

**Task Force to Evaluate Virginia's Early Intervention System**  
**Planning Session #7 Summary**  
**February 9, 2004**  
**Henrico Mental Health, Richmond**

**Present:** Deana Buck, Debbie Burcham, Nancy Butts, Beverly Crouse, Donna DeChant, Mary Ann Discenza, Karen Durst, Tom Geib, Jim Gillespie, Carol Granger, Debra Holloway, Jean Hearst, Jan Jessee, Heidi Lawyer, Phil Markert, Phyllis Mondak, Jennifer Peers, Kathy Phillips, Shirley Ricks, Glen Slonneger, Deborah Sprang, Beth Tolley, Tera Yoder, and Judy Burtner and Kathryn Burruss (facilitators).

Judy Burtner reviewed the participation guidelines, emphasizing that “consensus” of the group indicates a decision which members can walk out of the room and support. She then introduced Mary Ann Discenza who reviewed the agenda for the day. The intention of today’s meeting had been to review hybrids which had been developed from the three alternatives presented at the January 12 meeting. At that meeting, the group had not been ready to embrace any of the three alternatives for restructuring the Part C system. The reality of implications of restructuring must be addressed with regard to funding. The Part C system is underfunded, and the question must be what to do with the model of the forty councils, to consider what is broken with the present system, and to fix what is broken.

Mary Ann Discenza then presented the following key issues for today’s discussion:

Discussion with Karleen Goldhammer, and the cost study data itself, does not lead to the conclusion that moving to a regional model, even though there would be the capacity to achieve economies of scale, is reasonable at this point in time. Start-up costs, plus the costs to maintain the system, would be prohibitive. Hence, discussion of the hybrids does not appear to be a wise use of time at this meeting.

Alternative 1 – Local Lead Agency would be the least expensive alternative to implement. The local contract is an issue, and “who” or “what” is a legal entity must be addressed. There needs to be consistency across the state and in multiple jurisdictions, for public and private providers. The state lead agency could take the leadership role and develop consistent standards, e.g., administrative costs, provider rates, provider enrollment and perhaps credentialing, or assurance that providers meet minimum requirements. The systemic issues which the state lead agency could take over, e.g., child find, also need to be discussed. The reality is that there may not be any additional funding from the General Assembly, but the Task Force can retain the vision of the important aspects of the alternatives for the future.

Recommendations to the Commissioner from the Task Force can include the immediate fixes, but also a description of the system in three years, five years, etc.

Task Force members asked for clarification of the following issues:

Enforcement: There are Part C policies and procedures at the state level, but no real ability to sanction entities when these are not followed. Mary Ann responded that there needs to be a way to have the authority from the state office, i.e., administratively with the Department of Mental Health, Mental Retardation, Substance Abuse Services, and with the public/private partnership for the authority role to be carried forth.

Statewide forms and processes: Rather than giving up on other alternatives, there can be a framework for the future with points from other alternatives. The IFSP as a statewide form has been adopted and is in use. Is there resistance to such a form? Mary Ann responded that the frequency and intensity of services is an issue, as well as the developmental versus medical model of service delivery. Utilization reviews have been inconsistent across the state. Another challenge for the state office is the mechanism for more reviews within the context of Alternative 1.

Additional funds being sought from the General Assembly: Without approval of the budget amendment, will there be additional money lost from the Part C system? Mary Ann answered that the budget amendment will only replace one-time funds, not increase the level of Part C funds. Discussion occurred as to whether or not it is a disservice to children and families to back away from a close look at the infrastructure, based solely on fiscal issues. Does the Task Force need to build a system based on whatever alternative the group thinks is appropriate? Others shared the viewpoint that the system is broken because of management concerns and frustrations and that these specific issues should be the focus of the infrastructure group. Mary Ann noted that the words “the system is broken” had been given to her, and if that is the case, then it is the responsibility of the group to deal with those issues. She supported keeping the vision of the system, and reinforcing the constituencies who advocate for the system.

### **Summary of work for today’s (February 9) meeting:**

Mary Ann summarized the focus of the meeting as being to accept the premise of Alternative 1 – Local Lead Agency, and then to ask questions and make decisions regarding Alternative 1. What about Alternative 1 needs to change to achieve efficiencies that need to happen, e.g., difficulty in doing business with multiple jurisdictions; rates (possibly caps) for administrative costs, attendance at IFSP meetings, etc.; enrollment of Part C providers who agree to meet Part C requirements and then have model contracts for localities to use with the providers, thus a consistent process. The local contract may not be with local councils; thus, what will it take to achieve a contract signed by an entity with legal standing? Determine the system-wide issues and the ones with local perspective. There was discussion that Virginia runs with locally-driven systems, and that families identify with local services. The support from the local system cannot be negated. Another perspective offered was that local dollars are not in place all across the state, and providers must be supported to be able to remain as Part C providers.

