

PROCESS: Review and discuss; make a preliminary decision; send for comment to constituent groups		
Topic	Discussion and preliminary decisions and next steps	Final decisions
Review of Handouts	<ul style="list-style-type: none"> <li>Practitioner Qualifications, Responsibilities, Services and Reimbursement Codes</li> <li>Reimbursement Sources for Steps of the Service Pathway</li> <li>Reimbursement Categories (Color Coded Table)</li> </ul> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>The forms will be revised based on today's input, then posted on the Infant &amp; Toddler Connection of Virginia Website</li> </ul>	
Choice of Provider	<ul style="list-style-type: none"> <li>Brian distributed a copy of the Administrative Code related to Free Choice of providers – 12VAC30-10-490                             <ul style="list-style-type: none"> <li>Exceptions to free choice do not apply to EI services</li> <li>Enrollee can choose any certified Part C provider in their payor network</li> </ul> </li> <li>MCOs are required to go out of network if they don't have available providers.</li> <li>DMAS is working with the MCOs to develop a mechanism for transition between fee for service and an MCO and they will also work on transition between MCOs so there is no drop in reimbursement when a child's coverage changes from Fee for Service to MCO or from one MCO to another.</li> <li>The 2010 Local Contract states: <i>Local Lead Agencies must allow families to have access to any certified practitioner in the family's payor network and working in the local system area, contracting or otherwise arranging for services with the selected provider if needed to allow for exchange of Part C funds.</i> This language was acceptable to the task force.</li> <li>Concerns were raised about potential lack of control/oversight if provider does not have a contract with the local system. Providers must communicate with other IFSP team members.</li> <li>Several mechanisms will be in place to facilitate collaboration and provide for quality oversight:                             <ul style="list-style-type: none"> <li>Practitioners will need to sign an assurance on their EI Certification Application that they understand that they must have a relationship with a LLA in order to provide services for children served by that LLA</li> <li>The Contract or Memorandum of Agreement between the provider and the LLA should contain language related to quality and compliance</li> <li>The state Part C Office will be providing quality reviews as part of the early intervention Medicaid Initiative. Providers (agencies or independent practitioners) are subject to pay back if reviews indicate that requirements were not met.</li> </ul> </li> <li>A suggestion was made that ethical standards be addressed on the application for EI Certification (as one of the assurances). In particular, it was suggested that language be included that practitioner agrees not to see a child they are seeing through Part C additionally for private therapy unless the need for medically based services is discussed as</li> </ul>	<ul style="list-style-type: none"> <li>Choice of provider for Part C services is among certified Part C providers who participate in the family's payor network.</li> <li>If a family's Medicaid coverage changes to an MCO in which the current provider doesn't participate, the family will have to switch to a provider in their network, or the provider will have to agree to receive out of network reimbursement.</li> <li>It is not a violation of provider choice to limit the choice of practitioners to those who provide services in natural environments.</li> <li>Local Lead Agencies must allow families to have access to any certified practitioner in the family's payor network and working in the local system area, contracting or otherwise arranging for services with the selected provider if needed to</li> </ul>

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	<p>part of the IFSP team process and listed on the IFSP.</p> <ul style="list-style-type: none"> <li>A suggestion was made to develop a Practitioner Tool Kit that includes information about ethics, compliance requirements, etc.</li> </ul> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>The Part C Office will discuss the issue of state vs. local responsibility for quality of services when the provider does not have a contract with the LLA. This question will also be posed to the Office of the Attorney General.</li> <li>Ethics will be addressed in the Practitioner Certification module</li> </ul>	<p>allow for exchange of Part C funds.</p>
<b>Provider Requirements</b>	<ul style="list-style-type: none"> <li>In order to meet payor of last resort requirement, practitioners who wish to provider early intervention services must have a mechanism to bill third party payors, including Medicaid (either independently or through agency)</li> <li>Since provider choice is limited to providers within the payor network and since Part C funds must be used as payor of last resort, it is expected that providers will participate in as many payor networks as possible.</li> </ul>	
<b>Billing for Services and Contracting with Providers</b>	<ul style="list-style-type: none"> <li>Local systems can do their own billing.</li> <li>Individual therapists working for a provider agency (which can include a LLA) that is enrolled with DMAS to provide EI services can provide and bill services using the agency NPI number. The individual therapists working for the agency must be EI Certified, but do not need to be enrolled individually in Medicaid.</li> </ul>	
<b>Who receives the reimbursement rate?</b>	<ul style="list-style-type: none"> <li>The EI reimbursement rate is paid to the provider, whether that is provider agency or an independent provider (independent contractor).</li> <li>What is paid to the individual practitioner depends on whether they are an employee (which can include a contracted employee) or an independent contractor.                             <ul style="list-style-type: none"> <li>Just as a private therapy agency can determine the contract amount they will pay their contracted employees, LLA can determine the rate they will pay employees they contract with.</li> <li>If there is not an employee relationship, the provider is paid the standard EI rate. However, if some of the functions that are included in the standard EI rate are performed by/through the LLA, the cost of those functions can be "paid" by the provider to the LLA for performing those functions.</li> </ul> </li> <li>Information about distinguishing between contracted employees and independent contractors can be found at: <a href="http://www.irs.gov/businesses/small/article/0,,id=99921,00.html">http://www.irs.gov/businesses/small/article/0,,id=99921,00.html</a></li> </ul> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>The Part C Office will seek clarification about distinctions regarding employee vs. non-employee relationships, including consultation with the Office of the Attorney General.</li> </ul>	
<b>TPL – Third</b>	<ul style="list-style-type: none"> <li>So far, data collected from 13 local systems show that 6 families who have both Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>A process has been</li> </ul>

