



Infant & Toddler Connection of Virginia

Part C Infrastructure Task Force Report

July 7, 2004

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I. Executive Summary

In August 2003, the Department of Mental Health, Mental Retardation, convened a group of stakeholders and Substance Abuse Services (DMHMRSAS) to examine Virginia's Part C system, identify the system's unique strengths and challenges, and make recommendations about infrastructure changes that will improve Virginia's Part C system. At the first meeting of the task force, Virginia's Secretary of Health and Human Resources, Jane Woods, charged the group with developing recommendations that are driven by and built around effective service delivery for eligible children and their families.

In the course of its work, the task force carefully examined administrative, funding and service delivery issues in Virginia's Part C system. Virginia is faced with a number of significant challenges, including the following:

- Virginia faces a significant fiscal crisis in the Part C system. The number of children served through Virginia's Part C system has increased almost 30% since 2000. However, in that same time frame, state and local agencies have reported a reduction in their voluntary contribution of state and local dollars budgeted for early intervention; public and private insurance reimbursement rates have fallen; the federal Part C allocation has increased about 8%; and other federal funding through DSS and unspent Part C funds have been eliminated. State general funds for early intervention had remained at \$125,000 per year through 2003 but were increased to \$825,000 per year starting in 2004 to begin addressing these fiscal issues.
- The current administrative structure, which is based on local interagency coordinating councils (LICC), leverages existing local working relationships and allows for flexibility to best use available resources to meet local needs and priorities. Local flexibility means, however, that there is inconsistency across the state in implementation of Part C requirements, policies and procedures. The LICC structure also raises difficulties and increased costs for private providers who serve children and families in areas that comprise more than one local council area.
- In order to disseminate Part C funds to localities and establish local accountability for Part C requirements, DMHMRSAS signs a contract annually with the local council and the local fiscal agent. However, the *Code of Virginia* provides no legal authority by which the LICC (or its agent) can enter into a contract. The current "contract" is unenforceable.

Based on their analysis of all aspects of Virginia's Part C system, research into Part C infrastructure issues in 5 other states, and public comment on the draft of this report, the task force makes the following recommendations:

- The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) will remain the State Lead Agency for Virginia's Part C system.
- The other state agencies involved in Virginia's Part C system will remain involved in the Early Intervention Interagency Management Team and the VICC. They will provide leadership and guidance to their local counterparts.
- In each of the 40 CSB areas, there will be a Local Lead Agency. The Local Lead Agency may be any public agency, as determined by the local Part C system.
- The LICC will advise and assist the Local Lead Agency in implementing the local Part C early intervention system.
- The local participating agencies/providers will carry out the responsibilities outlined in contracts with the Local Lead Agency and/or in local interagency agreements.
- Part C funds will be allocated from the State Lead Agency to each of the Local Lead Agencies through a Part C contract with DMHMRSAS.
- The *Code of Virginia* will be revised to reflect the duties, as outlined in these recommendations, of Local Lead Agencies and of Local Interagency Coordinating Councils.

- Each local Part C system will have a single point of entry for all referrals.
- State and local policies and procedures will make clear that the payor of last resort requirement does not supersede the individualized determination of entitled supports and services.
- Individualized services, data systems, benchmarks for service delivery (which will be developed with stakeholders), and review/appeal procedures will be developed and implemented to support use of the guidelines detailed in *Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places*.
- A quality assurance system, including routine monitoring of IFSPs, will be developed and implemented.
- A comprehensive data system will be developed and implemented to manage and monitor Virginia's Part C system.
- DMHMRSAS will use its authority to more carefully monitor/supervise and enforce contract obligations.
- Uniform billing practices are supported by the task force and will be more thoroughly explored in long-range planning.
- A task force will be established to further research and make recommendations related to possible additional economies of scale and efficiencies.
- Virginia's criteria for Part C eligibility (e.g., 25% delay, atypical development, or diagnosed condition with high probability of resulting in delay) will remain the same.
- DMHMRSAS will continue to work with other participating state agencies to identify possible funding assistance for the Part C system from those agencies and to coordinate interagency support for efforts to increase state funding for Part C in the 2006 budget.

II. Background

In August 2003, the Department of Mental Health, Mental Retardation, convened a group of stakeholders and Substance Abuse Services (DMHMRSAS) to examine Virginia's Part C system, identify the system's unique strengths and challenges, and make recommendations about infrastructure changes that will improve Virginia's Part C system. The task force membership is comprised of state agency representatives, members of the Early Intervention Interagency Management Team, DMHMRSAS staff, Community Services Board (CSB) Executive Directors, CSB MR Directors, local council coordinators, private providers and families (Appendix A provides a list of task force members). At the first meeting of the task force, Virginia's Secretary of Health and Human Resources, Jane Woods, charged the group with developing recommendations that are driven by and built around effective service delivery for eligible children and their families.

Aspects of the Part C infrastructure examined and discussed included, but were not limited to, the following: what agency should be Virginia's Lead Agency for the Part C system; the relationship of the Lead Agency with other state agencies involved in Part C; the roles and responsibilities of the local interagency coordinating councils; the issues and difficulties in service delivery; and the process for contracting with local Part C systems for implementation of Part C to ensure accountability for receiving and managing Part C funds as well as implementing Part C programmatic requirements. In order to address the complex issues related to implementation of Part C, the task force formed three committees: Service Delivery, Infrastructure, and Local Contract. The task force also reviewed a number of documents in the course of its work (Appendix B provides a list of those documents).

The task force adopted the following set of guiding principles to be used in all decision-making:

- Children and families will remain the primary focus of the task force throughout the process of studying the issues and considering possible solutions.
- The task force will consider its work in the context of the following criteria:
 - The impact on stakeholders and partners, including caregivers, providers, schools, other public entities, taxpayers, the medical community, the General Assembly, insurance providers, businesses, and the multilingual community will be fully examined.
 - Interim or short-term solutions, as well as long-term solutions, will be identified and implemented when appropriate.
 - Potential unintended consequences will be anticipated and possible solutions identified.
 - The proposed solutions will:
 - Be in compliance with federal regulations;
 - Maintain or increase families' access to supports and services;
 - Maintain or enhance the quality of supports and services;
 - Promote quality and consistency across the state while maintaining local flexibility;
 - Support evidence-based early intervention practices;
 - Be the most cost effective/efficient solution to simplify administrative and programmatic paperwork;
 - Provide the most cost-effective and time efficient mechanism to collect essential data;
 - Include a mechanism for continuously evaluating the effectiveness of the system especially in response to changes in the external environment, including changes in federal and state regulations, funding sources, etc.; and
 - Be relatively easy to modify when evaluation indicates that changes are needed.

Note: Within this report, the term "local" will be used to refer to the 40 local Part C systems. The term "regional" will be used to refer to a consolidation or clustering together of some group of the 40 local Part

C systems. “Local Part C system” refers to the local service delivery system, which includes the Local Lead Agency, the Local Interagency Coordinating Council, and local Part C service providers.

III. Brief History of Virginia’s Part C System/Description of Current Administrative Structure

The development and implementation of early intervention programs across Virginia was facilitated by local initiative in the 1970s. In 1980, prevention/early intervention was recommended as a core service for the local Community Services Boards (CSBs). Historically, then, CSBs were the primary providers of early intervention services in Virginia (using state mental retardation funds targeted for early intervention services beginning in the early 1980s).

Congress enacted federal early intervention legislation in 1986 as an amendment to the Education of Handicapped Children’s Act to ensure that all children with disabilities from birth to three would receive appropriate early intervention services. This amendment formed Part H of the Act, which was re-authorized in 1991 and renamed the Individuals with Disabilities Education Act (IDEA). When the IDEA was re-authorized in 1998, Part H became Part C of the Act.

Virginia has participated in the federal early intervention program (under IDEA) since its inception. In 1992, the Virginia General Assembly passed state legislation, which codified an infrastructure for the early intervention system that supports shared responsibility for the development and implementation of the system among various agencies at both the state and local levels. This legislation was designed to help Virginia meet federal regulations and guidelines by facilitating a move from a model of programmatic, single-agency responsibility for service provision to an interagency, shared responsibility for developing the early intervention system and providing direct services to infants and toddlers with disabilities and their families.

The *Code of Virginia* (§§ 2.2-2664, and 2.2-5300 - 2.2-5308), which was revised in 2001, provides the framework for Virginia’s Part C early intervention system as follows:

- Defines “participating agencies” as the Departments of Health, of Education, of Medical Assistance Services, of Mental Health, Mental Retardation and Substance Abuse Services and of Social Services; the Departments for the Deaf and Hard of Hearing, for the Blind and Vision Impaired, and for Rights of Virginians with Disabilities; and the Bureau of Insurance within the State Corporation Commission.
- Establishes an Early Intervention Agencies Committee at the state level to ensure the implementation of a comprehensive system for early intervention services (NOTE: During the 2004 General Assembly session, House Bill 15 amended the *Code of Virginia* and eliminated the Early Intervention Agencies Committee as part of efforts to streamline state government);
- Specifies that the Governor-appointed Lead Agency (currently DMHMRSAS) have responsibility for administering the statewide interagency system of Part C early intervention services.
- Establishes local interagency coordinating councils across the state to enable early intervention service providers to:
 - establish working relationships that will increase the efficiency and effectiveness of early intervention services;
 - identify existing early intervention services and resources;
 - identify gaps in the local service delivery system;
 - identify alternative funding sources; and
 - develop local procedures and mechanisms for implementing policies and procedures in accordance with state and federal statutes and regulations.
- Specifies the duties of participating agencies at the state and local levels.

Please see Appendix C for the full text of the *Code of Virginia* sections related to Part C early intervention.

Within the infrastructure established by the *Code of Virginia*, the broad parameters for Virginia’s Part C system are established at the state level to ensure implementation of federal Part C regulations. Within the context of these broad parameters, local Part C systems determine exactly how their Part C systems will look based upon local resources and needs. In order to support local implementation of the requirements of the *Code of Virginia*, Virginia’s Part C Policies and Procedures further delineate that each local interagency coordinating council is, among other things:

- Strongly encouraged to be staffed by a local council coordinator;
- Required to elect a chairperson to preside over council operations; and
- Required to designate a fiscal agent to administer Part C funds at the local level.

In order to disseminate Part C funds to local Part C systems and establish local accountability for Part C fiscal and programmatic requirements, DMHMRSAS signs a contract annually with the local council and the local fiscal agent. However, the *Code of Virginia* provides no legal authority by which the local interagency coordinating council can enter into a contract for continuing participation in Part C. Similarly, the fiscal agent cannot be required to carry out Part C programmatic activities on behalf of the local council. Therefore, the current “contract” is unenforceable (it is neither a legal contract nor a provider agreement).

Strength:

There are strong local working relationships among agencies/providers that have been cultivated over time.

Challenge:

The existing contract is not enforceable and the local council has no authority under which to enter into a contract.

IV. Summary of Funding Issues in Virginia’s Part C System

Federal Part C Fiscal Requirements

Federal Part C funds are intended to be used by states as “glue money” to facilitate the coordination and collaboration of interagency resources and to expand and improve services. This intention is clear in the language of the fiscal assurances that states must agree to when receiving federal Part C funds:

- Federal funds made available under Part C will be used to supplement and increase the level of State and local funds expended for infants and toddlers with disabilities and their families and in no case to supplant such State and local funds appropriated or budgeted at the state and local level for Part C services. (34 CFR 303.124)
- Part C funds must be used as payor of last resort. Every effort will be made during planning and implementation of the interagency system of early intervention services to consider and access all available sources of funds prior to use of Part C funds. (34 CFR 303.126)

Virginia Policies, Procedures and Legislation Related to Funding for the Part C System

The following Part C policies and procedures and legislation have been developed and implemented in Virginia to address funding for the Part C system:

- State General Funds in the amount of \$125,000 were appropriated annually from 1992 through 2003 to DMHMRSAS for the provision of early intervention services for unserved and under-served Part C eligible children. Beginning in 2004, that amount was raised to \$825,000 per year.
- Through 2003, the allocation of Part C funds (federal and state) to Virginia's 40 local interagency coordinating councils included \$25,000 to each council plus a proportional share of the remaining funds, which are disseminated by a formula designed to address local differences and local need. The formula includes a population factor to which adjustments are made based upon a population change variable, the locality's ability to pay and a poverty index. The factors and weights of the formula were reviewed annually, and updated statistical data were entered into the formula each year to reflect current local needs. Due to the Part C budget deficit in 2004-2005, the State Fiscal Year 2005 Part C funds (state and federal) were disseminated to the 40 local Part C systems using a modified allocation methodology recommended by a stakeholder group. In an effort to maintain current services as much as possible despite reduced funding, this methodology used a combination of factors to balance the impact of using a three-year averaged child count formula and an across-the-board reduction in the allocation of Part C funds.
- The *Code of Virginia* was amended in 1997 and 1998, respectively, to require the State Employee Health Benefits Plan (§ 2.2-2818) and private insurers (§ 38.2-3418.5) to cover early intervention therapy services for Part C eligible children. This early intervention benefit only applies to certain classes of private insurance and is not available to all Virginia families with private insurance.
- A statewide, uniform ability to pay scale and process has been in place since January 1, 2002.

Revenue Sources in Virginia's Part C System

Based on a 2003 cost study of Virginia's Part C System, the following sources of revenue were accessed in State Fiscal Year 2004 (SFY-04):

- Part C Funds (State and Federal) = 23%
- Local Revenue = 38%
- Insurance = 14%
- Medicaid = 21%
- Family Fees (through ability to pay) = 2%
- Private/Other Funding = 2%

(Percentages refer to the percentage of the total Part C system revenue that comes from that source.)