The issues to be addressed in any alternative chosen were determined to be the following:

1. Local contract/legal entity
2. System-wide functions

3. Administrative costs-services in natural environments
4. Insurance-public and private
5. Rates
6. Standardization of the process-consistency
7. Provider enrollment
8. Utilization review-authority (locus of responsibility), accountability, service delivery
9. Data collection

The group process was as follows:

1. The Task Force members identified, through a brainstorming activity, the following points under each issue. An asterisk indicates more than one member identifying a particular point.
2. Small groups then met to come forward with recommendations for the entire group, with some recommendations being short-term and others, long-term.
3. The entire group then determined for which recommendations there was agreement or consensus. The recommendations will be the foundation on which to build an effective system for children and families.

### **Local Contract**

There is the issue of the local lead agency also being a provider.

Some LICCs have members “in name only” who may not be willing or able to make decisions/take responsibility.

Local lead agency (CSB or designee) balanced with local interagency coordinating councils that approve budgets and ensure coordination. Council coordinators may need increased education regarding finance.

Can the Code be changed to make LICCs legal entities and/or can we modify the role of the LICCs so they meet the requirement?

Define responsibility of local entity in ways that can be fulfilled by public agencies, not just CSBs. Give localities the option.\*\*

Need to ensure that services are truly coordinated in order that system could be as efficient as possible.\*

Define the functions of local leads and administrative costs associated-thus increasing consistency statewide.

Continue to use resources of public and private agencies.

Should there be a threshold of numbers of children to be a local lead agency? (LICC areas are not at all comparable.)

Recommendations from small-group work:

A state RFP process could help maintain public/private partnership and provide for local choice.

State determines who is eligible to apply.

Role of LICC is still in question.

Coordination of local system needs to be included in responsibility of local lead agency, with state monitoring this and spelling it out in RFP.

Discussion with entire group:

There was clarification that the local lead agency is the legal entity. It is a federal requirement that the lead be a public agency, as Part C is a public system of services. The RFP versus a contract was discussed. An RFP could lead to the potential to change the local lead over the years. The local lead agency needs to be determined and remain there. In the localities where the CSB is currently not the fiscal agent, there could be language for "CSB or designee" - or the CSB could sign the contract and designate another agency. The question then would be the oversight of the designee and the responsibility of the CSB.

Agreement items among Task Force:

A contract is the best process to identify the local lead agency. For CSB or designee who chooses not to sign the contract, the state would have responsibility to identify the entity to sign the local contract.

The Code of Virginia will need to be changed to amend the responsibilities and functions of LICCs. Currently, the Code states that members have "fiscal and policy-making authority."

### **System-wide Functions**

Don't lose effectiveness by changing local responsibility to state responsibility.\*

Look at state function for provider reimbursement (long-term) Concept of central finance.

Work with main insurance companies to set up streamline system for statewide EI comprehensive system of personnel development. (Wrong Place!)

State should make an assessment of where things are working well and where not and consider budgetary requests accordingly. This should be based on "published" priorities.\*

Suggest local and state child find/public awareness; training with opportunity for specific local requests as state driven or organized.

Active technical assistance.

Training (state). Expand long-term.

Systemize approval process for payor of last resort. (See standardization of process)

What is the relationship between local lead and central point of entry, temporary service coordination, service coordination?

Responsibilities of LICCs have to be clarified.

Define administrative fee and what it covers with consideration of differences of communities.

Recommendations from small-group work:

Training and technical assistance are definitely statewide functions, with input from localities.

Public awareness would occur at the state level with the development of master items, and then with the localities using the items as they know best.

Child find would be the primary responsibility of the localities.

Discussion with entire group:

If the localities are the lead for child find, the state could play its role in determining specific priorities or areas to fund, based on the data about child find. There was also discussion about the relationship among the local lead agency, central point of entry, temporary service coordination, and service coordination. If these functions of central point of entry and service coordination are a statewide responsibility, then it is possible that these functions would occur differently from the way they work now.

Agreement items among Task Force:

Training, technical assistance, and public awareness will be led by the state.

Child find will be led by the local lead agency, with the state assisting in identifying the needs and determining the implementation. The decision-making regarding the funding for priorities in implementation would remain at the state level.

### **Administrative Costs – Services in Natural Environments**

Need to immediately find funding for this because of immediate loss of providers.\*

Can costs be standardized across the state (are differentials for areas needed)?\*

Is directly linked to service delivery model.

Standardized reimbursement for each region of the state determined by the state, perhaps using Goldhammer's data.\*\*\* Use this rate as a minimum administrative fee. Localities may supplement if they choose.

