

INFANT AND TODDLER CONNECTIONS OF VIRGINIA
SYSTEM OF PAYMENTS STAKEHOLDER MEETING

November 15, 2006
MEETING NOTES

10:00 a.m. – 3:00 p.m.



Anticipated Outcomes

Stakeholders will:

- Understand and appreciate the Part C System of Payments and the interrelationship of resources to one another and implications upon Family Cost Participation.
- Arriving at a common understanding of the context of Medicaid in the current Part C system
- Develop consensus re: priority outcomes to be realized in the review and development of the 0-3 allocation models.
- Review and discuss potential allocation concepts.

Welcome! Overview and Anticipated Outcomes

Present: Mary Ann Discenza, Deana Buck, Jim Gillespie, Debra Holloway, Frances Rudd, Carol Granger, Allan Phillips, Margaret Jones, Kathy Phillips, Nancy Butts, Tracy Miller, Brenda Crockett, David Mills, Tammy Whitlock, Karen Ivey

Conference Call Link: Beverly Crouse, Mary Lou Hutton, Anita Eggleston, Kim Bebeau, and Lindsey Brooks.

Consultants: Sue Mackey Andrews, Karleen Goldhammer

Participants verified that the October Meeting Notes were accurate.

NOTE: These are process notes and often reflect actual comments from participants. Typically these are not attributed to any one individual. Where appropriate, items for continued dialogue or study are identified.

Review of Outcomes from October 2006 Meeting

Sue provided a brief overview of the focus of this stakeholder group, emphasizing that the recent consulting services provided to the Commonwealth by SOLUTIONS Consulting Group, LLC started with the examination of ability to pay (Family Cost Participation) and, over time, grew to include all facets of the System of Payments. Federal requirements related to payor of last resort, nonsupplanting, maintenance of effort, the EDGAR provisions and a variety of other relevant federal and state regulations.

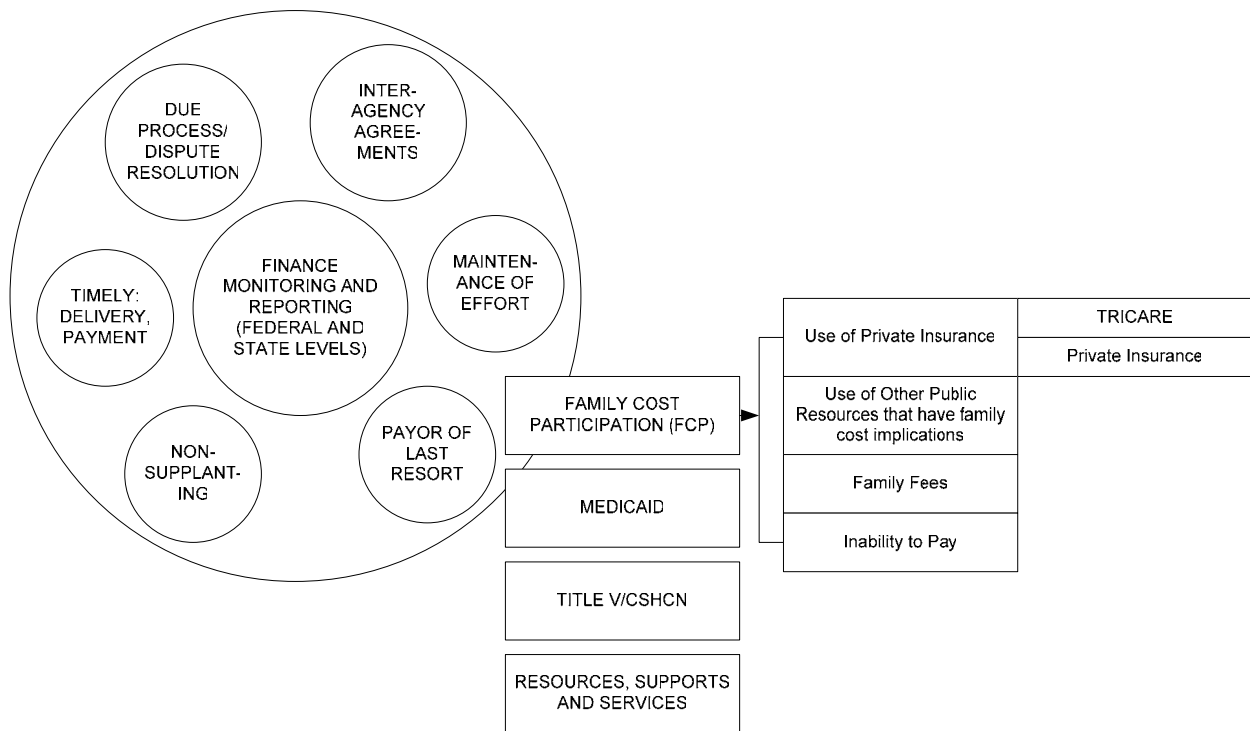
This stakeholder group has in some ways “morphed” from an earlier ATP group that met 10-12 months ago. All efforts around finance touch program components and

