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January 24, 2007

TO: Tammy Whitlock, DMAS
cc: Shirley Ricks, Mary Ann Discenza, DMHMRSAS

FROM: Sue Mackey Andrews

RE: Medicaid Initiative: A Concept Paper

The purpose of this Concept Paper is to provide a description of the developing consultant recommendations related to Medicaid reimbursement for Part C services in Virginia. This document is distributed internally within DMAS and DMHMRSAS with the intent that they will review, present questions or challenges to the consultant, and work together to ensure departmental support for this approach before this document is distributed to a wider audience.

Accessing Medicaid: A Variety of Approaches Are Utilized

States utilize a variety of ways to access Medicaid to early identification and the provision of services and supports for very young children and their families. These include:

- Outreach/Enrollment Partnership that recognize the system's ability to collect documentation to support enrollment into Medicaid
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- Targeted Case Management (TCM)
- Medicaid State Plan services, particularly physical, occupational and speech/language therapies
- Development of a State Plan Amendment for uncovered services, such as special instruction/developmental therapy, social work services, family therapy, etc.
- Waivers including 1915(c) Home and Community Based Waivers targeted to specific population(s) and/or service(s). The intent of waiver services is to reduce the frequency of institutionalism, promote self-determination and to permit states to provide targeted programs for individuals based on need which often reflects services not otherwise available under Medicaid to the general population.

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- Katie Beckett/TEFRA (Tax Equity and Financial Responsibility Act of 1988) permits states to enroll children with disabilities who live at home and need extensive care but who would not otherwise qualify for Medicaid due to their family income and resources.
- Managed Care Initiatives
- Medicaid Administrative Claiming (MAC) to include system activities at the state and local levels required to assure the delivery of quality services to children and families
- Title V and State Rehabilitation Agency Interagency Agreements represent the unique Federal requirement for state Medicaid agencies to partner with "sister" state agencies in the planning and delivery of services to targeted populations, such as children with special health care needs (CSHCN), pregnant women, low birth-weight babies, children with sensory losses, etc.

States typically utilize multiple avenues to access Medicaid to support programs and services to very young children and their families.

In planning system improvements related to financing for early childhood and family supports and services, there are multiple issues which must be considered. In order to ensure that all resources are effectively utilized, supports and services to eligible children and families should:

- be cultivated or improved in terms of accessibility and utilization,
- "match" or conform to the population to be served,
- be consistent with the method or desired approach(es) to providing services,
- expand and support the variety and availability of appropriately trained and qualified providers,
- be compatible with how data will be collected and verified, and
- facilitate service monitoring and supervision to ensure timeliness, quality and compliance.

Eligibility Criteria	
CHILD AGE (0-3, 0-5, 0-21, etc.) Lifespan Considerations	DIAGNOSIS OR DISABILITY
INCOME/ FEDERAL POVERTY LEVEL	TYPE OF SERVICE OR SUPPORT
DEGREE OR LEVEL OF NEED	POPULATIONS OF SPECIAL CONSIDERATION

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Key to any state reconfiguration of Medicaid is the state's will to pursue these avenues of opportunity.

The above chart illustrates the six (6) different criteria which are used to establish eligibility for services and/or funding by a variety of Federal, state and local resources. Sometimes multiple criteria are utilized, such as child age and family income. As such, children will have a greater likelihood of "multiple eligibilities," requiring coordination between resources to ensure that the funding hierarchy is honored, and that POLR (under Part C) can be assured. Resource coordination also includes use of family resources, including fees, to meet the Part C requirement re: "inability to pay." Some state Part C systems employ a process called "financial case management" or "resource management" which is a service coordination activity that helps to inform and education the family about the variety of resources that are available, so that they utilize appropriate resources when possible, and have this information with them as they age into other systems of care.

The Deficit Reduction Act (DRA) (2005)

The DRA established a variety of state-directed options designed to change the way that Medicaid is constructed, and gives considerable state latitude and decision-making ability to constructing alternative ways of "doing business." Long-term care, or supports for individuals with disabilities, accounts for 37% of all Medicaid dollars nationally. The importance of de-institutionalism, personal freedom and independence are hallmarks of the DRA – anticipated to refocus Medicaid to a person-centered and consumer-controller program. For families with young children with disabilities, these opportunities are the most significant as they couple with the requirement that the provisions of EPSDT – Early, Periodic Screening, Diagnosis and Treatment – which remains as a requirement for the <21 population.

Guidance through SMDs and/or regulations governing many of the DRA options and changes will not be available until early 2007; this Concept Paper is built upon an extensive review of the literature available on the DRA, various interpretations on the implications for the target population, and a creative approach to ensuring comprehensive, coordinated care for the states' most vulnerable children. There are several options to consider as one reconfigures Medicaid for any population. Key considerations from a public policy perspective include:

- Ease of management at state, local and provider levels, particularly in terms of accessibility, documentation and monitoring/surveillance;
- Cost projections – figuring out the potential impact (people and funding) for state consideration;
- Continuity of care for individuals as they "age" from one public system to another, or when eligibility changes and service needs continue; and
- Adequate capacity or availability of appropriately qualified providers.

