Medicaid Stakeholders Group
Minutes
September 17, 2007

Attendance

Sue Mackey Andrews
Beth Tolley
Jill Donaldson
Jennifer McElwee
Elizabeth Faulk
Lynn Wolfe
Phyllis Mondak
Betty Crance
Anne Simmons
Anna Chase-
Tracy Miller
Nancy Butts
Nancy Bailey
Jim Gillespie
Tammy Whitlock
Molly Carpenter
Cori Hill
Eva Thorpe
Gary Woodlin

Outcomes for Today's Meeting:

- Provide a brief orientation to the Medicaid Enhancement Initiative
- Provide stakeholder members with constituent feedback opportunities; ensure that they understand key questions, outcomes for these activities
- Establish communication pathway for the next several months.

<u>Orientation to the Stakeholder Group Task</u>

Solutions Consulting Group began working with Virginia last year with an initial focus on the Ability To Pay (ATP) System with a number of stakeholder meetings. It became apparent pretty quickly that ATP couldn't be repaired independently because of the interconnectedness with other funding/reimbursement components of the total system of payment.

Sue provided a brief overview of the recommendations in the Medicaid Concept paper. She identified three current Federal CMS actions relevant to Medicaid reimbursement.

- Tightening of eligibility requirements for S-Chip (e.g., FAMIS in VA)
- Notice of proposed rulemaking (NPRM) – proposing reduction in coverage/reimbursement for rehabilitation services (mostly for older Americans)
- Notice of proposed rulemaking (NPRM) – proposing the elimination of reimbursement for administration costs for school therapy

The proposed Part C/IDEA regulations are more specific than the current regulations regarding use of families' insurance. Consequently, private insurance reimbursement may need to be configured differently in the future.

An important goal for the work on Virginia's System of Payment is to have common rates across the state and across funding services. The Cost Study must be updated to provide essential information in order to formulate recommendations. This update, to the 2003 Study, is being conducted "as we speak."

Questions were generated for discussion today or at future meetings.

The following questions were addressed throughout the meeting today:

- What happens with children who don't fit into the primary provider model, which will be supported by this Medicaid initiative? Will there be a "same old" approach for private insurance? Response: There are kids for whom the PP model is not appropriate. What

is being proposed will support the breadth of approaches that respond to individual needs or children.
- How will the Service Coordinator categories be delineated? This will start with information gathering that is part of the "homework" for the stakeholder representatives.

The following questions will be addressed in November:
- Will we be working toward expanding EPSDT? Concern was expressed about the process for authorization.
- Will there be a streamlined process for documentation and authorization. Sue will be working on recommendation about documentation. (EI audit findings are usually related to incomplete or wrong completion of documentation.)
- How will these changes with Medicaid impact private insurance reimbursement?
- How will changes impact the Health Insurance Premium (HIP) program?
- What about children dually enrolled in Medicaid and private insurance (HIP)?
- Will there be a statewide billing process. Will discuss in November.
- What is impact on cost settlement process for providers?
- How will establishing specific requirements for system managers be implemented?
- What will billing Medicaid required? Will physician script/order for special instruction be required?
- How will we deal with barrier about getting physician orders? Clarified that this issue needs more study – who requires the script?
- **Number of kids in straight Medicaid versus those in MCOs. State doesn't know. Local systems know**.
- How many of the 10,000 (annualized count of children) currently being served will be at 300% of poverty level?
- Barriers are encountered in service approval (timelines, paperwork) and in obtaining physician "script" for services. Varies by practitioner type and type of service.
- What is the impact upon private health insurance by reconfiguring the Part C and Medicaid relationship?
- Will this initiative mean more documentation requirements?
- What is meant by establishing qualifications for System Managers? They are very diverse in terms of what they do – some more clinical than others, some more administrative. What about System Managers who do direct service?
- What is certification of match for Medicaid?
- How will this tiered system of service coordination actually work?
- Services on the IFSP not on the list – respite care identified.
- Questions re: educational requirements vs. experience and skill. How to incorporate some of these great people who are highly skilled and effective yet lack the "paper."

The following question will be addressed through other venues:
- Are financials required for all children – will be addressed through Family Cost Participation work

Sue emphasized the importance of looking at how supports and services are now being provided. We have the opportunity to tweak/reconfigure the VA Part C system now, prior to making changes in reimbursement that will be built around the system.

