

INFANT AND TODDLER CONNECTIONS OF VIRGINIA  
SYSTEM OF PAYMENTS STAKEHOLDER MEETING  
October 3, 2006  
MEETING NOTES



Present: Brenda Crockett, Alison Standring, Deana Buck, Tammy Whitlock, Tracy Miller, Debra Holloway, Bev Crouse, John Clary, Kathy Phillips, Allan Phillips, Anita Eggleston, Rachel Valenti, Mary Lou Hutton, Karen Ivey, Karen Walker, Kim Bebeau, Jim Gillespie, John Clary, Lindsey Brooks, Glen Slonneger, Tracy Miller, Mary Ann Discenza

**Welcome! Overview and Anticipated Outcomes  
Introductions and Expectations**

Mary Ann Discenza gave an overview of the history of work on the Commonwealth's Part C system finance issues, emphasizing:

- Cost Study completed by Karleen Goldhammer, SOLUTIONS Consulting Group, LLC in 2004
- Sue Mackey-Andrews' work on ATP, also with SOLUTIONS Consulting Group, LLC
- The Part C Infrastructure Task Force Report (April 30, 2004) (reference; posted on the website)

Mary Ann highlighted that all of the financial issues come together under the state's requirements to have a System of Payments; this includes the allocation methodology for state and federal Part C funds, Medicaid reimbursement structure(s), Family Cost Participation/ATP and the Local Lead Agency (LLA) use of other resources including local funds.

The charge to this Task Force is to make recommendations to the consultants in the design of a master plan for how all of these resources come together. Mary Ann reviewed the complement of individuals invited to attend, noting that Debra is present today and that she will assist us in contacting family members to review the final document/recommendations.

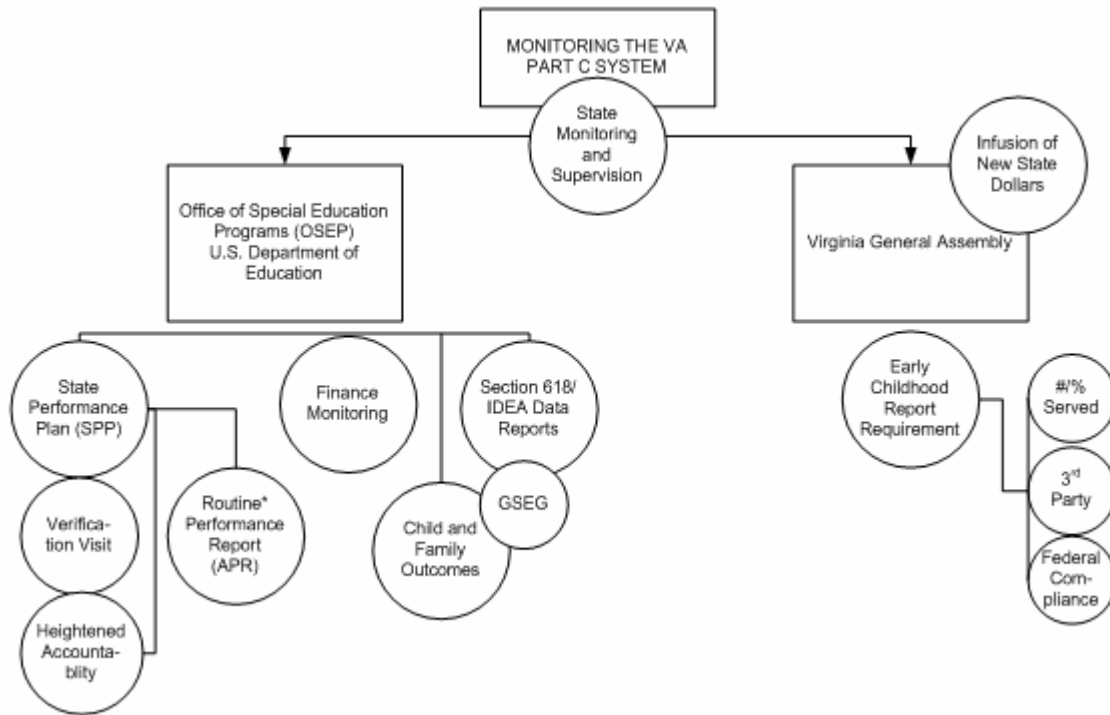
Sue Mackey Andrews: PowerPoint Presentation to guide discussion

