Infant & Toddler Connection of Virginia: System of Payments

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
1) Required Federal and State Data	a. Virginia General Assembly: *By October 1 of each year, the department shall report to the Chairmen of the House Appropriations and Senate Finance Committees on the (a) total revenues used to support Part C services, (b) total expenses for all Part C services, (c) total number of infants, toddlers and families served using all Part C revenues, and (d) services provided to those infants, toddlers, and families.* b. In the past, OSEP has required each state to report the dollar amount of all resources (federal, state and local; public and private) in the Part C system. Reporting requirements are currently under review and it is not known if this requirement will continue.	DMHMRSAS as the Lead Agency (LA) is not able to report the total revenues or expenses used to support Part C services to the General Assembly. The General Assembly requires finance information regarding both the Part C system "infrastructure" at the state and local levels (*(a) total revenues used to support Part C services)* and the total expenses for all Part C services. The LA has not ever had the ability to collect and report these data; this situation is more significant since the infusion of state General Fund dollars to the Part C system under the LA's Transformation Initiative two years ago. Whatever the solution is here, there will be an additional administrative burden placed upon the LLAs and the providers. There are a variety of options under study to ensure adequate and appropriate data collection. These are in consideration with the Commonwealth's efforts under the General Supervision Enhancement Grant (GSEG).

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
2) There is a lack of consistency and uniformity in the application of Ability to Pay (ATP) REVISION 11/16/06	Participants at the ATP Stakeholder Meeting confirm that: a. ATP sometimes results in families declining services, especially special instruction, that their insurance does not cover and that they would have to pay for. b. LLAs vary greatly as to who completes the ATP documentation with the family and the accuracy and consistency of these practices. c. Since providers collect the ATP, the LLAs and the LA have no information about what monies are collected, which families are declined services due to the lack of payment, and if payment is being consistently collected statewide. d. Neither the LLAs or the LA can report the amount of money collected from family fees e. No assurance that family fees are used as program income and, as required by EDGAR, must be committed back to the Part C system. f. ATP is assigned to different provider rates (full cost vs. negotiated cost) at the local level, resulting in a lack of equity for families and providers re: how much providers earn while collecting ATP, how "far" the family resources go (collection at full cost vs. negotiated rate), some providers bill ATP and others never have this opportunity. g. Providers sometimes terminate services when ATP is not paid, resulting in disruption in services and additional work for the LLA in locating another provider. This is a serious compliance issue and risks due process. These circumstances place the Commonwealth is a very vulnerable position. DMHMRSAS is not able to ensure that services are not withheld from families based upon their "inability to pay." Reference: ***The State is required to have procedures that ensure services are provided to infants and toddlers with disabilities and their families under this part in a timely manner pending the resolution of any disputes among public agencies or service providers. (20 U.S.C. 1435(a)(10)(D))*** Reference: ***The State is required to have policies and/or procedures that identify the State's system of payments for Part C services. (20 U.S.C. 1432(4)(B) and 1437(a)(3)(A))***	The ATP Stakeholder Workgroup has assisted the Consultants in developing some general policies and principles related to ATP; the majority of members concur that the ATP system has to be overhauled. Options include: 1. Implement a Family Cost Participation approach that incorporates consideration of other resources (e.g., private insurance) in the assignment of family cost. 2. Implement a Family Cost Participation approach that is one-step and includes extenuating circumstances. 3. Consider a "capped" monthly fee attached to the IFSP vs. individual service fees for family payment. This might dilute the occasions where families decline needed services when the ATP is required. 4. Have the LLAs collect the family fee and create a reporting mechanism to the LA so that a variety of data is collected (amounts collected, number of families who opt out of the system due to ATP, number of families who fail to pay, collections efforts, and utilization of Part C funds at the LLA). a. The LLAs would pay providers for all services rendered, with the exception of Medicaid covered services for which the providers would continue to pay. b. This protects families, the LA, the LLAs and providers against a variety of issues including the timely delivery of services, POLR, the "inability to pay" requirements, and permits a reporting capacity that currently does not exist. 5. We need to develop a policy for the purchase of assistive technology and the relationship with family cost participation.

