

PROCESS: Review and discuss; make a preliminary recommendation; send for comment to constituent groups		
<i>Topic</i>	<i>Discussion and Preliminary Recommendations/Decisions</i>	<i>Final Decision</i>
Medicaid Reimbursement for Components of the Service Pathway	<p><u>4-13-09</u></p> <ul style="list-style-type: none"> • 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 • Intake, eligibility determination, etc are reimbursable activities for TCM • He stated the following are not reimbursable by Medicaid <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 • 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? • 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, assessment should be limited to a targeted assessment simply to gather the additional information needed unless the child is found to be eligible. <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><u>4/29/09</u></p> <ul style="list-style-type: none"> • The handout, <u>Reimbursement Sources for Components of the Service Pathway</u> was discussed. A corrected copy of the handout will be sent to the ITF members and posted on the web. 	•
Billing Medicaid	<p><u>4-29-09</u></p> <ul style="list-style-type: none"> • Brian Campbell stated that when Medicaid is the secondary payor, the provider should bill the private insurance first using whatever code the payor 	•

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	<p>requires; then bill Medicaid using the required Medicaid codes and forwarding documentation of the reimbursement from private insurance.</p> <ul style="list-style-type: none"> • Providers must continue to check children’s eligibility each month for Medicaid 	
Medicaid MCOs	<p><u>4-29-09</u> <u>Implementation of Changes by Medicaid MCOs</u></p> <ul style="list-style-type: none"> • Concern has been expressed by some MCO’s that providers will seek higher reimbursement than the standard rate that is being established since the provider pool will be limited to only those providers who have Early Intervention Certification. Part C is working with DMAS to address the standard rate requirement through the Local Contract. Part C Providers cannot charge more than the standard rate. • Another potential issue for reimbursement by MCOs is concern among some about non-therapists (for developmental services). The MCO contract is changing and will require that MCOs use EI Certified providers. The contract will not say they have to use specific certified provider. It doesn’t say they have to use every provider category. But if one is appropriate and they are not paying for it, the family can file a complaint and this can be addressed. • MCOs will receive a cap adjustment from the match money to offset their higher reimbursement for EI • Tammy and Brian will talk with MCOs about transition to be sure there is no break in services. • The codes for billing MCOs will be the same codes used to bill children covered by Medicaid Fee for Service • Implementation of the new data elements for the DMAS data system and the data exchange that will occur between DMAS and DMHMRSAS will allow MCOs to know immediately if a child is in EI when the MCO receives the list of new enrollees. • Tammy requested that providers let her know if/when there are issues or problems. 	<ul style="list-style-type: none"> •
Rates and Reimbursement: Cost of Living Adjustments	<p><u>4-29-09</u></p> <ul style="list-style-type: none"> • A question was raised about whether adjustments for cost of living increases could be built into the rate. This would have to be included in the reimbursement regulations. <p><u>Preliminary Recommendations/Decisions:</u></p> <ul style="list-style-type: none"> • DMAS and DMHMRSAS will look into inclusion of cost of living adjustments in the rate structure. 	<ul style="list-style-type: none"> •

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<p>Rates and Reimbursement: Private Insurance</p>	<p>4-29-09</p> <ul style="list-style-type: none"> SOLUTIONS has prepared a Rates report. This document is being reviewed by the Part C Office and DMAS. Mary Ann reported that this will be disseminated following the review by DMHMRSAS and DMAS. <p><u>Preliminary Recommendation/Decision:</u></p> <ul style="list-style-type: none"> Use reconciliation process to determine Part C portion of the standard reimbursement rate for each child (after the primary insurance and family fee up to the monthly cap is paid for each service). 	<ul style="list-style-type: none">
<p>Rates and Reimbursement: Taking into Account Functions Incorporated into the Rate but Not Performed by the Provider.</p>	<ul style="list-style-type: none"> How is the cost calculated and captured for functions provided by the LLA rather than by the provider? When is a contractor considered a contracted employee for the purpose of determining the payment to the individual for providing services? <p>(To be addressed May 8, 2009)</p>	<ul style="list-style-type: none">
<p>Family Cost Share: Billing and Collecting the Monthly Family Fee</p>	<p>4-13-09</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). <ul style="list-style-type: none"> 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 At least one local lead agency does not do any billing; technical assistance would be needed if billing becomes the responsibility of the 	<ul style="list-style-type: none">