Reimbursement methods were discussed including monthly payments by payors and the current method of billing for/reimbursing each services. The Stakeholder Group's current tasks

include studying and commenting on a variety of reimbursement approaches, including changing the reimbursement methodology to one where payments are made based on number of children and average cost of supports and services for each child. It may be that there are different approaches to reimbursement depending upon the fund source, how many children/families the resource involves, etc.

It is important to recognize that money will drive services including who provides them, where they are provided, frequency, etc.

Medicaid covers 40-45% of the infants and toddlers in Virginia's early intervention system. Medicaid doesn't reimburse providers for Special Instruction, so 100% of the reimbursement for these services is from state, federal or local funds. We need to know how many children receive another service instead of special instruction because special instruction is not reimbursed, as well as the number of children's whose parents have declined special instruction services since it is not reimbursed by any third party payors.

Sue asked the group to consider the following questions between now and the next meeting:

- Do all of the providers, etc have the same interpretation of Virginia's supports and services approach?
- Are services really being individualized?

The proposal for the changes in Medicaid includes reimbursement for all of the early intervention functions as part of the EPSDT – Early Periodic Screening, Diagnosis and Treatment. This will not eliminate MCOs as they have EPSDT obligations in their contracts.

Periodic Screening includes regular and routine screening (such as done by Pediatrician as part of well-baby visits) and interperiodic screening (which could include screening by Part C in one or more of the developmental domains). If an issue is identified through screening, then diagnosis and (comprehensive) treatment must follow, whether the service is covered under the state's Medicaid State Plan or not.

Covered services would include:

- Screening
- Evaluation for eligibility
- Assessment for IFSP planning
- IFSP Teaming/Collaboration
- Early Intervention Services. (See revised slides, slide 14 for list) Participants suggested adding transportation and respite to the list).

Early Intervention Providers

Virginia has an exhaustive list of qualified provides (policies and procedures) with qualification based on "highest standard". This is interpreted to mean licensure or certification based on state requirements. (The OT requirements in this document need to be updated to reflect the requirement for licensure rather than certification. COTAs are still certified rather than licensed).

Participants were directed to Page 12 of Medicaid Concept Paper. Providers from each of the organizations listed on the chart are used by at least one state for provision of Part C supports and services. This chart can be used as a stepping off point to figure out what additional

organizations/providers can be added to the early intervention system provider mix, and what could their functions be within the whole system. We need to learn who/what organizations are already serving kids and figure out how to credential them to do what they are doing as well as perhaps some additional Part C services.

Sue emphasized the importance of considering the number of children served. Virginia is currently serving 1.72% of the birth to three population. It was estimated in 2003 that 6% should be served – 15,000 instead of 5,000 (annual Child Count estimate). This 6% was conservative upon the request of the stakeholder group overseeing this project.

Sue reported that in some states, the Developmental Teacher for Early Head Start is coached by Part C and may be the primary provider for the child/family. The Family Support Worker may be trained in service coordinator responsibilities. Lynn reported that CDR uses a similar model for dually enrolled children. To make this successful, work is needed to increase the confidence of Headstart/Early Headstart personnel so they will accept these roles and also to increase the willingness of current Part C providers to release these roles to someone else.

Stakeholders were asked to think about what the other organizations at the local system provide services for infants and toddlers, using the list on page 12 as a starting point. Individuals from other organizations performing Part C functions would be compensated for the proportion of their time spent on the Part C functions.

The potential transition from the current description/categorization of providers to a grouping of providers in three categories was discussed. The three categories are Specialists, Associates and Aides. (See Slides). The majority of Virginia's current list of providers falls in the specialist category for the most part, with the exceptions of PT Assistants, OT Assistants and Early Intervention Assistants. Sue recommended that stakeholders consider possibilities for providers in addition to the specialist level (people at BS/BA of masters level who provide their own supervision).

What are other possibilities of practitioners and what could assistants and aids do? For example, in some states – evaluation for eligibility and assessment for IFSP planning must be done by specialist. While an assistant/associate could be at the IFSP meeting, the supervisor would have to be there for "treatment planning." Aides can be used in the child care environment for implementation of strategies, including assisting several children. Aides would be high school graduates and would require a high level of supervision. What are the ideas appropriate to VA related to the appropriate use of personnel? Sue encouraged people to think about the universe – without boundaries or consideration of "what is." Be creative!!