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Key to any state reconfiguration of Medicaid is the state's will to pursue these avenues of opportunity. States typically have preferred or historical ways of accessing Medicaid – waivers, EPSDT expansions, etc. The DRA challenges us to think "outside of the box" and focus on what is best for the consumer FIRST and then to fashion Medicaid in a manner that best supports their vision and need. There are certainly fiscal concerns subsequent to the DRA including the potential impact of Federal budget cuts for individual state Medicaid programs.

Considering the numerous avenues to accessing Medicaid as presented earlier in this Concept Paper, the following recommendation is presented for consideration for Virginia's 0-3 CONNECTIONS system. The Consultant submits this option in the spirit of interagency collaboration, knowing that DMAS, the state Medicaid agency and its partner in DMHMRSAS desire to partner and maximize opportunities for dually referred and enrolled children and their families. Considerable collaboration and coordination across and within both state departments is essential to ensure that initiatives successfully respond to the local needs, are in alignment with the individual IDEA program requirements, and the influence of data upon projections for utilization and potential revenue, including match requirements as the coming years unfold. This department partnership could reasonably expand as the Commonwealth moves towards more partnership with other early childhood programs and services, to involve the Governor's Office and the Department of Education.

Resource Allocation

> Recommendation #1
>
> The distribution of all funds under the authority of DMHMRSAS should be allocated proportionately based upon a combination of demographics and consideration of third party resources, including Medicaid, private insurance and family fees. Measures should be incorporated to encourage local contributions (MRDD, local county funds and agency partnerships) through incentives that promote utilization of third party opportunities.

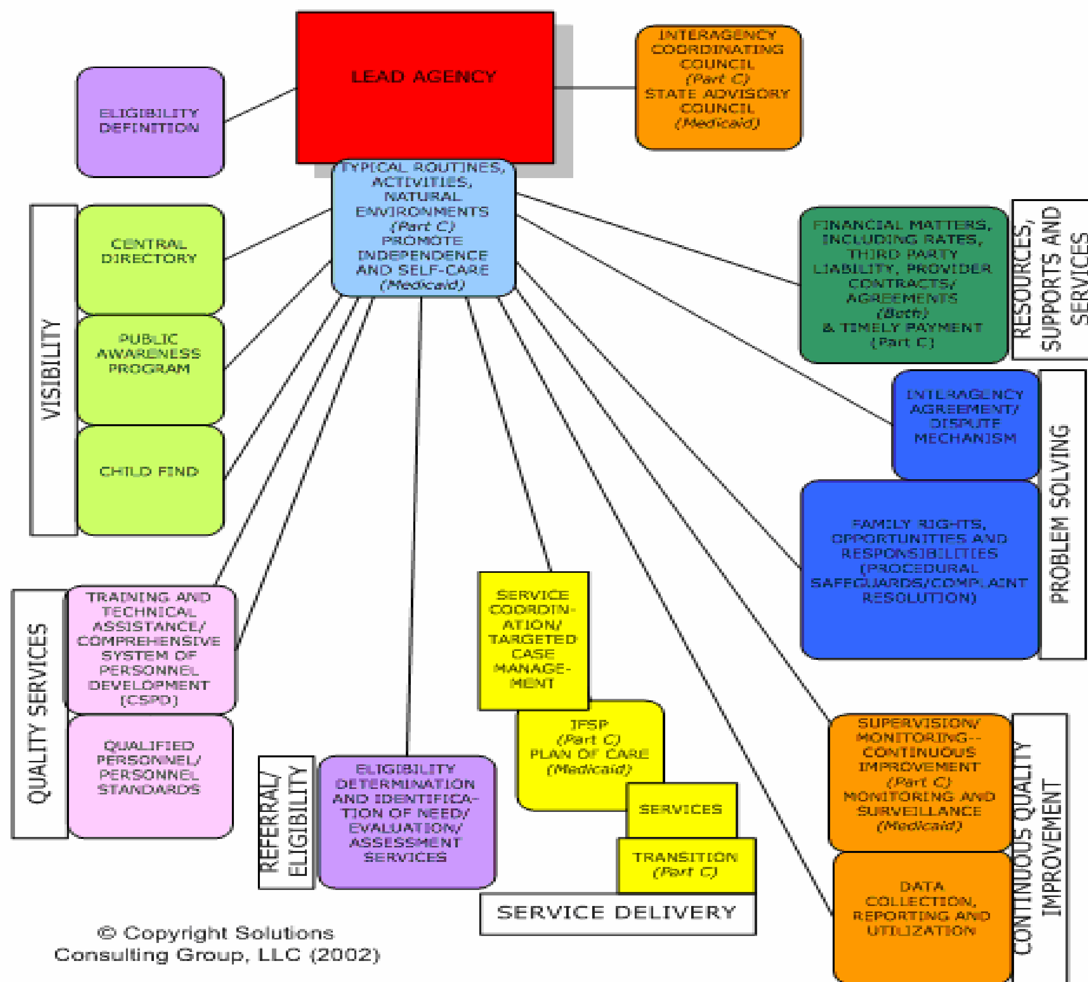
Resources will vary within and across the counties in Virginia based upon county demographics and will vary due to the significant, individualized character of county resources. Excluding demographics, which can be easily managed by rigorous and frequent data review, the variations of eligibility and resources make it more challenging to create a "statewide" system of payments that includes all resources. The distribution of funds under the authority of DMHMRSAS should be proportionately allocated based upon a combination of demographics and consideration of third party resources, including Medicaid, private insurance and family fees. Measures should be incorporated to encourage local contributions (MRDD, local county funds and agency partnerships) through incentives that promote utilization of third party opportunities.