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
3) Payor of Last Resort Federal Requirement (POLR)	a. DMHMRSAS has limited ability to ensure and demonstrate to OSEP that the POLR requirements are implemented statewide. POLR requirements are reflected in LLA policies and procedures and in the assurances that they sign in their LLA contract. b. POLR requires that all other fund sources are used before federal Part C funds are tapped to support direct services. Some states have extended this POLR requirement to include state general funds as well. Reference: ***The State is required to have formal interagency agreements that define the financial responsibility of each agency for paying for early intervention services (consistent with State law) and procedures for resolving disputes and that include all additional components necessary to ensure meaningful cooperation and coordination.*** *(20 U.S.C. 1435(a)(10)(F))* and Reference: ***The State is required to certify that the methods or arrangements to establish financial responsibility for early intervention services provided under Part C pursuant to 20 U.S.C. 1440(b) are current as of the date of this Application certification. (20 U.S.C. 1437(a)(2) and 1440)*** c. The implementation of managed care/Medicaid in VA has created complications in 1) providing enrollment as a "rehab" provider, 2) difficulties for local provider agencies in successfully negotiating a reasonable reimbursement for Part C services, 3) difficulties in obtaining referrals from managed care physician practices, and 4) delays in reimbursement for providers who are responsible for individual client billing. d. Providers also use Medicaid fee for service reimbursement for children who are not enrolled in managed care/Medicaid. They are responsible to bill for these services and receive the reimbursement. e. Providers are paid a negotiated rate by the LLA for all non-third party services. Depending upon the local contract, many providers also "return" to the LLA for additional compensation when: 1) up to the negotiated rate when the Medicaid reimbursement is less than this rate, and/or 2) for payment for associated costs (if available by the LLA).	1. LLA policies and procedures re: POLR should be reviewed and data identified that can be used to document compliance with POLR at the LLA level. There are some policy questions that will come up in this review – e.g., how does POLR apply when there are no Medicaid providers? Goal would be towards statewide consistency. 2. The Lead Agency is required to develop interagency agreements which make assignment of financial responsibility to all appropriate agencies. The VA Interagency Agreement should be updated, with individual agency agreements developed that demonstrate the unique relationship that has been negotiated. 3. Local interagency agreements should to be developed as part of the LLA responsibility, with these agreements and their compliance incorporated into the state's monitoring and supervision protocol and practice as part of their contractual requirements. 4. Routine (quarterly or monthly) LLA reporting to the LA needs to be instituted to ensure that financial data is collected, verified and available to the LA for their state and federal reporting requirements. 5. Develop and submit a State Plan Amendment in collaboration with the state Medicaid agency to streamline and make more efficient and cost effective the approach with which Medicaid is reimbursing for Part C services. **A concept paper is attached which discusses this in more detail.**

