

**Virginia Part C Ability to Pay
Stakeholder Group Meeting Notes
March 6 -7 2006**

MARCH 6, 2006

Participants:

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Welcome and thank you for agreeing to meet on such short notice. This work will impact the upcoming local contracts.

Introductions....

Today I will need to learn from you what ATP is in Virginia. We will develop consensus on the following

- Policies and Procedures
- Assignments of ATP with individual families
- Collection methods and procedures
- DMHMRSAS reporting requirements
- Use of generated revenue

OSEP is beginning to monitor state's financing systems. We don't know what that means yet; we know that it will impact your work in the state.

It was the intent of the federal government that Part C was never intended to be fully funded... From the federal language from the beginning, Part C funds were payor of last resort. The intent of Congress was for federal Part C funds to be used as "glue money" to bring together the resources that are already available for services and supports for children and families.

Part C is different than Part B because it is expected to use family resources. We now have 38 states that have some form of family cost participation including fees.

It has been 2 years since implementation of ATP

The local lead agency (LLA) charges for services unless families say that it a financial hardship. Then the ability to pay fee schedule is applied. A second step in VA occurs when the families "appeal" this decision, that the cost to them exceeds their ability to pay; cost in this case may include the ancillary costs of accessing their private insurance (co-pays, deductibles, etc.)

Why is ATP important to the Commonwealth?

- VA code requires that we have it
- It's important so that families are treated the same across the state – consistent

- Families can access treatment and aren't left behind
- Increase families participation
- Increases funds
- Are fees worth the effort to collect? donation?
- Biggest "arguments" with families are related to fees and insurance
- Even with fees it could be a sore spot with families.
- VA state legislature likes the idea that families doing their share – not just EO, generalized across service systems
- The state lead agency and most LLAs do not know how much is collected in fees.

Do the policies and procedures reflect the practices and behaviors of the localities? (chartpack notes)

- They are not clear
- Interpreted differently
- Definitions are poorly written
- Cost share is used interchangeably with terms
- FAQs are different between the one attached to the document and the ones that are on the link. Hard to know which ones are correct
- Not consistent with practice and activities are not consistent.
- Confusing
- The language is difficult
- Terminology inconsistent and confusing

Are the policies and procedures used consistently when working with families (chartpack notes)

- Families are confused because the person explaining is confused
- Each agency does explaining at a different time supposed to be done before the IFS, some before service can be done all at once.
- Policies still don't address assistive technology

Assignment of ATP – What is the process /challenges? (chartpack notes)

- It is very quick when the family is on Medicaid – they can't be charged any fee, even if the service is not covered by Medicaid
- Taxable income/return vs appeal
- Hours are endless
- Families are confused.
- Appeals process is difficult
- Backside of the billing is additional time when bill comes due – families caught off guard.
- Families really believe insurance will cover
- Difficult to collect when insurance has denied coverage
- Families want to get more for their dollar because the cap is the cap – there is no more expense – it depends on how it is presented to the families
- The old way was that families paid a fee for service – some localities had their own cap on fees – it was locality dependent
- The old system was cumbersome but was more equitable

- Sometimes a family will have more than 1 child in the system and they would get 2 caps or different caps that don't match, or the cap split between the two children and then one exits and the cap is no longer complete
- Sometimes because insurance provides PT, OT SP and families may decline special instruction because they would have to pay the ATP fee, or they decline special instruction (which might be more appropriate) and ask for a therapy which would/may be insurance covered.
- People who are high ranking military or families who own their own business – difficult to determine their taxable income, or it changes.
 - Military families have different “rules” for determining taxable income
- Approximate #of families on ATP – just about everybody full pay or are using their insurance Approx 98% of those families who are not Medicaid-covered
 - Level I ATP majority
 - Level II appeal – very few – income changes
 - Decline services? We don't know. We also don't know how many families elect not to even approach 0-3 because of the use of insurance and/or ATP.
- The bill goes out after the fact and there is a “dispute.”
 - Issue of non-collection. When families don't pay you move into termination of services
 - Pay something – stay in
 - Regular collection
 - Others after closed cases go to collection
 - Public providers have attachment abilities (state tax return, lottery winnings); private providers do not.
 - Each CSB has their own collection process
- Sometimes families insurance changes or income changes; provider and/or local lead agency don't know this
- Some localities have the private provider collect the fees and pay the CSB and charge the family the co-pay only.
 - There are differing policies and procedures; different invoices—all manual billing
 - Providers who cover multiple and different local leads have different policies and procedures to follow; lots of variety in documentation
- Private providers bill the families, LLAs bill Medicaid
- ATP cannot be retroactive. Families assume that once insurance is denied they can go back and pay the scale rate for previously provided services. They must do full pay.
- Sometimes a family is getting services from 2 providers – this means that each agency must keep track of who is collecting what.
- Full reconciliation may take up to 1 year – child has exited the system by then
- Insurance mandate \$5,000; X self pay policies; X out of state policies

