

Early Intervention Transformation Implementation Task Force
April 13, 2009

Participants: See attached list

Purpose of Task Force:

- Identify implementation issues
- Provide input to be considered for final decisions
- Identify implementation strategies

Discussion Guidelines

- Solution oriented approach
- Stay on topic
- Listen to understand all perspectives
- Keep the focus on statewide consistency
- Recognize the interrelatedness of issues
- Keep requirements in mind as potential solutions are offered

Tammy Whitlock provided a brief overview of the Medicaid Initiative. The Medicaid Initiative was begun 2 years ago for the purpose of maximizing Medicaid coverage for children enrolled in Part C and Medicaid. Some decisions have been made and others are in process. Some decisions are governed by regulations and cannot be changed. Input is needed from the task force to identify implementation issues and strategies for addressing the various issues in order to implement the initiative consistently across the state.

Beth Tolley provided updates on personnel requirements. The personnel requirements meet both the requirements for the Medicaid Early Intervention Initiative as well as the Federal Part C Requirements for a comprehensive system of personnel development. Beth referred attendees to the Transformation section of the Website (<http://infantva.org/ovw-Transformation.htm>) for the current documents related to personnel requirements including:

- Provider Qualifications and Responsibilities Table
- Training/Competency Requirements for Early Intervention Certification
- Personnel Qualifications Questions and Answers – Updated 3/25/09
- Infant & Toddler Connection of Virginia Core Competencies

The Provider Qualifications and Responsibility Table was reviewed briefly:

- Changes in terminology were identified
 - Professional (listed as specialists in previous documents)
 - Specialists (listed as early intervention assistants in previous documents)
 - Elimination of the term “developmental therapy
- (Physical Therapist Assistant is incorrectly listed as physical therapy assistant; this will be corrected)

The Training/Competency Requirements for Certification been revised to eliminate the 18 month requirement. Successful completion of four online training modules is required for certification, in order to cover all of the early intervention competencies. Deana Buck presented information about the training modules. Two modules have been pilot tested by approximately 40 individuals. The Child Development Module is ready to “go live” as soon as the server is ready. Pilot feedback for the Family Centered Practices module is being used to make final revisions to this module. The Service Pathway and the Practitioner Requirements modules are being written. Initial feedback from the individuals piloting the modules has indicated a range of time with an average of 2 hours necessary to complete the child development module including taking the module and the test. For the 2nd and subsequent modules, the pilot participants will provide input about the time to take the module or just the test. Several experienced early intervention practitioners have piloted going straight to the test for the Family Centered Practices and were able to successfully complete the test in 11 – 14 minutes. Deana invited anyone interested in participating in the piloting to contact her. Successful completion of a module as a pilot participant counts toward meeting the early intervention certification requirements. Deana also reported that the supervision module, which will address supervision requirements specific to early intervention, is also in process.

The Personnel Qualifications: Questions and Answers has been updated to reflect the changes in requirements and terminology.

DMHMRSAS is in the process of developing emergency personnel regulations as authorized by the General Assembly.

Work is continuing on development of a practitioner database which will be an ITOTS Application. This database will provide the mechanism to tract the certification process and maintain the list of practitioners who are certified as Early Intervention Professionals, Early Intervention Specialists and/or Early Intervention Service Coordinators. This database will enable lists of providers to be generated for the purpose of family choice of provider and for identification of qualified early intervention providers for Medicaid MCOs .

A brief update was provided on the Service Pathway. Current materials related to the service pathway are posted on the Infant & Toddler Connection Website in the Transformation section. (<http://infantva.org/ovw-Transformation.htm#SvcPath>). Documents include the Service Pathway Chart, the draft practice manual, Eligibility Determination Questions and Answers, and Service Pathway Questions and Answers. Beth clarified that the date for statewide implementation of the service pathway and the practice manual has been moved to October 1, 2009 to be consistent with implementation of the Medicaid Initiative. The service pathway is being implemented to provide a consistent framework within which family-centered, individualized planning occurs for each child and family. It address issues identified through review of Part C data which shows that approximately half of the children referred to the Part C System actually go on to receive services. A number of local systems have self-identified as

“early implementers” and are receiving technical assistance from the state Part C Office as they develop their local processes for eligibility determination, etc. Preliminary feedback from several systems indicate that implementation of this process has the potential to get children to services more quickly and reduce resources used for children who are found not to be eligible. Beth asked that any local systems who wish to implement the process early contact their regional technical assistance consultant (Karen Durst, Beth Tolley or Bev Crouse) for assistance.