Costs associated with Virginia's Part C System

The 2003 cost study of Virginia's Part C System determined the following with regard to the cost of Virginia's Part C system:

- The total cost of Virginia's early intervention system is estimated at \$32.5 million. This total includes provider costs, local council costs, and state level costs.
- Using the total cost estimate and child count data, the annual cost per child for a full year of services is calculated to be \$7,786.

Other Virginia Funding Issues

- Several state agencies voluntarily provide state and federal funds to localities for the provision of services under various initiatives but do not specify an amount that is to be spent on early intervention services. As a result, agencies decide the amount of money spent on early intervention based upon other state and local priorities, and there is no central control of funds for Part C services.

- Economic conditions and state budget cuts since FY-2001 have required some state and local agencies to reduce or eliminate funding for early intervention as they stretch their resources to meet multiple priorities. Presentations to the Task Force by the participating state agencies indicated that there were no additional funds or revenue sources available through their agencies to support Part C.
- Part C service providers have noted falling reimbursement rates from Medicaid and other third party payors.
- Additional Part C funds have been available since State Fiscal Year 2002 to local Part C systems that demonstrated the need for such funds in order to ensure Part C services for all eligible children and families (e.g. to avoid waiting lists or to keep in the local system providers that would otherwise leave due to insufficient reimbursement rates). These additional funds are comprised of unspent federal Part C funds that are available to Virginia as a result of Virginia being a year behind in accessing federal grant awards. These unspent funds are essentially one-time funds and have now been spent. There is currently no other funding to replace these federal dollars.
- One million dollars (\$1 million) of federal funds available through the Virginia Department of Social Services for the past 3 years will only be available to Virginia’s Part C system until the end of the current state fiscal year (SFY-04).

Strengths:

1. The early intervention insurance mandate has been in place since 1998
2. A consistent ability to pay process and scale has been in place since 2002

Challenges:

1. Budget cuts in other areas of state government have resulted in cost shifting that reduces state and local dollars budgeted by state and local agencies for early intervention services.
2. Providers have experienced decreasing reimbursement rates from Medicaid and other third party payors.
3. Local dollars make up over one-third of all revenue in the Part C system, yet this funding source is based on voluntary contribution by local agencies and, therefore, cannot be considered secure or stable.

V. Summary of Service Issues in Virginia’s Part C System

In considering services issues in Virginia’s Part C system, the Service Delivery Committee of the task force reviewed the early intervention process from entry to discharge from the Part C system. For each step in the process, the committee discussed relevant regulations, facilitating factors, barriers, and proposed actions. In order for infrastructure changes to have a positive impact on children and families, the new infrastructure must support the following:

- Consistent information to families about the philosophy of Virginia’s Part C system, beginning with the family’s first contact with the Part C system.

- Consistent implementation of the Part C supports and services guidelines, in accordance with *Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places*.
- Use of a quality assurance system including routine monitoring of IFSPs.
- Use of the local contract to clearly identify specific service requirements (e.g. use of existing evaluation information, adherence to Part C eligibility requirements, implementation of supports and services guidelines, and adherence to 90-day transition conference requirement).
- State authority to more carefully monitor/supervise and enforce contract obligations.

A complete chart reflecting the committee’s discussions and recommendations is included in Appendix D.

<p><u>Strengths:</u></p> <ol style="list-style-type: none"> 1. Technical assistance is available from the state to support LICCs and Part C providers 2. State provides training and written technical assistance documents to LICCs and Part C providers on statewide systems topics (e.g. supports and services in typical routines and environments, transition, hearing and vision evaluation, etc.). 3. Statewide monitoring system, MIMS, is in place. Record review forms have been developed and disseminated to LICCs for quarterly review of IFSPs. 	<p><u>Challenges:</u></p> <ol style="list-style-type: none"> 1. Inconsistency across the state in how local Part C systems implement various Part C requirements (e.g. eligibility, “team” evaluation, required evaluation team members, writing outcomes, recording data, frequency and intensity of services, service documentation, etc.) 2. There is no means by which to monitor on an ongoing basis the services identified on IFSPs, yet Virginia is obligated to provide those services. 3. Perceptions by some that more is better, services in clinics are better 4. Variability in service coordinator training, skills, abilities, caseloads across the state
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VI. Overlap of Administrative, Funding and Service Issues

Virginia is faced with a number of significant challenges in maintaining a Part C early intervention system that meets federal and state requirements and results in positive outcomes for eligible children and their families.

- Virginia faces a significant fiscal crisis in the Part C system. The number of children served through Virginia’s Part C system has increased almost 30% (based on annualized child count) since 2000. Natural settings were the primary location for Part C services for approximately 65% of eligible children in 2000 and for 95% in 2003. Services provided in natural environments increase costs (due to inadequate insurance reimbursement rates, increased associated costs such as travel, etc.). However, in that same time frame, state and local agencies have reported a reduction in state and local dollars budgeted for early intervention; public and private insurance reimbursement rates have fallen; and the federal Part C allocation has increased approximately 8%. In addition, funding previously available through DSS and unspent federal Part C funds (as a result of Virginia being a year behind in accessing federal grant awards) are no

longer available. State general funds for early intervention had remained at \$125,000 per year through 2003 but were increased to \$825,000 per year starting in 2004 to begin addressing these fiscal issues.

- A deficit-based, services-driven, medical model (i.e., public and private insurance) is being used to fund an assets-based, functional outcomes driven, developmental model of supports and services. This results in constant challenges as providers attempt to satisfy two “masters,” while avoiding costly duplicative paperwork and ensuring that children and families receive the supports and services they need through the Part C system.
- The current administrative structure, which is based on local interagency coordinating councils, leverages the strong local working relationships that are in place and allows for flexibility to best use available resources to meet local needs and priorities. In addition, local revenue provides over one-third of all revenue in Virginia’s Part C system. Local flexibility means, however, that there is a great deal of inconsistency across the state in terms of how Part C requirements, policies and procedures are implemented. Eligible children and families may experience different service delivery and service coordination approaches based on where they live (rather than based just on the child’s and family’s priorities, interests, needs, etc.). The local council based structure also raises difficulties and increased costs for private providers who serve children and families in areas that comprise more than one local council area (and, therefore, must have contracts with multiple council areas with different requirements, paperwork, billing systems, etc.).

VII. Profiles of Current Part C Infrastructure in Virginia and in Five Other States Studied by the Task Force

The task force examined the Part C systems of five other states to help inform the group’s efforts to develop and analyze possible infrastructure alternatives for Virginia. The five states were selected based on discussion with the National Early Childhood Technical Assistance Center (NECTAC) and chosen to reflect a variety of billing systems, lead agencies, and administrative structures (e.g. local councils, regional systems, etc.). The states interviewed were North Carolina, Maryland, Kentucky, Indiana, and Louisiana. The questions used in gathering information from these five states fell into the following categories:

- Service Issues
- Natural Environment Issues
- Local System Issues
- General Finance Issues
- Insurance/Medicaid/Payment Issues
- Central Billing Issues

The full list of questions asked is provided in Appendix E. The table provided in Appendix E summarizes the information gathered from the five states as well as corresponding information about Virginia’s current infrastructure.

VIII. Possible Infrastructure Alternatives for Virginia’s Part C System

Based on the discussions of the task force and their review of Part C systems in five other states, three infrastructure alternatives were identified for further consideration by the task force:

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.

Each of these three infrastructure alternatives considered by the task force, as well as two hybrid alternatives that pull together pieces from each of the original three alternatives, are discussed in more detail in Appendix F. The role of the State Lead Agency, role of other state agencies, role of the Local Interagency Coordinating Council, role of local participating agencies/providers, flow of funds, billing system, and the pros and cons are examined for each alternative.

The infrastructure alternatives were discussed and evaluated by the task force in the context of the following five questions:

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?

IX. Recommendations of the Task Force

Based on their analysis of all aspects of Virginia's Part C system, research into Part C infrastructure issues in 5 other states, and public comment on the draft of this report the task force makes the following recommendations:

1. **The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) will remain the State Lead Agency for Virginia's Part C system.** The role of the State Lead Agency will remain the same as in Virginia's current infrastructure. The duties of the State Lead Agency will include:
 - Promulgating regulations and adopting the policies and procedures as necessary to implement an early intervention services system and assure consistent and equitable access to such services, including, but not limited to, uniform statewide procedures for public and private providers to determine parental liability and to charge fees for early intervention services in accordance with federal law and regulations, in consultation with other participating agencies;
 - Providing technical assistance to local Part C systems;
 - Establishing an interagency system of monitoring and supervising the early intervention services system; and
 - Determining priorities associated with and allocating funding for child find to Local Lead Agencies based on monitoring results and data review.
2. **The other state agencies involved in Virginia's Part C system will remain involved in the Early Intervention Interagency Management Team and the VICC.** They will provide leadership and guidance to their local counterparts about ways in which they can be involved in the local Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the LICC; provision of financial support; etc).
3. **In each of the 40 CSB areas, there will be a Local Lead Agency.** The Local Lead Agency must be a public agency. In order to determine the Local Lead Agency in each area, the agency currently serving in that role will be given the opportunity to continue. If that agency is not willing to continue as Local Lead Agency, then other local public agencies will be considered by the local Part C system. If the local Part C system is unable to determine a Local Lead Agency through the process described above, then the State Lead Agency will work with the local Part C system to make that determination. If there is a reason that the number of Local Lead Agencies becomes different than 40, then local

determination will drive the decision as to why current local Part C systems might combine; thus, any number that is appropriate at a particular time is allowed. Some activities, such as public awareness, may occur at a regional level as occurs now among some local Part C systems.

Responsibilities of the Local Lead Agency will include ensuring that a local system of early intervention services is in place and meets all Part C regulations and state Part C Policies and Procedures (including those related to public awareness, child find, evaluation and assessment, IFSPs, personnel, data collection, natural environments, monitoring, procedural safeguards, etc) and that all Part C fiscal and program assurances are met. In addition, the Local Lead Agency will receive Part C funds from the State Lead Agency, contract or otherwise arrange for services with local providers, prepare and submit budget and expenditure reports, etc. The Local Lead Agency will be responsible for ensuring that all available sources of funding are accessed for payment for Part C services in accordance with Part C payor of last resort and non-supplanting requirements. The Local Lead Agency will ensure that Medicaid and other third party payors are billed, as appropriate, and that the statewide ability to pay procedures to determine and collect family fees are implemented (in accordance with regulations, policies and procedures adopted by the State Lead Agency and as stated in the *Code of Virginia*).

Responsibilities related to being the Part C Local Lead Agency will be detailed in a contract between DMHMRSAS and the Local Lead Agency. Since the Local Lead Agency may also be a service provider in the local Part C system, the local contract between DMHMRSAS and the Local Lead Agency will specify safeguards to eliminate any conflict of interest in budgeting and use of Part C funds.

4. **The LICC will advise and assist the Local Lead Agency in implementing the local Part C early intervention system** (in the same way that the VICC advises and assists the lead agency at the state level). Issues on which the LICC will advise and assist the Local Lead Agency will include, but not be limited to, the following:
 - Identifying existing early intervention services and resources;
 - Identifying gaps in the service delivery system and developing strategies to address these gaps;
 - Facilitating the development of interagency agreements and supporting the development of service coalitions;
 - Implementing policies and procedures that will promote interagency collaboration; and
 - Developing local procedures and determining mechanisms for implementing policies and procedures in accordance with state and federal statutes and regulations.

The need for a core group, as currently outlined in the *Code of Virginia* will be eliminated since all fiscal and policy decisions will be made by the Local Lead Agency.

5. **The local participating agencies/providers will carry out the responsibilities outlined in contracts with the Local Lead Agency and/or in local interagency agreements.** Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the LICC. In addition, all local participating agencies/providers will be responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.).
6. **Part C funds will be allocated from the State Lead Agency to each of the Local Lead Agencies through a Part C contract with DMHMRSAS.** The local contract between the Local Lead Agency and DMHMRSAS will clearly identify specific service requirements (e.g. use of existing evaluation

information, adherence to Part C eligibility requirements, implementation of supports and services guidelines, and adherence to 90-day transition conference requirement). The Local Lead Agency will contract with local Part C service providers as needed. The Local Lead Agency may also be a provider of services. The Local Lead Agency will provide budget and expenditure reports to the State Lead Agency.

7. **The *Code of Virginia* will be revised to reflect the duties, as outlined in these recommendations, of Local Lead Agencies and of Local Interagency Coordinating Councils.** Revised wording in the *Code of Virginia* will support implementation of a valid local contract for Part C participation between the Local Lead Agency and DMHMRSAS, including the scope of responsibilities that need to be covered within that contract. Ability to pay policies and procedures will be reviewed (e.g. family responsibility and how assistive technology devices are addressed under the ability to pay practices), and the *Code of Virginia* will be revised accordingly.
8. **Each local Part C system will have a single point of entry for all referrals.** Consistent information will be given to families about the philosophy of Virginia's Part C system, beginning with the family's first contact with the Part C system.
9. **State and local policies and procedures will make clear that the payor of last resort requirement does not supersede the individualized determination of entitled supports and services.** Those supports and services identified on the IFSP are those determined by the IFSP team to be necessary and appropriate in order to meet the IFSP outcomes, and it is the supports and services listed on the IFSP to which the child and family are entitled under Part C. Determination of payment and reimbursement sources are considered only after the entitled supports and services are identified by the IFSP team.
10. **Individualized services, data systems, benchmarks for service delivery (which will be developed with stakeholders), and review/appeal procedures will be developed and implemented to support use of the guidelines detailed in *Individualized Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places*.**
11. **A quality assurance system, including routine monitoring of IFSPs, will be developed and implemented.**
12. **A comprehensive data system will be developed and implemented to manage and monitor Virginia's Part C system.**
13. **DMHMRSAS will use its authority to more carefully monitor/supervise and enforce contract obligations.**
14. **Uniform billing practices are supported by the task force and will be more thoroughly explored in long-range planning.** Centralized billing may be an option in the future, but with the lack of data regarding cost of implementation and other matters, it will not be implemented at this time.
15. **A task force will be established to further research and make recommendations related to possible additional economies of scale and efficiencies.** The following aspects of Virginia's Part C system will be considered as ones which could be better implemented in new ways, once conditions and data support a better and more efficient way: provider enrollment, contracts with providers, consistency in forms, consistency in billing for Part C funds, and consistency in use of procurement. It is recommended that this new task force revisit more recent activities in the five states interviewed

for this report and consider whether there are other state Part C systems whose experiences may also inform task force work.