Accept that all/most insurance companies do not reimburse for natural environments, thus collaboratively fund. How much would it cost to have Part C 100% fund just the cost of the natural environment versus paying for the whole service for most all kids?\*\*\*

Revise reimbursement formula.

Make sure to consider extraordinary cost of travel to natural environments in very rural areas (Consider TIBL model).

Define what administrative costs include (i.e., travel to provide EI services, and to conduct IFSP meetings). Just be consistent.

Pay attention to/set productivity rates so that they are consistent in public/private settings.

Advocacy for natural environments and education to “powers that be” that natural environment is not only best practice but is also the most cost effective model. And it is required.

Recommendations from small-group work:

The state is the lead on this issue.

Long-term goal-All insurance companies cover natural environments costs.

Short-term goal-Establish a minimum statewide administrative fee with consideration for differentials based on regions and urban and rural.

Procedures-Use data gathered from cost study to adjust administrative fees until long-term goal is reached.

Discussion with entire group:

There was agreement that the state is the lead agency on this issue, and needs to define what is to be covered in the administrative costs. The group also recognized that service provision is more costly in certain areas of the state.

Agreement items among Task Force:

Establish a minimum statewide administrative fee with consideration for differentials based on regions and urban and rural areas.

### **Insurance – Public and Private and Rates**

Carve out Medicaid at prospective payment rates.\*\*\*

IFSP process serve as authorization process.\*\*

Statewide advocacy for adequate insurance funding for early intervention.\*

Education of insurance companies about service model and advocacy for reimbursement according to model (teaming, co-visits, consults, etc.)\*\*\*

State insurance commission – advocate for broader description of early intervention covered services and who can provide.\*

Address immediately the preauthorization process concerns with Medicaid (WVMI) and the goals required.\*\*\*

Advocate for insurers to grant providership to therapists and agencies approved by Part C system.\*\*

Sponsor legislation through advocacy organizations (if appropriate) to tighten loopholes regarding insurance reimbursement for Part C services.\*

Prior to Part C reimbursement, design process to approve payor of last resort to be followed across system.

There should be a method developed to establish rates for services (Part C) that are reimbursed to providers, and state should tackle this.\*\*\*

Will have to take into consideration that providers have participation agreements with insurance companies to accept reimbursements as payment in full.

Part C funding of therapies as payor of last resort should be at the Medicaid rate. We need to advocate for raising the Medicaid rate.\*\* What is the Part C rate in comparison to the Medicaid fee-for-service and MCO rates?

Use data from cost study to help identify rate.

Recommendations from small-group work:

Long-term goal-All insurers recognize that early intervention services as defined by IDEA are fully reimbursable, based on cost study.

Short-term goal-Sharing appropriate cost study data and cost savings data with General Assembly-via an organized advocacy approach.

Short-term goal-Part C fees for evaluation and treatment are based on cost study and are region consistent.

Advocacy issues – 1) Identify partners who will be willing to contribute time or money to Part C, such as other provider organizations, cities, ARC, VACSB; 2) Part C at state level advocate for agencies to be preferred-provider status with insurers.

Discussion with entire group:

Part C at state level must advocate for agencies to receive preferred provider status with insurers.

Agreement items among Task Force:

None noted.

### **Standardization of Process**

State, short-term:

Invoicing for services should be consistent across state.\*

State, short-term:

Process by which the “authorizer” of using Part C funds should be consistent (i.e., what does provider provide to demonstrate that Part C is being requested as payor of last resort).\*\*\*

State, long-term, but local in short-term with training from the state for consistency and development of forms:

Computer program/method systemized so each entity is entering and requesting same information.

Single intake form/process and financial.

Single centralized intake, financial, and evaluation – look at this for long-term.

Do you mean requirements?

Do you mean in each locality? Yes.

In the long-term, local lead agency contracts with all providers, guaranteeing payment for services. (Place in contract group)

State, long-term:

Electronic billing

Recommendations from small-group work:

Conduct survey to determine where the inconsistencies are problematic, and where standardization of forms and processes would be helpful.

Discussion with entire group:

Having a consistent invoice may not be compatible with software at provider companies.

There needs to be a way to track what is paid for what service, so insurance and Part C do not pay for the same service.

Maintain now how the locality currently handles local evaluation teams, but consider as a long-term solution the possibility of a centralized evaluation team.

The local lead agency will contract with all providers.

There was clarification that the statewide ability-to-pay process and accompanying intake process requires the procedural safeguards, etc. to be given to families.

Agreement items among Task Force:

None noted.

### **Provider Enrollment**

Ensuring providers are in multiple networks with as many insurance companies as possible.\*

Choice is very important!\*

Process needs to reflect personnel standards and training functions, if possible.

