

Infant and Toddler Connection of Virginia  
Questions/Comments about the System of Payment (SOP) Summary Report  
April 30, 2007

**A. Implementation**

- Dates for Phase 1 and Phase 2 seem very optimistic. I understand the concerns regarding the need to move toward improved compliance with federal Part C requirements; however, this type of turn around time for change may have a negative impact on smaller systems that have few options in dividing the workload that comes along with change. For example, we have 3.5 FTE's for E.I. other than contracted providers. One of these FTE's is vacant and 1 is on leave. This leaves a System Manager and one Service Coordinator/Special Instructor to manage serving all active Part C consumers, bill Medicaid CM, and monitor the system. We are having difficulties ensuring compliance. We recognize and agree with the need for change and can make changes in increments but perhaps with a more realistic time frame. There are at least two systems in my region that are struggling with the same staffing patterns.

Response: We believe that July 1, 2007 is a realistic start date to initiate the following activities:

- Regional forums will be conducted with family members and providers to discuss these recommendations, the timeline and activities for implementation, and to obtain feedback and opinions.
- Achieve the improvements in ITOTS and data collection immediately
- Consultants to complete the Medicaid justification paper for DMAS
- Funding formula will be developed for implementation in FY08/09. This will mark a new approach to fund distribution.
- Implementation of the Medicaid Enhancement Plan, including necessary revisions in the MCO contracts in concert with DMAS, by July 1, 2008.
- Complete the state-level Interagency Agreements; initiate the local agreement process by July 1, 2008.
- Implementation of the Family Cost Participation (FCP) procedures by January 1, 2008; no later than April 1, 2008.

We are also closely examining the DRAFT Part C Federal regulations for policy and procedural changes and will integrate these changes through the above initiatives.

The proposed system changes will occur over an 18 month period of time with the schedule and sequencing carefully and thoughtfully planned in partnership with local and state stakeholders.

**B. Allocation Methodology and Recommendations for Restructuring the System**

- It would be important to have more detail, including a cost analysis, to show that proposed restructuring would be likely to be more cost efficient and would not have any potential side effects that would impact equity. This would include any changes to the billing procedures, the new service pathway, different models of case management, requiring that the evaluation and the IFSP be done at separate times, etc. Initial projection in our locality indicates that it would cost substantially more to require that the evaluation and IFSP meeting be held at separate times. In addition, the likelihood that this requirement would result in this locality being outside of the 45-day timeline from referral to IFSP is very high.

Response: The report points out the importance of honoring the procedural safeguards moments that occur throughout the process of a family's involvement with the Part C early intervention system. It is critical that families understand their rights and safeguards at each step in the process, as well as have the information, support and confidence needed to be an active participant in each step. While the report recommends re-examining the service pathway and considering what constitutes minimal vs. good. vs. best practice at each step in the service pathway, there is no specific recommendation to require that the evaluation and IFSP meeting be held at separate times. Similarly, families are not required to have the evaluation and IFSP meeting at the same time. Service coordinators must provide families with the information necessary to make an informed choice about whether to complete these 2 activities together or separately. Please note that if a family is offered an IFSP meeting within the 45-day timeline but opts to have the IFSP meeting later, then that is an acceptable reason for exceeding the 45-day timeline.

- Localities would very much like flexibility in how we move from intake to IFSP development. In many localities the financial is done at intake, during the second visit the evaluation is completed and if the family wishes the IFSP is also completed. Some families request time to consider the evaluation results and schedule the IFSP to be held a few days later. Generally services can begin after 2 – 3 visits. It sounds as if it is being suggested to have one visit for intake, one for the eval, one for the financial, and one for the IFSP meeting. This will significantly increase cost (staff time, driving time, mileage) and will impact our ability to meet the 45-day timeline. How will this change benefit families? Families are often anxious to begin services and multiple visits can be very challenging to their schedules. In addition, many families now comment that we have too much paperwork and it feels like too much of a process to get into early intervention as it is. How will it make them feel if we add additional visits to a process that they are already anxious about.

Response: Any changes to practice should be driven by compliance with Federal regulations as well as information obtained from families and others through the public forums and other feedback mechanisms. These decisions should be supported with documentation from the literature, based upon research, is identified as good or "best" practice.

**§ 303.403 Prior notice; native language.**

(a) *General.* Written prior notice must be given to the parents of a child eligible under this part a reasonable time before a public agency or service provider proposes, or refuses, to initiate or change the identification, evaluation, or placement of the child, or the provision of appropriate early intervention services to the child and the child's family.

The early engagement and enrollment activities with families form the base of their long-term relationship not only with Part C, but with a variety of public systems that they may come into contact with as the years unfold.

Written Prior Notice is currently set forth in Federal Regulations §303.403-405, requiring both written notice to be provided BEFORE the public system "proposes, or refuses, to initiate or change the identification, or placement of the child, or the provision of appropriate early intervention services..." This section goes on to require that "The notice is translated orally or by other means to the parent in the parent's native language or other mode of communication." Under the current proposed Federal Part C regulations §303.420, these

requirements are not only maintained but are made more comprehensive to include the administration of any screening performed in conjunction with the determination of eligibility, etc.

While families may not waive the “written prior notice” (WPN) requirement, it is speculated that families may “waive” or agree to suspend the number of days that an individual state has established as the WPN period. Regardless of the timeline, the public system must provide WPN to all families before an event is conducted and must ensure that, in obtaining parental consent to proceed, the family fully understands the event that will be performed, its relationship to the child’s eligibility including service delivery, and that they are fully cognizant of their rights, opportunities and responsibilities under their procedural safeguards. This requires the prior notice to be given to the family in writing and also explained fully to them in a language easily understandable to them.

Federal regulations emphasize a “reasonable time” in providing this information to families and are not precise as to the length of time. It is up for each state to determine what “reasonable” means. If we are asking and expecting families to have meaningful involvement in the variety of enrollment, eligibility and service activities, they clearly should have an adequate amount of time to learn about the process, ask questions, consult with others (e.g., other family members, the child’s physician, etc.) as they feel is important, and often to collect information or their thoughts prior to an event taking place.

The consultants have encouraged more dialogue about the use of appropriate practices which help to support, inform and educate families and which are individually paced and planned. If practice changes are needed to better respond to families, accomplishing these may cost more. Cost shouldn’t drive good practice.

When states have a discussion about “timeliness” it is often stated that families are in a “hurry to get to services.” The consultants would respectfully argue that every contact with a family is a “service” in that information is imparted and something happens. This belief is consistent with the Commonwealth’s approach to services and supports, and emphasizes the family as the major decision maker in all aspects of planning and service delivery.