16. **Virginia’s criteria for Part C eligibility (e.g., 25% delay, atypical development, or diagnosed condition with high probability of resulting in delay) will remain the same** since cost study data and data from other state Part C systems indicate that more restrictive eligibility does not necessarily result in cost savings. DMHMRSAS will determine whether parents are consistently informed of their option to transition to preschool special education services under Part B at age 2 (by September 30th) and will provide technical assistance in any areas where this is not occurring. The August 2003 technical assistance document, *Early Childhood Transition from Part C Early Intervention to Part B Special Education and Other Services for Young Children with Disabilities*, provides a reference for successful implementation of transition requirements, including families’ options with regard to age at transition.
17. **DMHMRSAS will continue to work with other participating state agencies to identify possible funding assistance for the Part C system from those agencies and to coordinate interagency support for efforts to increase state funding for Part C in the 2006 budget.** DMHMRSAS will work with the Department of Medical Assistance Services (DMAS) to investigate a potential “carve-out” of Part C services under Medicaid.

X. Rationale for Recommendations

The task force recommendations reflect the strong belief of task force members and those who submitted public comments that local Part C systems are (1) most responsive to family needs; (2) able to build on existing relationships and public-private partnerships; (3) consistent with DMHMRSAS’ service delivery system, which invests in local control of services; (4) the only way to preserve the local revenue that provides 38% of the total revenue in Virginia’s Part C system; and (5) already a consolidation of the over 100 cities and counties in Virginia. Major concerns related to a more regionalized approach to Part C service delivery centered around costs/funding, legal and political barriers to creating a regional entity, and moving the infrastructure too far from the children and families it serves.

APPENDIX A:

List of Task Force Members

Task Force To Evaluate
Virginia's Early Intervention System
Membership List

Karen Adams County of Henrico P. O. Box 27032 4301 East Parham Road Richmond, VA 23273	Assistant County Attorney 804-501-4677 ada14@co.henrico.va.us
Martha Adams PO Box 1797 Richmond, VA 23218-1797	Director, MR Services (804) 786-5850 MAdams2@dmhmrsas.state.va.us
Janet Areson P.O. Box 12164 13 East Franklin St. Richmond, 23241	Director, Policy Development Virginia Municipal League 804/649-8471 JAreson@vml.org
Deana Buck Infant & Toddler Connection of Richmond VCU Box 843020 700 E. Franklin Street - 10 th Floor Richmond, VA 23219	Local Council Coordinator 804-828-0198 dbuck@mail2.vcu.edu
Debbie Burcham Henrico Area MH & R Services Board 10299 Woodman Road Glen Allen, VA 23060-2798	MR Director 804-261-8520 bur23@co.henrico.va.us
Scottie Burnette 3104 Sylvatus Highway Hillsville, VA 24343	Parent Representative 276-730-0213 sburnette@arcfip.org
Nancy Butts 1421 Third Street, S.W. Roanoke, VA 24016	Program Manager 540-982-2208 nancy@ptor.com
H. Doug Cox Department of Education James Monroe Building Richmond, VA 232162120	Assistant Superintendent Special Education & Student Services (804) 225-3252 dougcox@mail.vak12ed.edu

Donna DeChant
Naval Medical Center Portsmouth
Code 0465C-ATTN-Donna DeChant
620 John Paul Jones Circle
Portsmouth, VA 23708

Pediatric OT
757-953-5168

dadechant@mar.med.navy.mil

Pat Dewey
Virginia Department of Health
P.O. Box 2448
Richmond, VA 23218-2448

EIIMT Representative
804-786-1964
pdewey@vdh.state.va.us

Tom Geib
Prince William CSB
8033 Ashton Avenue
Manassas, VA 20109-2892

Executive Director
(703) 792-7700
tgeib@pwcgov.org

Paul Gilding
PO Box 1797
Richmond, VA 23218-1797

Office of Community Contracting
(804) 786-4982
pgilding@dmhmrsas.state.va.us

Jim Gillespie
Rappahannock Area CSB
600 Jackson Street, 2nd Floor
Fredericksburg, VA 22401

MR Director
540-899-4420
jgillespie@racsb.state.va.us

Carol Granger
Chesterfield Infant Program
P.O. Box 92
6801 Lucy Corr Boulevard
Chesterfield, VA 23832

Local Council Coordinator
804-768-7205
grangerc@co.chesterfield.va.us

Jean Hearst
Rehabilitation Associates, P.C.
4560 South Blvd. Suite 310
Virginia Beach, VA 23452

Director
757-490-3223
jhearst@rehabilitationassociates.com

Louis I. Hochheiser, M.D.
Humana Military Healthcare Services 2/5, Inc.
514 Butler Farm Road
Hampton, VA 23666

Regional Medical Director
757- 846-2210
lhochheiser@humana.com

Marilyn Hoexter
Loudoun Interagency Coordinating Council
906 Trailview Blvd., Suite A
Leesburg, VA 20175

Local Council Coordinator
703-777-0561
mhoexter@loudoun.gov

Debra Holloway
The ARC of VA
2025 East Main Street, Suite 120
Richmond, VA 23223

Part C State Family Representative
804-649-8481
dholloway@arcfip.org

Julia Hood, RN, FAHM, CPUM
Humana Military Healthcare Services, Region 2
514 Butler Farm Road
Hampton, VA 23666

Regional UM Manager
757-846-2267
jhood@humana.com

Terry Jenkins
Pembroke Six, Suite 208
VA Beach, VA 23462

Executive Director
(757) 437-5766
tjenkins@vbgov.com

Jan Jessee
1421 Third Street, S.W.
Roanoke, VA 24016

Director
540-982-2208
jan@ptor.com

Brenda Laws
PO Box 70
15150 Merry Cat Lane
Belle Haven, VA 23306

VICC Chair
757-442-4578
luvdoes@intercom.net

Heidi L. Lawyer
202 N. Ninth Street, 9th Floor
Richmond, VA 23215

Executive Director, Virginia Board for
People with Disabilities
804-786-7335
lawyerhl@VBPd.State.VA.US

Dean A. Lynch, CAE
Virginia Association of Counties
1001 East Broad Street, Suite LL 20
Richmond, VA 23235

Director of Local Government Affairs
804-343-2506
lynch@vaco.org

Phillip Markert
Staff Attorney, VOPA Regional Office
114 MacTanly Pl
Staunton VA 24401-2373

EIIMT Representative
(540) 332-7130
MarkerPJ@vopa.state.va.us

Martha Mead
PO Box 1797
Richmond, VA 23218-1797

Office of Legislation & Public Relations
804-786-9048
mmead@dmhmrsas.state.va.us

Phyllis Mondak
Department of Education
James Monroe Building, 20th FL
Richmond, VA 23218

EIIMT Representative
804-225-2675
pmondak@mail.vak12ed.edu

Miriam Owens
3617 Harris Ave.
Richmond, VA 23223

VICC Parent
804-343-3617
ownezcrew@aol.com

Jennifer Peers
202 N. Ninth Street,
9th Floor
Richmond, VA 23215

YLF Program Assistant/Parent
Virginia Board for People with
Disabilities
804-786-3441
peersjr@vbpd.state.va.us

Kathy Phillips
Rural Infant Services Program
PO Box 40
Saluda, VA 23149

Local Council Coordinator
804-758-5250
kphillips@ccsinc.com

Ray Ratke
PO Box 1797
Richmond, VA 23218-1797

Deputy Commissioner
(804) 786-3921
RRatke@dmhmrsas.state.va.us

Shirley Ricks
PO Box 1797
Richmond, VA 23218-1797

Office of Children & Family Services
804-786-0992
sricks@dmhmrsas.state.va.us

Rosanna Roberts
PO Box 1797
Richmond, VA 23218-1797

Office of Grants Management
(804) 371-0361
rroberts@dmhmrsas.state.va.us

Bob Schmid
PO Box 1797
Richmond, VA 23218-1797

Office of Grants Management
(804) 371-4607
bschmid@dmhmrsas.state.va.us

Glen Slonneger
Dept. for the Blind and Vision Impaired
397 Azalea Avenue
Richmond, VA 23219

EIIMT Representative
804-371-3113
SlonneGR@DBVI.State.VA.US

Deborah M. Sprang
Maternal Child Health Policy Analyst
600 E. Broad St, Suite 1300
Richmond, VA 23219

DMAS Representative
804-225-2364
dsprang@dmass.state.va.us

Sandra Whitaker
37465 General Mahone Blvd.
Ivor, VA 23866-3017

VICC Parent
757-859-9431
ddadvocate@netzero.net

Tera Yoder
Partnership for People with Disabilities
VCU Box 843020
700 E. Franklin Street - 10th Floor
Richmond, VA 23219

Director Program Planning
804-828-3879
tyoder@titan.vcu.edu

Infant & Toddler Connection of Virginia Staff:

Mary Ann Discenza
1220 Bank Street
PO Box 1797
Richmond, VA 23218-1797

Virginia Part C Coordinator
804-371-6592
mdiscenza@dmhmrsas.state.va.us

Karen Durst
1220 Bank Street
PO Box 1797
Richmond, VA 23218-1797

804-786-9844
kdurst@dmhmrsas.state.va.us

Beth Tolley
1220 Bank Street
PO Box 1797
Richmond, VA 23218-1797

804-371-6595
btolley@dmhmrsas.state.va.us

Beverly Crouse
Part C Early Intervention
222 Lane Hall
Virginia Tech
Blacksburg, VA 24061

540-231-6208
btcrouse@vt.edu

APPENDIX B:

List of Documents Reviewed by Task Force

Documents Reviewed by the Infrastructure Task Force

- Overview of the Infant and Toddler Connection of Virginia
- H.R.5 Part C – Infants and Toddlers with Disabilities – Section 631. Findings and Policy; General Authority; Eligibility; Requirements for Statewide System; Individualized Family Service Plan
- *Code of Virginia* related to Part C Early Intervention (2.2 – 2664; 2.2–5301 – 2.2-5305; 38.2-3418.5)
- Natural Environments – Correlations with Federal Regulations, Policies and Procedures and OSEP Policy Letters
- Local Contract for Continuing Participation in Part C – SFY 2004
- Infrastructure Chart
- Part C Regulations
- IFSP Form
- Cross-Reference of Federal Part C regulations, *Code of Virginia*, and Virginia Policies and Procedures
- Matrix of Committee Structure
- Other documents provided in the Appendices to this report

APPENDIX C:

Code of Virginia
Related to Part C Early Intervention

House Bill 15 (2004)

Code of Virginia

§ 2.2-2664. Virginia Interagency Coordinating Council; purpose; membership; duties.

- A. The Virginia Interagency Coordinating Council (the council) is established as an advisory council, within the meaning of § 2.2-2100, in the executive branch of state government. The purpose of the council shall be to promote and coordinate early intervention services in the Commonwealth.
- B. The membership and operation of the Council shall be as required by Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). The member of their agency who serves on the early intervention agencies committee shall appoint the agency representatives. Agency representatives shall regularly inform their agency head of the Council's activities and the status of the implementation of an early intervention services system in the Commonwealth.
- C. The Council's duties shall include advising and assisting the lead agency in the following:
1. Performing its responsibilities for the early intervention services system;
 2. Identifying sources of fiscal and other support for early intervention services, recommending financial responsibility arrangements among agencies, and promoting interagency agreements;
 3. Developing strategies to encourage full participation, coordination, and cooperation of all appropriate agencies;
 4. Resolving interagency disputes;
 5. Gathering information about problems that impede timely and effective service delivery and taking steps to ensure that any identified policy problems are resolved;
 6. Preparing federal grant applications; and
 7. Preparing and submitting an annual report to the Governor and the U.S. Secretary of Education on the status of early intervention services within the Commonwealth. (1992, c. 771, § 2.1-765; 2001, c. 844.)

§ 2.2-5300. (Effective October 1, 2001) Definitions.

As used in this chapter, unless the context requires a different meaning:

"Council" means the Virginia Interagency Coordinating Council created pursuant to § 2.2-2664.

"Early intervention services" means services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended, designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. Early intervention services provided in the child's home and in accordance with this chapter shall not be construed to be home health services as referenced in [§ 32.1-162.7](#).

"Participating agencies" means the Departments of Health, of Education, of Medical Assistance Services, of Mental Health, Mental Retardation and Substance Abuse Services, and of Social Services; the Departments for the Deaf and Hard-of-Hearing, for the Blind and Vision Impaired, and for Rights of Virginians with Disabilities; and the Bureau of Insurance within the State Corporation Commission.

(1992, c. 771, § 2.1-760; 1999, cc. 640, 684; 2001, c. 844.)

§ 2.2-5301. (Effective October 1, 2001) Secretaries of Health and Human Resources and Education to work together.

The Secretaries of Health and Human Resources and Education shall work together in:

1. Promoting interagency consensus and facilitating complementary agency positions on issues relating to early intervention services;

2. Examining and evaluating the effectiveness of state agency programs, services, and plans for early intervention services and identifying duplications, inefficiencies, and unmet needs;
 3. Analyzing state agency budget requests and any other budget items affecting early intervention services,
 4. Proposing ways of realigning funding to promote interagency initiatives and programs for early intervention services,
 5. Formulating recommendations on planning, priorities, and expenditures for early intervention services and communicating the recommendations to the Governor and state agency heads,
 6. Formulating joint policy positions and statements on legislative issues regarding early intervention services and communicating those positions and statements to the General Assembly; and
 7. Resolving interagency disputes and assigning financial responsibility in accordance with Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.).
- (1992, c. 771, § 2.1-761; 2001, c. 844.)

