

**Medicaid Stakeholder Meeting
November 8, 2007
Tuckahoe Library, Richmond**

Attendance

Phyllis Mondak, 619 Coordinator (Department of Education)
Allan Phillips, Director/System Manager, Infant & Toddler Connection of Fairfax/Falls Church
Kathy Phillips, System Manager, Infant & Toddler Connection of Middle Peninsula, Northern Neck
Tracy Miller, Director, Rehabilitation Associates
Elizabeth Faulk, System Manager, Infant & Toddler Connection of Norfolk
Jill Donaldson – Program Manager, Rappahannock Area
Anne Simmons, System Manager, Central Virginia
Anna Chase – Child and Adolescent Services, Mt Rogers CSB
Brian Campbell – EPSDT Coordinator, Department of Medical Assistance Services
Joanne Boise, Director of child and adolescent health, Virginia Department of Health
Nancy Butts, Private Provider
Molly Carpenter – Policy Analyst, Department of Medical Assistance Services
Debra Holloway, Parent, Manager of Family Involvement Project
Liz Fletcher – representing Henrico CSB's Director of MR Services
Brenda Sprinkle, Parent
Jennifer McElwee, System Manager, Virginia Beach
Tera Yoder, Partnership for People with Disabilities
Jim Gillespie, Mental Retardation Director, Rappahannock Area
Mary Ann Discenza, Part C Coordinator
Beth Tolley, Technical Assistance
Sue Mackey Andrews, Consultant

Update on Medicaid Recommendations

Sue reviewed the current status of discussions with DMAS re: the establishment of an EPSDT initiative for Early Intervention Services. (“Consultant Medicaid Recommendation Summary; November 8, 2007 – attached)

With respect to the proposal that Virginia implement the Family Opportunity Act, Joanne reported that the Virginia Department of Health has a funding stream (Title V) that currently allows them to purchase direct services for children in families whose income is up to 300% federal poverty level (FPL). She expressed interest in the possibility of using those funds to purchase insurance for children eligible for the Medicaid buy in option (families up to 300% population).

Changes in Medicaid would occur in stages.

- Change from reimbursement under Rehab Services to reimbursement under EPDST
 - CMS has a notice of proposed rulemaking out which includes a reduction in coverage of rehab services. So this switch from Rehab to EPSDT is critical.
 - Change the definitions of what is covered (system changes, provider definitions, rates, etc)
- The expansion through the Family Opportunity Act would be a second phase and could include a phase in. (This is a change in defining who is eligible for Medicaid).
 - Families could buy into Medicaid if between 133% (200% for FAMIS) and 300% of FPL.
 - Part C funds could possibly be used to support the buy in for the Medicaid insurance for families depending on where they fall on the family fee scale.

The process includes a gap analysis between the cost with the current configuration and the expected cost with the proposed changes. This analysis includes consideration of all of the costs and savings to the state for early intervention services, not just Medicaid costs.

Benefits of moving Part C reimbursement from Rehab to EPSDT

- There is more flexibility in programming; allows services to support child development
- All Part C services would be included in the model
- Part C providers would be defined and included in the State Plan Amendment (SPA)

Relationship of Waivers to EPSDT

Waivers and EPSDT work together. When an individual becomes eligible for a waiver, they are eligible for Medicaid, including any service that is not part of the waiver. Waivers cover specific services, including some things that EPSDT and Medicaid don't cover (such environmental modifications, respite).

Sue reported that consideration was given to developing an EI waiver. This option is not being pursued because the disadvantage of a discreet number of waiver "slots" is a barrier to including all dually eligible children and would mean waiting lists.

EPSDT Requires:

- Professional standards
- State approved screening tool (likely)
- Family choice of providers
 - Recognition of current provider shortage; however anticipate additional providers available with increased rate
 - IDEA requires that provider meet required qualifications as well as be appropriate for providing services that child/family
 - Discussions need to happen about allowing option for family to wait for provider they want.
- Dedicated service coordination. CMS does not allow reimbursement for blended service coordination
- Signature of primary care physician (medical home) on IFSP authorizing the service.
 - Physicians can be reimbursed for review of the plan.
 - Consideration is being given to allowing up to 60 days to obtain the signature.
 - Local systems would need to have a monitoring system in place to assure that the signatures were obtained within the required timeframe).
 - MD order would not be required for screening, evaluation or assessment. **Need to check if revised PT regulations permit evaluation without MD order.**

Screening

- Physicians should be screening for development and autism per AAP guidelines.
- Details about screening, including who will be reimbursed for screening will need to be determined.