The distribution of Federal and state resources should promote utilization of third party resources by establishing this incentive within the formula itself.

> The Commonwealth's need to respond to OSEP concerns regarding the integrity of their data – as well as the General Fund reporting requirements – will, to a large degree, force the need for data consistency and standardization efforts to occur.

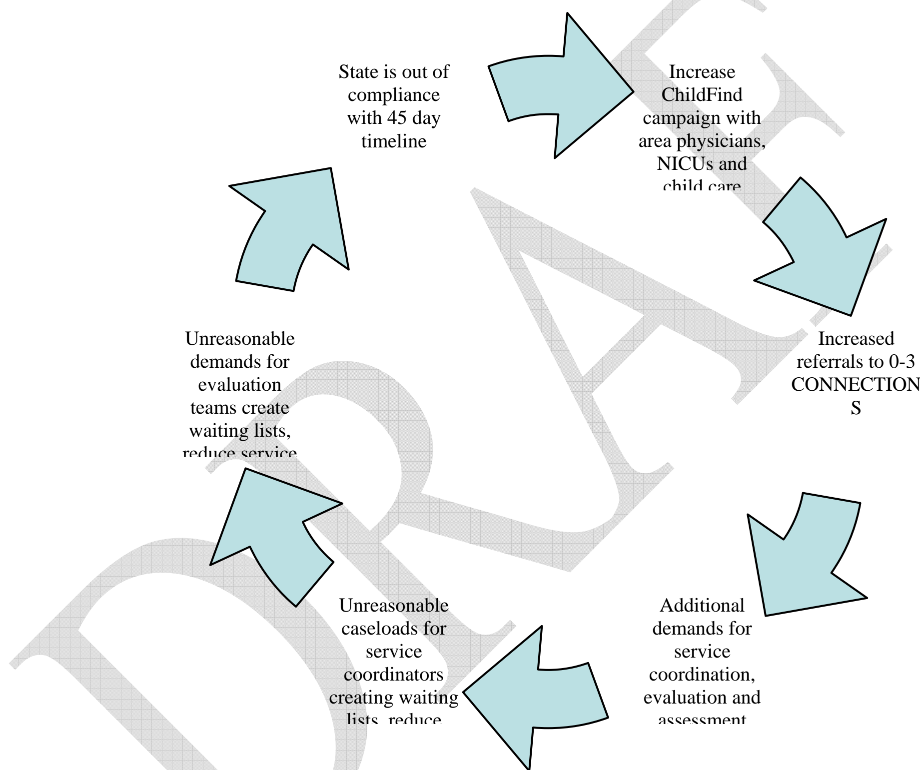
Historical enrollment data is useful, particularly when used in a trend analysis format, in crafting and evaluating an allocation formula. Hopefully these data, including planned and delivered service data, timelines (referral, enrollment and IFSP), and family/child demographic data will be incorporated in the new iteration of ITOTS. The Commonwealth's need to respond to OSEP concerns regarding the integrity of their data – as well as the General Fund reporting requirements – will, to a large degree, force the need for data consistency and standardization efforts to occur. **Greater efforts at local and state data validation are essential.**

A Total Systems Approach



State early childhood systems operate based upon the balance of resources – people, time and money. Efficiencies and economies of scale require that decision makers carefully examine all aspects of a system to be sure that the required activities that the system infrastructure demands are not only performed, but are performed in a way that is timely, accurate, responsive to needs, and are statewide and equitable. As new resources are available to a system, it is critical that the entire infrastructure be examined against the impact of potential growth or substantial programmatic change.

DMAS values these system components as they help to ensure the integrity of the Part C system including adherence to state and federal regulations, policies and procedures, timelines, and the provision of appropriate services to eligible children and families by appropriately qualified providers. These components are logical cost centers to include in any reimbursement methodology with Medicaid.



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Because of the interrelatedness of the 0-3 CONNECTIONS system components, considerable effort needs to be directed to think about the "domino effect" of any change in financing to the system as a whole, and to assist the Commonwealth in prioritizing their efforts. The "domino effect" is displayed in this diagram, focusing on what is likely to happen in a state which increases its ChildFind efforts.

Increased caseloads and timeline challenges are the two outcomes most commonly observed during system change. More than often, decision makers fail to consider how an increase or decrease in enrollment will affect timelines, the need for additional training (particularly if new procedures or eligibility is instituted), new monitoring requirements, etc.

Understanding the potential prevalence facilitates financial forecasting, and assists the state to plan related system components such as provider recruitment, training and credentialing with a particular focus on selected geographic areas or specialty areas. Efforts to incentivize ChildFind are important; the basis for growth needs to be incorporated into allocation formula.