Reporting Requirements

- You don't know how much is collected because local providers do their own billing, LLA is doing own billing and no one reports to state LA
 - Fairfax does know because they require fee and insurance information monthly.
 - Others can tell by the invoices
 - Inconsistent statewide
 - There are 4 or 5 different software system that CSBs are using or were in place when EI came along.
 - EI is such a small piece of what the CSBs do.
 - No idea if families drop out due to \$\$\$

Improvements – options and solutions
Use of Revenue (together)

NOTES -- March 7, 2006

Participants: Kim Taylor, Debra Holloway, Mary Ann Discenza, Carol Granger, Tracey Miller, Allan Phillips, Beth Tolley, Sandra, Carol Burke, Liz, Mary Ann Johnson, Karen Ivey, Brenda, Lisa, Bev Crouse, Shirley Ricks (partial)

Welcome and housekeeping

We will review and validate what we heard yesterday. We will brain-write solutions/creative ideas on what is possible

Any concerns/worries –

Concern – Will our program be able to charge up to the full cap for parents?

Would this group, agency or legislature ever consider not charging family fees

- We would need to have lots of data to justify
- The state agency has the code for family fee
- I would object to increasing fees
- Some families (higher income) have told us they could/would pay more
- If we are accessing private insurance, co-pays and deductible cannot be waived

Focus/Outcome:

Streamline what we are doing, make it easier, and quantify what revenues are being collected

This is a small group and puts the onus on you to talk with your constituents

Overview of requirements of the Law –

- Never intended to full fund Part C. First piece of legislation to require partnering.

- It is incumbent on this state to figure out what resources are used in this state, and to make this happen through interagency agreements.
- Part C does permit system of payments that includes family fees
- The system has changed since 1974 – passage of PL 94-147 (primarily 5-200 year olds with disabilities in public schools)
- PL 94-142 did not bring along those public supports that were happening prior to the Law; exclusive obligation given to public schools who didn't have the funds, the skills or the resources to meet the needs of these students
- Part C was “glue money” not an entitlement.
- Family fees are on the table as well as private insurance different from FAPE
- Child find, IFSP, Service coordination, evaluation & assessment

Who do you partner with?

- Child care
- EHS
- CPS – because of CAPTA
- Gymboree

There is a range of what states do

- Some have a rate for each service against an maximum rate
- Some have a match or a cap
- Some have a percentage against each service
- Some have an annual fee, against the IFSP total cost

In VA, families do not pay over their family cap. It is the responsibility of the Service Coordinator to monitor that families do not over pay their cap. There are different combination of how service coordination is provided (dedicated vs. combined).

AT NO COST does not mean “free.” Some services are required at no cost, but we can use other resources to either pay or provide the service.

What about Medicaid Administrative Claiming? No CSBs/LLAs do Administrative Claiming. It was on the table several years ago but was not ever pursued.

Family Cost Participation includes all family resources. Some states do not have FCP because it is not a part of their culture, or their enrollment in 3rd party resources such as Medicaid is very high.

You need to know what your prevalence rate is, what the multiple eligibilities of your total population are and how it impacts the resources that you tap.

We have to think about administrative ease and how clear and complete the information is provided and there needs to be accountability. Need to be sure that there is equitability. But we do not know that because we do not have the information documented re: any of this.

More and more families are staying in C at age 2. Schools are narrowing their eligibility. Often families who are paying a fee will go to the schools. Those who are not paying a fee are staying in C.

CSHCN –

Care Connection is the Title V/CSHCN in VA. They don't do Part C service coordination or other Part C services (in general). There have been challenges that Title V is payor of last resort in VA.

Bubble Chart –

Look at who is providing a service and the qualifications of the provider

- EHS
- Child care -- providing pull out and consultation (and combinations there of)

In some areas it is more costly because we do not have a high Medicaid eligible population.

MR waiver with kids on waiting lists This is how they access TCM. There are about 100 slots for kids who meet the urgent care qualifications.

We have done a "matrix" that addresses the resources in VA.

Financial/Resource Case Management (do as part of service coordination)

- It is done sporadically in this state.
- We have done this in the past in training.
- Because this is unfunded we have very little resources to spend time with families for service coordination.