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
4) Nonsupplanting/ Maintenance of Effort Requirement	a. The Cost Study completed for VA (May 2004, page 28) indicated the following revenue distribution, illustrating that more than one-third of funds supporting the Part C system at that time were local funds. This is based upon the total reported of $16.4 million by 24 organizations. **Figure 1. Revenue Survey** Type / Survey / Regional Adjustment Insurance / 12.9% / 13.5% Medicaid / 22.0% / 21.1% Local Lead Agency / 39.8% / 38.6% Part C / 24.1% / 25.4% Private / 0.6% / 0.8% Other / 0.6% / 0.7% b. DMHMRSAS has no data or ability to ensure and demonstrate to OSEP that Part C federal funds are not being used to replace current resources in the system, such as CSB or other public funds at the local level. Reference: ***The State is required to ensure that the Federal funds made available under 20 U.S.C. 1443 to the State will not be commingled with State funds; and will be used so as to supplement the level of State and local funds expended for infants and toddlers with disabilities and their families and in no case to supplant those State and local funds. (20 U.S.C. 1437(b)(5))*** c. DMHMRSAS has no data or ability to document that they have identified and are coordinating all available resources at all levels including local (e.g., LLA funds) and private sources (e.g., family fees and use of private health insurance). Reference: ***The State is required to ensure the identification and coordination of all available resources within the State from Federal, State, local and private sources. (20 U.S.C. 1435(a)(10)(B))*** and ***The State is required to ensure the assignment of financial responsibility in accordance with 20 U.S.C. 1437(a)(2) to the appropriate agencies. (20 U.S.C. 1435(a)(10)(C))*** d. DMHMRSAS has no data or ability to document that they have assigned financial responsibility (Reference: ***The State is required to ensure the assignment of financial responsibility in accordance with 20 U.S.C. 1437(a)(2) to the appropriate agencies. (20 U.S.C. 1435(a)(10)(C))*** or that it has a description as to how these funds are used (Reference: ***The State is required to have a description of the uses for which funds will be expended in accordance with this part. (20 U.S.C. 1437(a)(5))***	1. This component of the Cost Study would be important to update, including the new state funds and determining the distribution of resources as a baseline for future reporting to the General Assembly and to OSEP. Reference: ***The State is required to certify that the methods or arrangements to establish financial responsibility for early intervention services provided under Part C pursuant to 20 U.S.C. 1440(b) are current as of the date of this Application certification. (20 U.S.C. 1437(a)(2) and 1440)*** 2. This wouldn't be necessary if the LA was able to fulfill the data requirements in item #1 on this summary chart.

Infant & Toddler Connection of Virginia: System of Payments

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations

5) There has been an infusion of new state general fund dollars that will result in increased resources at the LLA, bringing more LLAs back to earlier funding levels prior to the loss of some one-time Federal funds. LLAs also have experienced a loss of revenue as a result of the implementation of managed care in their locale. This new state Part C money should result in increased numbers of children served in the 12/06 Child Count.

Year	2001	2002	2003	2004	2005
Annualized Count	6865	7451	8038	8653	9202
Child Count	3497	4163	5228	5369	5338
1. % Growth CC		19.04%	25.58%	2.70%	-0.58%
2. % Growth Annualized		7.86%	7.30%	7.11%	5.97%

a. The chart above illustrates the growth in both the annualized (unduplicated count of all children in service for one year) and the Child Count (point in time, children in service on 12/1 of each year).
b. Note 1 illustrates the percentage growth in Child Count over five years, showing an actual decline for 2005.
c. Note 2 illustrates the percentage growth in the Annualized count over five years, reinforcing the overall decline in children served for 2004 and 2005.
d. The table below reflects the State General Fund appropriation amounts from FY2003 through FY 2008

FY2003	FY 2004	Fy2005	FY2006	FY2007	FY2008
$125,000	$3,125,000	$3,125,000	$3,125,000	$7,203,366	$7,203,366

e.

1. The System of Payments Stakeholder Group should examine data to identify the status of the Child Count, including the annualized count, at their January meeting.
2. Further discussion needs to occur related to the 'inactive child policy" which may be inflating enrollment in some localities.
3. Further discussion needs to occur related to the transition of children at age 2 to the Part B, early childhood special education program. How does this affect Part C? Are more families electing to move to Part B or are they staying in Part C? What is the relationship of the age of the child at referral and LLA efforts re: enrollment, transition?