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Family Cost Share: Billing and Collecting the Monthly Family Fee (cont.)	local lead agency <ul style="list-style-type: none"> 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>4-29-09</p> <ul style="list-style-type: none"> Clarification was provided that today's discussion was about centralized billing for family fees, not about centralized billing for all fees. Comprehensive fiscal data is needed from the state to document Part C payor of last resort (POLR) <ul style="list-style-type: none"> Must document that co-pays are billed. Discussion about whether documentation that they are billed is sufficient (vs. documentation of whether they are collected) Concerns raised about centralized billing by the state included: <ul style="list-style-type: none"> Some local systems have effective system in place and see no need to change what is currently working for them Is it possible to get a system in place for centralized billing by the state by October 1, 2009? Clarification was provided that if the billing was done by the state, it needed to include billing for all systems, otherwise we are back to 39 options about who will bill. Several participants requested that local systems be allowed to continue their current processes for billing which involves assigning who will collect the co-pay for each child rather than having one entity responsible for billing the family fees in each local system. It was suggested that more TA be provided to the local systems which do not have an effective system in place and that the contract requirements for data reporting be enforced. States with centralized billing include Massachusetts, Connecticut, Indiana and Kentucky Concerns expressed about continuing with current processes for billing the 	<ul style="list-style-type: none">

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<p>Family Cost Share: Billing and Collecting the Monthly Family Fee (cont.)</p>	<p>family fees included:</p> <ul style="list-style-type: none"> ○ Fairness and consistency for families ○ Families will receive multiple bills for (portions of) the family fee (from providers and the local lead agency) when the family has services for which there is not a third party payor ○ Inconsistencies in billing and collection of family fees will continue ○ Greater opportunity for errors in billing when billing is done by multiple entities ○ Required data about family fees will continue to be unavailable to the state ○ Despite contract language and TA, the current system has been implemented inconsistently and required data has not been provided to the state. ○ As the changes are made with the EI System transformation, what is currently working may no longer work ○ Now is the time to make changes in billing practices while the other changes are occurring in the EI system. Lack of action now will leave the system with the same issues and problems a year from now. <ul style="list-style-type: none"> ● Suggestions to address concerns included: <ul style="list-style-type: none"> ○ Local systems who have an effective mechanism for billing assist those who do not ○ Build requirements for provision of data into the early intervention certification process (individual responsibility) ○ Strengthen language in the Local Contract for provision of data ○ Improve clarity of Family Cost Share practice requirements to improve consistency of implementation <p><u>Preliminary Recommendation/Decision:</u></p> <ul style="list-style-type: none"> ● Local Contract will specify that collection of the family's co-pay must be assigned to one entity for each child (using language similar to language for the Medicaid Waiver requirements). ● Contract will specify that receipt of funding will be contingent on meeting the contract requirements for provision of the required data ● Contract will specify whether the amount billed vs. the amount collected is to be reported. ● Part C Staff will look at the draft Part C Certification Application and see if provision of data is captured in assurances section ● Provision of the required data is a local lead agency requirement. The 	

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<p>Family Cost Share: Billing and Collecting the Monthly Family Fee (cont.)</p>	<p>local lead agency must collect the information from the providers in their system and provide all of the data for their local system. (It will not be acceptable for local lead agencies to provide partial data and for providers to provide aggregated data directly to the state).</p> <ul style="list-style-type: none"> • Subgroup will address FCS practices document • Begin process of identifying what is necessary (including automated data system) to move to centralized billing for family fees. Mary Ann Discenza will begin the discussion with the DMHMRSAS IT staff this week. 	
<p>Family Cost Share: How will deductibles be handled?</p>	<p><u>4-13-09</u></p> <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 their deductible is met. It was not clear how extensive an issue this is. • 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. <ul style="list-style-type: none"> ○ 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. • 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 co-pay 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. 	<ul style="list-style-type: none"> •