RECOMMENDATION:
Establish Home and Community-Based Services (HCBS) State Plan Amendment

Background
Historically Medicaid waivers provide states with the opportunity to create initiatives which respond to the needs of specific populations or to waive certain provisions of the Federal Medicaid regulations. Many HCBS waivers were established to support the long-term care needs of individuals who would otherwise be institutionalized. Section 1915(a) of the Social Security Act established several opportunities for states to "waive" any or all of the three Federal requirements of standard Medicaid:

- Statewideness (§1902(a)(1))
- Comparability of services (§1902(a)(10)(B))
- Community income and resource rules for the medically needy (§1902(a)(10)(C)(u)(III))

The DRA offers flexibility that allows states to offer HCBS without a waiver, which considerably removes many of the rigorous application and documentation requirements from earlier HCBS. Under the DRA, HCBS can be offered as a State Plan optional benefit. This means that the state can establish a new standard that is not linked to the institutional care requirement. The eligible population will be offered individualized care plans based upon an assessment of needs and may be offered the option of self-directing their care. Under the DRA the state has considerable latitude in defining the population, the services and may even have regional or local variations in coverage based upon the diversity of need.

Medicaid State Plan Amendment: Through a State Plan Amendment (SPA), the State would create a new service entitled "Early Intervention Services" (EIS) as a new EPSDT service, available for children who meet the State's eligibility criteria for 0-3 CONNECTIONS (both those children at risk for and those identified as having a developmental delay or diagnosed medical condition) and who have an Individualized Family Service Plan (IFSP).

Access to these services would be through 0-3 CONNECTIONS, according to the Part C regulations, policies and procedures. This SPA would be framed around five (5) consolidated functional components within the 0-3 CONNECTIONS system, and is a modification of the traditional service unit approach used by Medicaid while reflecting the variety of qualified practitioners performing functions with the 0-3 CONNECTIONS system.

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Proposed Part C Functions

- **Newborn, infant and toddler comprehensive developmental, vision and hearing Screening, Evaluation and Assessment**
- **Multidisciplinary Team Services**
- **Early Intervention Services**
- **Transportation and related costs** necessary for the child or family to receive a service.
- **Service Coordination/case**

Five service categories would be implemented in this reimbursement structure.

- o **Screening, Evaluation and Assessment**: A rate would be developed for the both 1) the newborn screening service, and for the 2) evaluation/assessment services provided by individual practitioners for children in the at risk or Part C programs of 0-3 CONNECTIONS.

In order to control for costs, an allowable "not to exceed" number of evaluation/assessment services could be defined for a given period and only exceeded with state-level approval. Reimbursement would include costs for preparation, administration, family discussion/explanation, and report development.

- o **Multidisciplinary Team Services**: Teaming is essential in the planning and delivery of appropriate services for an enrolled child and family. Reimbursement for teaming would be based upon two types of contact. One, a team meeting – either for the purpose of IFSP development, review or evaluation. The second reimbursement would be for collateral contact, encouraging team consultations through phone, e-mail, report sharing, and one:one consultations as set forth in the IFSP. This reimbursement would more effectively support the primary provider model that is the philosophical foundation of the 0-3 CONNECTIONS system.

- o **Early Intervention Services** (EIS) could include but are not limited to family training, counseling, home visits and team consultation that promote the competency of the family or designated caregiver(s) to respond to the developmental needs of the infant to toddler through the delivery of:
  - o Assistive technology devices and services
  - o Health services necessary to enable the child to benefit from early intervention services
  - o *Home visiting services including family training and counseling (anticipatory guidance)*
  - o Medical services for diagnostic or evaluation purposes only[1]
  - o Nursing services
  - o Nutrition/dietician services
  - o Occupational therapy
  - o *Parenting education*
  - o Physical therapy
  - o Psychological services

[1] Medicaid covered medical services, including well child care, immunizations, laboratory, x-rays, surgery, etc., would be reimbursed through traditional methods currently in place in Virginia Medicaid.

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- *Sign language and cued language services*
- *Social work services – covered service?*
- *Special instruction/developmental therapy*
- Speech-language pathology and audiology services
- Vision services

The services above appearing in *italics* are currently uncovered services in the Virginia Medicaid program (perhaps with the exception of social work services?). created for 0-3 CONNECTIONS participants. Additional discussion is also warranted regarding Assistive Technology services and devices, primarily related to the inclusion of AT under "durable medical equipment" and the current funding mechanism established by the Commonwealth's Medicaid program for this category of service.

Additional discussion is also warranted regarding Assistive Technology services and devices, primarily related to their inclusion under "durable medical equipment" and the current funding mechanism established by the Commonwealth's Medicaid program for this category of service.

A common rate would be developed for all practitioners for family or caregiver and child services. This rate would include consideration of all related costs such as practitioner travel time and cost, preparation and report development. Data on current service frequency and intensity will guide the determination of how best to configure this rate (e.g., monthly vs. individual unit). The rate should support the variety of individualized treatment model approaches to service delivery (including but not limited to the primary provider model) that are emphasized within the 0-3 CONNECTIONS system, ensuring the provision of appropriate services which the child and/or family needs.

0-3 CONNECTIONS EIS are determined by the Multidisciplinary Team based upon the child's developmental status and unique needs, and upon the family's concerns, priorities and resources. Services are interdisciplinary in nature and focus on the family, and their designated caregivers, as the primary educator and support person for their very young child.

- **Transportation and related costs**: Reimbursement at the state rate for transportation when it is required that a family/child travel to a facility or setting in order to receive services, including related costs such as overnight expenses and meals as the travel necessitates.