### **C. Data Integrity**

- Data Integrity. We share the concerns expressed by Middle Peninsula-Northern Neck. The ITOTS data in the SOLUTIONS report are significantly different than what we are finding in our locality. If recommendations in the report are being based on this data the questions about the accuracy of the SOLUTIONS report data need to be addressed before final recommendations are made. Our understanding is that the State Part C office is assessing the accuracy of the data.

Response: Several confounding issues did affect some of the statistics reported in Table 6, page 32 of the DRAFT Report.

1. Comparisons of that data to the ITOTS Report titled "Referral Outcome By Referral Source" provided the first issue:
  - a. The two columns titled "Unable to Contact" under "Evaluated" and "Not Evaluated" are duplicated. The referral information reported correctly as "referrals child not evaluated unable to contact" is duplicated in the column reporting referrals

"evaluated eligible unable to contact". This of course makes the total in the evaluated column inaccurate as well.

- b. Further complicating the matter is a factor relating to how the information related to an individual child's referral was stored in the old ITOTS system. In the referral table there was no code for the local system that received the referral. This caused a number of referrals to be reported incorrectly. This was changed prior to ITOTS moving in-house and now all referrals are identified with the local system so this will not be an issue in the future.
  - c. Further complicating the manner with which referrals are assigned to local system is the factor of the referrals that came to the ITOTS system via the VISITS pilot project
2. The most significant issue with Table 6 on Page 32 resulted from a sorting problem where the data was sorted in descending order using the Total Number of Referrals. Data from the 5<sup>th</sup> column labeled "Deceased" all the way over were not also sorted so the results are inappropriately aligned to the specific Local Council listed. For example, the data in the eight columns from "Deceased" to "Unable to Contact" identified as Fairfax is really for Alexandria. This has been corrected.
- a. Secondly, there are some minor adjustments of child records to Local Councils based on more scrutiny with referral records. Overall the SOLUTIONS count, not using the ITOTs reporting system, captured information on eight (8) additional children not in the former ITOTS system data.
  - b. The final SOLUTIONS Report uses data from the ITOTs data reporting system.
- The SOLUTIONS report indicated that revenue data was not available. At one of the Stakeholders meetings there was discussion about the availability of the revenue data and several localities indicated that the data could be provided if requested. We recommend this be corrected in the report. Arlington can provide revenue data on family fees, Medicaid and Medicaid MCOs, and private insurance and other localities have commented they could also provide the data.

Response: A qualifying statement related to information on family fees has been inserted in the Issues Summary of Section V. Participants in the Stakeholder Group reported on several occasions throughout the meetings that while some localities may have this information, it is not consistently, generally or readily available throughout the Commonwealth.

#### **D. Integrity of Referrals/Moving to Eligibility Data and Recommendations:**

- The ITOTS data review that begins on page 28 of the Report includes figures that are substantially different from the data collected in our locality. For example, the data used in the Report states that a significant number of children in our system were evaluated and either found not eligible or, if they are found eligible, do not accept services. This is not accurate for our locality (only 2% of the children were, in fact, evaluated and found ineligible, rather than 59% as shown in the Report). The consultants are basing their recommendations about Virginia's Child Find, referral, and assessment/evaluation processes on the data in the Report, and if the data does not appear to be accurate, at least in some instances. It is important that the questions about the Report data be cleared up before moving forward, and that there be a way to verify locally any data that is used in determining next steps for Virginia's system.

Response: Based on ITOTs data, the chart on page 28 is different by eight (8) children in total and is either +/- a few children in some localities. The 59% represents the number of children

who, after referral, move into service. The total of 223 that we had for MPNN was adjusted upward by one child based upon the ITOTs updated data. Of the 224 total referrals, 90 referrals moved to service leaving 134 as not moving to service for an overall percentage of 59.4% (133/224=59.4). The number in the draft report is adjusted slightly.

#### **E. Evaluation for Eligibility**

- On page 31 of 71, there was discussion on the cost of evaluating when a child is likely to be ineligible. This will be a big shift for systems as in the past, guidance has emphasized that few screenings should be done by the local system. How to make this shift in philosophy through training will need to be a priority.

Response: Since the preparation of the Draft Report, we now have new DRAFT Federal Part C regulations which provide the opportunity, formally, for utilization of a screening once a child is referred for evaluation for eligibility. The new proposed regulations also elaborate on the definitions of the evaluation for eligibility as compared to the assessment of the child and family for service planning purposes. We recommend that a stakeholder conversation be conducted to assess current practice more thoroughly, certainly within the context of the proposed regulations, and to determine if and – if so, how – the service pathway that was developed by the SOP Stakeholder Group should be revised. This information would then be used to finalize the Medicaid initiative and would be incorporated in policy changes, form revisions and consequent training efforts designed to ensure statewide consistently and uniformity in practice.

#### **F. Medicaid Initiative**

- In the Medicaid Initiative: A Concept Paper, page 9: Wouldn't vision also be italicized or am I not using the service correctly. The service for our system means a person with credentials to provide vision services, but Medicaid has NEVER paid for the service because they do not see the credentials of the person in the medical necessity real. It falls into the same category as "special instructor".

Response: The draft regulations have addressed some of the historical lack of clarity re: vision specialists by including them in the generic definition of special educators ("Special educators, including teachers of children with hearing impairments (including deafness) and teachers of children with visual impairments (including blindness).") and clarify the term "vision specialists" to "include ophthalmologists and optometrists. Historically these professionals were considered under the general category of "physician." We will study the current VA credential materials carefully in framing the provider definitions and qualifications for the Medicaid initiative.

- page 11, the Occupational Therapist is no longer certification in Virginia it is licensure.
- I probably should have had questions about other parts of it, but sometimes I was lost.
- We have questions about the move to EPSDT. Even with the recommendation to increase eligibility for Medicaid for children having an IFSP to 300% of the Federal Poverty Level, this will still not include all children in early intervention. Will we not still need to keep meeting outpatient rehab standards to bill private insurance plus meet the additional requirements of EPSDT? Will not Medicaid still be payor of last resort if the family has private insurance and would we not be required to bill private insurance first?

Response: There is no state in which all Part C children are covered by Medicaid. Other fund sources including private insurance and family fees remain a viable option for many families in the Commonwealth to compensate for services.

In the development of the State Plan Amendment with DMAS, we will work to streamline the provider qualifications and remove barriers to provider participation throughout the Commonwealth. Likewise, private insurance would typically be the payor of first resort if the child is dually enrolled. We are not sure how much this applies to children in the Commonwealth and will work with the LLAs and DMAS to identify this. Some states have developed policy whereby they have defended that pursuing third party insurance for dually enrolled children have, in fact, been more costly to states than the revenue collected. CMS in these instances has permitted these states, for this population, to forgo the third party requirement as it represents a higher cost to the state.

We see no reason why the rehab standards would still be required for private insurance and would include this in our discussion related to the current insurance legislation review.