EPSDT vs. FAMIS

- Financial eligibility for Medicaid is 133% of FPL; it is 200% of FPL for FAMIS
- Children with FAMIS have 99% of benefits Medicaid kids do. Personal care is not covered by FAMIS.
- FAMIS is based on the old state KEY Advantage model. It is not known (at this time) if changes can be made to FAMIS.

- There are separate State Plans for Medicaid and FAMIS. Including FAMIS as part of the Medicaid Initiative will require two State Plan Amendments (one for Medicaid and one for FAMIS)
- EPSDT is a Medicaid term. The comparable benefit for children with FAMIS is well baby care.

Provider Information

- Provider enrollment should take just two weeks from the time DMAS receives the completed application.
- There will not be a lag in reimbursement for new providers in an agency that is already enrolled because the agency bills under their agency number. The agency signs off to indicate that everyone hired meets the provider requirements and is qualified. Utilization review will verify this.
- Providers would bill under their existing provider number. (There will probably be a different code for billing for early intervention services). Moving from section of the plan to another should be transparent

Notes:

- Need to learn whether MCOs require enrollment of individual therapists and if so, how this can be addressed to prevent a delay in reimbursement for services provided by newly hired/contracted providers.
- Need to find out what must be included for cost reporting.

Monitoring and Accountability

There needs to be coordination and not duplication between DMAS monitoring and state Part C monitoring. It is a goal to move to more desk monitoring through increased capacity of ITOTS. Data exchange and expansion of ITOTS will enhance accountability, including the capacity for verification that services authorized were delivered.

Reimbursement

- CMS will not allow a monthly rate for service coordination.
- Collateral services (meaningful contacts on behalf of family) can be reimbursed
- CMS is asking that reimbursement be based on 15-minute rates, including reimbursement for service coordination.

Medical, Developmental, Educational Services

- “Medical therapy” (ex: intensive physical therapy following a rhizotomy) will be reimbursed under rehabilitation and would be listed on the IFSP under other services.
- Therapy services beyond those determined necessary based on the outcomes, would be billed according to the code for that discipline and would not be coded as early intervention services
- Medicaid does not pay for educational services. Medicaid does cover developmental therapy but would not cover a child’s participation in a general educational curriculum.

IFSP Status – see handout

Some selected children had already been discharged (issue of keeping ITOTS up to date)

Rate Survey Participation (see attached)

- Only 20/40 surveys have been received. Solutions will follow up with those who have not sent in their information. In addition, stakeholders will follow up with local systems in their region that haven't submitted info.
- This data will be used for the "gap analysis" with DMAS. The gap analysis includes looking at the cost of doing business in comparison to what is currently being paid for the services
- The rate is what Part C is paying the provider, not what the provider is billing.

Note: Sue will check on the rate listed for TCM. Stakeholders reported that this rate is \$326.50.

UPDATE: The handout showing the rates was only for Form #1 – reports from the local lead agencies. Additional summaries of Form #2 (contracted providers) are still being collected and analyzed.

Stakeholders commented that the special instruction rates don't reflect the cost of providing special instruction because many local systems have lowered the rate for that service to make it affordable to families.

Small Group Work to Develop 5-6 Sentence Summary That Defines the Virginia Part C Services and Supports

Reports Out from Small Group Work

Group One

- Building on each child's strengths and interests to enhance his/her ability to participate in a way that is meaningful within his/her family and community through a carefully individualized combination of direct and consultative services including coaching and hand's on
- Use of interest based natural learning opportunities and support to families
- Identifying and using natural learning opportunities
- Recognizing families as the primary agents of change in their children's development
- Using one primary service provider
- Individualizing frequency of services to meet each child's and family's unique needs
- Using resources efficiently
- Developmental model/not a medical model

Group Two

- In natural environments
- "Family is the team, interventionist is the coach"
- Focus on everyday routines – set the foundation and give families tools to make it through the day
- Individualized and integrated across discipline

Implementation Issue: "Still gaps, philosophy is good"

Group three

- Primary provider model
- Team process – team decisions
- Parent coaching model using daily routines – acknowledge that the majority of learning happens outside therapist-child interaction

- Time-limited
- Individualized and fluid

Group four

- Developmental/consultative model
- Emphasis on routines and activity setting
- Family centered service planning

Implementation Issues:

- Varied operational structure
- Patchwork approach to funding and implementing services
- Inconsistency in level of services delivered
- Evaluation processes vary
- Multiple roles and increased caseloads = problems in recruitment/retention

Primary provider model: Primary provider does not mean “sole provider”. It means that one person, supported by a team of professionals, has the most contact and primary responsibility for providing supports and services for the child and family. The model assumes a team is supporting the family and primary provider and is visible to the family and to others. This model does not fit all children and individualized planned must be a component of the EIS initiative.