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- **Service Coordination/case management**: Service coordination requires well prepared practitioners who have appropriate caseloads, and who are provided effective supervision. More study or examination is needed to better understand the current status of the 0-3 CONNECTIONS service coordination system, and the willingness of DMAS to reimburse for "blended" service coordination. This study would assist to identify the current and potential range of provider qualifications, caseload sizes, training and supervision needs.

More study or examination is needed to better under-stand the current status of the 0-3 CONNECTIONS service coordination system, particularly as it relates to caseload size, and the willingness of DMAS to reimburse for "blended" service coordination.

This activity would assist the Commonwealth to create rates that support good practice, establish appropriate caseload sizes and recruit for new service coordinators from the wide range of public and private partner programs and services. It would also identify if there is a value to promoting a designated model of service coordination as compared to a blended model, establish supervision requirements, caseload sizes (for both designated and blended practitioners), and identify training and technical assistance services needed by the LLAs.

The reimbursement for service coordination could be configured by functions (face:face client services, team activities, and documentation/administrative services) or by reimbursement for face:face family or team activities which include consideration of documentation requirements, travel, telephone, etc. in the rate.

Children determined to be eligible by 0-3 CONNECTIONS would qualify for these services, using the IFSP as the basis for service identification to include frequency, intensity, frequency and duration. No service would be reimbursed by either the Part C system or Medicaid if it is not on the IFSP. All services in this SPA would be provided by qualified providers recognized as such by the Part C Lead Agency.

Qualified Providers
All 0-3 CONNECTIONS services and support personnel include the following categories. All personnel must successfully complete the initial and ongoing 0-3 CONNECTIONS credentialing requirements **in addition to** the following requirements:

- Audiologist – Master's degree plus state licensure
- Certified Therapeutic Recreation Therapist – Bachelor's degree plus national (NCTRC) certification
- Counselor, including Licensed Professional Counselor (Master's degree and state licensed) and School Counselor (Master's degree plus licensure as a school counselor (VADOE))
- Early Childhood Special Education – Bachelor's degree plus licensure in special education early childhood) (VADOE)
- Educator – Bachelor's degree plus: licensure in early/primary education pre-K (VADOE), or licensure in Work and Family Studies (VADOE), OR Technical Professional License in Work and Family Studies (VADOE)

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- Early Intervention Assistant – DMHMRSAS Approval
- Early Intervention Generalist – (need current qualifications)
- Educational interpreter – Certification from Registry of Interpreters for the Deaf of VA
- Educator of the Hearing Impaired – Bachelor's degree plus state licensure (VADOE)
- Educator of the Visually Impaired – Bachelor's degree plus state licensure (VADOE)
- Family and Consumer Science Professional – Bachelor's degree plus national certification (AAFCS)
- Family therapist – state license
- Nurse – includes Registered Nurse and Nurse Practitioner: R.N. plus state licensure with additional state licensure in specialty area
- Nutritionist – Bachelor's degree plus state registration
- Occupational Therapist – Bachelor's degree plus state certification
- Occupational Therapy Assistant – Two year degree plus certification exam
- Orientation and Mobility Specialist – Bachelor's plus state certification
- Physical Therapist – Bachelor's degree plus state licensure
- Physical Therapy Assistant – Two year degree plus state licensure
- Physician – Doctor of Medicine plus state licensure
- Psychologist – includes Clinical (Doctorate with state license), School Psychologist (Masters plus state license) or Applied Psychologist (Doctorate plus state licensure)
- Social Worker – includes Licensed Social Worker (Bachelor's degree plus state licensure (case management and supportive services), Licensed Clinical Social Worker (Master's degree plus state license), School Social Worker (Master's degree plus state license), and Visiting Teacher (Master's degree plus state licensure (VADOE)
- Speech-Language Pathologist – Master's degree plus state license

State early intervention systems are often diverse in their organization and who constitutes a "provider." This diversity is usually a strength, providing choice for families and recruiting a variety of part- and full-time practitioners in areas where the volume of service need, or service specialty, cannot support a full time practitioner, or where distance or special considerations pose challenges to provider recruitment.

Expanded partnerships with the general early childhood community, health, medical and social service sectors provide multiple opportunities for expanding the 0-3 CONNECTIONS referral and provider base. The visual on the next page identifies the variety of Federal, state, public and private resources that exist in most states; blank circles can be added to identify unique state and local resources. This chart has been modified to illustrate some specific resources in Virginia.

These resources, supports and services are intended to partner with 0-3 CONNECTIONS to provide the range of needed, sometimes termed "entitled" services, as well as the variety of supports and prevention efforts to families and eligible children based upon their individual eligibilities, unique characteristics (e.g.,

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pregnant/parenting teens, migrant families, etc.), child age and other criteria. Early Head Start and Head Start Family Support Coordinators provide service coordination, as do most state Title V/CSHCN programs. Parent education and support is provided through a variety of vehicles (Community Extension Services, Parents as Teachers, Teen Parenting Programs, etc.) and can serve as the foundation for special instruction/developmental therapy. If these programs and services are to be incorporated into the 0-3 CONNECTIONS system as providers, interagency agreements need to be developed that ensure maintenance of effort, conformance with state and federal Part C requirements including personnel standards, program policies and procedures, confidentiality, participation in training, documentation and data reporting, etc.