Three outcomes planned for today:

- To review the System of Payments workscope, product and timeline
- To obtain stakeholder input and direction to the process and product
- Establish communication expectations and timelines

Participants introduced themselves and spoke of their primary interest for attending today's meeting. The majority of participants were attending to focus on the funding formula, some were here to talk about the Medicaid reimbursement and its impact upon the formula, and still others wanted to better understand the consultant recommendations re: the FCP (ATP) policies and practices in the Commonwealth.

Sue reviewed the expectations of the Commonwealth's monitoring system, responsible and responsive to the General Assembly and also to OSEP.



Components of a State's Part C Monitoring System:

- Lead Agency
- Role of the SICC
- Interagency Agreements
- Dispute Resolution Process
- Assignment of Financial Responsibility in writing
- Payor of Last Resort
- Services to children and families in a timely manner
- Arrangements with providers – contracts, timely reimbursement
- Description of the Use(s) of Federal Funds (budget)
- Assurances, Reporting Requirements
- Compliance with a variety of federal regulations
- Non supplanting
- No commingling
- Equitable distribution of resources statewide
- Payments by parents reflecting consideration of their "inability to pay"

The System of Payments includes, at a minimum:

- Family Cost Participation
- Provider Rate Setting Methodology
- Allocation of Resources
- Identification and effective utilization of all other resources
  - Family fees
  - Public and Private Insurance proceeds
  - Locally generated funds
  - Other state agency/department resources (grants, payments for services, "in kind" contributions based upon agency mission and responsibilities, etc.)

Sue provided a brief overview of how we got to where we are now. Our work subsequent to the Cost Study picked up with which rate to use for ability to pay assignment with families – the full cost rate or negotiated rate. This discussion then led to bigger issues with payment in general; this is linked to allocation, rates, etc. There are also new federal requirements for monitoring the system of payments which will be rolled out in January 2007. Sue and Karleen's focus is to help the Commonwealth to prepare for this monitoring and also, to create a linked and connected System of Payments that results in supporting the Part C system and all of its participants – families, Local Lead Agencies, providers.

Sue clarified that we are not talking about all of Part C system responsibilities; the focus for today is on monitoring and accountability. There has been unfolding federal interest to establish heightened levels of accountability pursuant to the regulations (which haven't changed since 1989 in this area), including the new financial monitoring. The Part C program has gone for the better part of 12 years without any monitoring. OSEP has moved from an improvement/technical assistance process to a more strident and focused monitoring. Congressional questions: Are you making a difference? There are States who are in rigorous compliance agreements today. They have two years to correct their problems and one year to maintain progress in order to be released from their compliance agreement.

In the Commonwealth, Part C has two "bosses:" OSEP: \$10 million in revenue: State performance plan (SPP); annual performance reports (APR). States are now required to report their progress on focused items regularly – some report monthly, others quarterly. Some focused items have a 100% compliance requirement. What is new is the fiscal monitoring focusing on the state's System of Payments, and asking states: tell me all of the funding sources that support your system.

Through a combined process of reporting on Child and Family Outcomes, the 618 data reports and the SPP/APR, OSEP will start to "rank" states by their indicators and publish on the web a series of performance reports.

The second "boss," the VA General Assembly, has historically limited involvement until the recent allocation of considerable resources totaling more than \$15 million across the biennium. The GA requires data reporting on an annual basis looking at how many children were served, the total resources in the Part C system at the federal, state and local level, and what services were provided. Last year – the first year reporting was required – the Part C office was not able to provide the required data on total funds in the system.