A question was raised about the proposed change is reimbursement configuration in relation to Targeted Case Management. Concern was expressed about potential loss of revenue if the service coordination functions were done by another organization such as Headstart. Sue responded that the Medicaid proposal is recommending that there be one system for service coordination for all EI children who are covered by Medicaid (not separate MR and MH TCM service coordination system) which includes billing for Service Coordination. By having one reimbursement "portal" for all EI services including service coordination/case management/care coordination reimbursement, documentation requirements would be consistent. The more difference there is between documentation based on funding requirements, the more you are likely to make errors and be subject to potential payback. Documentation requirements for reimbursement should be based on Part C requirements and blend with Medicaid requirements. There is considerable overlap here and we should be able to agree on documentation which

supports good or best practice and compliance without it being burdensome, overly time consuming or “unfriendly” to the family.

Parent/Family Choice was discussed. Family choice of provider is a Medicaid requirement. Family Choice of provider means a wide array of credentialed public and private providers so families can choose. Some states establish provider qualifications and anyone who meets the requirements can contract with the local lead agency to provide services.

There are challenges, such as providers who do not work out for the family or providers who refuse to go to the child’s home because the distance is too great. A question was raised about parents requesting a specialist when the IFSP team determined that an associate or aide was the appropriate provider. It is expected that a specialist would be involved initialing, perhaps at a high level, then decrease frequency of involvement. The team determines how the specialist weaves in and out of service provision.

Sue outlined the steps necessary to transform Virginia’s system. These are not necessarily in a sequential order – as steps 1 and 2 are mutually dependent upon one another.

1. Grow enrollment
2. Grow Provider capacity:
   Revise provider policy/procedures about who can provide services
   Consider who are all of the people in local community who could provider services
   Look for additional providers from hospitals, nursing homes, and providers taking time off for child birth, etc.
3. Take the steps needed to make changes
4. TRAINING
5. Align funding

Homework: Stakeholders are to review Virginia’s list of providers and think about who else in the community is already working with infants and toddlers and what they do and what they could do. Are there professions not currently listed as Virginia EI providers who could be added?

Methods of Service Delivery (see revised slides)

Components of the Part C Pathway include:

- **Screening** (Screening can be simple or comprehensive).
- **Evaluation for eligibility**
- **Assessment for IFSP planning**
- **IFSP teaming/collaboration** (Consider face-to face, telephone, email communication; teaming with and without family.) Is it consistent in the VA philosophy and practice for teams to meet without the family? This is a big public policy issue to consider. To qualify for potential reimbursement, team meetings must be individualized, planned and strategic, not just discussions in the hall. Some reimbursement systems don’t pay for team meetings that occur with providers in the same agency. Teaming meetings without the family may or may not be reimbursable depending on the reimbursing agency.
- **IFSP review**
- **Therapeutic/Comprehensive developmental services**
- **Transportation and related costs**

Reimbursement shouldn't drive or restrict appropriate services, but rather should facilitate more appropriate services. Associated costs (e.g., travel, preparation, report development, Part C specific training requirements) would be examples of typical costs to be encapsulated in the rates.

Service Coordination is other category (in addition to the service pathway) for reimbursement.

A question was raised about whether there would be reimbursement for other mechanisms for child find (in addition to screening). Sue will put together definitions of what would be covered in each category.

Sue referred the group to the two flow sheets in the slides. The first is a flow sheet based on all of the required EI functions. The second flow sheet represents Virginia's flow as developed by the System of Payments Stakeholder Group last year. Virginia combines evaluation for eligibility and assessment for IFSP planning. Discussion followed about the requirements for the evaluation for determining eligibility, including the fact that some children are automatically eligible. The proposed Part C regulations describe Evaluation for Eligibility as an evaluation of documents (physician information, prior assessments, etc.) and other available information to determine eligibility. Eligibility does not require face-to-face time with the child. (Neither current nor proposed Part C regulations require this.) The eligibility team determines the kind of assessments that are needed to develop the IFSP. Much discussion followed about what it would look like to separate evaluation for eligibility and assessment for IFSP planning, and how that would play out with Medicaid reimbursement.