Provider Qualifications: Who can provide which services?

- One provider responded on survey that any discipline could provide any service, and on follow up commented that Virginia’s model supports this
- Sue clarified that while there are some services that can be provided by any discipline (family counseling, training), others (such as PT, OT, etc.) can be provided only by a provider credentialed in that discipline
- Different perspectives provided on who can provide special instruction; educator vs. other providers.
- Concern was expressed about the existing qualifications for personnel; that personnel with the accepted credentials may not have the background and skills to provide appropriate services (example: consumer certification).
 - Credentials are not the same as qualifications. Providers must have the appropriate credentials AND must have the required qualifications. A statewide training and technical assistance system is required in provide the mechanism for achieving and retaining qualifications.
- Early intervention providers should be knowledgeable about and able to address all aspects of development, including knowing when to refer to/consult with a different discipline. A comment was made that many parents will insist on a specific discipline. Another participant responded that parent acceptance is impacted by how the information is presented.

Update Family Survey on Ability to Pay/Family Cost Participation: Over 4,000 surveys have been sent to parents, with over 400 responses received to date.

Service Coordination Survey

Comments on what was learned when completing the survey:

- “One person’s pro is another’s con” (one local system’s experience)
- “Based on the way we currently provide services”
- Individuals in our system had similar responses

Report Out from Small Groups:

Temporary Service Coordination

- Easier to meet the 45 day timeline because the service coordinator would not have to choose between working with a family in crisis and shepherding a new family through the intake, eligibility and IFSP process.
- Consistent information provided to all families
- Teams have better knowledge of individual provider strengths which would facilitate assignment of appropriate members for the assessment team

Would/might require for success:

- All of the information the TSC receives from the family would need to be written and transmitted to the ongoing SC so the family doesn't have to repeat info.
- TSC and OSC in same agency.
- Face to face meeting with TSC and OSC.
- Informing families upfront that they will start with one person and switch to someone else.

Sue reported that many states call the person serving in this role the intake coordinator. Benefits include higher rate of meeting 45-day timeline as a result of individuals with the specialized skills required for these functions focusing specifically on these particular functions. In addition, service coordinators who do both functions are not pulled away from the intake functions to deal with crises for families they serve in an ongoing service coordination role. Pros of this system include a positive impact on quality and training (different skill set for TSC than OSC) and funding efficiency.

Sue responded to concerns that this is problematic to families because of having to get to know and "bond" with two different people. She reported that families she has talked with have not have issues with being involved with two different people in states where this is implemented. Families have responded that they just want to "get through" the process to learn whether their child is eligible.

One system manager reported that separating the functions has been very successful. Another system manager reported that in their system, one SC serves both functions and this works well. The difference in localities may impact what works most effectively, for example for a system with a large geographical area.

Independent Service Coordination (Service Coordination from a Different Agency)

- Doesn't have an inherent conflict of interest as do all other models

Challenges:

- Communication between teams
- Mechanism to deal with grievances
- Compliance – how can local system assure that the SC provided is appropriate, high quality and that Part C requirements are met, and what can the local system do if they are not meeting the requirements

How would this work?

- Some states have independent providers who provide service coordinators
- Some states use nurse who is with SCHCN
- Partnering with other early childhood programs, home visiting programs

Sue expanded on the requirements and potential benefits of this approach:

- All service coordinators are trained in Part C.
- Service Coordination capacity is increased.
- Builds in the capacity to continue service coordination beyond age three for individual children

Cautions:

- Need diversity in caseload
- Need good supervision

Need to decide whether the partner agency providing service coordination would provide the Part C components of service coordination as an in-kind service through their agency.

Phyllis commented that what the group was commenting in terms of what is needed by the local teams from the service coordinators is exactly what the state needs from 40 different local systems. Upgrading the ITOTS to facilitate this flow of information at the state level is essential to ensure timely and accurate communications, and ensure that data-driven decisions are made at the state level with local input.