§ 2.2-5302. (Effective October 1, 2001) Early intervention agencies committee.

An early intervention agencies committee shall be established to ensure the implementation of a comprehensive system for early intervention services. The committee shall be composed of the Commissioner of the Department of Health, the Director of the Department for the Deaf and Hard-of-Hearing, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Commissioner of the Department for the Blind and Vision Impaired, the Director of the Department for Rights of Virginians with Disabilities, and the Commissioner of the Bureau of Insurance within the State Corporation Commission. The committee shall meet at least twice each fiscal year and shall make annual recommendations to the Secretary of Health and Human Resources and the Secretary of Education on issues that require interagency planning, financing, and resolution. Each member of the committee shall appoint a representative from his agency to serve on the Virginia Interagency Coordinating Council.

(1992, c. 771, § 2.1-762; 2001, c. 844.)

§ 2.2-5303. (Effective October 1, 2001) Duties of participating agencies.

The duties of the participating agencies shall include:

1. Establishing a statewide system of early intervention services in accordance with state and federal statutes and regulations,
2. Identifying and maximizing coordination of all available public and private resources for early intervention services;
3. Developing and implementing formal state interagency agreements that define the financial responsibility and service obligations of each participating agency for early intervention services, establish procedures for resolving disputes, and address any additional matters necessary to ensure collaboration;
4. Consulting with the lead agency in the promulgation of regulations to implement the early intervention services system, including developing definitions of eligibility and services;
5. Carrying out decisions resulting from the dispute resolution process,
6. Providing assistance to localities in the implementation of a comprehensive early intervention services system in accordance with state and federal statutes and regulations; and

7. Requesting and reviewing data and reports on the implementation of early intervention services from counterpart local agencies.

(1992, c. 771, § 2.1-763; 2001, c. 844.)

§ 2.2-5304. (Effective October 1, 2001) Lead agency's duties.

To facilitate the implementation of an early intervention services system and to ensure compliance with federal requirements, the Governor shall appoint a lead agency. The duties of the lead agency shall include:

1. Promulgating regulations and adopting the policies and procedures as necessary to implement an early intervention services system and assure consistent and equitable access to such services, including, but not limited to, uniform statewide procedures on or before January 1, 2002, for public and private providers to determine parental liability and to charge fees for early intervention services in accordance with federal law and regulations, in consultation with other participating agencies; the regulations shall be adopted in accordance with the provisions of the Administrative Process Act (§ [2.2-4000](#) et seq.);
2. Providing technical assistance to localities in the establishment and operation of local interagency coordinating councils; and
3. Establishing an interagency system of monitoring and supervising the early intervention services system.

(1992, c. 771, § 2.1-764; 2001, cc. 562, 844.)

§ 2.2-5305. (Effective October 1, 2001) Local interagency coordinating councils.

- A. The lead agency, in consultation with the Virginia Interagency Coordinating Council, shall establish local interagency councils on a statewide basis to enable early intervention service providers to establish working relationships that will increase the efficiency and effectiveness of early intervention services. The membership of local interagency councils shall include designees from the following agencies who are authorized to make funding and policy decisions: community services board, department of health, department of social services, and local school division. These designees shall designate additional council members as follows: at least one parent representative who is not an employee of any public or private program that serves infants and toddlers with disabilities; representatives from community providers of early intervention services; and representatives from other service providers as deemed appropriate. Every county and city may appoint a representative to the respective local interagency coordinating council.
- B. The duties of local interagency coordinating councils shall include:
 1. Identifying existing early intervention services and resources;
 2. Identifying gaps in the service delivery system and developing strategies to address these gaps;
 3. Identifying alternative funding sources,
 4. Facilitating the development of interagency agreements and supporting the development of service coalitions,
 5. Assisting in the implementation of policies and procedures that will promote interagency collaboration,
 6. Developing local procedures and determining mechanisms for implementing policies and procedures in accordance with state and federal statutes and regulations; and
 7. Implementing consistent and uniform policies and procedures on or before January 1, 2002, for public and private providers to determine parental liability

and to charge fees for early intervention services pursuant to regulations, policies and procedures adopted by the lead agency in § [2.2-5304](#).

- C. Localities shall not be mandated to fund any costs under this chapter either directly or through participating local public agencies.

(1992, c. 771, § 2.1-766; 2001, cc. 562, 844.)

§ 2.2-5306. (Effective October 1, 2001) Duties of local public agencies.

Local public agencies represented on local interagency coordinating councils are responsible for:

1. Providing services as appropriate and agreed upon by members of the local interagency coordinating council;
2. Maintaining data and providing information as requested to their respective state agencies;
3. Developing and implementing interagency agreements;
4. Complying with applicable state and federal regulations and local policies and procedures; and
5. Following procedural safeguards and dispute resolution procedures as adopted by the Commonwealth.

(1992, c. 771, § 2.1-767; 2001, c. 844.)

§ 2.2-5307. (Effective October 1, 2001) Existing funding levels.

Any federal funds made available through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.) and any state funds appropriated specifically for Part H services shall supplement overall funding for services currently provided under Part of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.).

(1992, c. 771, § 2.1-768; 2001, c. 844.)

§ 2.2-5308. (Effective October 1, 2001) Licensures as home care organization not required.

Notwithstanding the provisions of § [32.1-162.9](#), no person who provides early intervention services in accordance with this chapter shall be required to be licensed as a home care organization in order to provide these services in a child's home.

(1999, cc. 640, 684, § 2.1-768.1; 2001, c. 844.)

CHAPTER 38

An Act to amend and reenact § 2.2-2664 of the Code of Virginia and to repeal § 2.2-5302 of the Code of Virginia, relating to the abolishment of the Early Intervention Agencies Committee.

[H 15]

Approved March 4, 2004

Be it enacted by the General Assembly of Virginia:

1. That § [2.2-2664](#) of the Code of Virginia is amended and reenacted as follows:

§ [2.2-2664](#). Virginia Interagency Coordinating Council; purpose; membership; duties.

A. The Virginia Interagency Coordinating Council (the Council) is established as an advisory council, within the meaning of § [2.2-2100](#), in the executive branch of state government. The purpose of the Council shall be to promote and coordinate early intervention services in the Commonwealth.

B. The membership and operation of the Council shall be as required by Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). *The Commissioner of the Department of Health, the Director of the Department for the Deaf and Hard-of-Hearing, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Commissioner of the Department for the Blind and Vision Impaired, the Director of the Virginia Office for Protection and Advocacy, and the Commissioner of the Bureau of Insurance within the State Corporation Commission shall each appoint one person from his agency to serve as the agency's representative on the Council.*

Agency representatives shall regularly inform their agency head of the Council's activities and the status of the implementation of an early intervention services system in the Commonwealth.

C. The Council's duties shall include advising and assisting the lead agency in the following:

1. Performing its responsibilities for the early intervention services system,
2. Identifying sources of fiscal and other support for early intervention services, recommending financial responsibility arrangements among agencies, and promoting interagency agreements,
3. Developing strategies to encourage full participation, coordination, and cooperation of all appropriate agencies,
4. Resolving interagency disputes,
5. Gathering information about problems that impede timely and effective service delivery and taking steps to ensure that any identified policy problems are resolved,
6. Preparing federal grant applications; and
7. Preparing and submitting an annual report to the Governor and the U.S. Secretary of Education on the status of early intervention services within the Commonwealth.

2. That § 2.2-5302 of the Code of Virginia is repealed.

APPENDIX D:

The Early Intervention Process From Entry to Discharge

The Early Intervention Process– From Entry to Discharge from the Early Intervention System

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
Identification	<p><u>Federal:</u> Referral to Central Point of Entry within 2 days</p> <p><u>Federal:</u> Participation of state education, health and social service agencies and (including Maternal and Child Health program under title V, EPSDT, DDA and Bill of Rights Act, Head Start Act, and SSI) in a coordinated child find system.</p>		<ul style="list-style-type: none"> • Contact with families is not always what it should be. Families don't always get a return call in a timely manner. • Contact from locality back to referral is not always what it should be. • Primary consumers need to know that they can make direct contact with central point of entry • Referrals from Dr. with set frequency. • Bad experiences result in bad PR. 	<ul style="list-style-type: none"> • Essential: Designate Central meaning single point of entry for each council or region with consistent information provided at point of entry into system. (Change Virginia policy and procedure language) • Contract specify that there is one central point of entry 		
<p>Initial Contact with Family</p> <p>Beginning discussions about priorities, concerns, resources --- and about activity settings, daily routines, hopes for child</p>	<p><u>Federal:</u> Prior Notice, Procedural Safeguards</p>		<ul style="list-style-type: none"> • Clarify timeline with all including referral sources (45 days is very open ended). • Local and state “paperwork” – intake, procedural safeguards, HIPAA, financial. • Needing copies of some family information • State contributions are already too low causing inadequate levels of services 	<ul style="list-style-type: none"> • Authority in contract language to ensure that the temporary service coordinator delivers the Part C philosophy information at the initial and subsequent visits with the family • (Possibly consistent scripts 	<ul style="list-style-type: none"> • State grants for digital camera, portable copier, and/or laptops to obtain copies of essential information in families’ homes • Let family know in advance what copies are needed. • Essential – and Related to Central Meaning Single Point of Entry: Use first contacts to lav 	<ul style="list-style-type: none"> • Information on more family friendly way to gather information • Provide consistent training across the state to support consistent application of Virginia’s service guidelines at each step of the IFSP process

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
				for what is said to families and consistent forms for intake, intake logs, forms for accessing Part C funds for assessment and services and associated costs of providing services (and documenting use of Part C as payor of last resort)	the groundwork for preparing families for how supports and services are provided through the ITC of VA and for obtaining information necessary for establishing initial outcome(s).	throughout every community in Virginia
Financial Intake	<u>Federal:</u> Procedural Safeguards <u>State:</u> Standard ATP Scale and Procedures	<ul style="list-style-type: none"> • EI mandate for private insurance statewide • Consistent ATP Scale and process • (Financial issues impact the IFSP meeting and the Provision of Supports and Services. Many of the issues are addressed in the Provision of Supports and Services Section) 	<ul style="list-style-type: none"> • Discomfort of having to ask parents to disclose personal financial information • Using a deficits-based, services-driven, medical model (insurance) to fund an assets-based, supports and services, parent education model. This results in a constant tension as providers try to satisfy two masters. Insurance company policies are compromising evaluation and service delivery, eg discipline specific evaluation and payor specific service requirements. 	<ul style="list-style-type: none"> • Expand Medicaid eligibility standards and programs (short-term) • State Grants to replace family fees and insurance (Long-term) 	<ul style="list-style-type: none"> • Essential: Establish a single model for a financial form to be used statewide by all Part C providers to explore financial resources with families. 	

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
<p>Evaluation</p> <p>Review of existing evaluation data and selection of evaluation team, tools, location</p>	<p><u>Federal:</u> Prior Notice, Procedural Safeguards</p>	<ul style="list-style-type: none"> • Training has been provided in 2003 (Phase II NE and at the November EI conference). 	<ul style="list-style-type: none"> • Duplication of services (i.e., child with current evaluation or IFSP not used) • Variability in meeting timelines and going over 45 days in some areas • Misunderstanding in purpose of evaluation • Overuse of resources (PT, OT, ST not needed for each evaluation) • Questions about disciplines, Rx, license, etc. • Varying test results from different tools/locations 	<ul style="list-style-type: none"> • Essential: Development of a data system that is consistently implemented at the local level and that provides meaningful information including use of resources and baseline information for determining program effectiveness. • Authority in contract language to ensure that evaluations less than 6 months old are used to determine eligibility rather than using Part C or Medicaid dollars to pay for additional evaluations and assessments. 	<ul style="list-style-type: none"> • Discipline free evaluation • <i>Use of existing test results</i> • <i>Strive for more true “team” approach, evaluating at same time</i> • <i>Consistency of evaluation tools</i> • <i>Increase awareness at referral sources and families about what will happen</i> • Encourage providers to review ICDF information • Suggest that Evaluation teams have the ICDF Guidance Document available with them at the evaluation for reference in case there are questions about eligibility. 	<ul style="list-style-type: none"> • Provide consistent training about the purpose of evaluation (for eligibility determination) and functional assessment across the state to support consistent application of Virginia’s service guidelines at each step of the IFSP process throughout every community in Virginia.
<p>Determination of Eligibility</p>	<p><u>Federal:</u> Prior Notice, Procedural Safeguards</p>		<ul style="list-style-type: none"> • Questions about medical vs. developmental needs • What to do if you have differing “scores”? • Needs to be more information about what 1) eligibility for Part C means and 2) 	<ul style="list-style-type: none"> • Authority in contract language to ensure that the evaluation teams adhere to Part C eligibility requirement in accordance with Virginia’s 		