- The proposed Home and Community-Based Services State Plan Amendment, if funded, would significantly increase revenue to support needed Part C services in Virginia. It is recommended that it be determined as soon as possible if this can be implemented, and then move forward quickly with this very encouraging possibility.
- Note that Medicaid reimburses CSBs for their charges, not their costs. Reimbursement for some additional costs is only possible under very specific and well documented situations in which a CSB can be shown to be a nominal charge provider. This is not typical and does not include all costs.

Response: Based on rereading of 12 VAC 30-80-20 related to CSB reimbursement, we believe that the original statement in the report is correct.

- If there is to be payment for time for documentation for providers, it would be important to have a consistent means of oversight to ensure that the amount of time that is allowed for documentation is equitable and justifiable. This would also apply to the payment for travel, in order to ensure that providers would use the most cost efficient means in scheduling travel to different homes/locations.

Response: We propose to include consideration for documentation in the overall rate for direct service reimbursement which would be based upon the updated Fiscal Study information through the Time Study data collected. The same applies for provider travel consideration.

#### **G. "Growing" the Provider Capacity**

- While we understand the issues around all of us doing different things with associated costs, the report seems to imply, if we have a uniform process, new providers will surface that we have not seen before. It is very concerning that this is the assumption. Those of us who have lived and worked in our rural local systems for years know that there are not extra therapists available. We feel so thankful that providers have stepped up and offered their therapists to us. We are not in a position to negotiate a rate. If we do not pay what they expect, they have enough business without us and we will not have therapist to deliver services. The end result will be that we have more significant issues than inconsistency across local systems with associated cost.

- Those of us in rural areas look at this issue differently. Providers get what the market will bear. If there is only one provider in the county, they will be able to charge a higher rate. If they are one of many, they have to be more competitive.

Response: In many other states, when reimbursement has been appropriate and provider enrollment made more universal with some of the exclusions removed (e.g., having to be a rehab provider), new individuals and agencies have appeared who have been excellent service providers for Part C. This can be particularly true for rural areas where there are many providers who work in other settings (e.g., public schools/special education or nursing homes) who are interested in participating in training to become Part C providers. They often provide services on nights and weekends, or over the summer, etc. Additional providers have also come forward who are home, raising their children, and seeking a way to reenter the job market and still have flexible hours to tend to their family responsibilities.

It is also important for us to reaffirm that parent choice of provider is a requirement in most private insurance programs and certainly for Medicaid funded services. Families should be provided with a list of enrolled and credentialed providers and assisted to make a choice of provider who perhaps has specialized skills that are consistent with their child's needs (i.e., feeding skill expertise), a provider who speaks the family's language, a provider who would visit the home during non-traditional hours which are more convenient for them, etc.

#### **H. Assistive Technology**

- It would be important to clarify what are the issues with payment for Assistive Technology. It is not clear whether there are problems in some localities with accessing insurance coverage for these items or if this is a state-wide system issue with localities using Part C dollars first rather than using them as payor of last resort.

Response: The consultants will provide draft policies related to Assistive Technology including resolution of ownership such as purchase/transition to the public schools. The Commonwealth may determine that they want to exclude the purchase of AT from the family fee, which would be permissible. It is often the case that AT is thought about as being expensive, "exotic" equipment while – in fact – for this population, it is more often inexpensive modifications to appropriately adapt conventional child equipment or the family home more appropriately for the child.

We will suggest that a survey be conducted to gather the issues related to Assistive Technology devices and services from families and providers; policy development will occur once these issues are confirmed.

#### **I. Implementation of Ability to Pay**

- In addition, it is not clear whether the thought is that families should be paying more of the cost of early intervention services and that the new method calculating fees would provide this. In a number of localities, such as ours, it is possible to identify specifically how much has been billed and how much has been collected from families in previous years. It would be helpful to see what, if any would be the possible financial impact on families. Families and referral sources continue to have options, such as bypassing the Part C system and seeking therapy services through non-participating providers. It has been suggested that some referral sources are already doing this, particularly for families with private insurance for

whom the co-pays are not prohibitive or if it is less costly for them to just pay for their therapy co-pays rather than for special instruction.

Response: The revised family fee closely approximates the amount of the fee that a VA family would be responsible for under the current ATP.

Just to clarify, families have the option of declining to participate in the public system but providers do not have the right to make this decision for families (either by not referring them, or advising them not to use the public system, etc.). If a family were to realize, later on, that the fact that they weren't referred to Part C resulted in a financial loss or service discrepancy for them – they may have the right to their use procedural safeguards and potentially, receive compensatory services or reimbursement. This is especially true if the provider who failed to refer them to the public system is a contracted provider in the VA Part C system.

Providers who fail to refer families and inform them of the public system have in fact denied these families their civil rights under Federal law.

If the family fee is keeping families from joining the Part C system, or “encouraging” them to leave once they are enrolled, then the fee structure needs to be repaired. We trust that the families will inform the Lead Agency about these barriers through the public informing process, etc.

- It is recommended in the Report that all families, including those who are below poverty and will not have a fee for any IFSP services, complete the financial information. The Report refers to this being a means to access “other initiatives”. Please clarify what these initiatives could be that require greater detail about family income, beyond stating that they are below poverty. In addition, it would also be necessary to provide information to families who are not seeking a reduction in fees why they need to provide their financial information, since this is likely to be seen as highly intrusive.

Response: We have proposed a more brief collection of information for those families who already are exempt from direct cost. As one example of a potential outcome, the state of Indiana has been able to receive more than \$23 million dollars in TANF funds for their Part C system – simply as a result of having family income information available and being able to document the overall percentage of TANF eligible families who are also enrolled in Part C. If the Medicaid initiative is to proceed, we will need to quantify the number of families to be impacted up to 300% of poverty. These data will assist to accurately inform us of this impact.

- It is not clear how families would respond to a monthly fee that would not adjust for their child's illness, family vacations, or other instances where they would not receive services. It would be most helpful if this area could have significant family input.

Response: Families will be asked to comment on this during the public informing events.

- There is a recommendation that the new service pathway include “resource case management”. However, this has been required in Virginia's Part C system for a number of years. If this is not being implemented in some areas or if it should be enhanced, it would be helpful to state that as a concern.
- Although it wasn't completely clear, it looks like we will have a choice regarding who can do the financial intakes. We very much support allowing local systems to make this choice. If we

have to have a person from our CSB who does financials for other clients come out to the home to do them for Part C (families are not always going to be able to make it to the office), this is going to impact our 45-day timeline. It is also felt that it is not necessarily true that those who do financials for the CSBs are any more capable of doing it right or consistently than EI staff. Please let local systems decide what is best for their system and then ensure those doing financials get proper training. If that is what the proposal is, that is great and thank you.

Response: It has always been our recommendation that the locality decided who would conduct the FCP interview. Localities would designate individuals who would receive targeted training.