Interagency Agreements at the state level can define these partnerships, create requirements for credentialing, documentation, etc., and serve as a "springboard" for the local counties to articulate more individualized agreements based upon their resource base, unique needs and demographics. These agreements define reimbursement; in some circumstances, money may not actually "change hands" depending upon the purpose and priorities of the partner entity. The key here is to figure out what is available for all children <age 3, and to create these linkages in a formal manner which then ensures that they are available for very young children at risk or identified with developmental delays and/or medical conditions that are

likely to cause or contribute to development delay or disability in conjunction with the 0-3 CONNECTIONS system.

Further development work has to be done to align the provider types with the service definitions, as recommended, together with training and ongoing professional improvement requirements. Supervision also needs to be a component of this analysis, to include the role and credentials of the Systems Managers.

Reimbursement/Rate Considerations

The organization of reimbursement is a critical consideration in order to ensure that funding promotes appropriate services, by qualified personnel, designed to respond to the child's developmental concerns and the family's concerns, priorities and resources. Reimbursement must take into consideration the following elements:

- Provider qualifications
- 0-3 CONNECTIONS continuing credentialing requirements
- Site of service, acknowledging transportation as a cost to ensure that services are provided in the child's typical setting, emphasizing their daily routines and activities.
- Specific tasks (beyond face:face services) that practitioners are expected or required to perform, such as documentation, team meetings, training, collateral contact, etc.
- Efficient use of all personnel through consultation, collateral service delivery and training that provides the optimal environment for the family's active and engaged participation.
- Overall system administrative costs including monitoring and surveillance, data collection, record maintenance, supervision, training and reasonable personnel costs.
- Incentives that promote the delivery of services in a manner that is consistent with the vision, policies and procedures of the Lead Agency.

Reimbursement should consider the ease of administration in documentation, billing and payment reconciliation. Common payment systems, including common rates of reimbursement, for all fund sources used to support Part C assist to streamline fund accessibility, facilitate training, and improve documentation practices and accountability.

The System of Payment Stakeholder Group confirmed that funding often drives services anywhere from influencing the frequency, intensity or location of service, to whether the service is available at all.

Equity across reimbursement sources can also serve to reduce the opportunity for services (type, frequency, location, and/or provider) to be "driven" by funding, as well as eliminate bias or the potential for funding to influence services for children based upon their funding source(s). The System of Payments Stakeholder Group confirmed that funding often drives services -- from influencing the frequency, intensity or location of service, to whether the service is available at all.

It is ideal if the same rates for reimbursement are used for all fund sources that come together to support a state's Part C/IDEA system. Often states implement

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common rates using the Medicaid rate as the "standard." In at least one state, this rate is "complemented" by an additional amount to support travel considerations in recognition of the requirement for home and community based service delivery. This cost center is often not included in traditional Medicaid rates.

Any reimbursement approach must be based upon cost data that would be obtained through updating the VA Cost Study. Approaches may include:

- Individual Service Reimbursement for a designated unit; typically units are a specific number of minutes or hours
- Episodic Reimbursement: One visit (guidance material usually defines what the minimum contact is that constitutes a "visit" – e.g., up to 2 hours, no less than 45 minutes, no more or less than 2 visits/month, etc.)
- Per month, "flat" charge regardless of the frequency or intensity of the visit(s)
- Event-Based: Examples include:
    - One comprehensive developmental screening
    - One comprehensive assessment of child and/or family strengths and unique needs in all domains (by practitioner or by team to be composed of at least two disciplines)
    - Participation in the IFSP: initial development, review or annual evaluation
    - Transition Planning
- Average annual per child cost to include all system infrastructure costs and required activities as well as direct service and related expenses

System infrastructure components (training, monitoring, data collection, etc.) should be an allowable cost center in rate development, as well as a consideration for practitioner time spent in direct services, teaming, consultation, documentation and an acknowledgement for reasonable planning and preparation.

For the Commonwealth, for those already covered services, we will have to justify why the current rate needs to change to fit in the Part C program.

Option 1: Current State Approved Medicaid Rates
The current state rate approach for reimbursement would be the "standard" for 0-3 CONNECTIONS reimbursement. INSERT VA METHODOLOGY LANGUAGE HERE

A complement could be negotiated to reflect the additional consideration of travel, training, etc. that is not currently included in the Medicaid rate cost centers.

Option 2: Cost Reimbursement
Reimbursement under this option would include the variety of costs that are required to ensure the delivery of quality services to Medicaid eligible and enrolled infants, toddlers and their families. The State Plan Amendment requires that a cost methodology be determined, but not that the rates be stated in the agreement itself. There are a number of ways to configure rates for reimbursement that also support the desired service delivery system. Reimbursement would be clustered to match the five "functions" earlier discussed:

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- Newborn, infant and toddler comprehensive developmental, vision and hearing Screening, Evaluation and Assessment
- Multidisciplinary Team Services
- Early Intervention Services
- Transportation and related costs necessary for the child or family to receive a service.
- Service Coordination/case management

The Virginia 0-3 CONNECTIONS system utilizes a combination of agencies and individual practitioners to provide services to eligible infants, toddlers and families. Any of the above structures could "fit" for this service delivery model. Many states are seeking to implement less of a "therapy" model of early intervention supports and services and promoting more of a consultative teaching model that is seen to facilitate more active family participation and involvement. Whatever models are utilized, the approach to reimbursement should support the model and not work against it.