Tammy Whitlock and Brian Campbell provided information about the status of the Medicaid Initiative.

- Though discussed initially, the Medicaid Early Intervention Initiative does not include service coordination or administrative claiming. This decision was made in response to the federal issues and uncertainty with CMS reimbursement for service coordination
 - Targeted case management will continue to be available with no changes associated with the Medicaid EI initiative.
- DMAS is in the middle of the regulatory process. Both DMAS and DMHMRSAS will be promulgating emergency regulations in response to General Assembly Budget Amendments. The DMAS regulations will indicate that only Early Intervention Certified providers will be reimbursed for early intervention services.
- The State Plan Amendment will follow promulgation of the regulations and will be consistent with those regulations.
- DMAS is in the process of defining the claims process. The process will include enrollment, reimbursement and reporting (enrollment and claims)
 - Codes. DMAS is developing 8 EI codes. They will be HCPCS (Healthcare Common procedure Coding System) codes rather than CPT codes. Providers will bill using their NPI number
 - There will be nothing to prohibit billing for EI and through Rehab for those children who have medical service needs in addition to EI needs, as is the case now for children receiving therapy through the school system as well as medically based services through Medicaid rehab. Brian and Tammy requested that providers let them know if they encounter issues with being able to bill for a child who needs both medically based services as well as EI (or school system) services. DMAS will work with Keypro (preauthorization agency) to be sure they understand this.
 - Beginning July 1, 2009, rehabilitation reimbursement will no longer include a cost settlement component
- MMIS system: The system will allow for enrollment (and identification) of children enrolled in Part C and certified early intervention providers. Reports will be able to be generated including child-specific Medicaid reimbursed EI and non-EI services
- Pre-authorization will not be required for children with fee for service Medicaid coverage.
- Medicaid Managed Care Organizations
 - Early Intervention Services will not be carved out of the MCOs
 - MCOs may require preauthorization

- It is expected that the reimbursement by MCOs will be closer to the fee for service reimbursement than is currently the case. Current reimbursement is impacted by the inability to distinguish which children are receiving Part C services and which providers are early intervention providers. The combination of changes in how services will be reimbursed (use of HCPCS codes for fee for service and for MCOs), established early intervention rates and the ability to distinguish EI providers with specific qualifications is expected to have a positive impact on reimbursement by MCOs
- A DMAS representative from the MCO division will be joining the Task Force
- EPSDT Manual (Early Intervention Chapter)
 - The outline has been drafted by DMAS and an initial review has been done by Part C
 - The DMAS manual will be consistent with Part C Manual
- Quality Review will be the responsibility of the state Lead Agency

Identification of Implementation Issues

The following list includes issues and specific questions generated by the task force members today as well as issues and questions that had been identified previously. The issues will be organized and grouped by DMAS and DMHMRSAS and prioritized according to which decisions or answers are required in order to meet DMAS and/or DMHMRSAS deadline requirements (such as development of the Local Contract for Continuing Participation in Part C).

Allocation

- Initial
- Ongoing
- Funding for and documentation of expenses –
 - child specific services
 - other expenses (system expenses)

Data System

Family Fees

- What is included in family fees?
- Billing
 - Who is responsible for billing?
 - State, local lead agency
 - How is amount to bill calculated and tracked?
- Collection of Copays
- How deductible is considered
- Family Fee Scale

Consumer Choice

- LLA responsibility for contracting with any qualified provider
- Choice of agency vs. individual practitioner
- Choice of targeted case manager (only CSBs can bill for TCM)

EI Rates

- What is included in the \$150 and \$110 rate?
- How is reimbursement rate impacted when provider does not provide all of the services that were considered as making up the rate
- How is the difference between private insurance reimbursement and the EI rate handled?
- What is the family's responsibility if they allow insurance to be billed, but do not participate in Family Cost Share

Reimbursement

- Which elements of the service pathway are reimbursable by which payment sources
- Is it permissible to bill for 90 day TCM if eligibility is determined through a process of review of existing documents rather than through use of formal assessment procedures?
- If Medicaid EPSDT does not pay for assessment that is required in order to determine eligibility (for those children for whom eligibility can not be determined through review of existing information), can Medicaid Rehab be billed for that service? Is Part C responsible
- Billing through EPSDT will involve use of HCPS codes. Providers bill private insurance companies using CPT codes. How can they bill Medicaid as secondary using a different coding system?
- Who will be responsible for reimbursement in situations where families loose their Medicaid coverage, then regain it later?