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Family Cost Share: How will deductibles be handled? (cont.)	<ul style="list-style-type: none"> There should never be an issue of Medicaid not being billed when Medicaid is primary because use of Medicaid will never 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. 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 	
	<p>4-29-09</p> <ul style="list-style-type: none"> Participants indicated that clarifications are needed in the Family Cost Share Practices (draft document) regarding determination of extraordinary expenses, how deductibles are handled, and consideration of flexible spending accounts. <p><u>Preliminary Recommendations/Decisions:</u></p> <ul style="list-style-type: none"> A subgroup will be formed to improve the clarity of the Family Cost Share Practices and reduce places where there are options for discretion (and therefore possibilities of less consistency). It was suggested that documents written for parents be written on an 8th grade level. Requests were made to define terms. The subgroup will meet via teleconference. Members of the subgroup include: <ul style="list-style-type: none"> Joanne Boise (worked with Care Connection for Children practices to address similar concerns) Deana Buck (representing the Integrated Training Collaborative) Medicaid representative SCC representative Tracy Miller (private provider) Kathy Pierson (has experience with intakes) one more service coordinator Debra Holloway and Heidi Faustini (Family Involvement Project) Sophia (Virginia Office of Protection and Advocacy) Debra Holloway was asked to spearhead development of a brochure for 	<ul style="list-style-type: none">

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	families	
Family Cost Share: Declining Use of Insurance because Insurance is being used to cover private services	<p>4-29-09</p> <ul style="list-style-type: none"> • Are families allowed to decline use of insurance because they are using the insurance for private services • Sophia said that they see a fair number of this and in one situation child would have not done nearly so well if not for the additional services • Examples of situations where child needs rehab services post surgery as well as EI services. DMAS pays for both. Need to work with private insurance so they will follow suit. • Is it ok to decline use of insurance to use it for private insurance when team disagrees with the need for additional therapy than recommended by the team • The subgroup formed to clarify Family Cost Share Practices will address this. 	•
Family Cost Share: Procedures and Responsibilities When Families Who Have Both Private Insurance and Medicaid Decline Billing of Their Private Insurance	<p>4-29-09</p> <ul style="list-style-type: none"> • One of the premises of the Medicaid EI initiative is that Part C will not pay for services for children who have Medicaid coverage. <p><u>Preliminary Recommendations/Decisions:</u></p> <ul style="list-style-type: none"> • DMHMRSAS and DMAS will research options. 	•
Family Cost Share: Family Payment Responsibilities	<p>4-13-09</p> <ul style="list-style-type: none"> • Tracy Miller stated that 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. 	•
	<p>4-29-09</p> <ul style="list-style-type: none"> • If a family has insurance and allows it to be billed – but insurance denies covering the service, then the family is responsible for the entire part C rate or up to the monthly cap • For services for which there isn't a reimbursement source (TR, MT, etc) families are responsible for EI charge up to monthly cap 	•
Family Cost Share:	4-13-09	•

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Selection of Fee Scale Family Cost Share: Selection of Fee Scale (cont.)	Considerations for fee scale options included: <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. <p><u>Preliminary Recommendations/Decisions:</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 	
	<p><u>4-29-09</u></p> <ul style="list-style-type: none"> • Communication was sent to FCP Stakeholder group to inform members that the ITF will now be addressing the issues. Request was made for FCP members to contact ITF members with any input they have. • Tidewater and Kathy Pierson input – Biggest issue is help needed in being consistent across the state. Concern about options for discretion in FCS manual giving more leeway and possibility of less consistency across the state • ARCFIP recommends Option 1 	<p><u>Final Decision:</u> The Task Force recommended Option 1 for the Fee Scale</p>
Dissemination of Part C Funds	<p><u>4-13-09</u></p> <ul style="list-style-type: none"> • Concern was raised that with the \$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>4-29-09</u></p> <ul style="list-style-type: none"> • The Infant & Toddler Connection of Virginia is moving away from the process of “allocation” to the process of cost reconciliation. • Mary Ann reported 75% of the state and federal funds will be distributed to the local systems (based on 2 year average child count). The amount distributed in the 4th quarter will be distributed based on need which will be 	<ul style="list-style-type: none"> •