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
6) Parity/equity in Provider Reimbursement	a. Contractual arrangements between local providers and the Local Lead Agencies (LLAs) are constructed using a variety of approaches to reimbursement. i. Rates for direct services are sometimes "bundled" and cover a whole month of services; other times, a unit rate (e.g., per hour) reimbursement is used. (1) The methodology for arriving at the provider rate varies considerably, resulting in reimbursement ranging from $50/visit to $150/visit without any criteria that would warrant these differences (e.g., reportedly higher costs in Northern VA). (2) Depending upon the reimbursement approach, there may be untoward implications re: service delivery that would result in a compliance issue for the LA. Examples would include insufficient rates to ensure adequate capacity of providers, influence of rate in the determination of the IFSP services for individual children, etc. (3) Some providers have contracts in multiple LLAs resulting in varying rates for the same service, different methods of documentation and billing, and payment schedules. (4) In many instances, the LLA negotiated rate is less than the state Medicaid fee for service rate which is a compliance issue under federal Medicaid regulations. b) The reimbursement for evaluation/assessment services is equally diverse. c) Associated costs are considered differently, ranging from no reimbursement at some LLAs to reimbursement for travel and time even for missed appointments at others. Further the "mix" of what is considered an "associated cost" varies significantly. d) Few LLAs reimburse providers for time spent in team meetings and consultation; activities which are required by federal regulations.	The Commonwealth has made a commitment to implement a primary service provider model for Part C. This model includes case consultation by other disciplines to the child and to the family. The current reimbursement method does not support this model and instead, drives services to a therapy model rather than a more developmentally appropriate approach. Options include: 1) Utilize the Medicaid fee for service rates for all Part C reimbursement, regardless of source. a) Rates would have to be determined for special instruction and other currently uncovered Part C services. b) Reimbursement for Associated Costs should be a common, state-wide policy and practice. 2) Utilize a common rate determination methodology approach to arrive at a service delivery cost that would include standardization of essential administration costs, and permit flexibility in personnel costs (reflects regional diversity). There is field review of this approach happening now, with some concerns emerging as to its efficacy.

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
7) Ensure that there is an adequate capacity of providers who participate in the Part C system sufficient to meet the needs of identified children and families	The Stakeholder Group overseeing the finance issues under study have confirmed that adequate reimbursement, paperwork and other requirements of the Part C system are barriers to ensuring an adequate capacity of providers in all required services statewide. Reference: ***The State is required to have procedures that ensure services are provided to infants and toddlers with disabilities and their families under this part in a timely manner pending the resolution of any disputes among public agencies or service providers. (20 U.S.C. 1435(a)(10)(D))*** There is a variety of contractual approaches at the LLA level which do not support the requirement of the LA to ensure consistency and uniformity in compliance with Part C requirements. Reference: ***The State is required to have a policy pertaining to contracting or making of other arrangements with service providers to provide early intervention services in the State, consistent with the provisions of Part C, including the contents of the application used and the conditions of the contract or other arrangements. (20 U.S.C. 1435(a)(11))*** Participants on the Stakeholder Group have stated that third party billing is often cumbersome and expensive, with delays in reimbursement sometimes lasting over 12 months. This situation has increased some provider administrative/overhead costs, and may influence providers against using third party resources to the extent that they are available. Reference: ***The State is required to have a procedure for securing timely reimbursements of funds used under this part in accordance with 20 U.S.C. 1440(a). (20 U.S.C. 1435(a)(12))***	See other discussions related to parity and equity in reimbursement, and changes recommended in the allocation formula. These two issues will be important in resolving capacity issues at the local level.

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
8) Standardize the process for replacement of Local Lead Agencies when a current Local Lead opts out.	Over the past several years, at least four (4) LLAs have notified the LA that they no longer intend to be the LLA for their catchment area. This has placed the Part C state office in a position of having to recruit a new LLA and, at times, actually operate the Part C system at the local level while this recruitment and contracting process is being conducted. If more than one LLA needed to be replaced, this would put a tremendous responsibility upon the state office – one that far exceeds their current resources, and risks the state's compliance with Child Find and timely delivery of services requirements. Reference: ***The State is required to have procedures that ensure services are provided to infants and toddlers with disabilities and their families under this part in a timely manner pending the resolution of any disputes among public agencies or service providers. (20 U.S.C. 1435(a)(10)(D))***	1. The contract language for LLA should be clear that they must continue to provide LLA services until a replacement agency is located and fully prepared to assume these responsibilities. 2. Employ an RFP mechanism to solicit LLAs for VA 0-3 Part C services statewide that includes an incentive for local fund contributions. The RFP would define the range of potential applicants, the program and compliance requirements, and provide an incentive for local contributions/ maintenance of effort. 3. Incentives should be built into the current LLA contract for existing LLAs to promote the local maintenance of effort. 4. As the revised monitoring system is implemented and more strident accountability is demanded at all levels, it is likely that some LLAs may be unable or unwilling to demonstrate even minimal compliance.