- It is said several times that we should somehow know who opts out of EI services because of financial reasons and, because we don't, it is a training issue. We have all been trained regarding cultural issues but anything short of "how to read minds" is not going to help with knowing with certainty when families opt out because it is a very hard thing for families to tell us this. Imagine having to tell someone that you couldn't afford services for your baby! (As a parent of a child that went through the early intervention system, this is something I would have NEVER said to anyone and, if I had been asked if that was the reason, I would have denied it completely.) It can be a humiliating and embarrassing thing to admit. We disagree that it would be somewhat easier to tell us if we wait to do the financial after the evaluation. Is there data to prove this is true? In addition, we have families we strongly assume leave services because of financial reasons – so they are already getting services for a while but then they start to get the bills and they "disappear" or just tell us they don't want services anymore but will not give a reason. So opting out of services for financial reasons can and does happen at any time during the process and usually we just guess that this is the reason – because it is a hard thing for families to share.

Response: The Federal regulations require the Part C system to ensure that families and children are not denied services based upon their inability to pay. Families who believe that they are not able to pay the charges have procedural safeguards to protect them in this case, and to continue to receive services while finances are being worked through.

- Even with what is written, we do not understand the value of asking families on Medicaid and FAMIS to give us financial information since they are going to continue to receive EI services at no cost. How does knowing one family on Medicaid makes \$15,000 and another makes \$23,000 going to "advance the system funding"? Why do we need to display the demographics of families served in this kind of detail? It feels like it is enough to know that they meet the Medicaid/FAMIS income requirements. Financial information has already been provided for Medicaid/FAMIS eligibility; therefore we know their income falls within a certain range. Given that it is recommended that the information be collected through an interview and no documentation would be required, isn't a statement that the child has Medicaid/FAMIS sufficient? It seems somewhat intrusive to have to ask them for additional personal information about their finances that is not going to change what they pay to the EI system. One of the Q&As says, in response to this issue, "probably the most important outcome here is that families understand the range of supports and services available to them." We already talk with them about resources and supports. What are the additional supports and services that they can access if we know the exact amount they earn?

Response: We are seeking the outcome that families are aware and able to access appropriate resources, supports and services through the Part C system. Some of these resources – like home teaching services – could also be considered developmental therapy/special instruction with

appropriate consultation from the Part C system. The Consultants would be happy to provide an overview of these other resources to the Stakeholder Group; we acknowledge that much of the investigation about what “is” as compared to what “could be” must be done locally. Figure 1 in the Report provides a summary of resources which are used by at least one state for Part C services. This summary list does not detail specific state resources which are always highly unique and vary from locality to locality.

- In addition, if we are not to do the financial before the evaluation, what about getting insurance preauthorization (with Medicaid HMOs this is a requirement) for the eval? We need to have a financial signed which allows us to contact the insurance company and get the required preauthorization. If we have to discuss insurance to get the information needed for the preauth, it also seems that we will need to discuss the rest of the financial issues.
- Please allow local systems to make their own decisions regarding how to move from intake to IFSP development.
- It is stated several times that local systems cannot report how much is collected in family fees. We can in our local system and have been able to since we started to collect fees. We break out our revenue by sources, including fees paid by families. It is believed that many CSBs can report this data. (I personally receive this report on a monthly basis from the administrative office of the CSB.)

- On page 2 of 10 in the handout entitled “I&TC of VA System of Payments” we did not understand the third option of a capped fee. We already have a monthly cap that includes all direct services. We are not sure how this would be a change from what we do now.  
Response: We are not sure about the document that you are referencing. There are several options for constructing fees, including having an assigned “cap” that is based upon family income which is paid monthly but is not related to the IFSP services. Some states do this, assigning families a routine monthly payment regardless of the number or amount of services, etc.

- The statement is made that LLA’s vary greatly in the accuracy and consistency of the ATP documentation practices. This is a fairly strong statement and implies that localities are not accurately implementing the ATP. We would like more information on the accuracy issues that have been identified and whether accuracy of ATP determination is a widespread issue or could be addressed through technical assistance to a few localities.

Response: The Consultants do stand by our statements related to the inconsistency of the implementation of ATP throughout the Commonwealth. Very little data is available as to the frequency of ATP assignment, collection issues, or information about families who decline to participate based upon the cost. We know also that some LLAs do not collect the family fees. Because the majority of the fees are collected by the individual provider, we cannot be sure if these fees are consistently collected. References to “accuracy” have been deleted in the final report.

- Request that recommendations be made or guidance developed on procedures for payment of Part C services when a family refuses to pay their Cap based on the ATP. The SOLUTIONS reports notes that terminating services when an ATP is not paid is a “serious compliance issue.” As part of the next step, clear guidance is needed on the use of Part C state and federal funds to pay family caps when the family does not pay the assessed fee.

Response: This degree of public policy will be recommended in the final FCP document from the consultants.

- Rate Methodology. Page 44. We agree that there needs to be clear policy on how the negotiated rates are used when assigning the family ATP.
- Rate computations. We suggest that final recommendation on the rate computations include an assessment of the fiscal impact on local and State Part C budget. For example, any significant increase in negotiated rate (which is suggested by findings from the pilot) or associated costs in Arlington would have a major impact on the Part C budget. The increase in rates is needed to cover Part C costs, but will also have a fiscal impact.
- Suggest that the implementation of a new Family Cost Participation also be worked out during Phase II. This will require wide family input as well as an analysis of the impact on local budgets and services. Any changes in FSP would also be tied in with the allocation formula and rate methodology and all three are integral to the Part C funding system.
- We are not sure of the usefulness of data collection on families who decline services due to financial reasons. Part C is a voluntary program and we have specific guidelines for services and family can choose whether or not to participate. Families who decline for financial reasons may not want to share that information and may decline for multiple reasons. If this data is collected this is a strong possibility it may not be completely accurate.
- Recommend not having to obtain financial information from families on Medicaid since their ATP will be zero.
- Also request clarification of “other initiative” as discussed in the Middle Peninsula-Northern Neck comments. We are also not clear on how completing financial and ATP for clients with Medicaid will be a means to access “other initiatives”. Also agree that some families who are willing to pay the full cost of services should not have to provide income information. Many families prefer to keep that information private and may decline Part C services and access service privately if required to provide income information, particularly if it does not reduce their fee.
- More clarification and specific examples are needed about how various resources are expected to impact Part C funding. We concur with comments from Middle Peninsula-Northern Neck that some of the resources listed are not potential funding sources for Part C services. Many of these resources provide services supplemental to Part C and supportive family services, but not the specific Part C services entitled under IDEA. Again, further discussion and needed on the specifics of how these resources will contribute to funding for the Part C system.
- We concur with other Regions that localities would very much like flexibility in how we move from intake to IFSP development as well as who completes the financial intake. For some programs we must have the flexibility to move this process in various ways to assist the family, to meet staffing needs and in order to meet our timelines. Also due to large geographic areas and limited resources we do not foresee how our system would be able to have financials completed by someone other than the service coordinator.

