provider and community resources who provide services to 0-3 year olds within the context of the IFSP. These funds should be captured and are part of the whole Part C system in any state.

60. I continue to be uncertain how collecting the family financial information from all families can assist in “advancing the system funding”. I completely support the outcome of having families understand the range of services and supports that could be available to them. However, families would not actually be applying for many of the types of financial assistance from Part C and would still have to go directly to the agency that manages those supports (ex: Medicaid, FAMIS, SSI, Lions Club vision services). The concern is that families who would not typically have a payment, such as those on Medicaid or FAMIS, would now have to pay a fee. In addition, another concern is that families who find it acceptable to pay their copay may now have to pay more if they do not share their financial information.

The request to collect family income information is not connected to any family cost participation assignment; it is simply a data collection item that other states have found useful to collect and that has helped to identify other resources which can support the system. These resources are typically negotiated at the state level.

There is no recommendation that families on Medicaid or FAMIS would pay a fee for covered services. Further, the recommendations provide for families to pay their co-payments as their cost participation if they consent for the system to access their insurance, as long as this doesn't present a financial barrier for the family to receiving services.

As the SOP Stakeholder Group emphasized, one of the primary outcomes of revamping the current Ability to Pay process is to ensure that children and families receive the services that they need. Currently, reports from the SOP stakeholders confirmed that families often decline special

instruction because this is currently an uncovered service by insurance or Medicaid. The revised Family Cost Participation process would respond to this situation by equalizing all early intervention services and including Medicaid reimbursement for all Part C services.

61. Recommend that the review of the Medicaid State Plan Amendment that you are drafting for DMHMRSAS and DMAS include the stakeholders group, since it is a significant change in how Part C services are delivered and billed. There were many questions at the end of the stakeholders group meeting, particularly how this would impact private insurance billing and family fees. Further dialogue before this is “cast in stone” would be very beneficial.

There is a concept paper which will be included in the final Report that discusses the Medicaid State Plan Amendment (SPA) in more detail. We particularly designed the service categories to “fit” the variety of service delivery models offered to families in Virginia, and to accommodate billing private insurance and family fees. This model of service components was built using the service pathway that was developed by the SOP Stakeholders Group.

The Lead Agency will determine the next steps to stakeholder participation. Certainly, reconvening the SOP Stakeholder Group is a viable option, as is the possibility of conducting regional forums which would provide an opportunity for a broad dialogue with a variety of stakeholders. Specific approaches are needed to connect with families and we are working on these options with our family advocacy partners. Thank you for offering help.