There is a heightened emphasis on interagency agreements as a key component of OSEP monitoring; there is also significant potential for changes in how the state operates its Medicaid program per the Deficit Reduction Act (DRA). Together, all of these factors are creating a perfect storm resulting in the need for this stakeholder group.

## Family Cost Participation/Ability to Pay

- Consultant findings and recommendations
- Stakeholder response/reaction

Sue outlined the major approaches/options under review related to FCP/ATP:

- Construction of the Fee: Options
  - General IFSP fee, collected monthly
  - Annual enrollment fee
  - Fee per each IFSP service
    - Perhaps with a “cap” (not to exceed annually)
    - Dollar amount
    - % of total cost
- Mechanics
  - Who collects?
  - How reported?
  - How utilized?

Sue’s proposal developed to date:

- One-step process proposed which includes extraordinary circumstances
  - Performed with all families including Medicaid-covered
  - Linked to utilization of private insurance, TRICARE
  - Document collection incorporates an interview to confirm family income
  - Includes resource case management
- Location of family financial information
  - At the Local Lead Agency in a separate file (not the EI Record)
  - Noted for family access in safeguards; not subject to general FERPA access
- Who conducts process with families?
  - Service Coordinator **OR**
  - Local Lead Agency Individual with finance skills
- Who collects the fee?
  - Local Lead Agency – ensures federal obligation re: “inability to pay,” would monitor “cap” if one was established, and consolidates data for reporting/accountability purposes
- Providers receive their locally negotiated rate as reimbursement for all services provided
  - Local lead agency bills and receives FCP including insurance co-payments and deductibles
  - With documentation, providers receive the family co-payments and deductibles
- “Timely” requirement
  - Services are delivered in a timely manner
  - Providers paid in a timely manner, no matter what the source of reimbursement is.
- Undelivered services – consideration incorporated into reimbursement rate
- Family failure to pay (vs. inability to pay)
  - Responsibility to provide services during this process
  - Assurance of family due process and procedural safeguards
  - Timelines to define “how long”

- Roles and Responsibilities of Local Lead Agency/Service Coordinator vs. Provider
- Training and monitoring of the process for Service Coordinators and Local Lead Agency Staff
  - Statewide standardization
  - Ensures key principles: Accessibility, Equity and Parity
  - Local Lead Agencies
  - Families
  - Providers
  - Ensures reporting capacity
  - Ensures appropriate use of revenue
- May include “incentives” for Local Lead Agencies pursuant to the expansion of local resources, interagency agreements
- Cultivation and development of state and local level Interagency Agreements

There was mixed reaction to Sue’s proposal. Some participants discussed that 50% are covered under Medicaid, 10-15% ask for the sliding fee. The rest simply pay the co-pay; they would rather pay than share the financial information. Some of the stakeholders present expressed a concern re: the administrative burden for the Local Lead Agencies.

Discussion Points:

- What happens to the uninsured?
- What does Part C cover?
- The Medicaid Rate (fee for service) is “reasonable” for reimbursement
- What does Medicaid cover, and what doesn’t it cover?
- Concerns were expressed about obtaining \$ information from all families – this is a big shift for some.
- When families pay their co-pays, they don’t have to share financial information.
- Agreement: funding drives the services on the IFSP
- Try to avoid billing by service – just reinforces a “therapy” approach and does not reinforce the primary coach model that we have made a commitment to in the Commonwealth
- Insurance billing is problematic:
  - Requires a license as a rehab agency to bill Medicaid/rehab-fee for service
  - Requires medical documentation for each child vs. invoicing for service
- Providers currently do all of the billing (Medicaid, Insurance and Family Fee) – don’t want to turn this over to anyone else. There are probably others like this (reference slide 23)
- Brenda commented that she has 7 localities and 4 major providers – this approach won’t help them at all.