- We also concur with the Middle Peninsula-Northern Neck's concerns regarding how the resources, supports and services listed in the report would assist in funding the Part C system.
- We have concerns about a family fee system that charges families during a month they received no service or only received service coordination. While the example is given that we pay our insurance premiums each month, comparing insurance premiums and fees for early intervention services feels like comparing apples and oranges. You don't pay your physician every month because you might need to see them. We already have families who choose not to participate in early intervention for a variety of reasons and to have them pay for a service during a month when they don't receive the service is going to be troubling to at least some and could well be another reason for families to opt out. To charge them every month feels like we are in the business to make money (like insurance companies). We also have to remember that families receive special education services for free for the 20 years after they leave early intervention. We should do all we can to make the first few years of their involvement in special ed as low of a cost as possible. Where is the proof that a family who pays for services is somehow more invested in the services? The amount of investment a family has in our services varies from family to family, irrespective of income, and after many years of doing this work, we have not seen families who pay for services be more invested than those who do not pay. Whatever new plan is put in place should be the least burdensome in every possible way to families.

#### J. Service Coordination

- On page 28 a comment is made that "inactive" children in ITOTS were considered to be "service coordination" only. **Recommend that a distinction be made between "inactive" and "service coordination" only.** There is an occasional family who has an IFSP for service coordination only, but there is active service coordination. This may be to assist the family and child with transition or to assist with accessing non-Part C services through other community resources. **Active service coordination is more than monitoring** and would not be applied to "inactive" children since those are families we have lost contact with, but cannot close until the IFSP expires.
- Page 28: Pulling "Service Coordination only" children out of the federal count is NOT appropriate for Virginia. These children are most definitely receiving a service. Service Coordination is not only procedural safeguards and rights, but it is ensuring the coordination of care between physicians and therapists, ensuring the family has their basic needs met, helping the family with learning about their child's disability and how that affects their family. This is an integral part to all IFSPs.

Response: The clarification between "service coordination only" and "inactive" children has been helpful in better understanding this issue. We agree that there is a need to distinguish between inactive children and children and families who are receiving service coordination only. The report will be revised accordingly.

The issue remains that a large number of families do decline public services and it is important to figure out why this is happening. If the cost of service is resulting in the lack of participation in services, then the family cost should be adjusted accordingly since it may not be compliant with the "inability to pay" Federal requirement.

When families are “lost to the system,” it is the opinion of the consultants that these children should not be reported in the December 1 Child Count. Localities should be assisted to figure out why families are not pursuing services. When an IFSP is in force, the family has a right to the services that are listed. Leaving these IFSPs “in force” albeit inactive puts the public system at considerable risk for compensatory services or payment. We maintain that the core issue of families declining services, however they elect to do this, is really important to investigate and resolve.

- On page 69 of 71 the report indicates that service coordination could become a Medicaid reimbursement service under the SPA. Would this eliminate the need to bill CM for Part C service coordination? We hope that this would be the case, as billing CM and keeping up with two sets of documentation requirements is time consuming and places more risk for documentation errors resulting in potential for paybacks. Also in regards to Medicaid State Plan Amendment, page 7 of 20 the report indicated that this financial resource would be available to meet the state’s eligibility criteria for 0-3 and included those children at risk for delay. Are we looking at expanding the eligibility criteria?

Response: Under the Medicaid proposal, all EI services would be under EPSDT and billable only through that program. The reference to children at risk referred to children with medical conditions; no expansion of eligibility is anticipated for the Commonwealth.

#### **K. Additional Data Collection Recommendations**

- Page 40, B. We request more discussion on the purpose of some of the data items that are recommended to be collected. For example, the name of the practitioner for each service provided—would the type of service be sufficient? Also, under resources, “funding or supports to provide the service”—a definition of supports is needed in order to understand the specific data to be reported. It would be useful to have this information in the report. We also recommend collecting this data in aggregate rather than having to submit data by individual child.
- Page 36: General revenue / service data quarterly – why are we going to quarterly reports when we just were able to reduce to 2x/year? This increases administrative time and costs.
- \*\*Throughout the SOP document, there is an enormous amount of additional data collection and reporting. We are very concerned about the administrative impact this will have.
- Page 37: Offering \$10/child for correct and timely data is possibly the most ludicrous way of distributing dollars. It was our understanding from the System Manager meeting at the EI conference that Frank Tetrick has said he no longer wants allocations based on child count – that’s exactly what this \$10 per child is. What happens to overburdened, understaffed systems not able to provide accurate data in a timely manner? Will they not receive the funds and therefore be further burdened and understaffed /under funded? For \$4000 (Norfolk’s allocation if we had accurate and timely data), it hardly seems worth the effort – and we’re one of the larger systems. Truly, this is demeaning. Why not divide the \$360,000 by the 40 systems and give each \$9000 to each system to offset the increased data requirements (not that that amount of money will cover the increased demands.)

Response: Distributing dollars related to the number of children served will always be an underlying concept of most any conceived method of allocation for payment for services. The key concept of the \$10 per child amount is that it is an after-the-fact payment for timely and accurate work. While there may be better ways to achieve equity for this effort, it seems odd to describe this approach as “most ludicrous”. Future deliberations may produce other viable methods, however, this approach remains a valid method for consideration.

- Page 39: More data requirements in ITOTS. With 30 of the 40 LLAs residing in a CSB, why is ITOTS not integrated with the mandated CCS reporting?
- Page 40: A, 3<sup>rd</sup> bullet – “Local developed narrative analysis” quarterly – again, this is an increased burden on local systems.
- Page 40: B, Data – RE: family cost / families declining services / family fees collected, etc. Much of this data will need to be gathered from private providers.
- Page 40-41: This spreadsheet is too detailed. Breaking out the resources for every service is too time consuming.

Response: It is imperative that the data identified by the Consultants be routinely collected and analyzed. The proposal to compensate localities for data was developed in collaboration with the Stakeholders’ Group, who acknowledged that not all localities would necessarily provide the data unless compensated.

**L. Resources, Supports, and Services:**

- It is not clear how some of the resources listed in Figure 1 (Resources, Supports, and Services for Part C) would assist in funding the Part C system. Many of the resources, such as WIC definitely enhance the overall quality of life for children and families. Linking families with these additional resources is a routine part of service coordination.
- Is the recommendation that these resources supplement current Part C dollars, to such an extent that the funding formula would be adjusted if a community “accessed” them? It is important to keep in mind that many of these resources in the list target a specific population and would not be a potential funding source for Part C services. An example would be the Healthy Families program, which is targeted toward “at risk” children. While the collaboration between this program and Part C provides needed additional community support, the funding that provides this program could not support entitled Part C services. Some other resources that are listed, such as Head Start, serve a different age population (3-5) and, while they are excellent transition destinations, do not support the Part C population. In some communities, other resources such as Family Preservation funding and Juvenile Justice are currently being used to support local prevention services. If there would be a requirement that the Part C system compete for these funds, this could potentially reduce services that are currently available for other children in the community.

