

Topic	<i>Discussion and preliminary decisions and next steps</i>	<i>Final decisions</i>
Family Cost Share	<ul style="list-style-type: none"> • Family Cost Share subgroup met via conference call May 21 and: <ul style="list-style-type: none"> ○ Discussed policy issues: <ul style="list-style-type: none"> ▪ defining extraordinary expenses ▪ defining family unit ▪ appeal process ○ Reviewed information from Virginia Department of Health (documents sent to FCS subgroup) • Next call: June 2, 2009 to finalize decisions and discuss roll-out plan 	
Contract	<ul style="list-style-type: none"> • Contract revisions were reviewed. A handout summarizing the changes was distributed. • Additional clarifications will be made to be very clear about the differing requirements for Part C vs. ARRA funds. • The revised contract will go out this week. • June 15 is the date projected for contracts due back to DMHMRSAS. However, extensions will be granted as necessary 	
Fiscal Verification	<ul style="list-style-type: none"> • In the next several months, OSEP will determine which states will undergo fiscal verification. Virginia has and will continue to have access to technical assistance resources through national/regional TA organizations. In particular, Anne Taylor has been providing and will continue to provide technical assistance to Virginia regarding fiscal verification. 	
Expense-Revenue Reporting Form	<ul style="list-style-type: none"> • The conference call regarding the expense-revenue reporting form was held 5-28. • Jim Fleming, Alexandria drafted revisions to the form based on the stakeholder discussion. <p>Next Steps:</p> <ul style="list-style-type: none"> • The revised form will be sent to ITF members. • A follow up call will be held June 3 at 10:00 to discuss the revised form. 	
Billing Codes: Assessment after the Initial Assessment for Service Planning	<p>See Medicaid Reimbursement Codes Table</p> <ul style="list-style-type: none"> • T-1024 is the Code to be used for assessment after initial assessment. The description will be revised to include assessments that are done after the initial assessment for service planning. 	

<p>Billing Codes: Groups, Congregate Services and Individual Services</p>	<p>The terms “group” and “congregate” were discussed:</p> <ul style="list-style-type: none"> • DMAS views groups as center-based treatment of multiple children who have the same goals and who need the same intervention strategies. • DMAS considers congregate as treatment in natural environments of 2 or more children who have the same goals and who need the same strategies. • Individualized services provided to a child who happens to be in a group setting is considered individual services. Center-based group services are reimbursed at 1/3 the center-based rate • Congregate services are reimbursed at 2/3 the natural environments rate • There is not a mechanism to bill insurance companies for congregate services. • Some third party payors don’t have a mechanism to reimburse for group services • Examples of early intervention services provided in a group setting were discussed, including a “feeding group” in a center, feeding intervention during mealtime at a daycare, language intervention during library group time, etc. There was agreement that services provided to an individual child who has individualized goals is individual rather than group therapy and would be billed accordingly. If all of the children were working on exactly the same thing, that would be considered group (center-based) or congregate (in natural environments). • For children, such as twins or triplets, who will receive services by the same provider during the same intervention visit, the service is individual if each child has different goals and strategies necessary to address the goals. The IFSP should reflect the planned time to be spent for each child. Likewise billing for each child is based on the amount of time the provided spent providing services for each child. For example, for twins who will be seen during a one hour session every other week, the IFSP would reflect ½ hour for each child every other week and 2 units (1/2 hour) per session per child would be billed. 	
<p>Billing for Supervision Visits</p>	<ul style="list-style-type: none"> • Reimbursement for supervision visits was discussed. • The cost of supervision is built into the reimbursement rate. • There is not a mechanism to bill private payors for a lesser rate for PTA/OTA than the PT/OT rate 	<ul style="list-style-type: none"> • Supervision visits by PT for PTA or by OT for OTA will not be reimbursed.

<p>Reimbursement for Services Not Provided in Natural Environments with Acceptable Justification and for Which Providers Must Travel</p>	<ul style="list-style-type: none"> Center-based services that are justified and for which providers must travel can be reimbursed at the NE rate. The Part C Practice Manual will provide specifics regarding what is acceptable justification. Examples include a joint visit with biological parent and foster parent for very young infant, a situation where there is potential domestic violence, situations where the child/family are homeless, etc. It was suggested that the manual include instructions to consider all potential natural settings first prior to determining a center is necessary. <p>Next Step:</p> <ul style="list-style-type: none"> ITF members were asked to send Beth Tolley examples of alternative natural settings and examples where services could not be provided in natural settings. 	
<p>Draft Personnel Regulations</p>	<ul style="list-style-type: none"> The draft emergency Virginia Early Intervention personnel regulations will be posted on the Virginia Regulatory Town Hall as per NOIRA (Notice of Intention for Regulatory Action) requirements. Virginia has 280 days to finalize the emergency regulations after which permanent regulations must be promulgated. The process for promulgating the regulations includes (in addition to posting on Virginia Regulatory Town Hall) includes review by the Governor and public Comment. VICC will be used as the advisory body. VICC meetings will be posted (as they always are) in the Virginia Register and also in the Virginia Regulatory Town Hall. Public Comment to be provided through VICC meetings; Written comments will also be accepted. The uncertainty about federal regulation makes planning for promulgation of permanent regulations challenging. 	
<p>Personnel Qualifications, Responsibilities, Services and Reimbursement Category Document</p>	<ul style="list-style-type: none"> Family Counseling and Support Services is the descriptor for what is listed in federal Part C regulations as “family training, counseling, and home visits”. For the EI System Transformation, Family Counseling and Support Services is the broad descriptor that is used for those professions whose primary function is counseling and/or support. Professions which provide counseling and/or support within their scope of practice can continue to do so, but their service will be listed according to the service description specified on the table. “Developmental services” is the terminology that will be used for what is currently called “special instruction”. The term “developmental services” doesn’t prevent providers from providing counseling. 	