Sue noted that data needs to be collected re: what are the actual services that are delivered, and who pays for the service? Services are changing regularly requiring a single place for data collection in order to ensure the responsibilities of the Local Lead Agency. She discussed the need for written prior notice when services will be

discontinued or changed for any reason ... including lack of payment. This is not being done now universally throughout the Commonwealth.

Sue provided the citation for written prior notice, Section 303.403 – requirement that families receive advance notice (VA days five days) BEFORE a change in their child's eligibility, delivery of service, etc. is proposed. This applies to FCP when the family doesn't pay, or perhaps for missed visits, and providers want to terminate services. Providers should not be doing this without going through the service coordinator and giving parents written prior notice and holding an IFSP meeting. There is tremendous jeopardy for the state Lead Agency and each Local Lead Agency under the current practices.

### **Statewide access, equity and parity**

#### **Rate Methodology Template**

- **Consideration/inclusion of Rate Study findings including prevalence estimates**

Karleen provided an overview of the purpose of the rate methodology template, cautioning that we really need to pilot this in a few localities to see if the format works, or what needs to be change. We are not sure that when we get to the end of the System of Payments process that this specific template is what we will be using. Outcomes are that we will achieve more equity, get the system closer to what we believe is important – process may change.

Clarified that the purpose of the rate methodology template would be to ensure that all providers use the same approach to get to the negotiated rate; this negotiated rate (using the same ATP system that the Commonwealth uses now) would then be used to apply the ATP by the family. This was the agreement of the ATP Stakeholder Group who met earlier on these issues. The group present today acknowledged that there is a difference in which rate is used locally.

Brenda asked to confirm that rather than the one rate she has now, she would be using four different rates for each service based upon the number of providers. Sue emphasized that we are not recommending that VA stay with the same ATP process that they currently use.

We are seeking to make this administratively easy by standardizing the process across all providers, including consideration of associated costs. Karleen reviewed slide #26 which asks three simple, straightforward questions:

- What does the person cost?
- What is total cost?
- What is the billable/reporting basis?

One challenge here is to project the fiscal implication of implementing a more standardized way of rate setting with providers.

Karleen referenced slide #27 and talked about billable services. The concept is that this template could be used with each individual provider to compute their rate to include all cost considerations. We would end up with different results, but using the same process. Sue asked: would the same provider have the same results

across different local lead agencies? Should be. Tracy disagreed that travel time in the rural area would increase her costs and therefore, she does have a different rate depending upon this variable. If individual discretion is applied, then we end up with the same challenges and variations that we have now. When she did the Cost Study, she did the numbers as an agency. Was Deana subsidizing Brenda's region? Discussion (Bev) based upon the current allocation structure, which results in different ways that rates are developed. Reimbursement rate provided (cross multiple regions) may inflate what might have previously been a lower rate. Column 10 – exact face:face time. Is this counted in the negotiation. Does the 31% ever change? No – we were proposing the statewide average be universally applied – not part of the negotiation.

Tracy – this point is exactly right. Bev – if we go where you are taking us and don't think about how we are doing business now, we might have more to develop the concept more fully. At some point, providers have to control their business to remain "whole." Tracy noted that her costs are different in Tidewater from Richmond. There is more mileage and time in Richmond than in Tidewater.

Karleen believes that we have to seek greater systemization, and not leave this up to individual negotiation. It might make sense to do some things regionally. There will always be "winners and losers." Perhaps regionally, we can look at the data and adjust things regionally.

What are the things that give us commonality and does this model make sense to us? It does make sense to pilot this and see what the results bring. It is important to avoid making policy through exceptions. We will always try to push you back to a more standardized approach.

