

Task Force to Evaluate Virginia's Early Intervention System
Planning Session #6 Summary
January 12, 2004
Henrico Mental Health, Richmond

Present: Deana Buck, Debbie Burcham, Scottie Burnette, Nancy Butts, Beverly Crouse, Donna DeChant, Pat Dewey, Mary Ann Discenza, Jim Gillespie, Debra Holloway, Jean Hearst, Marilyn Hoexter, Terri Jenkins, Jan Jessee, Heidi Lawyer, Phyllis Mondak, Jennifer Peers, Kathy Phillips, Shirley Ricks, Joel Rothenberg, Glen Slonneger, Deborah Sprang, Beth Tolley, Tera Yoder, and Judy Burtner and Kathryn Burruss (facilitators).

Session Objectives:

1. A structured discussion about alternative infrastructure options
2. An opportunity for stakeholders to bring other alternatives forward
3. An opportunity to strengthen what's proposed

Judy Burtner (facilitator) reviewed the agenda and participation guidelines. The focus of the meeting was to review and discuss the alternatives for Part C infrastructure. The alternatives as proposed were to be considered in the context of the following:

1. Does the alternative make sense administratively?
2. What will be the impact on children and families?
3. What will be the impact on service providers?
4. How will overall system coordination occur?
5. What will be the interface with systems components, such as child find, public awareness, technical assistance, and monitoring?

Overall, any infrastructure must also be in compliance with federal Part C regulations and Virginia Part C Policies and Procedures.

Infrastructure Alternatives for Part C in Virginia

Mary Ann Discenza presented the following three infrastructure alternatives:

1. State Lead Agency contracts with local lead agencies;
2. State Lead Agency contracts with regional lead agencies;
3. State Lead Agency contracts directly with Part C early intervention provider agencies statewide.

The goals for any infrastructure alternative would be to better serve Part C eligible children and families in the most cost-effective way, and to streamline the system administratively. Currently, the Lead Agency contracts with local fiscal agents, to administer local Part C funds, e.g., to ensure compliance with Part C fiscal assurances, to complete Part C quarterly expenditure reports, to develop contracts with local participating agencies/providers. A local lead agency would administer local Part C funds (as the local fiscal agent would); make decisions, with the advise and assistance of the local interagency coordinating council; ensure a local system of early intervention services; meet all federal and state Part C requirements; and be responsible for ensuring implementation of system requirements and monitoring and supervision of the local early intervention system. Local fiscal agent and local lead agency are not synonymous terms.

Alternative 1: Local Lead Agency

In this alternative, CSBs might be the local lead agency, or any public agency might be the local lead agency, with the possibility of a Request for Proposal being issued to determine the local lead agency. Currently, 33 of the 40 local councils have CSBs as fiscal agent. The other seven have a local school division, local health department, either city or county government, or a public university as local fiscal agent. The question arose as to whether or not the local lead agency had to be a public agency, and this question will be researched, as well as the definition of “public agency.” In this alternative, the role of the local council would be to advise and assist, and the role of the core group would be eliminated. The local lead agency would implement all Part C regulations, Virginia Part C policies and procedures, and fiscal and programmatic assurances, e.g., payor of last resort, non-supplanting, ability to pay, etc., and would be held accountable for such implementation. The local lead agency would assure that Medicaid and other third party payors were billed.

Alternative 2: Regional Lead Agency

Four to eight regions would be set up across Virginia, and either a regional lead agency without centralized reimbursement and/or billing, or with centralized reimbursement and/or billing would be established. The responsibilities of a regional lead agency would include receiving Part C funds from the state lead agency, contracting or otherwise arranging for services directly with providers, preparing and submitting budget and expenditure reports, etc., and possibly also being a provider in the Part C system. Local interagency coordinating councils would no longer be required; there would be a regional council whose purpose would be to advise and assist the regional lead agency. The regional lead agency would enroll local/regional service providers, with enrollment agreements or contracts specifying programmatic requirements, billing procedures, etc. The centralized billing system, if in place, would require either the regional lead agency to bill Medicaid and private insurance, or the provider to bill Medicaid, private insurance, and families, with the regional lead agency being billed for the remaining cost. Documentation issues for both third party insurers and a central early intervention record would need to be addressed in this alternative. Questions arose regarding current local funds in the early intervention system, and how these funds would remain in early intervention in a regional system. Local governments view local funds as remaining in local systems. Another challenge would be how quickly a regional system could be developed and implemented, as well as the cost of such a system.