This rate configuration would support the VA 0-3 CONNECTIONS service delivery system, which is composed of a combination of service approaches including the primary provider model. Currently the configuration of rates is a barrier to a more full, statewide implementation of the primary provider model. Right now, it is questionable if this model is implemented in more than 30% of the IFSPs. If the Commonwealth is serious about committing to this model, rate reconfiguration will help to support this commitment substantially.

Option 3: Annual Average Cost Per Child
The average annual cost per child was estimated at $7,786 for Fiscal Year ending June 30, 2003 when using the December 1 Child Count (point in time). The average annual per child cost is $4,036 for Fiscal Year ending June 30, 2003 when using the annualized count. This cost includes consideration of all systems components and provider responsibilities. It will need to be updated through the cost study process in order to reflect increases since 2003.

By agreeing to a managed care model, utilizing the average annual cost per child as the billing basis, invoices could be created based upon the monthly report of children in service, reporting actual service detail as required for Medicaid 416 EPSDT data reports. This billing would rely upon the adjusted annualized cost per child. These data would include all children referred and in the eligibility determination/IFSP development process, as well as those receiving IFSP services.

A potential downside of the use of the annual cost approach is that, by using the average per child cost, reimbursement does not take into consideration those children for whom intense services are essential. This would include children with Autism Spectrum Disorder or those with extended health care needs. It would be possible to create another form of reimbursement specifically for these children. Given that there usually is a wide range of service delivery frequencies and

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intensities across the total enrolled population, the improved economies of scale and enhanced utilization may more than compensate for costs incurred for children with intense needs. Data would help to inform us of this current enrollment together with planned service intensity in order to determine if things equalize, or if a special initiative for one or both of these populations would be required.

Inclusion of Uninsured Children

The DRA, through the Family Opportunity Act (FOA), permits states to enroll families up to 300% of the Federal Poverty Level (FPL) in order that they can purchase Medicaid coverage for their child with disabilities or developmental delays. Utilizing this opportunity, a sliding-scale premium could be developed for these families who are between 133% FPL and (up to) 300% FPL (the maximum allowed) that ensures services based upon the determination of each family's ability to pay. Family payment could include premiums, co-payments, etc.

0-3 CONNECTIONS, for the Part C program, will need to balance these additional opportunities and potential costs for families through their System of Payments policies to ensure that children have access to needed services regardless of their family's "inability to pay" pursuant to Federal regulations.

State Medicaid "Match"

As earlier discussed, Medicaid is a Federal/state partnership requiring that the state provide a level of "match" in the form of state or local dollars in order to draw down the Federal share. Virginia's "match" or FFP is currently 50; FFP for the State's SCHIP initiative is 65%. For some services, depending upon who provides the service (e.g., physicians and nurses), the FFP may change pursuant to Federal Medicaid regulations. Additionally, Medicaid FFP strictly for administrative purposes may be matched at 50%.

The VA 0-3 CONNECTIONS system currently receives an excess of $7.3 million dollars in state general fund revenue which is currently not being matched. Caution is urged, however, about untowardly displacing the obligations of the state Medicaid program for EPSDT and general Medicaid services by utilizing alternative local and state funds for match requirements. If these programs "disappear" or eligibilities change, the Medicaid agency still maintains the obligation to serve eligible children in spite of the "match" source. Several states have recognized this and only employ alternative match arrangements for those services that are "above" the EPSDT standard and specifically designed to meet federal regulatory requirements. Examples of this are service coordination, teaming requirements including IFSP development, and special instruction or developmental therapy (as it is termed in several states). The costs for services in the "natural environment" may also be seen as "above" the EPSDT standard and could be "matched" by 0-3 CONNECTIONS state funds.

If 0-3 CONNECTIONS state funds are used for "match" purposes, this Consultant recommends that this be achieved through "certification of match" whereby these funds do not actually transfer to the state Medicaid agency. Only the FFP is paid

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upon presentation of an invoice in this arrangement. This invoice routinely certifies that there is sufficient state "match" available to warrant the FFP.

The Virginia System of Payments

The first two approaches to configuring reimbursement outlined earlier in this Paper (unit or function) would permit individual practitioner billing and collection. Of significant concern to this Consultant is the lead agency's inability to ensure the Federal finance requirements, include payor of last resort and nonsupplanting. Further, DMHMRSAS is not able ensure that there is no disruption in services for families when there barriers to accessing reimbursement or subsequent reimbursement problems.

DMHMRSAS has created a "System of Payments" in response to OSEP requirements that the "inability to pay" is ensured as it relates to family cost participation including the use of fees and/or their private insurance for 0-3 CONNECTIONS services.

Any financing configuration changes that are performed to the 0-3 CONNECTIONS system to respond to more efficient and effective Medicaid utilization must also incorporate consideration of the use of family resources. Together, all financing arrangements constitute the System of Payments which includes assurances of timely reimbursement to providers, protections related to the family "inability to pay" and appropriate utilization of private insurance.

Billing and Collection: Options

Billing and collection is obviously something to consider when developing a System of Payments to include Medicaid – for a number of reasons. Lack of provider payment can often result in a disruption in service for a child and/or family, which is unfortunate in and of itself. This situation typically then becomes a Part C compliance issue. We also know that the more complex or cumbersome reimbursement practices are, the less likely providers will be to access specific resources. This is currently happening in Virginia with respect to Medicaid reimbursement and relations with MCOs.