Dedicated Service Coordination:

- Clear relationship between service coordinator and provider from family's perspective – family better understand roles of service coordinator
- One master record exists for child
- Training is easier to accomplish
- Oversight of delivery of services is easier
- Good continuity of services, including
- More efficient model; Service coordinators can serve more; providers can serve more
- Continuity for family – always keep the sc
- Can be experts in their area
- Facilitates teamwork by being together
- May know the local provider skill sets better

Issue was raised about potential loss of local money if they are not directly connected with the service coordination – related to lack of trust because they are not part of their agency and the local agency doesn't know how they are assuring quality and monitoring services

Blended Service Coordination

- Pays provider for what s/he does (i.e., providers naturally do service coordination functions during contacts with families)
- Providers know the child and family best
- Families know their provider best; more likely to call provider
- More bang for your buck. Less expensive than having two people meet with families
- Too many cooks spoil the pot
- Families sometimes put more stake in what provider vs. what service coordinator says/does

Cautions:

- How does provider/service coordinator monitor the services (monitor self?)
- Inherent conflict of interest - who does the family complain to about the service provider
- Difficult to teach Part C service coordination in addition to Part C provider requirements

- Providers who work for private agency and are bound by productivity expectations.
- Concern that while the provider as service coordinator does collaboration with the rest of the team but may not do the other aspects – monitoring IFSP, addressing housing and other family needs beyond coordination of the supports and services

Discussion/Comments:

- A comment was made that the core function of Part C Service Coordination is protection of family’s rights and this requires a dedicated service provided. Another participant disagreed with the suggestion that family rights can’t be protected if the provider is the service coordinator.
- Dedicated service coordinators provide support to therapists who are asked by families to increase services beyond intensity/frequency identified by the IFSP Team. “Dedicated SC have a different set of skills and do service coordination better.”
- One local system has three models and use whichever is needed by the individual family:
 - Blended for families who are able to advocate for themselves
 - Some families need minimal service coordination assistance, though they do need someone who is overseeing supports and services. This is a dedicated model.
 - Dedicated for families who need extensive service coordination.
- Sue reported that she has seen service coordinators working beyond their level of training and expertise, when social work should have been called in.
- Monitoring and supervision of service coordinators is critical to the effectiveness of service coordination
- There are different mechanisms for funding service coordination through Medicaid

Family Comments:

One parent commented that she could argue the case for each model. She reported that after listening to the group conversation, she sees the benefit of the TSC. For her, building a relationship was not the primary issue in the beginning.

Another parent reported that ongoing service coordination is more family friendly; that it is a problem to deal with a number of people, and telling their story over and over is stressful. A comment was made that, though she received the blended model of service coordination and it worked fine for her, she would probably choose the dedicated model. Concern was expressed about basing the model on the funding or where the family lives.

Outcomes of Service Coordination (Generated By The Stakeholder Group)

- Children and families receive the supports and services they need
- Families are provided with procedural safeguards
- Families are assisted with transition
- Families are linked to resources
- Families learn what they need to learn in order to make informed decisions and function effectively day to day
- System does what it is supposed to do on behalf of families
- Families receive assistance with problem solving during crises
- Communication between team and Medical Home is achieved
- Families learn to advocate for their needs
- Families feel that they are better able to meet their child’s needs

Criteria to achieve SC Outcomes (Generated by the Stakeholder Group)

- Staff training and experience
- Appropriate caseloads and time to accomplish tasks
- Adequate supervision
- Adequate tools (phones, computers, etc)
- Families feel that they are better able to meet their child's needs
- Evidence in helping families making informed decisions
- Compliance with regulations
- Adequate service network (enough providers with appropriate diversity)
- Cultural Competency
- Equity across the state (fairness)
- Consistency across the state

There was disagreement about whether all of the models would meet the identified criteria and outcomes. Several people commented that any of the models could either meet or not meet the criteria. Two people responded that it is critical that equity and consistency be assured across the state and concern that not all of the models could assure this.

- Equity and consistency need to be defined
- Structuring processes through standard documentation is one mechanism for promoting consistency and equity
- Some states have put heightened monitoring on some models as a means of working toward consistency and equity
- Sue talked about the importance of assuring quality for families – focusing on monitoring the process and not rushing families through the intake, evaluation and assessment, IFSP process

Recruiting Providers

Sue shared some strategies with the group that were very successful in recruiting providers. The state found that many of the providers who began by working only a couple hours/week to start increased their hours over time. They conducted provider enrollment forums throughout the state to generate interest in EIS.

Stakeholders commented that training, supervision and oversight of providers who are seeing only one or two or a few is very challenging and expensive. Billing can also be an issue.

Note: Clarify and respond to Anne's question about reimbursement for providers who work limited hours.

Matching the Medicaid Initiative to the Service Pathway.

Sue directed the group's attention to the Service Pathway she developed (see attached document) and made the following comments:

- Some of the functions could be collapsed together. Some cannot due to need to provide written prior notice between the functions.
- Issue of written prior notice.
 - Federal language just says reasonable;
 - Virginia has defined reasonable as 5 days.
 - Must state why we are doing it and explain to the family about the implications.
- Regardless of the Service Coordination Model, families should not have to tell their story more than once. Communication of this information is a responsibility of the public system, and needs to be ensured for service coordination as well as with all members of the team.