Private Third Party Payors

- State level work with Private Payor organizations

Certification Process

- Certification of practitioners prior to their being allowed to bill

Service Pathway

- Facilitating receipt of more complete information from MDs – MDs doing screening

Parking Lot (to be considered at a later date):

- Reimbursement for service coordination (non-TCM) and administrative claiming

PROCESS: Review and discuss; make a preliminary recommendation; send for comment to constituent groups		
Topic/Date	<i>Discussion and preliminary recommendation</i>	<i>Final decision</i>
Service Pathway 4-13-09	<u>Service Pathway</u> Brian Campbell said the following activities are reimbursable by Medicaid: <ul style="list-style-type: none"> ○ Assessment for Service Planning for children who are eligible ○ Team meetings with parent present ○ Assessment for Service planning 	•

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	<ul style="list-style-type: none"> ○ Intake, eligibility determination, etc are reimbursable activities for TCM <p>He stated the following are not reimbursable by Medicaid</p> <ul style="list-style-type: none"> ○ Eligibility Determination, including more in-depth assessment for children whose eligibility determination requires direct assessment and who are found not eligible ○ Screening by EI providers is not reimbursable as an EI service ○ Team meetings that do not include the family <p>Questions raised include:</p> <ul style="list-style-type: none"> ○ Can 90 day TCM be billed for a child who is determined not eligible through eligibility determination process that doesn't include assessment of the child using an assessment tool? <p>For those situations where eligibility cannot be determined on the basis of the available information, including MD reports, screening results, observation of child, parent interview and for which assessment is needed, the assessment can be limited to a targeted assessment simply to gather the additional information needed unless the child is found to be eligible.</p> <p><u>Preliminary recommendations or decisions:</u></p> <ul style="list-style-type: none"> ● Color code the Service Pathway chart to indicate which services are reimbursable by Medicaid ● DMHMRSAS and DMAS will further discuss the question about reimbursement for assessment for those situations where the child is found not eligible. ● DMHMRSAS will research the question about billing for 90 day TCM requirements in situations where a child assessment with an assessment tool is not used. 	
<p>Family Cost Share</p> <p>4-13-09</p>	<p><u>Family Cost Share</u></p> <p>The following materials were sent to the task force members and reviewed today:</p> <ul style="list-style-type: none"> ● Family Cost Share: Responses to Issues Raised at December Stakeholder Group Meeting ● Fee Scale Options (Option 1, Option 2, Current) ● Determination of Family Cost Share: Flow Charts ● Family Cost Participation (Discussion Guide) <p>The following questions or concerns were raised:</p> <ul style="list-style-type: none"> ● Deductibles as the family's responsibility was discussed: <ul style="list-style-type: none"> ○ Concern was expressed that families may decline to receive services if they have a high deductible and are thus responsible for the full charge for the services until 	<ul style="list-style-type: none"> ●

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	<p>their deductible is met. It was not clear how extensive an issue this is.</p> <ul style="list-style-type: none"> ○ The draft practice manual indicates that high deductibles can be taken into account as an extraordinary expense when looking at the family cost share. ○ Need to consider the possibility that families being responsible for the full cost of a therapy service until their deductible is met could influence service decisions. For example, the IFSP team may decide to pursue special instruction because insurance (and the family's deductible) would not keep them from immediately accessing the fee scale. ○ Collection of deductibles has not been consistent across the state ○ A comment was made that the deductible is a family responsibility for their entire health coverage and using Part C funds to meet the family's health insurance deductible is not appropriate. More information was requested about the basis for the decision not to include the deductible in the family cost share. ● Clarity is needed regarding co-pays <ul style="list-style-type: none"> ○ Co-pays cannot be waived. Providers agree that co-pays will be collected when they contract with third party payors. It doesn't matter if the provider collects the co-pay or Part C collects it. There must be documentation that the co-pay was billed in order for providers to meet their contractual obligation with third party payors. ● What amount will the family be responsible for if they allow their insurance to be billed, but did not provide tax information in order to participate in the family cost share? Would they be responsible for their copay or for the difference between the insurance reimbursement and the \$150 EI rate. Concern was expressed that this could potentially mean the family has a higher cost to participate in Part C than if they were to receive services privately outside of the Part C system. ● The Part C Office and DMAS are working internally to address how to handle the situations where families decline to use their private insurance, but have Medicaid as secondary. ● There should never be an issue of Medicaid not being billed when Medicaid is primary because use of Medicaid will never 	