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			what eligibility for specific service would mean	Supports and Services document using the Part C eligibility definition and the IFSP guidance document.		
<p>IFSP Meeting</p> <p>Determination of Outcomes, including target dates, and short term goals with target dates.</p> <p>Selection of primary (and possibly other) providers</p> <p>Determination of services including frequency, duration, method, location, start date, end date (page 6)</p> <p>Discussion about Transition (page 7)</p> <p>Review of what has been decided – signatures (page</p>	<p><u>Federal:</u> Prior Notice, Procedural Safeguards</p>		<ul style="list-style-type: none"> • We are using a deficits- based, services-driven, medical model (insurance) to fund an assets-based, supports and services, parent education model. This results in a constant tension as providers try to satisfy two masters • It is challenging to articulate parents' hopes so insurance will reimburse (some councils/providers are doing duplicate paperwork to assure reimbursement). • Challenges in obtaining and utilizing the input of the evaluation team (and where does functional assessment fit in) when the IFSP team is different from the evaluation team. • It is hard for some parents to articulate what they want for 	<ul style="list-style-type: none"> • Essential: Develop an enforceable quality assurance system of routine monitoring of IFSPs 	<ul style="list-style-type: none"> • Provide adequate funding so there is not a conflict between how services are to be provided and what is required from a reimbursement perspective. • Consider requiring levels of written explanation for high levels of service frequency and intensities on IFSPs 	<ul style="list-style-type: none"> • Provide consistent training across the state to support consistent application of Virginia's service guidelines at each step of the IFSP process throughout every community in Virginia • Continue to provide presentations at the annual EI Conferences

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
8)			<p>their child</p> <ul style="list-style-type: none"> • It is a challenge to figure out how to best use expertise of people at table to help family articulate their needs and hopes – particularly with the clock ticking • Need clarification on WHAT IS and IS not an entitled service and clear guidance on how the decision is made 			
IFSP - Continued			<ul style="list-style-type: none"> • Lack of clarity about Part C's responsibility for children with complex medical needs including cochlear implants, post orthopedic procedures, autism, etc. • Different models of services across the state • Different frequencies and intensity of services across the state (Can vary as much as one hour per month to 20 hours per week from one location to another) • Parents sometimes come to the IFSP meeting expecting to have the IFSP team approve and pay for services at a specific 			

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			<p>private school or organization.</p> <ul style="list-style-type: none"> • <i>There is no means of monitoring services on the IFSPs for which the state of Virginia is liable.</i> • Virginia's strategy to have councils expand networks to have as many providers participate as possible may pose a challenge with those who are minimally involved yet require full training, teaming time, etc. 			
<p>Provision of Supports and Services</p>	<p><u>Federal:</u> Services must be provided in natural environments unless the outcomes cannot be met in natural environments.</p> <p>Note that local IFSP team has been relied on by OSEP to prevail</p>	<ul style="list-style-type: none"> • New service guidelines - some areas have a mechanism for reviewing random selection of outcomes and IFSP 	<ul style="list-style-type: none"> • Costs associated with travel to provide services in natural environments • Medicaid cuts in reimbursement – differential cut in private providers versus CSBs • Lack of reimbursement for costs associated with travel for services in natural environments (private and CSBs) • Low provider rates • Perception about NE cost, practices • Lack of providers (speech especially) • Variation across the state in service frequency and number 	<ul style="list-style-type: none"> • Essential: Develop data system and consistent way of data collection at the local or regional level that is broader than iTOTS • Authority in contract language to use MIMS record review quarterly to monitor service delivery by review of at least 10% or 10 charts whichever is greater. (Need trigger for tracking) • Authority in 	<ul style="list-style-type: none"> • All contracts should reflect the services guidelines • Incorporate implementation of service guidelines into performance reviews • Need more training/checklist review by council coordinator of IFSP • EPSDT as a funding source 	<ul style="list-style-type: none"> • All EI personnel will complete the orientation module that provides basic information about the service guidelines, expectations of the IFSP team, etc • Provide consistent training across the state to support consistent application of Virginia's service guidelines at each step of the IFSP process throughout every

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			<p>frequency and number of services being provided</p> <ul style="list-style-type: none"> • Some children receiving Part C services + additional services from the same provider or a different provider (as "other services) if the doctor order more frequent services and/or the family requested/insisted on more frequent services. • Some Doctors and therapists and families still believe that more services will make the child progress more/faster, etc. • See IFSP – inconsistent practices across the state; various models, etc. 	<p>contract language to require providers to follow services guidelines (by incorporating this into performance reviews of staff and building it into contracts with providers)</p> <ul style="list-style-type: none"> • Build into contract authority for ongoing supervision and oversight. • Build into contract language mechanism to close the loophole that Part C providers use to avoid the Part C regs, specifically, the use of classification of therapy services as "other" services so that they can be provided more frequently or in the clinic for Part C children. • Include in contract language requirement that providers complete the 		<p>community in Virginia</p>

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
				orientation module • Include in contract language documentation requirement for service delivery for providers		
IFSP Reviews	<u>Federal:</u> Prior Notice, Procedural Safeguards	<ul style="list-style-type: none"> • Parent and Service Coordinator communicate ahead of time. • Experienced service coordinators or providers who prepare families for the meetings 	<ul style="list-style-type: none"> • Paperwork requirements • Process requirements (prior notice, service coordination IFSP team meeting, etc) • Differing times for IFSP and Insurance reviews are due • Meeting multiple requirements, including IFSP, insurance, targeted case management • Service Coordinator's time and availability • Provider(s)' time and availability • Services vary greatly throughout Virginia • It can be a challenge for a service provide to be both the service providers and also the service coordinator (and this can also be a plus) • Great variability in training, skills, knowledge, ability of service coordinators 			

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			<p>across Virginia</p> <ul style="list-style-type: none"> • Great variability in SC caseloads across Virginia 			
Transition Activities	Federal: Prior Notice, Procedural Safeguards	<ul style="list-style-type: none"> • Transition Technical Assistance Document has been disseminated • Page 7 of the state IFSP form serves as a reminder of required transition activities 	<ul style="list-style-type: none"> • Confusion about requirements • There are different processes for each local school system – and some councils have multiple school systems within their council • Families are not always provided with complete information – ie, they are not provided with options beyond school services • Part B is very different than Part C • The 90 day conference is handled differently from council to council • Part B in some parts of the state but not in others may see children who turn 2 after September 30. 	<ul style="list-style-type: none"> • Include in contract, requirement to adhere to 90 day transition conference requirement 		
Discharge from Part C Services			<ul style="list-style-type: none"> • Families no longer have service coordination (unless they have targeted case management) 			

APPENDIX E:

Profiles of Part C Infrastructure for 5 States -
List of Interview Questions
Chart of Information Gathered

Questions for “5 State Review Team” To Use in Securing Information

Service Issues

1. As the Part C system in your state has undergone development and changes, how have the changes impacted supports and services for families? Specifically, do the changes support teamwork? Do the changes support a primary service provider model of service provision?
2. How is service coordination provided in your state? What is the average caseload? Can service coordinators also be providers of other EI services?
3. Has trend data been collected on frequency, intensity, and location of services?
4. Is data collected to reflect differences in the initial IFSP and subsequent revisions?

Natural Environments Issues

1. Who makes the decision to provide a service in a setting other than the natural environment?
2. How is this (setting other than natural environment) documented?
3. How is the service paid for if the family makes the decision?
4. What are the rates for services in natural environments? In center settings? Are there other rate differentials?
5. Has your state been monitored by OSEP with respect to natural environments? Was your state cited as being out of compliance?

Local Systems Issues

1. Who employs the local interagency coordinator?
2. How does your state handle a central point of entry?
3. Can the central point of entry also be a provider of services?
4. What is the relationship between the central point of entry and the local interagency coordinating council?

General Finance Issues

1. How much money is in your total EI system and from what sources?
2. Of the total early intervention costs, what percent of your budget is used by the lead agency for operating costs?
3. How many children are being served? What is the cost per child?
4. How is the local interagency council funded? How is the local interagency coordinator paid for?
5. How is service coordination paid for? Is it reimbursed by child or by contact hour or by a monthly rate?
6. How “secure” is the system in your state – do you foresee a problem in continuing to fund your system?
7. Has your state undertaken any cost analysis studies? If so, what are the results?
8. Is local government making financial contributions to the Part C system? If so, is this counted and reported in the state budget for Part C?

Insurance/Medicaid/Payment Issues

1. Is insurance accessed for Part C services in addition to Medicaid? If so, how is this done (re: need for authorization and getting therapists to have provider numbers with insurance companies)?
2. Are families giving permission for their insurance to be billed? What is the success rate in accessing insurance?
3. What problems have surfaced (re: private insurance billing)?
4. Are families responsible for co-pays and deductibles?
5. Does your state have an ability to pay policy?
6. Who is responsible for collecting fees through ability to pay?
7. Does your state use the IFSP as the medical plan of care?
8. What role does EPSDT play in funding EI services?
9. What EI services are covered under the state's Medicaid plan (state plan option)?
10. How else is Medicaid funding used? What other methods are used to seek Medicaid funding?

Central Billing Issues

1. Does your state have centralized billing?

If yes, ask 2-10

2. What problem were you trying to solve when you went to centralized billing?
3. What is the relationship of the centralized billing system to the lead agency?
4. What is the cost of the centralized billing system to the lead agency?
5. Is a per child cost established?
6. Is the centralized billing agency liable for (Medicaid) audits and meeting Medicaid requirements?
7. Who does the centralized billing agency collect from? What third parties are involved?
8. Does the central billing agency collect co-pays and/or fees from families?
9. What are the advantages?
10. What are the disadvantages?

Profile of States (updated 12/1/03)

	Virginia	Indiana	Maryland
Role of Lead Agency	<p>Lead Agency is the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS).</p> <p>Their role:</p> <ul style="list-style-type: none"> • Promulgating regulations and adopting the policies and procedures to implement an early intervention system and assure consistent and equitable access to such services; • General Supervision and Monitoring; • Technical Assistance to LICCs, providers and families; and • Contract Management. 	<p>Lead Agency is the Indiana Family & Social Services Administration (FSSA).</p> <p>Their role:</p> <ul style="list-style-type: none"> • General Supervision and Monitoring • Technical Assistance to providers, LICCs and families • Contract Management • Central Reimbursement (Contracts with Covancis to do the billing.) 	<p>Prior to Part C Maryland had a birth mandate to provide FAPE to children with disabilities from birth to 21. Therefore, historically, there has been significant support through local school systems for services to infants and toddlers with disabilities. Also, the school systems were required to maintain their financial level of support as a condition of receiving Part C funding. The lead agency initially was the Governor's Office for Children, Youth, and Families (OCYF). The Lead Agency changed on 7/1/97 to the Department of Education after a reorganization in the OCYF. The Lead agency staffing includes a part C Coordinator and full-time staff responsible for finance, data collection and analysis, training, technical assistance, and public awareness. There is State Interagency Coordinating Council co-chaired by a parent and a community provider.</p> <p>The State lead agency contracts with the local lead agencies to deliver services at the local level. The total Part C budget for Maryland in FY 03 was \$39.6 million. This includes federal funding (Part C and Part B – 22%) Medical Assistance (6%), State Funds (13%), and local government funds (58%). There was a recent legislative initiative for Educational Reform, as a result, State early intervention funding increased from \$400,000 to \$5.2million in FY 03.</p>
Local system and provider network	<p><u>Local Interagency Coordinating Councils (LICCs)</u></p> <p>The broad parameters for the PART C system are established at the state level to ensure implementation of federal Part C regulations. Within the context of these broad parameters, localities determine exactly how their Part C systems will look based upon local resources</p>	<p>Local Planning and Coordinating Councils</p> <p>Each of Indiana's 92 counties appoints a Local Planning and Coordinating Council (LPCC) whose primary responsibility is to advise and assist with the implementation of the First Steps System in their County. Through the Local Planning and Coordinating</p>	<p><u>Local Service Delivery and Coordinating Councils</u></p> <p>There are 24 local interagency Infants and Toddlers Programs (LITPs) in Maryland (which correspond to Maryland's 23 counties and Baltimore City). The executive authority in each jurisdiction designates a local lead agency which has the responsibility to</p>

	Virginia	Indiana	Maryland
	<p>and needs. Forty (40) local interagency coordinating councils have been established statewide to enable early intervention service providers to:</p> <ul style="list-style-type: none"> • Establish working relationships within communities; • Identify existing early intervention services and resources; • Identify gaps in the local service delivery system; • Identify alternative funding sources; and • Develop local procedures and mechanism for implementing policies and procedures in accordance with state and federal statutes and regulations. <p>Each LICC is composed of designees from the following agencies who are authorized to make funding and policy decisions:</p> <ul style="list-style-type: none"> • Community Services Board; • Department of Health; • Department of Social Services; and • Local School Divisions. <p>These designees designate additional members as follows:</p> <ul style="list-style-type: none"> • At least one parent; • Representatives from community providers that serve infants and toddlers with disabilities; and representatives from other service providers as deemed appropriate. <p>A council coordinator is employed in each of the forty (40) localities. In thirty-three (33) of the localities, the Community Services Board serves as the fiscal agent. In the remaining seven (7) areas, municipalities, and colleges and in one instance, the local school system serves as the fiscal agent.</p> <p>State's Provider Network</p> <p>Each of the 40 councils determines the set-up of their provider network. Most councils negotiate and contract with private providers for early intervention services. A few of the</p>	<p>Council, community resources are identified and service providers are invited to coordinate all available early intervention services for children.</p> <p>Each LPCC has a coordinator and members composed of local providers, parents and community leaders. Each council is responsible for developing and documenting a formal system of communication and coordination among participating agencies operating in its respective county.</p> <p><u>State's provider networks</u></p> <ul style="list-style-type: none"> • There are both state and private provider. • Rates are the same across the state – no difference between localities. • No difference in the rates paid to state providers and private providers. • Rate differences depend on location in which the service is provided (on-site or off-site) and the type of service. • FSSA pays for services within 10 days. 	<p>coordinate the interagency service delivery system and act as the fiscal agent for the federal and State early intervention funding. The local lead agency submits a local early intervention plan and budget to the State Lead Agency annually to access funds. Each local lead agency designates a program director to administer the local interagency system.</p> <p>Local Infants and Toddlers program deliver early intervention services to eligible children and families. Service providers are primarily employees of local public agencies. In most jurisdictions, local school system employees are the major providers of early interventions services, but employees local health departments, departments of social services, and private providers also provide services throughout the 24 LITPs.</p> <p>Each LITP has a local interagency coordinating council (LICC) that advises and assists the local lead agency to implement the local system.</p> <p>State's Provider Network</p> <p>As stated above, employees of public agencies or through contracts deliver services through local Infants and Toddlers Programs with private providers. Services are provided at no cost to the family, as required by Maryland's birth mandate status.</p> <p>The model for delivering service coordination varies throughout the state. In some LITPs there is a "dedicated" service coordinator for all families, while in others the same individual provides service coordination and the individual service (i.e., OT, PT, etc.). In most jurisdictions service a service provider provides coordination. Should the infant/toddler and family have complex needs, there is usually a designated service</p>