In some localities there is an expectation that service coordinator have visited the family 3 times – intake, evaluation and IFSP development

Participants felt that these discussions – multiple financing/provision options or financial case management – were distracting from the reason that the group was assembled in the first place. These are not issues we are dealing with now. Let's get back on track.

COMMON DEFINITIONS from VA docs and what we are used to seeing:

- Usual and customary Rate (UCR) insurance uses this differently – their usual rate that they will pay
 - It means what I charge to do my business
 - VA participants do not want to use UCR because this is more of an insurance term
- Negotiated Rate – negotiated from the full charge rate to what the LLA will pay for non—covered services
- Medicaid Rate of Reimbursement – again, different
- Insurance Rate of Reimbursement

- Deductibles
- Co-pay
- Family Cap (Part C) – there is a contract between the family and the LLA
- Others?
 - Discounted rate – this is a problem
 - Full charge – what I bill to everyone (this has changed over the years)
 - Negotiated rate = full charge to the LLA
 - Full Charge Fee = Fee Schedule which does not equal Agency Cost – cost centers (public sector = CSBs; private sector = everyone else)
 - EX: Average cost is \$150 and is bill to Medicaid, HMO, LLA, families, private insurance, private pay patient
 - Need to define what the cost centers are –
 - Limited # providers – did not include too much latitude in negotiating/ did not include hospitals in cost study
 - Issue of full cost is a challenge here

Where ATP is a concern is for the provider because the 1st provider in the door gets paid using the full charge rate, leaving the following providers w/o payment from family cap and going to the LLA using their negotiated rate.

In Roanoke we are not charging for special instruction. This can be a problem because as families move from place to place they would encounter a charge that they currently are not paying in Roanoke. Lisa's educator rate is higher than Liz's rate for serving children for Liz.

We agree to use the Full Charge Fee to mean the cost centers and cost of doing business (including the profit margin for private providers) and I could charge different rates for my services for different services that I provide.

We are accepting payment in full from

- XIX
- Ins
- HMO

Except for uncovered uncompensated associated costs of services (including travel, administration, IFSP, meeting teaming) these services are uncompensated:

- Special instruction
- AT
- Nutrition
- Vision teacher

Local Control—

With local control comes local accountability. What if the recommendation from this group was to make a recommendation to fund the system that would:

- Increased efficiencies
- Simple to implement
- Can't "cost" more to the providers, LLAs than it does now (write-offs)
- Must retain/grow providers
- Meets the VA Procurement and Purchasing Guidelines
- IFSP services are not driven by the reimbursement sources

Let's say that all of this was ensured and that there was a common methodology that there was equitable, quality services that are affordable and meet the needs of the child and family.

Issues Categories –

Remember that the system is broken, policies are not clear, there is inconsistent implementation

Key Outcomes to repair the system are

- Increased efficiencies – including how much time families are spending on this.
- Simple process to implement
- Can't cost more for LLAs, providers, families(?) maybe upper income families can afford more,
- Must retain/grow providers
- Meets the VA Procurement and Purchasing Guidelines
- IFSP services are not driven by the reimbursement sources

Aiming toward changes by July '06 allocation methodology

1. Policies and Procedures
 - Requires FCP – not only what but how you do it.
2. There is a belief that ATP results in increased family participation – no data to support or not but we believe that what you pay for implies a value -- importance.
3. We don't know if ATP helps you get closer to paying the cost of providing services – no data to support or refute.
4. Many times families are young and stressed and they don't remember having the conversation about their insurance
5. We don't have the time or the ability to explain families insurance to them.
6. There are some service coordinators that do take the time – it's difficult to keep up with changes and training for keeping up. Often it is the billing person explains.
7. It's a lot for families to understand and to be sure that what they were told is what they got and not what they think they should get.

Policies and Procedures

1. Providers who are working with multiple communities that are doing things in different ways.
2. Confusing process and differs from program to program and provider to provider
3. There has been no training other than what is done in a brief training overview at the local level
4. How AT are big ticket items that occurs one time and how it interprets into a monthly fee
 - Needs to be rewritten
 - Training needs to happen in more depth
5. If deductibles and co-pay all fall under the family cap. So if a family goes to a doctor before they get their Part C services they have paid their deductible, but if they get their therapy first then Part C is paying for much of the up front

Deductible for what the insurance will pay

Co-pay is the set charge for each visit

or

Cost share is % of every visit

Cost share to the individual for the purchase of health insurance (there are issues between in network or out of network) – this should not be included in their cost share -- **NO**

These are against insurance company's UCR

P&P need to be rewritten

- Clear definitions
- Training to support
- Guidance document need to be kept up to date and readily accessible
- Fee appeals need better definitions and guidance materials
- All documentation has to come back to these P&P to be sure that it is being implemented
- Where is the financial information stored and in the EI records or not and safe guards for not inappropriate sharing
- Documentation to support income – not necessarily 1040; open for debate W2, pay stub, taxable information 1040 levels the playing field. **SOME VISUAL VERIFICATION?**

Administration –

- Medicaid no cost
- Fee for uncovered Medicaid covered -- this comes into play when a state has waivers for families who are high income and could afford to pay more

Implementation –

We said that...