Response: Families in EI have multiple eligibilities and often benefit from other programs and services, including those designed for children or families at risk. Partnerships with these programs help to enhance the delivery of IFSP services and often can reduce the number of people entering a family’s home when the Part C system, for example, consults with the at risk program provider and the delivery of that service is augmented to incorporate considerations of the child’s developmental delay, etc. In this manner, Part C doesn’t compete for these funds but follows the Federal requirement of utilization of existing resources and maximizes their impact through the consultation and support of the Part C system.

- While there was mention of seeking these resources only in those areas in which those resources were possible, it may not be clear just how different these resources are across the state. One prime example would be the Public Health Departments, which in some areas provide direct services such as developmental screenings and case management. However, in other areas they provide no direct service other than family planning and could not be expected to fill in for existing Part C services. In order to prevent inequity, this needs to be taken into consideration. In addition, in some areas, revenue from Medicaid case

management for infants may not all be used to fund the Part C system. There could be additional challenges in requiring that all of this revenue go for Part C services, which will mean that some other needed disability services could go unfunded or underfunded.

Response: We acknowledge that the local resource base varies from locality to locality. Part of the expectation of the local coordinating councils is to work together to identify resource development needs, the potential for duplication, and where and how partnerships can be maximized to efficiently utilize all available resources and serve the greatest number of families and children.

#### **M. Allocation Formula Approach**

- What would be an example of incentives if the LLA maintains their effort? Has it yet been stated that each local system has to maintain their effort or is it the state that has to maintain effort as a whole? A few years ago, the state took away the MR General Funds from the CSBs. This has significantly impacted some local EI systems because the CSB allocated some of the MR General funds to EI. The assumption was that case management dollars would fill the gap. This has not proven to be so in all local systems. This decision, the state taking away our MR General Funds (so perhaps could be considered that the state did not maintain their effort) made it impossible to some to maintain the local effort.
- Service Payment, Page 41. More detail is needed on the process to “back-out” children that are funded with non-Part C money. In particular, the “Services Covered by Private Insurance” may be difficult to assess. This can vary considerably by type of plan and there are often limits on number of visits when the service is covered. More information is needed on how this “back-out process” will be determined.
- In general, the allocation methodology and rate computations that will be developed in Phase II have many associated questions and areas of discussion before being finalized. We are pleased that there is a recommendation to continue to obtain additional input and to reconvene the stakeholder group as the details for implementation of Phase II are developed.
- Page 40: A, 5<sup>th</sup> bullet – points for military installations. We have questions regarding this process:
  - Who gets NAB Little Creek – Virginia Beach or Norfolk, or both?
  - What about Chesapeake with no real base, but many military families?
  - \*\*\*With any new allocation formula, LLAs must be guaranteed their funding level will not decrease – there should be a hold harmless clause throughout this entire process.
- Page 41: C #2 Allocation methodology: “Back-out” children/services funded with non-Part C. This is problematic as our payor mix changes frequently. Children go on and off Medicaid quite often. I would not want a funding allocation based on point in time data.

Response: The update to the Fiscal Study will inform us what the current level of local funds is for Part C, as well as the utilization of Medicaid and private insurance. These data will form the basis for allocation discussions and the development of a meaningful and reasonable methodology.

## **N. Statewide Billing System**

- The concept of state-wide billing has possibilities, but this needs to be explored in much more detail, including projected cost analysis and comparison of local vs. state-wide billing. The most important consideration would be whether it would actually be cost effective. It is not clear whether the recommendation would be for the state to also bill private insurance for Part C services, which would add to the burden at the state level. If private billing is not to be included, this would still require providers to have their own billing system in place. If, in fact, Medicaid would cover children up to 300% of poverty, it is unclear whether this would mean that the additional children would qualify for HIPP and would have both Medicaid and private insurance, which would further compound the complexity of billing. If the billing, even just for Medicaid, were to be done at the state level, it is unclear how the follow up with insurance (notes, documentation of medical necessity, eligibility for benefits, etc.) would be done other than by the locality.

Response: We have proposed that the current private insurance legislation be revisited for potential streamlining and accessibility. Further, it is possible to “suspend” third party liability for dually enrolled children if the cost to the state to access private insurance exceeds the benefit to be obtained. These are issues that need to be studied in collaboration with DMAS.

- Some of the issues with reimbursement for physical therapy, occupational therapy, and speech therapy may be more localized rather than being a state-wide system issue. In some instances providers have billed Part C rather than successfully billing insurance, and it may be more cost effective to provide technical assistance to those providers rather than reconfiguring the system.

Response: Centralized billing is one approach that has been successful in reducing paperwork for providers and maximizing the receipt of third party reimbursements in eight (8) states (KY, IN, IL, LA, MO, WV, NJ, CT) for some or all of the third party resources for Part C services. This may not be a viable approach for the Commonwealth but one that we do recommend investigating.

## **O. Child Data/Reporting**

- Page 28: Having children on “inactive” status – these children should be counted in the annualized data as they were in service as some point during the year. Inactive status is a fairly new procedure and is not fully implemented statewide. What is the actual number of children inactive? I would guess that the number is lower than portrayed in this document.
- Pages 27-28: #2 Regarding short length of stay – we must remember that VA DOE picks children up at 2 years old. This reduces the length of stay for many children.

Response: Some members on the Stakeholder Group reported that more families were staying in the Part C system after age two, but the data doesn’t support this. The number of children reported by DOE has been and continues to be just about 1,000. Some of this information will be gleaned through the update in the Fiscal Study.

NOTE RE: THE FOLLOWING DATA COMMENTS: A considerable amount of effort was put forth to validate the data, resulting in a new ITOTS report using the new system. Minor corrections to the data in the final report have been made as a result of these new data.