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<b>Party Liability</b>	<p>and private insurance have not given permission to for their private insurance to be billed.</p> <ul style="list-style-type: none"> <li>• Questions raised today included:                             <ul style="list-style-type: none"> <li>• Can a family make a statement that billing their insurance would impact them financially or do they have to provide proof or signature when they decline billing their insurance?</li> <li>• Is it permissible for families to decline use of private insurance because they are using their insurance for private therapy</li> <li>• What kind of proof would be needed regarding the lifetime cap?</li> <li>• How will families know if this is going to escalate their premiums?</li> </ul> </li> </ul>	<p>developed to allow for Medicaid billing for children whose family has declined billing of their private insurance.</p> <ul style="list-style-type: none"> <li>• The questions raised today and procedures for declining billing of private insurance are being addressed by the Family Cost Share subgroup.</li> </ul>
<b>Medicaid Codes</b>	<p>Brian provided a draft handout on the reimbursement codes. The following terms were defined:</p> <ul style="list-style-type: none"> <li>• Co-treatment – multiple professionals working with the child</li> <li>• Congregate - multiple children seen together in one setting by one provider. (In such a situation, the “congregate rate” would be charged for each child.</li> </ul> <p>Brian explained when various codes should be used:</p> <ul style="list-style-type: none"> <li>• The T1027 and G codes are used only for services in natural environments</li> <li>• T1023 should be used for Assessment and for the Initial and Annual IFSP Development. These activities can occur in any location.</li> <li>• T1024 can be used for IFSP reviews</li> <li>• If a PT is doing a treatment or assessment independently, s/he should use the G code. However if the PT (or OT or SLP or Nurse) is treating with other team members, then the T 1023 or T1024 code should be used.</li> <li>• Whatever is billed must be listed on the IFSP</li> <li>• Ongoing assessments should be billed using the G codes and for Reimbursement Category II providers, the T1027 codes (Ongoing assessment is an expected component of services and therefore not listed separately on the IFSP).</li> <li>• T1026 and T1015 are the codes to be used for individual or group intervention in center-based locations. The reimbursement is 60% of the rate for services in natural environments.</li> </ul> <p>Discussion:</p> <ul style="list-style-type: none"> <li>• Reimbursement (and the code to use) for services provided in a non-natural “neutral” environment for those situations (such as foster care) where the services cannot be provided in natural environments for family reasons were discussed.</li> <li>• Clarification is needed from the Part C office regarding whether the natural environments requirement applies to any assessments (such as a PT assessment that is determined to be necessary for a child who has an IFSP in place).</li> </ul>	<ul style="list-style-type: none"> <li>• There is no change is how Audiology, assistive technology, physician services will be billed with this initiative</li> <li>• AT devices are reimbursed through DME. Audiology is reimbursed through EPSDT. Dietary/nutritional services are only covered under the MIC program, so are not covered by DMAS for EI. Nutrition services can be covered through MD services (dietitian bills under MD).</li> </ul>