Alternative 3: Provider Enrollment through State Lead Agency

In this alternative, the state lead agency would operate a centralized reimbursement and billing system. Through a Request for Proposal, the state lead agency would enroll service providers, who would meet Part C requirements related to licensure, personnel standards, etc. Part C funds would go to agencies/providers based on services provided, as documented on the IFSP. The same challenge would exist for this alternative as in alternative 2: how quickly such a state system could be developed and implemented, as well as the cost of such a system.

Follow-up questions regarding the three alternatives:

Alternative 1: What if no local agency wishes to be the local lead agency? Would an agency in another area be able to assume this responsibility? How often would an RFP be issued? What is the definition of a public agency?

Alternative 2: Would local system dollars go to the regional lead agency? What if the CSB can only serve children and families in the CSB “locality”? When “regions” are determined, how will various characteristics/challenges of particular areas be addressed, e.g., rural vs. urban? What is the implication of such a “model” with insurance companies and providers? Will a regional system be more costly to manage, as currently some fiscal agents provide “in-kind” support or provide support for a nominal fee?

Alternatives 1, 2, and 3: What is the cost of implementation of each alternative, recognizing that cost includes change as well as support costs? What are efficiencies of each alternative? What is the time factor involved in implementation? How will the decision of an alternative be “sold” to others?

Questions for clarification:

Do other states have local system dollars in their early intervention system?

What is the cost per child in the other states?

How does SPO case management fit into the alternatives? If a regional lead agency, would CSBs provide services and then bill DMAS, with the revenue collected going to the regional lead agency? And how would salaries of case managers be paid?

What is the motivation for CSBs with a non-CSB local lead agency to put SPO revenue back into the system to benefit Part C children?

How will the state lead agency maintain authority for supervision and monitoring of the Part C system, as well as “enforcement”?

What is the impact on technical assistance and training with a local vs. regional vs. state lead agency system?

Summary of Small Group Discussions Regarding the Three Alternatives

(Discussion points made multiple times are indicated with asterisks.)

Maintaining a local central point of entry is important, as families feel better about services happening locally, rather than three counties away.

Every local council does things differently, e.g., billing, reimbursement, etc. Moving from a local to a regional system may streamline activities. The cost of getting providers to different areas must be considered. How would centralized billing recognize the cost differential for provision of services in natural environments?

Statewide billing, reimbursement, and centralized authorization for Part C services will require considerable negotiation with payors. Would centralized billing assist with collaborative funding, e.g., payor reimbursing for service and another funding source supporting service delivery in natural environments?

Use an RFP from the state lead agency for fiscal management of the Part C system.

Is there a possibility for another entity to bill for SPO?

Why do SPO funds obtained from providing services to Part C children not remain in Part C?

If there is a regional or state system, how will localities know their funds go to serve Part C children?*

Maintaining a local system makes it easier to obtain local funds to support services. A regional or state approach may mean the loss of local funds for administrative/support/in-kind activities.

Localities have difficulty now getting family participation. How will participation by families work with regional or state lead agency? Might parents be paid for participation in the local council?

What will happen to jobs if there is regional or state centralized management?

If chosen alternative is a local lead agency, then it is probably best for the core group to select the local lead agency.

Consider RFP for the determination of local lead agency.

CSBs are only required to provide emergency services and case management services; other services provided by the CSB are determined by the local needs in a community.

If the CSB is not the local lead agency, it is less likely that the CSB will put state or local funds into Part C.

Suggestions for a “hybrid” alternative

Use one local or regional central point of entry to streamline administrative paperwork, and to reduce administrative structure in localities. Streamline the IFSP process as well as the IFSP document.