#### Discussion Points:

- Would it make sense to separate face:face from travel? This is really consideration of travel time. This is face:face time – with travel time consideration. May be a mis-labeling.
- Methodology is without consideration of missed time off work (sick, vacation). Issue raised: What if one provider gives one week of vacation vs. another who gives 8 weeks? This is not calculated in monetary terms. Tracy used some examples of using the common rate in two different environments. Where is the incentive for a provider in the rural area?
- For larger providers, this may equalize if they serve both large and small areas. What about the provider who works only in the top dollar area? Is one subsidizing the other? Karleen – this suggests regional approaches which account for the travel time differently. It was surprising how similar the regions look – potential for under-representation in the southwestern portion. Karleen is nervous that we may start something that can't be sustained when we move it to a universal application. Risk in regionalization that they are simply not going to like the regionalization.
- Tammy commented that a differential for northern VA has long been in place for almost all of the services in the HCBS. There is a salary differential for northern VA. The rate template would be the final step in contract negotiations.

- Concern here that there is no uniformity in procurement, there are many ways that procurement can be done. Comment: These are good and practical considerations for us to take into account.
- No reason to split out costs for an individual who is both C and non-Part C service provider. Won't make a difference in the long run. Tracy pays a differential for those who work in the school system because she makes a greater profit on those services. *Make note of this here; test for this in the modeling.*
- Remember Brenda's issue related to service coordination, inclusion of administrative costs. *Need to follow up with Brenda on this and other issues.*
- The provider would fill this out for the types of employees that they have.
- Deana – key list of changes need to be developed; all of this seems hard to her – what do we need to tackle?
- Kathy agreed that the way funds are distributed drives rate development at the local level, including asking for more money when they run out. How does actual need relate across the localities?

General agreement that working this template out would bring greater consistency to the system as a whole.

- Found two downsides to the model to test out – urged folks to think about other things. David would prefer examination by population by FIPS codes rather than regional approach. This is one tool to check out. Regional may be too broad.
- Brenda – no change, much more than we can afford, or much lower than what providers will accept. We will test for these outcomes. We need to have back up plan in place ... agreed that this is what we are saying.

Decision: We will proceed with the piloting and report back at the next meeting.

### **Statewide access, equity and parity**

- **Allocation of Resources**
  - What works, what doesn't
  - Brainstorming new ways of doing business
- **Stakeholder response/reaction**

This will be different resources coming together to make a whole. There would be a clear way to identify how resource identification and access is done. We will benefit from the ability to compare the per child cost in one locality as compared to another locality.

- Discussed the mechanics of an allocation formula:
  - Administrative ease, easy to understand
- Some possible variables to consider:
  - Population
  - Geography
  - Child Count
  - Low APGAR
  - Mother's age
  - Low Birth Weight

- Concern was expressed that this formula approach may be limiting – would provide dollars for who you should be serving and not who you are serving.
- Need some balance with actual vs. anticipated growth. Karleen stated that this would be a weighted approach to the formula.
- Don't consider local money in the mix.
  - o These vary
  - o May include personnel, in-kind contributions
  - o Don't want a penalty either way for LLAs
- Should be a hardship opportunity
- Utilize therapists from the school.
- Outpatient rehab is hard to apply for.
- Cumberland: No Medicaid providers.
- Should someone be funded using reward/penalty re: 45 day timeline (example)
- YES: Common rules and procedure to access additional resources from the state.
- This will be a big change
- Provider shortages are causing the delays: Real assessment of need by state office. Live with it for a year. Will need increased technical assistance in this area.
- Don't always have providers who can bill multiple sources

The last activity that we conducted was to poll the participants about common principles and practices that should apply to LLAs and providers in the Part C system:

- o 90-100% requirement and demonstrated practice of billing Medicaid (TCM, clinic)
- o 90-100% billing private insurance
  - o Encourage providers to seek as many vendorships as possible
  - o Penetration of insurance companies in one area
- o 90-100% bill and collect Family Cost Participation
- o Do not include local money in the allocation mix
- o Don't duplicate a service if it already was performed
- o Be true to the Part C model
- o Use of resources: equity re: services for each child/family, what is "appropriate," is this consistent from locale to locale, provide a range that would be considered to be the individualized requirement of the law
- o Data would be collected and provided on a routine basis
- o There would be hardship rules
- o The state office would conduct an assessment of need for one year only (related to compliance)

Meeting Adjourned