<p>Application form for Early Intervention Certification</p>	<p>The following revisions were suggested for the Assurances:</p> <ul style="list-style-type: none"> • While the assurance about abiding by Part C Practice Manual, etc. includes the requirements to coordinate services with the child’s service coordinator/IFSP team, the group recommended that both these assurances be retained. • Add “I understand that if I am an independent contractor,....” to the assurance regarding contracting with the lead agency or otherwise making arrangements for exchange of funds. • Add “and I must report revenue (and other required data) to the local lead agency to the assurances – either adding to one of the assurance or adding the following sentence: • I understand if I am an independent contractor, I must provide to the local lead agency revenue information and other required Part C data for the Part C children for whom I provide services. • Consider adding to acknowledgements “I understand that if I do my own billing, I will be required to report early intervention revenue” 	
<p>Training Modules</p>	<ul style="list-style-type: none"> • The Child Development module is ready to go live and the Family Centered Practices module is ready as soon as permission is received for use of one of the videos. • It is expected that all of the modules will be live July 2009. 	
<p>Employee vs. Independent Contractor</p>	<p>Employee vs. Independent Contractors</p> <ul style="list-style-type: none"> • Factors to consider in distinguishing between employee vs. independent contractor include the amount of control exercised over the practitioner’s work, whether the practitioner is on the payroll, whether taxes are paid by the agency, who is responsible for liability insurance, etc. <p>Next Steps:</p> <ul style="list-style-type: none"> • Beth will gather and compile information from several sources: <ul style="list-style-type: none"> ○ Beth will check with DMHMRSAS Human Resources for guidance and will check about EVA requirements. ○ Several local systems will send Beth the information their agency uses to distinguish between employees and independent contractors ○ Consider defining the following terms: benefitted employees, contracted employees, non-benefitted employees, subcontractors, PRN staff • Compiled information will include guidance to check with the agency HR department or a tax attorney or the IRS website. 	

<p>Paying the EI Rate</p>	<ul style="list-style-type: none"> • Whoever bills receives the standard EI rate. So if the Local Lead Agency bills for the service, the Local Lead Agency receives the EI rate and pays the employee or contractor who provided the services. Local Lead Agencies can negotiate with contracted providers regarding the portion or amount of the standard EI rate that will be “paid” to the LLA for doing the billing. • An independent contractor which is an individual or an independent contractor that is an agency each receive the full EI rate if they are billing and providing all of the components that are included in the rate. <ul style="list-style-type: none"> ○ The group discussed pros and cons of individual vs agency contractors in terms of supervision and the amount of oversight required. For some local systems, the amount of oversight required for independent contractors is much greater (and greater cost to the LLA) than that required for agencies who have individuals who provide supervision to their employees. ○ The contracting agency cannot provide supervision to an independent contractor because supervision is a function of an employer/employee relationship. • The group requested guidance/parameters/technical assistance for considering the value of the various components included in the rate such as billing, training, supervision, etc. so there can be consistency – while recognizing that specific amounts or percentages cannot be provided in order to avoid price fixing. One provider uses a general estimate of 70% of the cost being related to the personnel costs incurred for delivery of the service (including salary, benefits, mileage, etc.) and 30% related to overhead (cost of billing, etc.) • The EI rate is the same regardless of the payor source, including family fees. 	
<p>MCOs</p>	<ul style="list-style-type: none"> • Reimbursement at the EI rate and use of Part C Certified providers have been included in the MCO contracts. This is being reviewed by DMAS management. • If Part C provider refuses to contract with the MCO, the MCO will reimburse at 90% • DMAS is working with MCOs regarding recognition of the IFSP, authorization requirements and the process for moving from FFS to/from MCO and between MCOs. 	
<p>How to Become a Medicaid and Medicaid MCO Provider</p>	<ul style="list-style-type: none"> • Brian is drafting the application for enrollment as a Medicaid provider. Rehab agencies will be required to provide information including the agency license. Individuals employed by an agency will not need to enroll individually with Medicaid. The enrolled agency will be responsible for ensuring that their providers meet the EI Certification requirements. • Tammy Driscoll will address what is needed to become MCO provider. 	

<p>Change in Rehab Reimbursement Rates</p>	<ul style="list-style-type: none"> • According to DMAS, it is acceptable for Part C to pay an additional reimbursement amount for services provided between July 1 and October 1 to cover travel costs since reimbursement for travel is not included in the Medicaid rehab reimbursement rate. • It was reported that some providers have indicated that they can not provide PT or OT evaluations for children with Medicaid because the rates are so low. 	
<p>Fiscal Projections</p>	<p>Discussion about the Rates Report.</p> <ul style="list-style-type: none"> • The fiscal projections are examples, based on incomplete data. • Sustainability (after ARRA funds are no longer available) was identified as a concern. While the Medicaid revenue will be increased, Part C will have increased expenses (for children with private payors who don't reimburse the full amount, for services not covered by Medicaid or private payors, etc.) and more children are expected to be served. <ul style="list-style-type: none"> ○ After the initial transformation effort is in place, work will occur with the private insurance companies. • While there will be more complete data when the transformation is implemented, the group expressed a desire to gather more accurate data now to be able to project the fiscal impact of the changes that are being implemented. <ul style="list-style-type: none"> ○ Projections about the fiscal impact based on actual data will be provided by several local lead agencies (ideally at least one from each region) from Professional Therapies of Roanoke and Rehabilitation Associates. 	<p>Put on agenda</p>

Next Meetings: June 15 (VACSB)
 June 26 (location to be determined)