	Virginia	Indiana	Maryland
	councils employ service coordinators, therapists and educators within their own systems.		coordinator.
Service issues	<ul style="list-style-type: none"> • Costs associated with the provision of Part C services in natural environments; • Shortage of providers in some areas; • Medicaid cap; and • Medicaid policy on not paying for costs related to Part C services in natural environments. 		<p><u>Data entry and system use</u> Maryland has just implemented a statewide web-based Part C data system that is based on the IFSP. Prior to October 2003, data was collected by the State lead agency on a quarterly basis though 24 local databases.</p> <p>Every local Infants and Toddlers program has a data manager or assigned staff who enters data. The time averages from one morning a week to full-time data collection for 3-4 staff depending on the number of children and families served in the jurisdiction. There is a link to Part B data. Every time an IFSP change is made data is entered. To date, the State is not collecting data on service utilization, although some local jurisdictions are beginning to explore this possibility. In 2002, the annualized count was 9181; the December 1 count was 5450.</p> <p>Child Find/Public Awareness The State has a public awareness plan that has been focusing on reaching pediatricians. Every local lead agency has a public awareness plan that focuses on reaching pediatricians, and underserved populations.</p> <p>Parent Participation There is strong parent participation on State and local ICCs. Most ICCs are co-chaired by a parent.</p>
Natural environments	Services are provided in natural environments. Many local councils have negotiated rates with providers for the costs associated with the provision of Part C services in the natural environment. Federal requirements are followed with any exceptions documented where the outcomes for the child cannot be met within the natural environment. A transition plan is developed for services to	Yes, but services are also at clinics – it is the parent’s choice. There are two rates – one for on-site services and one for off-site services.	Maryland has been tracking the change from center-based service delivery to providing services in natural environments. As of 12/1/02 data, 80% of infants/toddlers are receiving services in natural environments. Primarily, the natural environment is the home, but services are also provided in child care centers, family day care, and other early childhood settings. The biggest issue is for

	Virginia	Indiana	Maryland
	be transitioned to the natural environment as deemed appropriate.		the 2-3 year olds, mainly because of the birth mandate and settings were primarily pre existing centers with children with special needs. There is concerted effort not to transfer the clinical model of service delivery into the natural environment.
General finance	<ul style="list-style-type: none"> • State funds; • Medicaid; • Private insurance; and • Family fees: <ul style="list-style-type: none"> ○ Implemented January 01, 2002 in accordance with Virginia Code whereby a system of payments for early intervention services was established by the Lead Agency; ○ Fees are not charged for evaluation and assessment; child find; service coordination; implementation of the procedural safeguards; and development, review and evaluation of the Individualized Family Service Plan (IFSP). ○ A sliding fee scale establishes a uniform monthly cap based on taxable family income; and ○ A fee appeal process is made available for families experiencing identified hardships. 	<p>State funds TANF Medicaid</p> <ul style="list-style-type: none"> ▪ FSSA pays all bills within 10 days. ▪ FSSA worked out an agreement with Medicaid to pay a set amount for each service. ▪ FSSA and Medicaid match the identifiers and pays the set amount for that service. 	<p style="text-align: center;">Funds include</p> <p>State Federal Medicaid Local government funds</p> <p>Local Infants and Toddlers Programs are required to submit an interagency budget for all funding sources that support early intervention.</p>
Billing system	Federal and state funds are disbursed annually by the Lead Agency to each of the forty councils based on a designated formula. Local councils and/or providers bill payment sources for eligible early intervention services. In some instances, the local council completes the billing with payment following to the provider. Rates to providers vary throughout the state and are based on a negotiated and contractual agreement between the local council and the provider. In other instances, the provider bills the payment source and reports the reimbursement to the local council Medicaid private insurance	<p>Centralized The Central Reimbursement Office (CRO) provides timely reimbursement to providers of early intervention services. The CRO receives and dispenses all relevant state and federal resources for early intervention services by reimbursing providers from a revolving fund as invoices are submitted. The CRO is designed to manage the finances for the First Steps system statewide ensuring:</p> <ul style="list-style-type: none"> ▪ All relevant state, federal and local resources available to support early intervention services and activities are 	<p>Medicaid billing is the only billing done for Part C services in Maryland. No Commercial insurance companies are billed.</p> <p>Service Coordination is a Medicaid reimbursed service. This began in 1990. The rates include initial case management, which is referral to development of the IFSP at \$500, with a reimbursement of \$250; ongoing service coordination (monthly) at \$150, with reimbursement of \$75; annual IFSP development at a rate of \$275, with reimbursement of \$137.50. EPSDT is a funding source The local Health Department</p>

	Virginia	Indiana	Maryland
	with parental permission, and family fees are collected and documented in order to assure that Part C funds are used as payor of last resort. All state, federal and local resources available to support early intervention services are identified and maximized.	<p>identified and maximized</p> <ul style="list-style-type: none"> ▪ Timely reimbursement to providers for early intervention services rendered ▪ Financial and data reporting needs of various federal, state, and local funding sources ▪ No duplication of effort to collect, maintain and report relevant data ▪ A comprehensive data and financial system that can monitor and manage the level of early intervention resources ▪ Short and long-term projection of costs of early intervention services is established ▪ The early intervention providers can expect from CRO: <ul style="list-style-type: none"> ○ Common service descriptors, rates depending on discipline, and sites of service. ○ Provider enrollment. ○ Common authorization and invoice documents. 	<p>in every jurisdiction does Medicaid billing for service coordination. Each local system determines how the money received from this billing is to be used to support the early intervention system.</p> <p>The Local Lead agency bills Medicaid for health related services on the IFSP for Medicaid consumers. MA-covered services on IFSPs are carved out as fee-for-service. There is a single rate for the provision of services, regardless of the service settings. Private providers that are MA providers bill Medicaid directly.</p>
Insurance, Medicaid, Payment	Private insurance, with the family's permission, is billed for eligible Part C services. Medicaid is also billed for eligible Part C services.		
Policy and procedure vs. code and regs.	The state's requirements for Part C in Virginia exist in policies and procedures. The <i>Code of Virginia</i> , Chapter 47, 2.1-760 through 2.1-768 provides the framework for Virginia's Early Intervention System.	Indiana Administrative Code	The State statute (code) establishes the State lead agency, the SICC, local lead agencies, and LICCs. State regulations establish the guidelines and responsibilities for the administration and implementation of the statewide early intervention system. State regulations require that most services be provided at no cost to families because of the birth mandate. These requirements cover most of the commonly utilized services: special instruction, PT, OT, speech, etc. Only a few services (e.g., nutrition) are not covered by the birth mandate, and it was determined it was not cost effective to set up billing systems for services that are not used frequently.

Profile of States (updated 12/1/03)

	North Carolina	Kentucky	Louisiana
Role of Lead Agency	<p>The Early Intervention Service System in North Carolina, known as “Together We Grow”, contains two broad programs, each of which is comprised of multiple agencies and programs: 1) Infant and Toddler Program (Birth to Age 3) and 2) Preschool Program (Ages 3-5 years). The North Carolina Interagency Coordinating Council is an integral part of the Early Intervention System, with statutory responsibility to facilitate the coordination of all needed services across participating agencies. North Carolina is in the process of examining and revising their early intervention system, with implementation due by July 2004. They are “piloting” what will be their new system in a number of areas until the time of full implementation. The lead agency has/will change from their equivalent of DMHMRSAS to the Department of Education.</p>		<p>The Department of Health and Hospitals (DHH) is the lead agency responsible for ensuring compliance with IDEA, Part C. As Lead Agency, DHH is responsible for ensuring that the minimum components of a statewide system of EI services for eligible infants and toddlers is established and maintained in the state. In July 2003, the Lead Agency changed from the Department of Education to DHH. Consultants are assigned to work with each of nine regions.</p>
Local system and provider network	<p>Entry into the NC system in their new system will be as follows: Family calls a central number to get to one of 18 Child Developmental Service Agencies (CSDAs) around the state (some may have some satellite offices also). At that time, the child’s name would get “routed” to a service coordinator. The service coordinator from the CSDA would set up the child’s evaluation/s and would help the family through the eligibility and the IFSP development process. The family would then get a list of providers “in their community” from which they could select their services.</p> <p>Those who are also direct service providers could in the past have done Service coordination, but the pilot programs are not functioning in this dual role.</p>	<ol style="list-style-type: none"> 1. Who employs the local interagency coordinator? If you are asking about the chair of the ICC it is a voluntary position. 2. How does your state handle a central point of entry? Each district has a single point of entry. Kentucky is divided into 15 Area Development Districts (ADD) districts. These are the areas where the Point of Entry offices are. Most of the offices are affiliated with either the local health department or the local comprehensive care center. Some of the POE offices also offer PSC services. There is also a 1-800 number that anyone in the state can call to find the closest POE office. 3. Can the central point of entry also be a provider of services? The POE agencies have been allowed to provide PSC services in the past and are now asking to provide PLE services so far that has not 	<p>Regional Interagency Coordinating Councils (RICCs) can support the early intervention system through a number of activities and provide a way to expand the collaborative and coordinated efforts of the Part C system and develop local leadership. RICCs support the early intervention system by identifying local resources and recruiting local providers.</p> <p>The System Point of Entry (SPOE), through contract with DHH, is the local entity responsible for ensuring that all under the age of three, and their families, receive the support they need. The SPOE carries out the functions by hiring qualified staff to function in the role of intake coordinators.</p> <p>Responsibilities include:</p> <ul style="list-style-type: none"> • Receiving referrals and establishing the initial EI hardcopy and electronic record • Conducting and completing the family

	North Carolina	Kentucky	Louisiana
	<p>All potential providers in the system will apply to be included in their new system, if they choose. Some providers who had been in the system have elected not to participate at this time. Some providers will be providing different services than they did previously (ex: DMHMRSAS will now only be providing mental health and emergency services).</p> <p>1. Who employs the local interagency coordinator? As their system changes over to their new model of 18 region central points of entry, the local interagency coordinating councils will be part of this set up. Part C grant funds would be able to be used for this. Currently, their LICC coordinators are volunteers from community agencies.</p> <p>2. How does your state handle a central point of entry? New model will have central points of entry located at each of the 18 regional centers, which will be directly under their lead agency.</p> <p>3. Can the central point of entry also be a provider of services? Central points of entry, under their lead agency, will be providers of service coordination.</p> <p>4. What is the relationship between the central point of entry and the local interagency coordinating council? Both would be under the direction of the lead agency, and would be located at each of the 18 regional centers.</p>	<p>been allowed, but is under consideration at this time.</p> <p>4. What is the relationship between the central point of entry and the local interagency coordinating council? The POE's are represented on the ICC. The ICC is an advisory board for the program.</p>	<p>intake</p> <ul style="list-style-type: none"> • Developing and maintaining the EI record for each child • Ensuring that eligibility determinations are completed according to regulations • Arranging for and ensuring the completion of necessary evaluation/assessments to either (1) determine eligibility, or (2) collect required information necessary to plan and complete an IFSP • Facilitating the IFSP Team Meeting and completing the initial IFSP • Supporting administrative functions related to CFO including ongoing data entry to ensure re-authorizations(s) for IFSP services and management of the electronic and hardcopy child records maintained at the SPOE <p>SPOE were selected through a RFP process. Applicants are prohibited from being a provider of EI services (with the exception of special instruction and/or assessments). SPOE personnel must meet the Part C personnel standards. While SPOEs are selected by the state, RICCs are responsible to routinely evaluate the effectiveness of the SPOE from a local perspective. This ongoing evaluation is helpful to DHH when new proposals are solicited for SPOE services.</p> <p>Providers of EI services are connected through an enrollment process that is coordinated through the Central Finance Office (CFO) (see question 4 below). Providers submit an application package and approved providers are listed in a Service Matrix. A Provider Agreement details the obligations for providers. Providers must meet the Part C system endorsement requirements and maintain their endorsement for the duration of their</p>