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	<ul style="list-style-type: none"> <li>Clarification is needed about when services provided in a center-based setting, such as going to a vendor's office to try out a variety of assistive technology is considered an assessment vs. treatment. The issues include how this should be written on the IFSP, whether it will be reimbursed at the standard rate (rather than the reduced center-based rate) if it is not considered "assessment" and the requirement that assessments not be billed to families or private insurance.</li> <li>Tammy indicated that there may be a mechanism to allow for billing for the standard EI rate for those situations where the services are not provided in natural environments for family reasons (foster care example).</li> </ul> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>Brian will revise the handout based on today's discussion, including addition the limits for each code.</li> <li>The Part C staff will develop guidance on:               <ul style="list-style-type: none"> <li>How to list specific circumstances such as congregate treatment, supervision visits by PT when a PTA is providing services, center-based assistive technology sessions, etc. on the IFSP</li> <li>Situations where it is appropriate for family reasons for services to be provided in settings other than natural environments</li> <li>Requirements about assessments including when/whether they must be in natural environments and when a service should be considered an assessment versus a consultation or ongoing treatment</li> </ul> </li> </ul>	
<b>Pre-auth</b>	<ul style="list-style-type: none"> <li>No preauthorization is needed for services once the child is enrolled for fee for service.</li> </ul>	
<b>Part C Non-payment for Medicaid Enrollees</b>	<ul style="list-style-type: none"> <li>The intention with this initiative is that Part C funds will not be used to pay for services which are covered by Medicaid for children who have Medicaid.</li> <li>Several examples of situations where Part C funds might need to be used were discussed:               <ul style="list-style-type: none"> <li>A child who switched from FFS to an MCO without the provider being aware of this – and the MCO required a pre-auth which would not be in place because FFS doesn't require pre-auth. Providers reported the following problems with trying to stay on top of the child's current Medicaid coverage:                   <ul style="list-style-type: none"> <li>Redline is not always up to date. Provider checks twice a month, but can't do daily</li> <li>ARS system is not always up to date.</li> </ul> </li> <li>Provider doesn't know who to get pre-auth from – FFS and MCO both say the child is covered by them – DMAS will be working on this.</li> <li>Situations where the pre-auth can't be done in time or provider can't be found or is not available in time to meet timelines. Part C policies stipulate that Part C funds can be used to cover services until reimbursement issues are resolved, but the expectation is</li> </ul> </li> </ul>	

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	<p>that the funds from the payor will go back into the Part C system when the problem is resolved</p> <p>A question was raised about whether Part C would be used to supplement the MCO rate if the MCO didn't pay the standard EI rate.</p> <p><b>Next Steps:</b> Discuss MCO issues at the June 1 meeting.</p>	
<b>DMAS Reports</b>	<ul style="list-style-type: none"> <li>• Brian distributed mock up reports for the following:                             <ul style="list-style-type: none"> <li>• EI Monthly and Annual Report</li> <li>• EI Monthly Master Enrollment Report (This will go to MCOs weekly)</li> <li>• EI Monthly Enrollment and Discharge report</li> </ul> </li> <li>• Reports will go to DMHMRSAS and DMHMRSAS will share with localities</li> </ul>	
<b>Data Elements and Timeframes</b>	<p>In order for children served through Part C to be enrolled as early intervention clients in DMAS, the Part C office needs the following information for each child from local systems:</p> <ul style="list-style-type: none"> <li>○ First Name, Last Name</li> <li>○ Medicaid number</li> <li>○ Admission date (Part C eligibility date or if the child becomes Medicaid eligible <u>after</u> he/she is already in Part C, then the admission date is the Medicaid eligibility date)</li> <li>○ Discharge date (day before child turns 3)</li> <li>○ Provider ID = NPI or API for LLA. This provides the link for associating kids with appropriate local system for the reports that are generated.</li> <li>○ Social Security number is helpful, but not essential.</li> </ul> <ul style="list-style-type: none"> <li>• Children will have to be enrolled as Medicaid EI clients only once even if they move in and out of Medicaid eligibility.</li> <li>• The Part C Staff who have access to this data function will be able to view the Child's Medicaid eligibility status.</li> </ul> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>• Part C Office needs NPI/APA number for each local system</li> <li>• Determine which LLAs need assistance in obtaining NPI/API number. Once an agency is enrolled as a Medicaid provider, DMAS assigns an NPI/APA number.</li> <li>• Develop a mechanism for local systems to inform the Part C Office when a child becomes eligible for Medicaid, so the Part C Office can enroll the child as an EI client in Medicaid</li> </ul>	
<b>2010 Local Contract</b>	<p>The 2010 Draft Local Contract was reviewed and the following was discussed and/or decided:</p> <ul style="list-style-type: none"> <li>○ Page 6: Local Lead Agency: Reword "public or private" to indicate that a public agency is first choice as LLA (due diligence will be used to identify public LLA), but that an RFP will be</li> </ul>	<ul style="list-style-type: none"> <li>• Revisions will be made to the contract and it will be disseminated by June 1,</li> </ul>