Next Steps: Sue will provide examples of how this works. She will also send the federal definitions for screening and evaluations and assessments. After additional information is provided by Sue (which may or may not include a conference call), stakeholders will be asked to have conversations with the people they represent about Virginia's flow sheet and how it might be modified.

The group discussed the issue of **screening**.

> The draft Part C regulations recognize screening as a component of the Part C Service Pathway. ITOTS statistics indicated that 45% of the children referred to Part C do not receive Part C services (for a variety of reasons). Evaluation/assessment for children is very expensive and there is a big cost to the system for providing evaluation/assessment for children who are determined to be ineligible. Sue urged the stakeholders to think about how screening can be used to decrease the number of "inappropriate" evaluations/assessments that are done. The cost study will tell how much the assessment is costing. The time and money spent on unnecessary evaluations/assessments can be invested in necessary supports and services for eligible children. The following questions were raised about screening:
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> - What is the cost for this (time and money)?
> - What about families who insist on a full evaluation? Sue's response: Evaluation is not defined in federal law as testing. We need to get very clear on terminology.

The group discussed the variety of ways that Part C is implemented across the 40 local systems, including differences in the % of referrals that result in children receiving services, the use of screening, etc. Sue recommended that Service Coordinators have good discussions with families in order to determine their understanding of why they were referred to early intervention

(to work toward more appropriate referrals). There are multiple of reasons why inappropriate referrals may be coming to the Part C system. You don't want to discourage referrals – and you don't want referral sources "determining" eligibility – this is the role of the local lead agency. Some consultation with referral sources may be indicated if there are lots of children coming from 1-2 sources where consistently the children are not eligible. Also, it may point to cultural "fit" challenges, language, or other issues related to personnel which are then linked to training and supervision.

Children should be coming to Part C with a lot of information, including a family that a Service Coordinator has interviewed and asked a lot of questions prior to "formal testing" (if necessary) to determine if child meets our eligibility requirements. Experienced early intervention providers should be able to watch a child play for 15 minutes and know whether they need to be "tested" further to determine eligibility.

Sue expressed concern about the number of children lost to follow up in Virginia. This is a higher percentage here than in other states. Analysis needs to be done to understand this, including whether this is a tie in to the referral sources and/or whether there is insufficient information from specific referral sources. There has been more than an 85% shift in families in the Commonwealth for whom English is not their primary language. Are providers, service providers equipped to talk with all families about early intervention?

Localities must classify referrals correctly and consistently (i.e., CAPTA, vs. DSS vs. Foster Care). A point was made that children referred to Part C while they are in the child abuse and neglect assessment process are listed as DSS referrals because they have not yet been classified. The disparity in how localities enter the data means that the data aren't as helpful as they could or should be for program review, policy development, problem solving, etc.

Service Coordination

The Service Coordinator worksheets were discussed. Stakeholders were asked to have conversations with their constituent groups even if they've had the conversations about these topics before. The worksheets should be completed based on careful consideration of all the pros and cons for each of the Service Coordinator possibilities (temporary and ongoing vs. a single service coordinator and three approaches to service coordination) without regard to current configurations, funding or other constraints. The information from the stakeholder group is considered feedback, not recommendations.

Sue shared that some states separate intake service coordination (through 45 days) and ongoing service coordinator. Some say this often works well because of delineation of functions, different roles/responsibilities, and different personalities or skill sets may be appropriate for the two different sets of responsibilities. Sue suggested that when thinking about a single service coordinator versus temporary + ongoing, consider how the single service coordinator might answer the following question: If you get phone messages from a parent who has just been referred to the system and one from a parent whose child has been in the system 7 months, which one will you return first?

The three service coordination configurations identified are: independent, dedicated and blended.

- Independent: only do SC, no other functions. They are usually outside of EI provider service delivery system. (Example Lead agency provides service coordination, but

contracts for services; another example is the local lead agency contracting out service coordinator functions.

- Dedicated: service coordinators are integrated into the early intervention service provider entity/agency system and do not perform any other early intervention function.
- Blended: service coordinators are also early intervention providers

CMS typically will not allow states to reimburse for SC/CM/CC if also provided by a provider of direct services. The point in this dialogue with constituents is to identify which approaches or approaches (more than one) are most appropriate to the culture of the Commonwealth and to its diversity.