Maintain local service delivery system with a local service coordinator. Consider combining some of the smaller catchment areas, i.e., geography or population.

Have providers serve multiple localities, as this already happens in many localities. A “regional” approach already exists among some councils and provider networks. There is strength in local relationships that have been established and cultivated over time.

Provide billing/reimbursement at the state level.*

State level centralized billing would appear to be more cost-effective, regardless of the organizational infrastructure which is determined. Currently, providers working among multiple LICCs must adhere to multiple ways of doing business because of way LICC is set up. It is more costly to provide services for those providers working with multiple councils.*

Use a regional or state mechanism for standardized credentialing of providers as well.

Have all Part C children eligible for Medicaid remain in regular Medicaid, rather than Medicaid HMOs. Use the IFSP process to serve as review in place of Medicaid preauthorization.

Continue with implementation of Part C services and supports guidelines as this implementation will have a positive fiscal impact. Strengthen role of state lead agency in monitoring and supervising this implementation, e.g., determining outcomes for children and frequency and intensity of entitled services to meet such outcomes.

Three proposed alternatives lack or do not have enough insurance of authority. There needs to be contract accountability indicating responsibility for all aspects of Part C system.*

Local interagency coordinating councils serve a valuable function; thus, streamline LICCs as a balance and check to any lead agency. Also use LICCs for budget approval, as that function of the LICC keeps involvement and attendance from members. Prescribe membership of LICC since the members will participate in budget approval. Strengthen LICC in its role regarding family rights and procedural safeguards.

Consider the role of the state lead agency in analyzing and determining priorities, using focused monitoring as way to allocate resources and meet priority needs in particular areas of state. Have the state be responsible for specific tasks or functions. Rather than all 40 LICCs being addressed in the same way, recognize issues unique to certain LICCs. Emphasize particular issues for particular areas with a local or regional lead agency mechanism. Some Part C funds may be specified for particular needs. Other items or priorities should be addressed at a state level, e.g., data collection, indicators from monitoring and supervision, etc. Oversight function of the state would include the articulation of priorities and benchmarks, with the resulting allocation of funds being based on priorities.

Provide cost analysis/cost benefit for whichever “model” is to be implemented.*

Next Steps

Next meeting: February 9, 2004, 10:00 a.m. – 3:00 p.m., Henrico Mental Health Mental Retardation, Woodman Road, Glen Allen

Part C Office will prepare summary of January 12, 2004 meeting, and will develop “hybrid” alternative(s) for review at the February 9 meeting. The hybrid alternative(s) will reflect the following 5 contextual considerations as were discussed today:

1. Does the alternative make sense administratively?
2. What will be the impact on children and families?
3. What will be the impact on service providers?
4. How will overall system coordination occur?
5. What will be the interface with systems components such as child find, public awareness, technical assistance, and monitoring?

At the February 9 meeting, the Task Force will begin the selection process (narrowing of the options) for the Part C infrastructure. Research on the questions which were discussed today will be shared. Following the narrowing of the options, the proposals will be shared with the field for review and discussion.

An “administrative costs” subgroup was established to address issues of costs associated with the provision of services in natural environments. Volunteers agreeing to be a part of this subgroup include Deana Buck, Scottie Burnette, Jean Hearst, Jan Jessee, Kathy Phillips, Mary Ann Discenza, Beverly Crouse, Karen Durst. A summary of work of this group will be provided.

The draft of the cost study report will not be ready until the end of February. The Cost Study group will meet on March 8 with Karleen Goldhammer, and a presentation will be made by Karleen Goldhammer of Solutions, Inc., to the VICC on March 10, 2004.

The Task Force adjourned, with the Infrastructure and Services Subcommittees then meeting together to discuss the proposed actions on the Early Intervention Process chart.

Meeting Calendar for 2004 – All meetings will be held at Henrico Mental Health and Mental Retardation Services, Woodman Road, Glen Allen.

February 9, 2004

March 15, 2004

April 19, 2004

May 17, 2004

June 21, 2004