Page 29: Table 4 – we believe all of these numbers to be inaccurate

Page 30: Table 5 – Our numbers for FY 06 are as follows:

Category	=	Actual Number	NOT	As reported in SOP document
All 2006 referrals	=	347	NOT	369
Referrals not moving to service	=	140	NOT	160
Referrals moving to service	=	207	NOT	209
% not moving to service	=	40.3%	NOT	43.4%
% moving to service	=	59.7%	NOT	56.6%

Page 32: Table 6 – This table is misleading to the reader as the percentages are based on those NOT moving to service, not to the total population. Our numbers for FY 06 are:

Category	=	Actual Number	NOT	As reported in SOP document
Total Number	=	347	NOT	369
Referrals not moving to service	=	140	NOT	160
% not moving to service	=	40.3%	NOT	43.4%

Based on SOLUTIONS data, calculating those percentages into actual children not moving into service – errors were found as follows:

Category	SOLUTIONS %	SOLUTIONS #	ACTUAL %	ACTUAL #
Declined Screening Evaluation	18.8%	30	37%	52
Evaluated Ineligible	8.7%	14	16%	23
Screened Evaluation Unnecessary	52.2%	84	11%	16
Unable to Contact	20.3%	32	35%	49
TOTAL	100%	160	100%	140

- Using the correct actual data above –  
23 children of the 347 referred, or 6.6%, evaluated ineligible.  
52 children of the 347 referred, or 15%, declined screening/evaluation.  
16 children of the 347 referred, or 4.6%, screened evaluation unnecessary.  
49 children of the 347 referred, or 14.1%, evaluated ineligible.

Of those not moving to service, 72% never have intensive service utilized – they were either unable to contact or declined screening / evaluation. As this is a voluntary program, it is expected that this occurs.

- Page 31: “The data indicate that more than a third of all referrals are evaluated with the outcome that the child isn’t eligible.” This is false! Data in tables 5 and 6 are inaccurate. Additionally, there appears to be a mixture of how percentages are used (% of those not moving to service and % of total referrals.) Please see notes above – only 6.6% of children in Norfolk evaluated ineligible in FY 06.
- Page 33: Although it is difficult to know statewide numbers, according to Norfolk’s FY 06 numbers, the data is as follows:

- Number of Referrals from a Pediatrician = 29 of the 347 referrals, or 8.3%. Of those 29, 4 (14%) children referred by pediatricians were found not eligible.
- Number of Referrals from a Parent = 153 of the 347 referrals, or 44.1%. Of those 153, 8 (5%) children referred by parents were found not eligible.
- Number of Referrals from a Hospital = 67 of the 347 referrals, or 19.3%. Of those 67, 1 (1.5%) child referred by hospitals was found not eligible.
- Adding the pediatrician and hospitals together gives us 96 of the 347 referrals, or 27/7%. Five (5) of the 96, or 5.2% were found ineligible. This is very different than the 41.7% reported on page 33.
- On page 28 of 71, there is some discussion of whether or not a child who is active (not inactive) but only receives service coordination is considered a child served. At times children, who are eligible based on a diagnosed medical condition that places them at risk for delay, may receive only Service Coordination if there are no current concerns of the family other than to monitor. I think not counting these children who are receiving a valuable service, much greater than the definition presented in this paragraph, would significantly impact our child count numbers as a state.
- Page 29 of 71 indicates that all localities do not enter all referral data into ITOTS. If we are going to use this data, we feel that it must be enforced that all referrals be entered at the time the referral is made to the central point of entry. Data on the number of programs not doing this should be collected before making many assumptions about the 2006 data.
- Our numbers were very wrong as well. I am going to type it up in excel and send it to everyone... but for example, they have that 45.2% declined a screening/eval - our numbers were 17.4%... Very concerning.

I reviewed the numbers section on page 32 and found as XX did that there are some very wrong numbers for Norfolk as well. For Example: The children referred and found "not eligible" for us was 6.2% and SOLUTIONS found us at 8.7%. For children screened, evaluation unnecessary for us was 4.3 and SOLUTIONS found us at 52.2%. Unable to contact we had 13% and SOLUTIONS found us at 20.3%. There are some other numbers that are not correct as well. As far as SOLUTIONS finding over half of our children as EVALUATION UNNECESSARY is totally ridiculous!

So again, where did SOLUTIONS come up with this data? They indeed make very strong recommendations which is a big concern if much of their data is inaccurate.

- But, I do have questions about the graphs, specifically the one:  
Reasons: Referrals not moving to service fiscal year 2006, all localities with <200 referrals by Percentage. As is natural we all go to our localities, and I guess I need to know how the percentage Evaluated-Ineligible was determined at 63.3%. Should the total percentage across add up to 100%? Then also I question there should only be a 0% in deceased. This may be a keying error on our part. So, in saying what I have, I probably need more

explanation of the numbers and the shading. I would really appreciate the feedback so I can be more knowledgeable when asked.

#### **P. Transition**

- On page 28 of 71, the report indicates that more families are deciding to remain in Part C at age 2 rather than transition with Part B. For at least two of our systems in our region this is not the case. Due to issues regarding lack of services due to provider shortages in Part C, some families are moving to Part B to get resources. In addition families are accessing Part B services that must go back into the workforce due to TANF requirements.

Response: We will examine this more thoroughly.

#### **Q. System Funding**

- Pages 27-28: 2<sup>nd</sup> bullet: In Norfolk, we do seek other payor sources. This statement is inflammatory to those of us who diligently work to use state and private insurance.

Response: The comment isn't meant to be inflammatory.

- 5<sup>th</sup> bullet: "Local funds are being withdrawn from Part C system as additional state dollars are allocated to LLAs." This is NOT true. Our LLA has continued to pay for Service Coordination, support staff and associated costs for Service Coordination / support staff including 2 supervisors. We have been able to increase services and the number of children we serve because the local commitment has kept pace with our growing program. Where did this data come from? Certainly, it is not wide spread.

Response: We recognize that many localities have maintained their local commitment even with the infusion of new state general funds. We are confident that the update to the Fiscal Study will identify the total resource base for Part C, including the overall percentage of local fund contributions. It is difficult to understand, as we are sure that you can agree, how the total funding picture balances out with the infusion of more that \$7 million annually compared with a growth in the ChildCount from 2005 to 2006 of approximately 200 children; the difference between 2004 and 2006 was a net loss of 79 children. During the update in the Fiscal Study, we will examine the relationship of the Child Count to expenditures, etc. as we are certain that each locality is equally committed to understanding the impact of new state funds upon enrollment.

#### **R. Cost Study**

- Page 36: The Cost Study was completed just 4 years ago. Why are we spending money on another one? How much is the current SOP costing?

Response: The update to the Cost Study will be very abbreviated. It would be very uncommon if overall costs hadn't changed in four years.

#### **S. Training**

- Page 37: Why would we re-visit training now? We need to improve what is already in place. Much of what is on the list is LLA specific (i.e. TCM) and needs to be trained locally.

Response: Provision of services by qualified providers and the expectation that providers participate in ongoing training are requirements not only of Part C but also of professional licensing bodies and public and private insurance agencies/companies. In accordance with federal Part C requirements, Virginia must have a comprehensive system of personnel development (CSPD) that promotes the preparation of ALL early intervention service providers who are fully and appropriately qualified to provide early intervention supports and services under Part C. The personnel development system must be comprehensive in terms of those to be

trained (paraprofessionals, primary referral sources, service coordinators, other services providers, administrators, families, etc.) as well as in the scope of training topics (covering all basic components of the Part C system). Stakeholders should expect that there will be significant changes in Virginia's CSPD in the coming months and years.