vice versa. Issues around the ATP, allocation method and Medicaid reimbursement all must be addressed concurrently in order to ensure that the system is coming together better for families and providers and access (to diverse funding and also services) is improved.

She emphasized that: 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.)

The Multiple Facets of Family Cost Participation



System of Payment Issues (handout)

Referenced handout with 9 issues focused on the System of Payments. How are we connecting good system change to whatever the problems or challenges are in the system? We have developed a series of "problem" statements or "non-negotiable system changes," including a discussion of why it is a problem and some potential options for resolution. We will use this document as a checkpoint to whether or not we are resolving these issues. We walked through the 9 problem statements, seeking input from meeting participants. This document has been used internally within DMHMRSAS for a couple of weeks, and has visibility in terms of the impact upon the lead agency, and ongoing dialogue with DMAS.

General reaction to the document? No surprises – which was surprising. It was sobering to read this. Nothing was new, but seeing it all together was new. Challenges of local administration and decision making with the need to consider standardization in order to accomplish something else, including compliance. Things that we have heard from stakeholders – lack of parity and equity across the system, as one example – coupled with the realization of the reimbursement method that we use, does not support the primary coach model that we have focused on for service delivery. Comprehensive, well done document which we are hoping to turn into a strategic plan. Didn't get here overnight; won't fix it overnight.

Item 1: It is definitely a new day for data. You cannot continue without having data, no matter how your system is constructed. There are requirements that the General Assembly has put on the system, as well as OSEP. In addition, you need data from a pure decision making perspective. How it gets done will be our task to figure out. Much of this will be local; some of this information can come from sister agencies who partner with DMHMRSAS for Part C. For too long, the Commonwealth has made decisions without information.

There are several layers of issues related to the data – lack of adequate infrastructure (bringing ITOTS in house, target date of March 1, 2007). Future ITOTS planning has now grown to include the dialogue about the potential role of CCS2 (data collection for CSBs) in data collection, particularly delivered service data, for Part C. Discussion is evolving.

The other issue is the quality of the data that is coming out of ITOTS. Using Medicaid as an example, the lead agency sent over more than a thousand Medicaid recipient IDs to Medicaid. Less than half of the numbers were accurate. Did capture the expenditure reports from all 40 localities – but the way that the collection form was constructed resulted in a portrait of the system that is not complete and therefore is not accurate.

Accountability with the General Assembly is real. Anticipating that they will say no to one more dime without data ... the same conversation is happening at the federal level. Mary Ann cannot accept that there isn't a solution to this issue – we just have to work it out. Alan – glad that the department is having the discussion. CCS doesn't cover most of the services that happen for Part C kids. We need a solution for the private sector ... this is a barrier for us. This is the most critical thing – the data system – to be resolved before we can tackle anything else. Everything pivots back to this barrier.

Question: what are the data that the General Assembly, OSEP wants? Response: These monitoring priorities were distributed to all stakeholders in the form of the monitoring priorities, which will be layered with the new fiscal monitoring system. Compromise was struck because some LLAs couldn't identify the funds by payor source, which resulted in aggregate numbers. These data elements are also delineated directly in the LLA contract.

Comment: The state has gotten what it has asked for ... when LLAs don't want to respond to what the LA needs, the state agency compromises. Can't blame the LLAs if the state agency backs off from the requirements or expectations.

