Concept Discussion for Collection of Delivered Service information (1/16/2007)

PURPOSE:
The Infant and Toddler Connection System of Virginia has a long history of needing data and information to make programmatic and fiscal decisions. Many attempts to enhance the data collection process have often been met with resistance and challenge since much of the data exists only at the provider level. The State Lead Agency contracts with 40 Local Lead Agencies (LLAs) who in turn, either deliver the service directly or sub-contract with other providers for the delivery of direct service. The data exchange between the providers and the LLAs varies from location to location. Standardization of these data exchanges would likely require changes to the contractual relationship between the LLAs and their contracted providers. In addition to the challenge of "where does the data exist", the State Agency responsible for the system only controls the State and Federal Part C. dollars, which is certainly no more than 50% of the system funding. There is no systemic data collection for service that occurs for all children eligible for Part C, nor is there a full financial reporting despite the contractual requirement to do so.

The limited data is problematic on any number of fronts but most importantly in meeting the statutory requirements attached to one of the State general Fund appropriations and also with respect to utilization data needed to understand the impact of some changes to service coverage for Medicaid eligible children.

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BACKGROUND:
The current web base ITOTS data system in use for the Virginia Infant and Toddler Connection System Virginia relies on data entry of information from the Individual Child Data Form ICDF Form 402. Referral, eligibility, some IFSP information and the planned service are captured within the system. The ITOTS is primarily used for meeting the 618 federal data reporting requirements. All information is data entered via the web by a responsible person at the Local Interagency Coordinating Council (LICC). Most of the information stored in the electronic system is not routinely updated. The current expansion to the ITOTS data system includes service level detail and will include the detailed frequency and intensity for each service. This will only be done for the child's initial IFSP. This expansion falls to staff at the Local Lead Agency.

MEETING CURRENT DATA CHALLENGES:
Actual delivered service information is one of the most viable ways to continue the work started by the Finance Group to look at the costs of the EI system in Virginia and to capture some of the most useful information about the System. The cost per hour of delivered service was computed through the cost study project in 2004 and may be adjusted with some inflation factor for a number of years. A good portion of delivered service information is all ready captured since speech, physical and occupational therapy services are all ready being billed by all providers to third-party payers like Medicaid and private insurance. According to the cost study these three services account for about 68% of all services. Service Coordination, special instruction and other services are not currently billed to Medicaid and/or private

insurance and may therefore not be included as part of a providers billing system. Discussion with the provider community may be necessary for this to come into the fold of this process.

DATA SPECIFICATIONS:

1. ITOTS Child Id (Not to Exceed 25 character text field or delimited with a comma)
2. Date of service: mm/dd/yyyy (10 character date field or a text filed of the same length.
3. Service provided (Numeric Field, long integer or comma delimited).
    1. Service Coordination
    2. Assistive Technology Services/Devices
    3. Audiology
    4. Family Training, Counseling, Home Visits, and Other Support
    5. Health Services
    6. Medical Services (for diagnostic or evaluation purposes)
    7. Nursing Services
    8. Nutrition Services
    9. Occupational Therapy
    10. Psychological Services
    11. Physical Therapy
    12. Respite Services
    13. Special Instruction
    14. Speech Language Pathology
    15. Social Work Services
    16. Transportation and Other Related Costs
    17. Vision Services
4. Duration in Minutes: Up to a 6 digit numeric field with two (2) decimals (####.##)
5. Resources: funding or supports to provide service (Numeric Field, long integer or comma delimited)
    1. Part C Federal
    2. Medicaid
    3. Medicaid HMO
    4. FAMIS
    5. TRICARE
    6. Private Insurance
6. Location of Service (Numeric Field, long integer or comma delimited)
    1. Program Designed for Children with Developmental Delays or Disabilities
    2. Program Designed for Typically Developing Children
    3. Home
    4. Hospital (inpatient)
    5. Residential Facility
    6. Service Provider Location
    7. Other
7. Provider Organization or Practitioner Name (50 character Text Field or delimited with a comma)

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8. Location of Service (Numeric Field, long integer or comma delimited)

The longer term strategy for collecting this data is to use the universal billing process defined by the Electronic Data Interchange (EDI) requirement of the Health Insurance Portability and Accounting Act (HIPAA). Through this study process the consultants determined that many providers are not yet ready for exchanging data in this more universal format. In the interim it is the recommendation o these Consultants that the State Lead Agency require the submission of all delivered services provided to children and families on a quarterly basis. The data would be required no later than the close of the quarter following the service delivery quarter. In other words data for the quarter ending September 30, 2007 would be due no later than December 31, 2007.

There would be three (3) options for data submission, namely a comma delimited plain text file, a download to a Microsoft excel worksheet (limited to 65,000 lines) or data entry into a standard Microsoft Excel® worksheet to be provided by the State Lead Agency. All files would have to be password protected and posted to a secure FTP site again provided by the State Lead Agency.

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Electronic Data Interchange (EDI) requirement of the Health Insurance Portability and Accounting Act (HIPAA):
These requirements provide guidelines for billing that all organizations billing medical transactions in an electronic format must follow. The specifics detailed in X12 837, Health Care Claim: Professional or Institutional. In addition, organizations, paying for medical services, must accept the CMS 1500 paper or the UB92 claim forms, which are used for the paper billing process. Providers billing, Medicaid, Medicare, or private insurance must have systems in place that are capable of generating either output. This provider system may be electronic or paper based. I might also suggest that transactions between the local councils and providers of service must also follow these two required billing options.

It is recommended that providers would submit information for all services delivered to a child and or family participating in Part C early intervention regardless of the funding source ultimately billed. The information could go through the LICCs or be sent directly to the State office. Trading partner agreements may need to be put in place for data sharing to occur. I would recommend that someone review the LICC contract document and other relevant agreements at the local level to make certain that private health information is protected.

Providers will need some indicator in their system to isolate records for children participating in Part C early intervention. Also important to the process, is the ability to link the delivered service/billing record to the ITOTS data system. Providers will need to understand the child identification numbering system used in ITOTS and should include that information in a non-specified field within the 837 format. Provider child identification field is an option if the provider doesn't need that field internally. Paper forms will also need the child identification number included.

The requirement could be for full-time data reporting of all delivered service by all providers for all children. Alternatively, the system could require specified time periods such as a quarter, every other month or May and November. Whatever process is selected it must be such that the information can be used to project for all providers for a full year.

The State office would have to develop an application to import the delivered service information from any of the specified formats and will have to have a workable database that links with ITOTS data. In addition, a data entry capacity would have to exist for the paper CMS 1500 or UB 92 forms that would also be submitted.

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