Billing and reimbursement for 0-3 CONNECTIONS services can be configured in several ways:

- Centralize through DMHMRSAS perhaps including family fees and use of private insurance;
- Centralize through Medicaid, using their billing and reimbursement provider entity for 0-3 CONNECTIONS;
- Contract with a third party administrator ("TPA"), usually outside of state government, to administer billing and reimbursements;
- Utilize a regional or local existing county or provider entity to administer billing and reimbursement for a targeted geographic area; or
- As is currently the practice, individual provider billing and direct reimbursement.

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Some states (IL, IN, MO, WV, NJ, KY) have developed central finance systems which utilize an external contracted entity as a TPA for all Part C resources. These structures vary considerably with some consolidating the receipt of all third party resources at the state level, and others established as a vendor-based payment system. As discussed earlier, a state considering this kind of structure should first search "within" to see if there are existing resources already performing this function and who could expand to include the Part C population. Options include each state's Title V/CSHCN program or the state's Medicaid agency, both of whom typically operate a payment system either directly or indirectly through a third party administrator.

A potential downside may possible be that some practitioners may perceive this centralization of payment as losing control of "their money." This is not an unusual reaction. Provider contracts could be at the state **or** local county level, with a common rate across all funding resources utilized to reimburse practitioners for delivered services regardless of the payment source.

The average annual per child cost approach described earlier is not clearly amenable to the current Virginia 0-3 CONNECTIONS system practitioner model, but could work very nicely if state level reimbursement could be conducted. The state, in this example, would bill monthly based upon total enrollment in all three components of the 0-3 CONNECTIONS system and would also provide individual service data to DMAS for documentation as well as inclusion in their Annual EPSDT reporting on Form CMS-416. Funds would then be released to the LLA based upon service records.

It is also possible that the 40 LLAs could formalize the regional configuration and, together, select a Third Party Administrator who would conduct their billing and data reporting.

Either of these approaches would provide greater management control to DMHMRSAS of all 0-3 CONNECTIONS resources, and assist them to equalize the distribution of resources in a more equitable way over time reflecting the general county demographics as well as enrollment changes. The administrative infrastructure costs could then be folded into the overall rate for service reimbursement allowing greater administrative ease and management at all levels.

Removing the obligation for Medicaid billing from the individual practitioner is usually greeted positively by the provider community! Given some of the barriers in fully accessing Medicaid for eligible/enrolled children, it is reasonable to anticipate that this approach would result in increased utilization of this third party resource. This approach also ensures that DMHMRSAS can respond to the OSEP finance monitoring requirements as well as provide more detailed and accurate information concerning the total funds supporting the system, but fund source.

Use of a centralized finance system would also incorporate family fees and access to private insurance, thereby "levelizing" the compensation for all providers in the

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0-3 CONNECTIONS system by the use of a common rate which fairly and reasonably incorporates all costs of doing business in accordance with Federal and state regulations, policies and procedures.

If a centralized model is not of interest to the Commonwealth, multiple or "tiered" approaches to reimbursement would need to be entertained including administrative claiming for both the state and local levels. As discussed earlier, this local practitioner rate could be either by 1) function (e.g., Newborn, infant and toddler comprehensive developmental, vision and hearing Screening, Evaluation and Assessment, Multidisciplinary Team Services, Early Intervention Services, Transportation and related costs, and/or Service Coordination/case management); or 2) by another configuration including individual service reimbursement for a designated unit as is the current practice.

Implementation Considerations and Potential Systems Changes
It is literally impossible to alter one component of the 0-3 CONNECTIONS system, including financing, without affecting other components. Thoughtful and plannedful approaches to system analysis and design can assist to avoid problems or resistance at any level; in Virginia's case, this system "redesign" should also consider the OSEP and General Assembly reporting requirements.

Understanding the potential prevalence facilitates financial forecasting, and assists the state to plan related system components such as provider recruitment, training and credentialing with a particular focus on selected geographic areas or specialty areas. Efforts to incentivize ChildFind are important; the basis for the target needs more investigation.

Because of the interrelatedness of the 0-3 CONNECTIONS system components, considerable effort needs to be directed to think about the "domino effect" of any change in financing to the system as a whole, and to assist the Commonwealth in prioritizing their efforts. The "domino effect" is displayed in this diagram, focusing on what is likely to happen in a state which increases its ChildFind efforts.

In Summary
Creating this SPA would expand reimbursement for 0-3 CONNECTIONS services to cover all of the required Part C services. This recommendation could expand the enrolled population beyond 133% of the Federal Poverty Level (FPL) (Virginia's current Medicaid eligibility criteria). Currently, these uncovered children are a challenge for some counties where the gap between Medicaid enrollment and private insurance is more pronounced. For these children, IFSP services and supports are dependent upon other Federal, state and local resources.

There will be children who require both 0-3 CONNECTIONS services as well as other medical services reimbursed by Medicaid. Partnerships in data sharing help to check for duplication, protect against fraud, and can truly monitor the total service package for individual children and assist to guide system evaluation and decision making in the future.

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For the Commonwealth, any change that will cause an increase in expenditures MUST go through the budget process. Unless these changes are part of a Governor's initiative, budget language or bill, regulations will take about 14 months unless Emergency Authority is granted.

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