	North Carolina	Kentucky	Louisiana
			enrollment as a Part C system provider. Family service coordinators are enrolled as providers.
Service issues	<p>NC currently serves “at risk” children, including those with a history of founded child abuse or neglect. Their definition of eligibility is being reviewed.</p> <p>Issues identified in the 1999 document include the following:</p> <ul style="list-style-type: none"> • Not finding all eligible children • Not meeting federal timelines • Lack of sufficient services • Need for better coordination among services • Transition concerns • Concerns related to specific conditions (vision and hearing impairments, autism) • Lack of funding <p>1. As the Part C system in your state has undergone development and changes, how have the changes impacted supports and services for families? Specifically, do the changes support a primary service provider model of service provision? They see the implementation of the changes going well with the four pilot sites across the state. They are not implementing what would be considered a “primary service provider model of service provision” – the service coordination is done by their lead agency. Therapy services are contracted with individual providers as indicated on their IFSP.</p> <p>2. How is service coordination provided in your state? What is the average caseload? Can service coordinators also be a provider of other EI services? Under their new model, service coordination is provided by the lead agency, with a current average caseload of 30. They are hoping to</p>	<p>1. As the Part C system in your state has undergone development and changes, how have the changes impacted supports and services for families? The major change to our program is the implementation of legislation that mandates a primary level evaluation for every child in the program. This legislation also makes parents or care givers responsible for parental participation. Parents must agree to participate in the program at the level that is appropriate for them. We are currently revising the IFSP and will begin mandatory training for every provider in the program on the new IFSP. We have implemented a rate reduction and we are creating a monitoring tool. We have begun to write interagency agreements with all of the local school districts to have a transition document. And the CSPD committee of the ICC is working on the implementation of new qualifications for primary level evaluators, developmental interventionists and primary service coordinators. All of these changes were implemented hopefully to improve the services we provide for our families. Specifically, do the changes support teamwork? We believe all of these changes support and encourage teamwork and support for the family. Do the changes support a primary service provider model of service provision? Yes, this is clearly supported by the new IFSP. PSC are encouraged to be the lead for the team and manage all of the services a team requests.</p> <p>2. How is service coordination provided in your state? We contract with both independent PSC’s and agencies to provide the service. We do however; have a requirement that all IFSP that more than 1</p>	<ul style="list-style-type: none"> • Since LA has undergone changes very recently, it is too early to know impacts. • The maximum caseload for service coordination is 35. Service coordinators are enrolled as providers. SPOE completes the IFSP in 45 days. • Trend data is not available with “new” system

	North Carolina	Kentucky	Louisiana
	<p>reduce that to a ratio of 1:20. Service coordinators are not the providers of other early intervention services.</p> <p>3. Has trend data been collected on frequency, intensity, and location of services? Yes, they have trend data on frequency, intensity, and location of services and they could generate a report to show that, if we wanted to see that.</p> <p>4. Is data collected to reflect differences in the initial IFSP and subsequent revisions? Yes, services on the initial and subsequent revisions of the IFSP are documented and included in their trend data.</p>	<p>First Steps provider on the plan be represented by more than one agency. What is the average caseload? Full time PSC's may have up to 40 cases or 50 cases if they have 10 or more children who will turn three in the next 90 days. Can service coordinators also be a provider of other EI services? No service coordination can be the only service provided. ISC's and PSC's may do service coordination only.</p> <p>3. Has trend data been collected on frequency, intensity, and location of services? Several years ago the Legislative Review Committee audited the First Steps Program. It was found that a significant number of children were receiving multiple services with no support for the service provision on the IFSP. At that time the program began the policy of limiting therapeutic intervention to one hour per week per discipline. We have also implemented a policy of Natural Environment, for all services. We held mandatory Natural Environments training for all providers. All services must be provided in the most natural environment for the child/family and it must be documented in the IFSP.</p> <p>4. Is data collected to reflect differences in the initial IFSP and subsequent revisions? We are just beginning this process and hope that the requirement for the annual evaluation will provide us with data that show the effectiveness of our services.</p>	
Natural environments	<p>OSEP monitoring last year indicated that services in NC are not currently meeting the requirement for natural environments, and that is one of the issues they are hoping to improve. "Serving more children in the natural environment" is part of their plan of improvement.</p> <p>1. Who makes the decision to provide a service in a setting other than the natural environment? Service coordinators make the</p>	<p>1. Who makes the decision to provide a service in a setting other than the natural environment? The team may discuss this but there must be a very compelling reason well documented in the IFSP for a setting other than the most natural environment.</p> <p>2. How is this (setting other than natural environment) documented? Each service provider documents in his or her notes and the setting is listed on the IFSP.</p>	<p>~The team makes all decisions for natural environments. ~Services are provided in natural environments and policies and procedures specify the process for how to document when services are not provided in natural environments. ~Reimbursement rates include a rate for natural environments, which is reflected in the IFSP and on the bill sent by the provider to the CFO. The</p>

	North Carolina	Kentucky	Louisiana
	<p>decision of whether to provide services in settings other than natural environments. North Carolina has a network of “Developmental Disabilities Centers”, many of which are being converted so that their population includes 50% typically developing children. This would then count as a natural environment.</p> <p>2. How is this (setting other than natural environment) documented? On the IFSP.</p> <p>3. How is the service paid for if the family makes the decision? This has not come up, as there have been no disputes and no complaints.</p> <p>4. What are rates for services in natural environments? In center settings? Are there other rate differentials? Providers have to agree to serve children in natural environment, or as indicated on IFSP, so this is not an issue. Rates for special instruction are currently \$82 per hour.</p> <p>5. Has your state been monitored by OSEP with respect to natural environments? Was your state cited as being out of compliance? Previous conversation with Lynne Graham had indicated that North Carolina’s Plan of Improvement from OSEP included increasing services in the natural environments.</p>	<p>3. How is the service paid for if the family makes the decision? First Steps will pay for some services provided in a setting that is not a natural environment for a child, but KCHIP, Medicaid or EPSDT pays for most of these services.</p> <p>4. What are the rates for services in natural environments? In center settings? Are there other rate differentials? The rates are set for each discipline and the rate for center-based services is lower than the rate for the home/ community.</p> <p>5. Has your state been monitored by OSEP with respect to natural environments? Was your state cited as being out of compliance? We have not been monitored at this time, however, OSEP will be in Kentucky for a fact finding visit 11-18&19.</p>	<p>reimbursement rates include a charge for three “billing categories” – a natural environment is one of these categories. ~cited by OSEP in previous configuration, but has not been monitored with since the change in Lead Agency.</p>
General finance	<p>1. How much money is in your total EI system and from what sources? They will send a breakdown of this information. Amount that was given for the total in the system was \$45 million, of which the majority is their state funding. This does not include funding from private insurance. \$11.6 million is their federal Part C grant. Balance is Medicaid, state funding, and parent fees. They will be going to their General Assembly to request change in insurance regulations to be able to bill private insurance.</p> <p>2. Of the total early intervention costs</p>	<p>1. How much money is in your total EI system and from what sources? I believe that these figures are correct if they are not totally correct they are very close. The total program is about \$40 million \$4 million is federal money, \$1million is tobacco settlement money and the remaining is state general funds we also bill Medicaid and KCHIP and are starting to bill private insurance..</p> <p>2. Of the total early intervention costs, what percent of your budget is used by the lead agency for operating costs? None of the federal money is used for operating costs.</p>	<p>~Will try to get figures on total in the system, however, this is difficult due to change in lead agency and the conversion to a different way of handling the whole Part C program. ~Approximately 3500 children currently being served and cost per child is currently being studied. ~Rates for services were determined by a cost study ~Service coordination is paid through the CFO at a rate of \$130 per month. ~There is never enough money, but system seems stable at this time. Rates were adjusted because of concerns.</p>

	North Carolina	Kentucky	Louisiana
	<p>what percent of your budget is used by the lead agency for operating costs? Lead agency operating costs total 8% of their federal grant (need to confirm this).</p> <p>3. How many children are being served? What is the cost per child? The amount that was stated was \$13,000 per child. Number of children served needs to be confirmed.</p> <p>4. How is the local interagency council funded? How is the local interagency coordinator paid for? Little funding is provided for the LICC, as much is "in kind" by collaborating agencies.</p> <p>5. How is service coordination paid for? Is it reimbursed by child or by contact hour or by a monthly rate? Medicaid funding is used where available. Otherwise, state and federal Part C dollars are used. Providers are reimbursed by the contact hour.</p> <p>6. How "secure" is the system in your state – do you foresee a problem in continuing to fund your system? Their Part C system is seen as secure right now but they are also now at capacity. Increase in referrals may cause some stress. They don't want to change their eligibility criteria.</p> <p>7. Has your state undertaken any cost analysis studies? If so, what are the results? They do cost finding to identify the cost of service coordination and special instruction.</p> <p>8. Is local government making financial contributions to the Part C system? If so, is this counted and reported in the state budget for Part C? Local governments contribute little financial support directly to the state Part C budget, but this is included in their total.</p>	<p>3. How many children are being served? The last number of children I have is about 5,000. What is the cost per child? The average is \$4,000/ per child</p> <p>4. How is the local interagency council funded? How is the local interagency coordinator paid for? The program provides some funding for the local DEIC's no funding is provided for the ICC.</p> <p>5. How is service coordination paid for? Is it reimbursed by child or by contact hour or by a monthly rate? A PSC is limited to 60 units per child per 6mo. Plan the units are divided into 1-22 min 1 unit etc. the amount per hour is \$61 in office and \$83 in home or community</p> <p>6. How "secure" is the system in your state – do you foresee a problem in continuing to fund your system? There are constant discussions about future funding. Our program was one of the few in state government that was not reduced this past legislative session. Some of our funding is from the tobacco settlement money, which is being reduced. We are not sure about future, but for the present we are stable.</p> <p>7. Has your state undertaken any cost analysis studies? The program was moved to the Commission for Children with Special Health Care Needs from MHMR three years ago at that time a rate study was done before a rate reduction was implemented. If so, what are the results?</p> <p>8. Is local government making financial contributions to the Part C system? If so, is this counted and reported in the state budget for Part C? There is no funding from local government.</p>	
Billing system	<p>1. Does your state have centralized billing? Yes, under their new model, which is being piloted.</p> <p>2. What problem were you trying to solve when you went to centralized billing? This is</p>	<p>1. Does your state have centralized billing? Yes, CBIS the Centralized Billing and Information System is housed at the University of Louisville.</p> <p>2. What problem were you trying to</p>	<p>DHH implemented a Central Finance Office (CFO) which is linked with the provider credential system and which maintains the Service Matrix of enrolled Part C providers. The CFO is connected through a child data</p>

	North Carolina	Kentucky	Louisiana
	<p>part of their reorganization to 18 regional centers under the lead agency.</p> <p>3. What is the relationship of the centralized billing system to the lead agency? 18 regional centers do the preauthorization and data collection, and the central office of the lead agency generates the bill.</p> <p>4. What is the cost of the centralized billing system to the lead agency? They do not have this information to date, as the system is not fully in place.</p> <p>5. Is a per child cost established? Cost is per service.</p> <p>6. Is the centralized billing agency liable for (Medicaid) audits and meeting Medicaid requirements? Yes, the central office of the lead agency is liable and responsible for meeting these requirements.</p> <p>7. Who does the centralized billing agency collect from? What third parties are involved? The 18 regional offices bill Medicaid for all Part C services. Also, while the 18 regional offices are handling the Medicaid billing, etc., that can still be done by the individual providers if they prefer.</p> <p>8. Does the central billing agency collect co-pays and/or fees from families? This is (or will be) done by the 18 regional offices.</p> <p>9. What are the advantages? Advantages that were stated were that the lead agency is now aware of the service delivery process and is part of the “data loop”.</p> <p>10. What are the disadvantages? This is a “hybrid” of some different models – it is not being fully implemented to date across the state, so they don’t yet have complete information on this.</p>	<p>solve when you went to centralized billing? Data collection was the main reason for the billing change from state government.</p> <p>3. What is the relationship of the centralized billing system to the lead agency? The Commission for Children with Special Health Care Needs contracts with CBIS to provide billing and data collection.</p> <p>4. What is the cost of the centralized billing system to the lead agency?</p> <p>5. Is a per child cost established?</p> <p>6. Is the centralized billing agency liable for (Medicaid) audits and meeting Medicaid requirements? Yes</p> <p>7. Who does the centralized billing agency collect from? What third parties are involved?</p> <p>8. Does the central billing agency collect co-pays and/or fees from families?</p> <p>9. What are the advantages?</p> <p>10. What are the disadvantages?</p>	<p>system to the network of SPOEs throughout the state. The SPOE is responsible for entering child data during the referral, eligibility, and IFSP process. This data generates service authorizations from the CFO. The CFO pays all providers from an interim-funding source using a fee for service reimbursement approach. The CFO then seeks reimbursement from an appropriate payment source (such as state general revenue funds, Medicaid) ensuring that the “payor of last resort” requirements are met. All providers receive the same reimbursement rates for a particular service.</p> <p>~trying to solve problems of providers having to bill multiple sources, of payor of last resort, of Medicaid billing and other insurance billing.</p> <p>~contract with CFO for billing is approximately \$500,000-\$600,000.</p>
<p>Insurance, Medicaid, Payment</p>	<p>NC does not currently have a statewide sliding fee scale, but they are working on putting one in place. Some areas in NC are currently waiving fees for families. It was unclear as to their use of private insurance for services. NC is in the process of</p>	<p>1. Is insurance accessed for Part C services in addition to Medicaid? If so, how is this done (re: need for authorization and getting therapists to have provider numbers with insurance companies)? We have just begun to write policy about mandatory billing</p>	<p>~Families give permission for insurance to be billed. No policy has been established, but this is being studied. Families do not pay at this point, however, that is also part of the study.</p> <p>~EPSDT is part of the Medicaid billing and</p>

	North Carolina	Kentucky	Louisiana
	<p>requesting an insurance bill through their General Assembly to assist with private insurance coverage.</p> <p>1. Is insurance accessed for Part C services in addition to Medicaid? If so, how is this done (re: need for authorization and getting therapists to have provider numbers with insurance companies)?</p> <p>No, private insurance is not currently accessed directly for Part C services. If they are successful with their General Assembly request, they hope that it will be within two years.</p> <p>2. Are families giving permission for their insurance to be billed? What is the success rate in accessing insurance? Not currently in place.</p> <p>3. What problems have surfaced (re: private insurance billing)? Not applicable at this time.</p> <p>4. Are families responsible for co-pays and deductibles? They do have family fees, but are not billing private insurance.</p> <p>5. Does your state have an ability-to-pay policy?</p> <p>They will have this in place soon.</p> <p>6. Who is responsible for collecting fees through ability-to-pay? Billing is done through the 18 regional offices.</p> <p>7. Does your state use the ISFP as the medical plan of care? Did not ask – not applicable at this time for private insurance.</p> <p>8. What role does EPSDT play in funding EI services? This is a source of payment under Medicaid.</p> <p>9. What EI services are covered under the state's Medicaid plan (state plan option)? They are trying to get special instruction covered but are not optimistic that this will be successful.</p> <p>10. How else is Medicaid funding used? What other methods are used to seek Medicaid funding? See #9.</p>	<p>of insurance by providers. We do not currently have a policy in place that requires that insurance be billed, but we ask providers to discuss billing insurance with families we also deduct the insurance reimbursements from the family share.</p> <p>2. Are families giving permission for their insurance to be billed? What is the success rate in accessing insurance? Some families do allow billing their private insurance it is not mandatory.</p> <p>3. What problems have surfaced (re: private insurance billing)? Providers who are not in the provider network of insurance, providers not able to bill insurance and families who are concerned that they will cap out their insurance.</p> <p>4. Are families responsible for co-pays and deductibles? Yes, but we deduct these amounts from family share.</p> <p>5. Does your state have an ability-to-pay policy? We have a sliding fee scale for family share.</p> <p>6. Who is responsible for collecting fees through ability-to-pay? The Commission for Children with Special Health Care Needs collects the family share billing.</p> <p>7. Does your state use the ISFP as the medical plan of care? No, but for children with established diagnosis we require permission for the PCP to provide services.</p> <p>8. What role does EPSDT play in funding EI services? No part.</p> <p>9. What EI services are covered under the state's Medicaid plan (state plan option)? We bill Medicaid for those families covered by the program. Medicaid reimburses for all services on the plan that are therapeutic intervention services.</p> <p>10. How else is Medicaid funding used? What other methods are used to seek Medicaid funding? The Commission has a central billing office that bills Medicaid for</p>	<p>mainly covers therapy services.</p>

	North Carolina	Kentucky	Louisiana
		those eligible families.	
Policy and procedure vs. code and regs.			