Work with major insurance companies to establish streamlined process to credential all Part C providers who meet criteria. Tie to Part C requirements and CSPD.

How will this work for providers of limited Part C services (i.e., assistive technology) who are somewhat unique in a community?

State certification to ensure early intervention staff are knowledgeable of Part C process, best practices, coordination responsibilities, etc.

This could occur via contract between regional/local entity or state with the provider of service. If local/regional, state should provide a boiler plate for consistency.

Individual providers-does enrollment process work the same way?

Advocate with insurers to use state provider enrollment as basis for acceptance as an insurance provider.

Recommendations from small-group work:

Part C provider enrollment – state level for providers of Part C services paid with Part C funds, and to include assurances for meeting Part C requirements.

If enrolled, then can enter into contracts with local lead agencies; contract would embrace consistent language and set administrative fees.

Interagency agreement with public agency participation on council may still be necessary.

Discussion with entire group:

The small group did not address state or regional or local ways to bill insurance companies. The provider enrollment issue needs further work.

Agreement items among Task Force:

None noted.

### **Utilization Review – Authority, Accountability, Service Delivery**

Frequency of services is an issue.

How will the CSBs be monitored for best utilization of funds? Including local dollars?

Are the CSBs the most cost effective local lead agency? A question we need to explore. There needs to be direct consequences for high level of frequency over long periods of time.\*

Need to monitor councils/providers across councils and have consequences to address areas of need.\*

Will this assist in saving money? Or will this be something that takes funds away from direct services?

Are there other agencies that could serve as lead agencies: cost effective should not be the only criteria.

What will consequences be if council out of compliance with natural environments, etc.?\*

State (with input) must set priorities for what should be looked at in utilization review.

Decide what is important now, then evolve as system changes.

Recommendations from small-group work:

State: Service Delivery

State utilization review (short term)

Possible consequences for poor review

Increased focused monitoring of local council/service providers  
Decreased funding – administrative costs for provider who overutilizes  
Local: Report who overutilizes in performance review and contract renewal  
State: Establish triggers for review (overutilization)  
Provide training  
Long-term: Pro-Active process at state level and implement at local level:  
“preauthorization” for high intensity services  
Continuing training on philosophy of service delivery and IFSP writing

Discussion with entire group:  
Utilization review would identify trends in service delivery, e.g., two-thirds of the children receive a particular service at the same frequency and intensity.

Agreement items among Task Force:  
None noted.

### **Data Collection**

Connect data collection to reimbursement system (long-term).  
Make less cumbersome and less time consuming and expensive.  
Analyze what is wanted and ask for it and provide the actual program (long-term).  
Data collection process goes through the LICC coordinator who reports for the service area and then to the state.  
Build integrated data system that is built into routine service delivery and billing functions and provides real time management, service delivery, fiscal, and program outcome – program efficacy data, and begins with a minimal data system that allows for state/local to analyze and manage system.\*\*  
Annually project and request dollars needed to serve the children in the Part C system (“ask consistently and often”). This should be done in consideration of “Guidelines” and should solicit power of advocacy organizations (ARC, VACSB).

Discussion with entire group:  
Because this issue was not discussed by a small group, other possibilities to address the points were considered. The data group could be reconvened, or the items could be folded into other areas.

Agreement items among Task Force:  
Mary Ann Discenza will identify other issue areas where the items belong, and will assign them to those particular issues.

### **Next Steps**

**Next meeting: March 15, 2004, 10:00 a.m. – 3:00 p.m., Henrico Mental Health and Retardation, Woodman Road, Glen Allen**

The Part C Office will begin preparation of the report, and decisions made today will be addressed in the appropriate section of the report. From the meeting summary, Mary Ann

will identify issues still to be decided, e.g., administrative costs, plus the list of decisions made thus far.

Shirley Ricks noted that since the structure of the system with a local lead agency is now known, the contract group can begin work to bring revisions to the contract back for reaction from the group. There was discussion as to whether or not the contract had to be on the fast track, since the deadline to submit legislation to amend the Code of Virginia has now passed for this year. The Code will have to be amended for local interagency coordinating councils, probably removing the LICC language. The decision was made to use the existing contract for 2004-2005, and to remove the signature of the LICC coordinator. Persons who will serve on the Contract subcommittee are Karen Adams, Karen Durst, Jean Hearst, Phil Markert, Jennifer Peers, Kathy Phillips, and Bob Schmid.

Mary Ann stated that the “walking” of a child and family through the system could now be done.

The three subcommittees will continue their work at the next meeting. Deana Buck noted that the Services Subcommittee work to outline ways to strengthen the service delivery system will feed into the local contract revision.

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

**March 15, 2004**

**April 19, 2004**

**May 17, 2004**

**June 21, 2004**