Sue doesn't have a preconceived recommendation, though we do need to recognize the CMS reimbursement requirement. Medicaid recognizes and reimburses for primary and secondary case management (prorated amount for the part each case manager/service coordinator does). This opens up additional options for consideration.
We will need to do a crosswalk of functions of the various agencies that currently provide case management/service coordination.

The third part of the Service Coordination Worksheets involves a delineation of the level of qualification (credential type) required for each of the service coordinator functions. Participants were asked to complete this worksheet with their stakeholder group. If the stakeholder group decides that a specialist is needed for all of the functions, then nothing more needs to be completed on the worksheet.

Typically, the credentials for the personnel categories are:

Specialist – Bachelors or Masters degree
Associate – 2-year degree or CDA
Aides – High School level

Specialists work independently. Associates and Aids require supervision. The local lead agency is responsible for seeing that everything gets done – how it is done (use of which personnel categories) can vary.

In Virginia, Early Intervention Assistants can do service coordination. There is not a correspondence with an education level for Early Intervention Assistants in Virginia.

Homework: Stakeholders are to complete with their stakeholder groups the two personnel worksheets. The first worksheet lists each type of provider across the top of the page and the EI functions in the first column. Stakeholders are to fill in which functions each provider type is qualified to perform. Stakeholder representatives can distribute these worksheets to their stakeholder group for completion and can complete them through discussions.

The second part of the provider worksheet is a list of all of the early intervention services with provider types again listed across the top of the page. Stakeholders are to indicate which provider types can provide each early intervention service,

Due Date (to Sue): October 19, 2007

The group discussed qualifications for providing special instruction. There were differences of opinion about whether special instruction could be provided by any discipline or whether it had to be provided by personnel licensed by the Department of Education. Some local systems use

the Family Counseling and Training category for instruction provided by disciplines other than providers licensed by DOE. It will be interesting to see how this is defined across the state. Sue advised that for the worksheet, stakeholders should list what is allowed under professional licenses. Special instruction and family counseling and training terminology and functions will be addressed later by this workgroup.

As part of the Medicaid initiative, all providers would be considered EI developmental specialists. Every qualified EI provider would be a developmental specialist and would bill for EI services in terms of functions, not specific "services."

Next Steps/Plan:

- Sue will send information about separation of evaluation for eligibility from assessment for IFSP planning
- Stakeholders will gather information from stakeholders and see that input is sent to Sue by October 19. Stakeholders were asked to send input as it is completed, rather than waiting to collect all of the input prior to forwarding it to Sue. Debra Holloway will be coordinating obtaining input from families.

Next meeting: Thursday, November 8 from 9:00 to 4:00. All members are asked to attend in person. The Service Pathway will be reviewed at this meeting in addition to a number of other topics as listed in the PowerPoint.

System Manager Homework:

Information that is necessary for presenting and obtaining approval for the proposed changes to Medicaid reimbursement for early intervention services include impact information (cost, number of children served, etc.). Sue will send System Managers two forms to gather essential information about rates to put together with information Karleen Goldhammer is gathering through an updating of the cost survey in order to determine impact of the recommended changes. The completed forms are also due to Sue by October 19. We are trying not to burden the System Managers or the localities with these information needs, and recognize that these requests are time consuming. We appreciate your commitment to take these requests in a positive and responsive way and reflect the partnership between the state and local levels in responding.

Key questions to answer now: The potential cost of making the changes, as well as the potential number of children served based on inclusion of children under current Medicaid finance requirement (133% of poverty) as well as the cost and number of children that could be served if the criteria were moved to 200% or 300% of the Federal poverty level (FPL). *Clarification:* Children under FAMIS are covered at 200% FPL., "regular" or "straight Medicaid is at 133% FPL.

The following steps are required for DMAS and DMHMRSAS to change the way reimbursement is provided for early intervention services:

1. Write and promulgate regulations
2. Develop Documentation requirements
3. TRAINING

We will work together over the next several weeks to communicate questions, information and clarifications so that the information collected by the Stakeholder Group is assembled

accurately, collated and shared with members prior to the November 8th meeting. Many thanks for a productive day together!