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Dissemination of Part C Funds (cont.)	<p>determined through completion (beginning July1, 2009) of the revised revenue-expenditure reporting form.</p> <ul style="list-style-type: none"> • There will also be dissemination of ARRA funds to each local system July 1 2009 with the possibility of additional ARRA funds in the fall. Systems who documented need for this fiscal year will also receive funds for FY09. ARRA funds must be spent by 2011. The ARRA funds can serve as “bridge” funding as the system transitions to the new practices. The State office is waiting for further guidance about how the funds can be used and the documentation requirements for these funds. A teleconference will be scheduled when that information becomes available. 	
Expense-Revenue Reporting	<p><u>4-29-09</u> Discussion of draft Expense-Revenue reporting and reconciliation form:</p> <ul style="list-style-type: none"> • The Expense-Revenue reporting form is being revised to: <ul style="list-style-type: none"> ○ Provide data required for OSEP and the general assembly ○ Document all revenue sources (as part of documentation of payor of last resort) ○ Provide mechanism for determining funds needed by each local system ○ Meet financial reporting requirements • The Expense-Revenue Reporting Form will drive the dissemination of Part C state and federal funds for FY11. FY10 will be used to refine the form and the reporting/reconciliation process. • David Mills explained the form <ul style="list-style-type: none"> ○ The first page provides documentation of costs, including services billed hourly (by 15 minute units) or monthly, services that are not included in the new reimbursement structure, and administrative costs ○ The 2nd page includes space to provide details about the administrative costs ○ The 3rd page is a revenue/expense reconciliation form, with spaces to list all revenue for the reporting period and all expenses for the reporting period. The costs from the first page automatically populate the third page; Totals are calculated by the form. • Decisions have not yet been made about the frequency of reporting (monthly or quarterly). It is possible to develop the form to be able to record monthly expenses and quarterly revenue – for quarterly reconciliations. • Discussion about the draft form include: <ul style="list-style-type: none"> ○ Service coordination categories – explanations and info is needed ○ The evaluation/assessment category should be replaced with “Eligibility 	<ul style="list-style-type: none"> •

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Expense-Revenue Reporting (cont.)	<p>Determination” and “Assessment for Service Planning”</p> <ul style="list-style-type: none"> ○ Where/how to document IFSP meetings ○ Correction of PT and OT (Assistant) labels on page 3 ○ Revenue to be reported is <u>what is collected during the reporting period</u>. (In other words, the revenue for specific services will likely show up in a later month from the expense) ○ Detailed instructions are needed for what is expected to be included in the administrative details section ○ Some providers indicated that they are able to report the revenue by child by local system now; others are able to, but it will take time and money to be able to do that level of reporting; concern was expressed that some provider agencies, such as hospitals may not be willing to invest the time and money develop the capacity to be able to report revenue by discipline by local system. ○ ARRA funding can be used to help systems and providers transition to collecting and reporting the information required on this form <p><u>Preliminary Recommendations/Decisions:</u></p> <ul style="list-style-type: none"> ● The form will be edited based on today’s discussion and will be sent to task force members who will disseminate the form for input, including input from fiscal staff in local systems and identification of TA needed for implementation. ● Consider the possibility of bringing together a service coordinator subgroup to address the questions raised around SC expense reporting. ● Jennifer Faison will request that the form be put on the agenda for the next CSB Data Management Committee meeting. ● It was clarified that Part C reporting will no longer be a part of the CSB Performance Contract requirements. ● Some task force members may bring fiscal representative to next meeting when this will be discussed again ● Questions to be addressed at the May 8 meeting include: <ul style="list-style-type: none"> ○ Will this new form be implemented July 1 or Oct. 1? (If July 1, need to recognize that the new reimbursement rates will not be in effect until October 1) ○ Will there be a standard rate for Eligibility Determination? ○ What TA is needed for local systems/providers for implementation 	
Personnel Qualifications: Do	<p><u>4-29-09</u></p> <ul style="list-style-type: none"> ● Practitioners must have their early intervention certification prior to providing 	<ul style="list-style-type: none"> ● Practitioners MUST be EI Certified in order to provide