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	<p>issued, and a private agency can be selected if no public agency can be identified. Clarify the role of the Local Interagency Coordinating Council in selection of the LLA. (OSEP has confirmed that the LLA can be public <u>OR</u> private).</p> <ul style="list-style-type: none"> <li>o A provider requested that a statement be included on Page 7 Scope of Work/Local Lead Agency/Fiscal that the LLA provide fiscal info to the LICC</li> <li>o Quarterly cost-revenue reports will be due 45 days after end of quarter (instead of 15 days as currently written)</li> <li>o Reword the requirement about billing for family fees as drafted in email that was sent to the field last week.</li> <li>o E (6) on page 11 - does it need to say "Family Cost Share" in the section about after October 1?</li> <li>o Page 18. Deliverables/3.1.2 - define "enrollment"</li> <li>o Page 21, 4.2.b - 2nd paragraph – clarify requirement about maintaining the same level of state funds in the system</li> <li>o Specify that the 5% for administrative costs refers to 5% of state and federal funds for the entire year. Need instructions for budget that while the allocation is set at 75%, the budget is to be built on 100%.</li> <li>o There was a request that the instructions be detailed and clear for the budget, budget narrative - including what can be budgeted in each category.</li> <li>o Clarification is needed regarding requirements for taking Service Coordination Training.</li> </ul> <p>Allocation of Part C funds:</p> <ul style="list-style-type: none"> <li>• The plan is to have enough data by the third quarter to know the level of funding that is required for the remainder of the year for each local system. It is possible that there will not be enough information this year, in which case the remaining 25% of the allocations will be disseminated.</li> </ul> <p>ARRA Funds</p> <ul style="list-style-type: none"> <li>• The Part C Office is seeking clarification about whether a separate contract is required for the ARRA funds.</li> <li>• The ARRA funds are one-time funds.</li> <li>• Reporting for ARRA funds must be separate.</li> </ul>	<p>2009</p> <ul style="list-style-type: none"> <li>• A memo will go out to the field from Frank Tetric clarifying maintenance of effort requirements</li> <li>• A teleconference will be held May 28 at 10:00 to discuss revisions to the budget, cost-expense reporting form.</li> <li>• Specific information regarding requirements for ARRA funds will be sent to the field as soon as information is received by the Part C Office.</li> </ul>
<b>Rehab reimbursement</b>	<ul style="list-style-type: none"> <li>• The Part C Office will provide guidance to the field regarding the drop in Medicaid Fee for Service Rates that will occur July 1, 2009.</li> </ul>	

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Expense- Revenue Reporting Requirements and Form	<ul style="list-style-type: none"> <li>• A request has been made to have a way to capture actual cost data. The possibility of adding such a column to the cost sheet was raised.</li> <li>• Capturing cost by discipline is challenging for some local systems.</li> <li>• Since we are changing terminology from “special instruction” to “developmental services” October 1, what are the implications for IFSP documentation?</li> <li>• Task members asked what was expected in terms of including private insurance, family fees, etc. as part of the budget they are to develop.</li> <li>• Should/how should local systems budget for expenses and revenues that never hit the LLA books (such as services provided by and billed by private providers)</li> <li>• A request was made that the Part C Office create a form to be used by all private providers to report the required information to each LLA with which they are contracted (in order to provide consistency of reporting requirements for providers who serve multiple LLA)</li> </ul> <p><b>Next Steps:</b></p> <ul style="list-style-type: none"> <li>• The Part C Office will make revisions based on today’s discussion and send the revised draft out to members next week</li> <li>• A conference call was scheduled for May 28, 2009 at 10:00 for further discussion on this reporting form</li> <li>• Develop a reporting form for providers to use to report the required information to LLA</li> </ul>	<ul style="list-style-type: none"> <li>• OSEP requires fiscal reporting of revenues by revenue sources for all of the Part C services</li> </ul>

**Part C Announcements:**

- There will be additional monitoring requirements for the Part C Office to oversee related to Medicaid quality reviews. An additional Part C monitoring consultant will be hired.
- A Certification Specialist will also be hired.
- A training session for system managers regarding the system transformation is being planned for August
- Fiscal training will be provided

**June 1 Meeting:**

Time: 10:00 AM – 3:00 PM

Location: Hidden Creek Recreation Center

Agenda:

MCOs

Independent contractor vs. contracted employee

Determine dates and locations for future meetings (BRING CALENDARS)