Review of Virginia's Service Pathway

Sue asked for reactions and comments from the stakeholders about the Virginia Service Pathway that was developed in December 2006. She commented that she will remove the references to local procedures that are not statewide requirements for the pathway. She also advised the stakeholders that OSEP does not require consent for referral. This is to prevent delay of referrals to the early intervention system. In fact, there could be negative ramifications for the state if there were delays because systems were waiting for parent consent before accepting referrals.

Sue asked group to see if there are things they would change in the service pathway based on the proposed regulations and/or based on today's discussion.

Draft regulations have added the option to include results of screening as one of the components for determining eligibility. Eligibility is not a test; it is a process of analyzing information that may include referral information, results of screening (prior to or after referral to Part C), information from the family, medical record information. It must be done by two different disciplines. It does not require the presence of family and does not require a face-to-face meeting of the professionals who are determining eligibility. The sole purpose of the evaluation is to determine if the child meets the criteria for eligibility.

Sue requested that stakeholders ask the individuals in their system who determine eligibility the percent of time that the eligibility team knew before doing any testing that the child was or was not eligible.

If a physician did a developmental screening specifically for referral to Part C, the MD would be considered a member of the team. Medical records received from physicians or others do not make the author of those records part of the IFSP team if the information in the records was not directly related to determination of the child's potential need for Part C Services.

Comprehensive developmental screening by the child's Medical Home or by other professionals such as home visitors, nurses, etc. could be an important component for the evaluation for eligibility. It is important to recognize that what the physician observes in their office must be checked in other environments.

Assessment for program planning follows determination of eligibility. A tool is needed initially to determine a baseline and for ongoing assessment for monitoring process.

A question was raised about whether OSEP permits the assessment and IFSP to be done on the same day. The Part C Office will need to pose this question to OSEP.

Comments were made that there are tremendous implications for funding if it is not permissible to have the assessment and IFSP on the same day. One stakeholder said that one advantage of doing the assessment and IFSP on different days is that it moves the control of the IFSP meeting away from the therapists and possibly could facilitate the continued efforts to move away from a deficit-based model of intervention.

Sue asked the stakeholders to consider what is best for families -- regardless of what OSEP says is permissible.

Sue asked the stakeholders to talk within their systems about the service pathway and about the comments that were raised and to email Sue about what they are hearing.

The service pathway has implications about how the reimbursement is constructed.

This is the window for making changes. It is a golden opportunity to thoughtfully consider what is best for families and consider how we could construct the change to promote what is best for families.

Sue commented that changing the process for determination of eligibility would result in cost savings for Virginia because it would eliminate/decrease the cost for testing so many children that are found ineligible. Every child/family would go through the intake process and receive an evaluation for eligibility, which would be a review of information. Assessment with a tool would not be done for all children as part of the evaluation process as is currently done.

Sue's response re: Question:

Are two disciplines required to conduct the assessment?

Sue's Response: I did review the regs (attached) and wanted to be sure that the requirement of the MDT was in the assessment section (which it is) and then to return specifically to the MDT definition. This definition is:

*As used in this part, multidisciplinary means the involvement of **two or more disciplines or professions** in the provision of integrated and coordinated services, including evaluation and assessment activities in Sec. 303.322 and development of the IFSP in Sec. 303.342.*

If VA recognizes service coordination as a separate "discipline" which can be a recognized team member in the determination of eligibility, assessment and IFSP, this person would "count" as one of the "two or more ..."

Further, if VA then says (as I think the group implied), that the service coordinator could also be a nurse (example), then the discipline of the nurse would be recognized as one of the "two or more" team members even if the service coordination was not a recognized "team" member for the purposes of evaluation and assessment.

The questions I would pose back to the stakeholders is "what is good or best practice?" Is one person a "team" – can one person have the skills of both the discipline and service coordination and practice them simultaneously? It is good or best practice to have a single person making these kinds of decisions with and for families?

IFSP participation is clear that the family must be present, but there is no similar requirement for the **Evaluation for Eligibility**. This decision must, obviously, be communicated to the parent and written prior notice would require that who is involved, the process for making the decision, etc., is provided to the family beforehand.

I would add that most states do not recognize the service coordinator as a "discipline" for the purposes of the team composition for eligibility or IFSP development. These folks are seen as the facilitators, keeping things on track, recording decisions, etc. Having "dual" roles (e.g., service coordinator and nurse) is not the general practice in other state Part C systems.

Next Meeting: Friday, **March 14, 2008** from 9:00 to 2:00. Location to be announced.