We need to figure out what are the ways to alleviate the administrative burden and get people thinking and talking about this, to return with reaction/responses. Karleen talked with the universal application of the HIPAA EDI electronic billing option, creating a uniformity of data that would allow a variety of players to take whatever data system that they have to use a data translator to convert the data to the 837P (Professional) format. This would permit you to capture delivered service data. Karleen asked people to go back and see if the 837P is a familiar term to those people in your organization responsible for billing. It was reported that this billing option is required for CSBs. If providers are doing electronic billing, they are in the 837 format already. Not all billing is electronic – this is the issue. The 837 provides some solution for mainstreaming the data. 837I is the institutional claiming, corresponding with the UB-92-02 soon to be the UB 04. It could be that Early Intervention is billed using the 837 I and 837 P.

Limits to this are that this system is used only for public and private insurance billing. Could apply to other fund sources already. What is the % that is not electronically billed? **FOLLOW UP DISCUSSION. This is an agenda for our January meeting.**

Item #2: Special instruction is an issue when it comes to selection of services, and family cost sharing. Request was made to modify the language in two places to reflect what participants felt was a more accurate statement of the status of collections. **REVISION HERE; see "issues" document.**

Item #3: They do have, at the LLA, policies and procedures to ensure POLR. Check into this to see if it meets the compliance issue under a. **REVISION HERE; see "issues" document**

Item #4. Loss of revenue from Medicaid during implementation of managed care has been replaced by state/federal funds. Needs more examination. The SICC Medicaid Team is talking about this. This was also discussed extensively during the state self-assessment from the finance committee. Same dollars are going to the HMOs but NOT going to Part C. Also relates to a cut in state general funds to help support EI. This is another MOE question which varies by CSB. Some CSBs make a local contribution to Part C, others don't. How would we recognize this contribution?

Observation: The cost study produced information that 39.8% of the total revenue in Part C was from LLAs, or \$10 million. The General Assembly report indicates this now at \$5 million. It is likely that the General Assembly data is more correct for this item than for many since this is always part of the LLAs reporting, unlike private insurance or Medicaid billing.

No state dollars to maneuver in the block grant for Part C. There are very diffuse dollars that are often used to contribute to Part C. There was a shift in revenue from Medicaid, especially in TCM, to replace the reduction in state general funds at

the local level. There has not been a lot of guidance in the development of the revenue report where to categorize some revenue.

Item #5: Difference between annualized and one day count. Lots of discussion here about whether, at what point, the new state funds would influence the local count. For Brenda's area, the new state funds balanced the loss of federal funds. The loss in federal dollars in 2004 was the precedence for the state general fund request. **ADD THIS AS A BULLET POINT TO THE NARRATIVE. REVISION HERE; see "issues" document**

Clarification was made that the federal funds weren't "cut" – but that the additional federal monies available were from the "bubble" money which was one-time only federal funds. States had to draw down these funds at one time in order not to lose them. This resulted in essentially a double federal allocation for 12-18 months which was not repeated. The Commonwealth put these funds into services which created an inflation factor in that component of the system that state funds were then not available to maintain the level of service funding once the federal funds were gone.

More and more families are choosing school at age 2 – what impact is this having upon the total numbers? Clarification of this. **DISCUSSION ITEM FOR FUTURE MEETING; DATA NEEDS?**

Discussed ChildFind budget issues – advice was to take all funds and put into direct services; instruction was not to do ChildFind. Once funds went into direct services, they "evaporated." Systems can't turn on a dime; sites are not ready for an increase in enrollment – perhaps to hold off on massive ChildFind initiative.

Comment: Relationship of increased accountability and compliance has resulted in increased costs.

Item #8: Discussed bringing this conversation more to the front in consideration of earlier dialogue re: performance of LLAs, compliance with contract requirements, etc.

Item #9: What is the purpose of the base amount? Tended to cover basic obligations such as the LICCs. History - \$3,125 state funds (\$125,000 divided by 40) and \$25,000 in federal funds.

Comment: the tighter the contract, the increased likelihood is that more CSBs will decline to sign the contract. General consensus that this is accurate.

At this point in time, (12:30) we reworked the agenda to focus on priority items for the afternoon including discussion of next steps, continuation of this workgroup and timelines.