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
9) Create an allocation process supportive of the programmatic directive.	Services are provided at the local level in 3 different configurations. One, where the LLA provides all of the services through LLA employees. Two, where the LLA provides all of the services through contracted personnel. Three, a combination of these two approaches with employees and contracted personnel. The historical allocation formula was composed of: – Base Amount ($25,000 plus) – Population (decline/increase) – Births (3 year average) – Child Count (most recent) – Poverty Indices – Ability to Pay Composite The base allocation amount was built into the formula initially, but was compromised due to interperiodic allocations based upon requests that at one point in time were "folded" into the base for a small number of the LLAs, but not all. The current allocation formula for federal and state Part C funds: – Utilizes a 3 year average of the Child Count plus a consideration for growth (incentives) The allocation formula does not provide any allowance or consideration for revenue earned through third party resources (Medicaid, Insurance, Family Fees), or any maintenance of local funds by the LLA. Minimally, revenue from family fees is subject to the provisions under EDGAR§ 80.25-Program income, which requires that these funds are returned to support the Part C system. It is possible, through state regulations, to extend the provisions of program income to include public and private insurance receipts. Reference: ***The State is required to certify that the methods or arrangements to establish financial responsibility for early intervention services provided under Part C pursuant to 20 U.S.C. 1440(b) are current as of the date of this Application certification. (20 U.S.C. 1437(a)(2) and 1440)*** and Reference: ***The State is required to have a description that ensures resources are made available under this part for all geographic areas within the State. (20 U.S.C. 1437(a)(7))***	1) The development of a new allocation approach is currently underway with a stakeholder advisory group. Essential to the success of this effort is: i) Review of the funds directed to support the various components of Part C that are the responsibility of the LA through the Part C office. These include: (1) Interagency efforts including the SICC, interagency agreements, resource development, etc. (2) Monitoring and supervision (3) Data collection, analysis and reporting requirements (4) Training (5) Technical Assistance (6) Highest entry level standard for provider enrollment (7) Child Find (8) Public Awareness/Central Directory (9) Due process/procedural safeguards (10) Oversight of funding, provider contracting and timely reimbursement (11) Assurances that quality IFSP services are provided to families and eligible children in a timely manner (12) Assurances that children are not denied needed services based upon the family's inability to pay 2) Development of a formula approach to LLA funding that recognizes the availability of third party resources (public and private insurance, family fees, other local, state and federal resources) in a balanced approach to the appropriation of federal and state funds. Reference: ***Sec. 303.147 Services to all geographic areas. Each application must include a***

Non-Negotiable System Changes	Problem Statement	Discussion/Options and Considerations
	New state general funds, now totaling $7,203,366 million per fiscal year, are distributed at 100% to the 40 LLAs for the provision of direct Part C services. More than $8.4 million federal dollars are allocated to the LLA annually as well. VA's state lead agency operates with -0- state funds, and approximately 13% of the federal allocation which is slightly more than $10 million dollars/year.	***description of the procedure used to ensure that resources are made available under this part for all geographic areas within the State.*** i) Incorporate into the formula approach consideration that provides an incentive for local resource contributions. ii) Establish LLA routine financial reporting of all resources, assist LLAs and providers in maximizing third party resources, development and implementation of Local Interagency Agreements, etc.