- Time consuming – family has info but when it is actually denied, the back end is time consuming and may hold up services.
- Prior authorization is not a guarantee of payment
- Limited TCM (does not pay for all Medicaid kids) and the family has to give authorization
- Local lead agencies pay for service coordination
- Taxable income is easy to identify and use as the base
 - Military families is done differently – housing allowance, and hazardous duty pay
- Problems when more than 1 child is served in a family –

Assignment of the fee would be ...

Tied to taxable income but maybe some different ways to do it so that it is less invasive or vulnerable

Needs to be an appeal process without having to bring in the insurance pieces so that families don't have a false sense that insurance will pay and find out that it doesn't later.

Historically -- You did not offer a fee scale unless a family said that they couldn't afford to pay.

The intent for ATP was that families knew what they would pay

Cap means that you pay up to the max amount identified

Fee means that you pay no matter what.

It is the family choice whether or not to use their insurance.

It seems to be fair to set a standard such as a monthly fee so that people are not penalized for good or bad insurance

OPTIONS:

Participation fee

- determined by income and maybe other resources (insurance and other funding eligibilities)
- % of cost of IFSP and is indexed – or deducts it from the family share or uses it in lieu of the family share

Some work on assessing the field of insurance and addressing the out of norm issues

Assessing what a family can pay for (# of services). For every service there is a flat rate per service up to a certain amount of services

Could the fee be looked at as fee for participating in the cost of the IFSP over time – if you looked at the end of the year you may not have paid in the end for as many services or they pay for more than they got.

No family fee is ever going to reach the place where they are paying for all of their services.

Participation fee may help with no shows.

Have not heard anyone say that they want to throw out the cap, If we clean up what and how we do business and do some training we may be okay.

COLLECTION:

- excessive duplication of effort –
- manual billing – assignment, billing, collection
- Nonpayment – what happens if the family doesn't pay – OSEP would say that you cannot terminate services without procedural safeguard b/c changes in IFSP etc.
- What if a private provider terminates services they would say that the child would remain in part c services -- you are still responsible for services on the IFSP if you are named the provider
- State mandate is a \$5,000 per year cap for services only. We know when the insurance cap is reached because insurance stops paying
- Do not bill families for missed services but do bill some EI programs for missed services

Options:

- Center-based and collect when they walk in the door.
- Separate what provider gets paid from the family fee (agency bills family) – simpler for service provider
 - Avoids messing with co-pay and deductibles Brenda collects the family copay and the associated cost depending on what their cap is
- Some states keep the collection separate from IFSP – some states collect the fees and family payment. This means that the providers at the local level would have a rate totally unrelated to what families pay. Would be at X rate that includes an associated cost. This would still be a problem for insurance collection. Would look like a "state rate".
 -
- Families pay up to their cap -- that includes copay and deductible
 - Cap = 100/mo
 - Co/deductible = $\frac{140}{40}$ /mo

Who pays? Part C? Not all someone "eats it" (Part C or provider)

What we have is an understanding of all of the permutations of the system?

What would make the most sense to “streamline” the system?

Guiding Rules

- Providers have to have a fair rate in order to stay in the system
- Greater good is when kids receive in EI
- EI services should be affordable
- There should be efficiencies for assignment, collection, fund management

Possibility of follow up meetings???

Sue’s comments:

There is tremendous vulnerability is how you are managing, collecting, and reporting – it is different from LLA to LLA. What would happen if family fees were taken “out” of the LLA’s responsibilities?

- One comment: “Feel comfortable with having family fee being pulled out from LLA management. However, would need to figure out how this works with insurance.” As long as we have assurances that families are not being over charged.
- One comment: Also need to remember that Part C is not the only funds. Approximately 50% of funds are local dollars.

Sue thanked people for attending. This is a hard and complex discussion; some came here to solve a problem and we know that we didn’t do that. Sue needs time to think about all of the input and assemble recommendations. She will share the meeting notes and these recommendations with participants beforehand, for comment, ideas, etc.