Rate Methodology Template: Update

- Rate Template Computations
 - o Provider # 1 \$149.47
 - o Provider # 2 \$175.09

- Provider # 3 \$130.73
- Provider # 4 \$128.47 (\$149.94)
- Budget Impact discussion

Karleen reviewed the different outcome of the pilot activities using the rate methodology. We need continued investigation especially in examining the fiscal impact – not sure that this is an appropriate approach, but still worth finishing. There was no reported negative administrative impact/burden reported from completing this template. There is likely a fiscal impact to standardizing rates that we will have to consider.

Providers are taking a loss on insurance payments; the rate obscures the real cost.

Agenda item for the next meeting once Karleen does continued investigation with pilot participants.

Medicaid Realignment: Discussion and Feedback

Tammy provided an overview of the joint meeting between DMHMRSAS and DMAS yesterday, focusing on seeing where the areas of collaboration and system efficiencies exist and plan together.

1. There are ongoing discussions between DMAS and DMHMRSAS about how to move Part C services out from the Special Rehab Option to better align service provision with some of the tenets of Part C and Medicaid. Examining placing Part C services under EPSDT which would open reimbursement for habilitation services more readily, expand provider enrollment options, etc.

2. The discussion, at this point, considers ways for all services under Part C to be included. The timeline for moving this process forward – sounds simple, but requires regulatory changes in concert with CMS. This process can take 12-14 months, to get things all the way through Planning and Budget, and then going to CMS for their approval. The other outcome that moving this to EPSDT is to explore the special instruction piece – no promises though. We are trying to do this. IF this happens and we include other providers, the rate changes (especially budget impact) needs to go through General Assembly, etc. Could be July 1, 2008 if there is a budget impact. If no budget impact, and we are trying to get data now on what Medicaid is spending on Part C kids, the timeline could be sooner. The individual child data will identify what is being spent on 0-3 year olds now by service, provider (includes state MA and HMO) with the assumption of either a percentage or all of these kids also being enrolled in Part C (to be determined).

We are waiting for some data for FY 2006 that will be used to assess the budget impact, which we all agree is the first step in the process. The timeline of doing something like this is affected by State budget impact, CMS approval and the scope of required changes to the MMIS. We are looking at Medicaid funding for all Part C services including special instruction or, as it is termed in other states, developmental therapy.

This realignment effort means that short term changes should be guided by the longer term strategies of change.

Discussed issue of using state general funds as Medicaid match, with the example of what historically happened with the MR waiver.

3. Work needs to happen to with the MCOs. While a discussion will occur about the possibility of carving a child's Part C services out of the managed care, it is prudent to proceed with an assessment of how to make the MCO option work better for children and families within Part C. We expect that this will include: training about Part C; data exchange; review of the MCO contract requirements, etc. Tammy and Mary Ann are working to address MCO informing needs re: the LLAs so that they will refer 0-3 children to them. Sue cautioned that this will mean an increase in referrals and response by the LLA to ensure that these children and families are in Part C. The reimbursement rate by most MCOs (low) was is a problem as this rate doesn't cover the cost of services.

A key issue is the associated costs ... what to do and how to deal with these in a judicious manner that achieves parity statewide.

Issue of lack of parity of rate was discussed ... CSBs vs. private providers. It does appear that all Medicaid reimbursement is cost based no matter what kind of provider is being discussed.

Tammy also talked about training for LLAs and others re: EPSDT and what is available for these kids.

Appreciation and recognition was extended to Tammy and her colleagues at DMAS for their collaboration and open willingness to address some of these challenges.

General Assembly Report – Overview

Total Part C expenditure: \$21.8 million

Revenue

– Federal and State Part C:	\$13.8 million
– Local Funds	\$5.1 million (20)
– Family Fees	\$238k (14)
– Medicaid	\$405k (11)
– TCM	\$549k (11)
– Private Insurance	\$519k (10)
– Donations	\$53k (6)
– Other	\$817k

Karleen provided an overview of the summary findings. These data reflect only the LLA data and not the individual private providers. Some participants talked about having collected these data from private providers earlier. It is clear that this is not a full picture of all funds in the system. **Considerable discussion about how to collect all of these data efficiently and accurately needs continued focus.**

Developing an Allocation Methodology – development dialogue

- Principles and Considerations
- Funding Partner Influences
 - Medicaid
 - Ability to Pay
 - Insurance
 - Local Funds
- Data Variables
- Modeling Options
- Contractual Implications/Changes
- Anticipated Impact/Reaction

Considerations for the Allocation Methodology

1. Local Lead Agency Obligations

Is there any merit to breaking the allocation process into some of the components (chart on last page)? Sue gave some examples of system component allocations (Child Find, system point of entry, data collection/reporting, etc.). This is already done for the CSB block grant, perhaps with 11 or more variables.