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	<p>result in a loss of coverage, reduction of coverage or escalation in cost of the insurance. Education of individuals with Medicaid coverage may be necessary to help them understand this. It was pointed out that the Medicaid flow chart on the Determination of Family Cost Share: Flow Charts needs to be revised to reflect this.</p> <ul style="list-style-type: none"> • Discussion about assistive technology and FCS included: <ul style="list-style-type: none"> ○ If third party reimbursement covers the major cost of a piece of equipment (for which the total cost is over \$5,000) and Part C pays a small proportion, does the equipment still belong to Part C even though the family's insurance covered the major cost of the equipment? ○ Can options be provided for Part B or for families to purchase the equipment at a pro-rated cost when the child leaves the Part C system • Concern was expressed that the original Family Cost Participation Stakeholder group has not had the opportunity to discuss the materials that were now being discussed by this task force. <p><u>Billing for and collection of family fees</u></p> <ul style="list-style-type: none"> ○ Need to be very clear about what "billing" means – does it include pre-authorization, tracking and follow – up as well as billing for the service that was provided ○ Billing by the state might make the most sense (per several comments) because it would be done consistently and efficiencies could be gained through consolidation. If billing was contracted at a state level (including pre-authorizations, tracking, follow up, etc., the state would have to have contractual agreements with the various private third party payors. ○ Could "billing" for children with Medicaid be done through an interagency "automated" arrangement? Must consider that fee for service makes up only about 25% of the population of Part C children with Medicaid coverage (about 1200 of the approximately 4800 children). ○ Billing is being handled consistently and without issues by some local lead agencies; in many others there are issues and inequities in how co-pays are being billed, collected and disseminated to providers ○ Parameters need to be defined regarding who can serve as the billing agency if billing is the responsibility of the local lead agency 	

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	<ul style="list-style-type: none"> ○ At least one local lead agency does not do any billing; technical assistance would be needed if billing becomes the responsibility of the local lead agency ○ Concern was expressed about management of the data for billing and collection of family fees (including co-pays and co-insurance, especially since the amount the family is responsible is not always known until some time after the service is provided). Allan Phillips reported that they have a data system that collects all of the information that has been discussed today. Fairfax is in the process of contracting for billing and their data system contains all of the information necessary for billing. Fairfax is making the data system to others who are interested in using it. Fairfax has demonstrated the data system to DMHMRSAS; internal meetings are occurring regarding state options, including how and if the Fairfax system relates to the Alaska system. <p><u>Fee Scale Options:</u> Considerations included:</p> <ul style="list-style-type: none"> ● A request by families to have the lowest cost possible ● Participating in Part C should not be more expensive for families than receiving services privately outside the Part C system ● Need to consider the impact of reduced fees on the total Part C revenue. It has been reported that family fees account for approximately \$750,000 to \$1,000,000 of the total Part C revenue, but this number is very much an estimate as concrete data is not available. ● With the i\$150 and \$110 rates for EI services, and potentially less family fee revenue, where will the additional funding needed come from. The following were suggested. <ul style="list-style-type: none"> ○ Increased Medicaid reimbursement ○ Work will be done with private third party payors ○ System efficiencies ● Can the stimulus money be used to bridge the gap between implementation of the EI Transformation and full realization of the increased revenue? <p><u>Preliminary Recommendation/Decision:</u></p> <ul style="list-style-type: none"> ● The Task Force recommended Option 1 for the Fee Scale but requested that the original Family Cost Participation Stakeholder Group be brought back together for the final recommendation 	

PLANS:

- Meeting Notes and materials for the next meeting will be sent to the Task Force members in advance of the next meeting in order to give them time to share the materials with stakeholders
- Meeting Notes will also be posted on the Infant & Toddler Connection Website (<http://www.infantva.org/ovw-Transformation.htm>)
- The Part C Office will communicate with the Family Cost Participation Stakeholder Group
- DMHMRSAS and DMAS will prioritize the list of issues in accordance with decisions and information that is necessary to meet timeline requirements of the two agencies for implementation October 1, 2009

**NEXT MEETING: April 29, 2009
10 AM – 3 PM**

Tentative Dates for Future Meetings: May 8, May 20, June 1