- Under Qualified Providers section on page 10 of 20, it states that all providers must complete the credentialing requirements. We concur that the training is important for our primary providers; however, this will be very difficult to enforce for providers that may be utilized only 1-2 times a year.

Response: This is both a State policy issue and a practice issue. Why should kids and families get perhaps a less comprehensive service by a provider who isn't properly oriented in Part C? Stakeholders including family members will have to sort this question out through the public forum process. Where do you draw the line? Two children, five children or ten children? Or, should all providers participate in the training regardless of how many children they serve?

- Recommendations have been made for state training for new data collection to occur in April/May 2007 with actual data collection to begin 7/1/07. This seems somewhat aggressive considering we are now at the end of April and the report still needs to be disseminated beyond the workgroup. Please consider adequate time to implement any changes that are agreed upon.

Response: As you are aware by now, the new data collection tool designed to address the General Assembly reporting requirements was not ready for inclusion in the SFY-08 Local Contract for Continuing Participation in Part C. Further work will be necessary to determine if and how this tool might be used in the future. In the meantime, steps will be taken to determine how and when this data can be collected through ITOTS.

#### **T. Associated Costs**

- Page 37: Study / develop method for associated costs – This should be optional for systems. What happens to the procurement regulations for CSBs? We are required to have a bid process for this. This is a local level decision. State can and should provide recommendations regarding associated costs, but not requirements.

Response: The current method for paying associated costs is quite varied throughout the Commonwealth with some providers not receiving any compensation at all. The intent of the Lead Agency is that these costs should be covered. A standard payment approach will ultimately be part of the overall all redesign of the service delivery system and will undoubtedly require change from current local practices. To the extent that there is a two stage change with regard to paying for associated costs, the idea would be to limit the scope of change in stage 1 and allow providers to opt out of a standard approach if they can assure the Lead Agency that providers are compensated in a reasonable way for these associated costs.

- We cannot implement interim options for 7/1/07 as our contracts with our private providers are already completed. They will be due again next March.

Response: Similar to the response provided for associated costs. there in fact could be a two-stage change ultimately resulting with a more standard reimbursement system. To the extent possible, the impact of stage 1 could be limited to mitigate the impact on providers while still assuring some of the tenets of the stage 1 principles.

#### **U. Rate Methodology/Standardization of Rates**

- Page 41-42: Standardizing rates/payments for 7/1/08 will have a severely negative impact on our system. I'm concerned with how we will pay for therapy services at a much higher rate than we have negotiated currently.
- Page 44-45 – We are thankful the rate will not be mandated, though we are still concerned as to what level of standardization would be created.

Response: See above response

#### **V. Interagency Agreements**

- Page 39: How are incentives for interagency agreements going to help the statewide system? How will it help remote areas?

Response: Interagency agreements at the state level help to pave the way for local implementation of partnerships to support Child Find, referrals, exchange of information, etc., in addition to the support of IFSP services. Each contribution, no matter its size, helps to maximize local service options and can save time, money and effort at the local level.

#### **W. Family Choice of Provider**

- On page 23 of 71, a family's choice of provider was discussed. In the past, some systems have received Technical Assistance that this is not required. This could have a cost impact. For example some providers are chosen because they have other children they serve in the same geographic location, which decreases travel costs (associated costs) to provide services or because the provider is a participating provider of the child's insurance company. We are not opposed to parent choice but for small programs that have few provider resources this may have some cost impact or impact provider availability (based on increase in time spent traveling from one end of a geographical area to another).

Response: See earlier discussion

#### **X. State Infrastructure**

- In regards to page 27 of 71, we concur with the report that we need to ensure a system infrastructure at the Lead Agency Level that can meet state and federal obligations. In particular several systems in our region have vocalized the need to have more technical assistance to local Part C system participants. This is especially needed when a local lead agency changes, when a new provider contracts with a program or when a new System Manager is hired. Increase support in this area, would help ensure more consistency among local programs and better understanding and follow through with Part C regulations.

Response: The Part C system concurs with the comments about the need for a Lead Agency infrastructure that can assist local systems to meet state and federal obligations and promote consistency among local programs. Additionally, the Part C Lead Agency will engage local systems in exploring how best to meet their TA needs.

#### **X. Consumer Input**

- In looking at ways to gather feedback from families across the state, please keep in mind that it may be difficult for families who live at a distance from the urban areas to attend, particularly depending on the time of day. In addition, some may not have access to the internet. Please ensure that there are other ways (written, telephone, etc.) to gather feedback from these parents and also please provide very clear and succinct summaries of the issues and recommendations.

Response: The Lead Agency is committed to ensuring that there will be broad participation of families in this process and will work closely the Family Involvement Project for developing alternative ways to gather feedback from families.

## Y. General Comments

- Thank you for the opportunity to give feedback on the SOLUTIONS Report. Some of this report includes information from other members of the Roanoke Region that I represent. However, all systems in my region have not had an opportunity to review this report and I may forward more responses in the future as we broaden stakeholder input.
- We do appreciate you letting us comment on the SOLUTIONS report.
- I understand that the SOLUTIONS report is going to be submitted to the field for full comment in the near future. Because Brenda shared it with Tidewater in order to carry back our recommendations, I want to let you know I have major concerns about the conclusions drawn based on the Data. Western Tidewater's data has serious errors that greatly impact the summary and recommendations. If I am jumping the gun on this one, sorry. I will respond more formally when it is fully distributed and wanted you to know up front of my concerns for our council and our state.
- Also if there was not consensus among the Stakeholders work group on some of the issues then no conclusions or recommendations can be made.
- Thank you for the opportunity to comment on the report and we look forward to working through the details of recommendations for Phase II.
- Attached are some comments from Arlington on the SOLUTIONS reports. We are looking forward to participating in the process for Phase II and appreciate the opportunity to review and comment on the report. There are certainly many issues and questions on the recommendations and we appreciate everyone's hard work in developing toward developing a solid Part C funding system for Virginia.
- Here are some comments from Norfolk for your review. Our main concern is that we found some very inaccurate data and hence the conclusions/suggestions for the system are based on erroneous information.
- We also take exception to the idea that we may be receiving a lot of invalid referrals when we know that isn't true and we've worked very hard with our referral sources. We'd like to take a different approach and look at everything that is right with our system and focus on what we think are minor issues. We all know improvements can be made and we are excited about making our system better. So much of the SOLUTIONS report was rather discouraging, almost like throwing out the baby with the bath water and starting over.
- Wow, what a lot of work went into the "draft" report. I am interested in seeing the operational end of the process. Even though I was part of the workgroup, I am not sure I can conceptualize it operational. Anyway, thanks.