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<p>practitioners have to be EI Certified in order to bill Medicaid for EI Services?</p>	<p>and billing for services.</p> <ul style="list-style-type: none"> • Processing the certifications will take longer initially when over 1000 applications will need to be processed during July – September. After that, the process should go very quickly. Practitioners will apply online. There will be a daily data exchange with VCU (for record of who has successfully completed the required training modules). Processing the application will include review of the application to assure that all requirements have been met including satisfactory completion of the training requirements, discipline specific requirements (such as current licensure) and that the assurances and acknowledgements have been signed. • Efforts are underway to provide information about the requirements to wide audiences including current providers, potential providers and students. <ul style="list-style-type: none"> ○ Faculty members of the Institute for Higher Education are discussing ways to incorporate the modules into the early childhood curriculum in their universities ○ Information is included in the updates and on the Infant & Toddler Connection of Virginia Website ○ Information is being shared at professional organization meetings and through newsletters 	<p>or bill EI services</p>
<p>Family Choice of Providers</p>	<p><u>4-29-09 Targeted Case Management</u></p> <ul style="list-style-type: none"> • TCM can only be provided by CSB, so families cannot be given a choice of agencies. If there are multiple TCM Case Managers within the agency, it is appropriate to offer a choice. Each agency must have a process in place to address concerns/requests for change in Case Managers, including the potential to contract with individuals outside the agency if necessary. <p><u>Early Intervention Services</u></p> <ul style="list-style-type: none"> • Providing families with a choice of agencies meets the requirement for providing family choice of providers. • Family choice must be documented for each family and there must be a process in place to address requests for a change in providers. • If there is only one EI provider within the family’s payor network, it isn’t possible to give a choice. That is just a fact. The local system must work to identify and contract with additional providers. If family finds a therapist who is certified, then you need to contract with that certified therapist. • Tammy said that it is not required that the local lead agency contract with a specific provider chosen by the family as long as there is a choice of 	<ul style="list-style-type: none"> •

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Family Choice of Providers (cont.)	<p>providers within the system. Tammy will pull the choice regulations to be sure on this.</p> <ul style="list-style-type: none"> • Participants discussed the requirement that local systems be required to contract with any certified provider if/when a family requests that their services be provided by a certified provider who is in their payor network. <ul style="list-style-type: none"> ○ Concern was raised that this should not be required if the system has enough providers to allow choice already, because the process for contracting is so complex and time-consuming for the LLA. ○ This concern was countered with a concern that family's choice and providers' ability to practice is limited if local systems limit who they will contract with ○ A representative from the Contracting Office at DMHMRSAS has indicated that because the contract will be with providers who have already been through a certification process and because the reimbursement is standardized, the contracting process for CSBs should be straightforward; procurement requirements should not be a barrier to contracting with any qualified providers. • A question was raised about families choosing providers/services from other Local Lead Agencies • Concern was raised that if all providers are from the same agency, the choice is limited to the approach/philosophy, etc. of that particular agency <p><u>Preliminary Recommendations/Decisions:</u></p> <ul style="list-style-type: none"> • Tammy will review the family choice regulations. • DMHMRSAS will research the requirements related to any willing provider. 	

The focus of the May 8 meeting will be financial issues:

- Revenue - expense form
- Reimbursement sources for each step of the service pathway
- Rehab reimbursement July - Sept
- Reimbursement when some of the functions incorporated into the rate are not provided by the therapist/agency providing the service