Is the funding a blend of historical experience and prospective – what is estimated to be the enrollment, etc.?

Comment: Would support infrastructure. What about areas where collaboration works and funds are not needed for certain infrastructure requirements? Liked the idea of some flexibility that would ensure the essential components are being done, but perhaps the funding is redirected (incentivizing).

Not thrilled about this – another perspective. If we took care of the other 100 problems, perhaps this would be timely. Make the outcomes clear that the LLA has as responsibilities within the Part C system, but don't worry about dividing up the pot in that precise of a way. Laid out as deliverables in the contract. Could increase the administrative allocation instead.

Perhaps we should define the individual components ... what is expected (example: Child Find materials). Discussed state plans for ChildFind and felt that it was not timely to advance this given the capacity issues at many of the local communities; it is likely that additional referrals will create challenges in some areas.

Stakeholder group didn't support the funding of discrete components. Provide a general administrative allocation together with direct service funds and they will sort it out, making sure that the system components are performed as required.

2. Target number of Children to serve

- a. Establish the target utilizing the Prevalence Study –
 - i. Currently using annualized count with a three year average as part of the formula.

- ii. Child count versus annualized count
- iii. Historic review versus projected target

Discussion: Karleen was asked if there was no existing system and she had to craft something from the ground up – how would she do it? Not sure that the 3 year average, or the annualized count, are the way to go. Annualized count doesn't represent kids who are in the system for a full year. History here of using annualized count. In other states, she takes one-half of the difference between the point in time and annualized count. Consider VA has the 2 year old option. This does affect the period or length of enrollment.

CSB current allocation formula for the general block grant monies is already built on multiple variables, some very similar to what we had listed.

Need to consider the balance of existing commercial insurance but doesn't pay for services. Same is true for Medicaid – using Part C funds to pay for both of these services. Participants introduced the idea of adding associated costs in an interim way while we are investigating our options.

Medicaid, private insurance and family fees would be backed out of the formula. See below.

- b. Back out the children/services that are funded with non-part C money
 - i. Percentage of Children/Services funded by Medicaid
 - 1. MCO
 - 2. Travel
 - 3. Data: Use percentage provided by DMAS
 - ii. Percentage of Children/Services funded by Private Insurance
 - 1. Differing Rates
 - 2. Data: Use <http://www.census.gov/hhes/www/sahie/data.html> for population under age 18
 - iii. Family Cost Participation
 - 1. Data: Composite ATP/Poverty Index
- 3. Geographic area – size, landscape, etc. challenges
- 4. Local Funds
 - a. Reporting of Expenditures
- 5. What is the expectation if it is reported that funds through the allocation process are exhausted?
- 6. Should there be a local incentive for maximizing the use of other resources?
- 7. Implications and considerations of Federal and state regulations, e.g., EDGAR.

Resolution: Karleen will review the current CSB formula, and create some models with fictitious data so that participants can discuss the merits of each model.

- 8. Anticipated Impact/Reaction to Change – **deferred to next meeting.**

Discussion of the Part C “model” is a pivotal dialogue. Discussed dates – December 18th confirmed, 10-3. Location to be announced.

Meeting confirmed for January 11th. Sue will develop a summary of issues to be addressed and sequence them, apply some “timeframes” for each item. Stakeholder members will need to review and determine if they are the right group for each topic and, if not, who is.

Parking Lot:

- ?Efficacy of the continued use of private insurance? (particularly given service model discussion)
- More dialogue re: LLA – what constructs are required, what is optional? What to do if an LLA won't sign contract, or won't meet contractual requirements? (accountability, performance)
 - Recommendation: Assign to Local Contract Stakeholder Group. Other agenda items for this stakeholder group include OSEP determination to the LLA contract,
- Service delivery guidance: “inactive” kids.