APPENDIX F:

Virginia Infrastructure Alternatives Considered By the Task Force

POSSIBLE INFRASTRUCTURE ALTERNATIVES FOR PART C IN VIRGINIA

To ensure shared understanding of the following terms, which are used in describing the infrastructure alternatives, their definitions are provided:

- Local Fiscal Agent – administers local Part C funds (e.g. ensures compliance with Part C fiscal assurances, completes Part C quarterly expenditure reports, develops contracts with local participating agencies/providers).
- Local Lead Agency – ensures that a local system of early intervention services is in place and meets all federal and state Part C requirements, including the Part C fiscal and program. Makes all decisions, with the advise and assistance of the local interagency coordinating council, regarding how Part C supports and services will be provided locally. Is responsible for ensuring implementation of requirements related to data collection, child find, public awareness, procedural safeguards and monitoring and supervision of the local early intervention system. Administers local Part C funds.
- Monitoring and Supervision – process by which compliance and continuous improvement with Part C requirements is determined and accountability is ensured.
- Centralized Reimbursement – system in which local participating agencies/providers do their own billing for Medicaid and other third party payors then bill one centralized entity (e.g. regional lead agency, state lead agency, private contractor) for payment with Part C funds for remaining allowable expenses.
- Centralized Billing – system in which one entity (e.g. regional lead agency, state lead agency, private contractor) does all billing, including through Medicaid, private insurance, Part C funds, etc, for all participating agencies/providers.
- Pre-Authorization – process through which authorization is sought from an insurance company prior to delivery of a potentially covered service
- Provider Credentialing – process through which an individual provider receives a provider number that is needed for billing insurance
- Provider Enrollment – process through which an individual provider or provider agency is determined to be a Part C provider in Virginia’s Part C system (e.g. qualifications are submitted, they are approved as Part C provider, provider agreement is signed between the enrolling agency and the provider indicating that the provider will abide by all Part C requirements)
- Region – a subset of the state, which may include 1 or more localities. The process for determining the number of regions and membership within each region would build on existing relationships and coalitions and would seek to create administrative efficiencies and improved supports and services for children and families.
- Service Provider – any individual who delivers one of the Part C services listed in Virginia’s Part C Policies and Procedures, including, but not limited to, service coordinators, special instructors, and therapists.

ALTERNATIVE 1:

Local Lead Agency

Alternative 1a: CSBs as Local Lead Agency

Role of the State Lead Agency

In this model, the role of the state lead agency remains the same as in Virginia's current infrastructure. The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. The Lead Agency is also responsible for statewide supervision and monitoring and provides technical assistance to the local lead agency, the LICC, and providers.

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the local Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the LICC; provision of financial support; etc).

Role of the Local Lead Agency (CSB)

In each of the 40 local council areas, the CSB serves as the local lead agency (or contracts that responsibility out to another public agency). Responsibilities include ensuring that a local system of early intervention services is in place and meets all Part C regulations and state Part C Policies and Procedures (including those related to public awareness, child find, evaluation and assessment, IFSPs, personnel, data collection, natural environments, monitoring, procedural safeguards, etc) and that all Part C fiscal and program assurances are met. In addition, the CSB, as local lead agency, receives Part C funds from the state lead agency, contracts or otherwise arranges for services with local providers, prepares and submits budget and expenditure reports, etc. The CSB may also be a service provider in the local system. CSB responsibilities related to being the Part C local lead agency would be detailed in either the CSB performance contract (if the performance contract could be revised to meet Part C needs) or through a separate contract between DMHMRSAS and the CSB.

Role of the LICC

The LICC would advise and assist the local lead agency in implementing the local Part C early intervention system (in the same way that the VICC advises and assists the lead agency at the state level). The need for a core group, as currently outlined in the Code of Virginia would be eliminated since decisions are now made by the local lead agency.

Role of Local Participating Agencies/Providers

The local participating agencies/providers carry out the responsibilities outlined in contracts with the local lead agency and/or in local interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the LICC. In addition, all local participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.).

Flow of Part C Funds

Part C funds are allocated from the state Lead Agency to each of the 40 CSBs through either the CSB performance contract process or through a separate Part C contract. As local lead agency, the CSB contracts with local Part C service providers as needed. The CSB may also be a provider of services. The

CSB provides budget and expenditure reports to the Lead Agency (through the CSB performance contract?).

Billing System

The CSB, as local lead agency, is responsible for ensuring that all available sources of funding are accessed for payment for Part C services in accordance with Part C payor of last resort and non-supplanting requirements. The CSB ensures that Medicaid and other third party payors are billed, as appropriate, and that the statewide ability to pay procedures to determine and collect family fees is implemented.

PROs	CONs
<ul style="list-style-type: none"> • Allows for allocation of funds through use of a valid, legal contract between the state lead agency and the local lead agency. • If CSB performance contract is used, this reduces duplication of paperwork for CSBs and DMHMRSAS and allows DMHMRSAS to deal with a contract process and paperwork familiar to them • Allows for local flexibility/control, while somewhat simplifying administrative structures since the state Lead Agency is dealing with only one type of public agency (CSBs) at the local level • Simplifies local administrative structures, since there is no longer a need for LICC signatures on some things, fiscal agent on others, both signatures on some, etc. 	<ul style="list-style-type: none"> • Potentially decreases interagency participation and may result in going back to the way we did business before Part C with all or most services provided by the CSB (resulting in fewer resources, supports and services for children and families; fewer funding sources accessed; etc.) • If performance contract cannot be used, then a separate contract will need to be written between DMHMRSAS and the CSBs to cover Part C requirements – this means no reduction in paperwork for CSBs or for the Department • State Lead Agency must still review 40 contracts, 40 sets of expenditure reports, etc. • Potential perception of conflict of interest since CSBs are a major provider of Part C services and, as local lead agency, are in charge of deciding who is awarded money locally

Alternative 1b: Any public agency may be Local Lead Agency

Note: Areas in which this alternative differs from Alternative 1a are italicized.

Role of the State Lead Agency

In this model, the role of the state lead agency remains the same as in Virginia's current infrastructure. The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. The Lead Agency is also responsible for statewide supervision and monitoring and provides technical assistance to the local lead agency, the LICC, and providers.

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the local Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the LICC; provision of financial support; etc).

Role of the Local Lead Agency

In each of the 40 local council areas, a public agency is selected through an RFP process to serve as the local lead agency. Responsibilities include ensuring that a local system of early intervention services is in place and meets all Part C regulations and state Part C Policies and Procedures (including those related to public awareness, child find, evaluation and assessment, IFSPs, personnel, data collection, natural environments, monitoring, procedural safeguards, etc) and that all Part C fiscal and program assurances are met. In addition, the local lead agency receives Part C funds from the state lead agency, contracts or otherwise arranges for services with local providers, prepares and submits budget and expenditure reports, etc. The local lead agency may also be a service provider in the local system. Responsibilities related to being the local lead agency for Part C would be detailed in a contract between DMHMRSAS and the selected local public agency.

Role of the LICC

The LICC would advise and assist the local lead agency in implementing the local Part C early intervention system (in the same way that the VICC advises and assists the lead agency at the state level). The need for a core group, as currently outlined in the Code of Virginia would be eliminated since decisions are now made by the local lead agency.

Role of Local Participating Agencies/Providers

The local participating agencies/providers carry out the responsibilities outlined in contracts with the local lead agency and/or in local interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the LICC. In addition, all local participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.).

Flow of Part C Funds

Part C funds are allocated from the state Lead Agency to each of the 40 local lead agencies through a contract. The local lead agency contracts with local Part C service providers as needed. The local lead agency may also be a provider of services. The local lead agency provides budget and expenditure reports to the Lead Agency.

Billing System

The local lead agency is responsible for ensuring that all available sources of funding are accessed for payment for Part C services in accordance with Part C payor of last resort and non-supplanting requirements. The local lead agency ensures that Medicaid and other third party payors are billed, as appropriate, and that the statewide ability to pay procedures to determine and collect family fees are implemented.

PROs	CONS
<ul style="list-style-type: none">• Allows for allocation of funds through use of a valid, legal contract between the state lead agency and the local lead agency.• Maintains local flexibility• <i>Requires the fewest changes from existing infrastructure to implement</i>• Simplifies local administrative structures, since there is no longer a need for LICC signatures on some things, fiscal agent on others, both signatures on some, etc.	<ul style="list-style-type: none">• State Lead Agency must still review 40 contracts, 40 sets of expenditure reports, etc.• Potential perception of conflict of interest since local lead agency can be a provider of Part C services and is in charge of deciding who is awarded money locally

ALTERNATIVE 2

Regional Lead Agency (with 4 – 8 Regions in Virginia)

Alternative 2a: Regional Lead Agency without Centralized Reimbursement or Billing

Role of the State Lead Agency

In this model, the role of the state lead agency remains the same as in Virginia's current infrastructure. The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. The Lead Agency is also responsible for supervision and monitoring and provides technical assistance to the regional lead agency, the regional ICC, and providers.

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the regional Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the regional interagency coordinating council; provision of financial support; etc).

Role of the Regional Lead Agency

Responsibilities of the regional lead agency include ensuring that a regional system of early intervention services is in place and meets all Part C regulations and state Part C Policies and Procedures (including those related to public awareness, child find, evaluation and assessment, IFSPs, personnel, data collection, natural environments, monitoring, procedural safeguards, etc) and that all Part C fiscal and program assurances are met. In addition, the entity selected as regional lead agency receives Part C funds from the state lead agency, contracts or otherwise arranges for services directly with providers, prepares and submits budget and expenditure reports, etc. The entity that serves as the regional lead agency may also be a service provider in the system.

The entity that will serve as regional lead agency is selected by the State Lead Agency through an RFP process. The responsibilities of the regional lead agency are outlined through a contract between DMHMRSAS and that entity.

Role of the LICC

LICCs are no longer required. Instead there is a regional interagency coordinating council (RICC) in each of the regions. The role of the RICC is to advise and assist the regional lead agency in implementing the regional Part C early intervention system. Membership of the RICC would include parents as well as representatives from a range of service providers across the region.

Role of Participating Agencies/Providers

The participating Part C agencies/providers carry out the responsibilities outlined in contracts with the regional lead agency and/or in interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the regional interagency coordinating council. In addition, all participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.).

Flow of Part C Funds

Part C funds are allocated from the state Lead Agency to each of the regional lead agencies. The regional lead agency contracts with local/regional service providers/agencies as needed. The entity serving as regional lead agency may also be a provider of services. The regional lead agency provides budget and expenditure reports to the Lead Agency.

Billing System

The participating agencies/providers continue to bill Medicaid, private insurance and families in accordance with current Virginia Part C Policies and Procedures.

PROs	CONs
<ul style="list-style-type: none">• Allows for allocation of funds through use of a valid, legal contract between the state lead agency and the regional lead agency.• Simplifies administration for the state lead agency since they now work with only 4-8 contracts instead of 40.• Facilitates regional planning for public awareness, child find, service delivery, monitoring, etc.• Simplifies contracting process for those providers who work across current LICC boundaries and currently must sign contracts with multiple fiscal agents.• May facilitate collaboration with other groups in the state that operate regionally (e.g. some health initiatives)• RFP process is a mechanism by which the state can require certain aspects of the system be in place or planned for (such as providing an avenue for continued employment of well-qualified personnel who are already in the system).• May improve consistency in the Part C system across the state, while still allowing flexibility to meet regional needs	<ul style="list-style-type: none">• If not carefully planned, this model could simply add an extra administrative layer (would have to deal with local, regional and state levels).• Places a large administrative burden on the regional lead agency to coordinate services for the region, manage contracts with providers, etc. – will anyone be willing to take on this role?• Potential perception of conflict of interest if the regional lead agency is also a provider of Part C services (since they are in charge of deciding who is awarded money)

Alternative 2b: Regional Lead Agency with Centralized Reimbursement or Billing
(This alternative is not giving the regional lead agency the option to choose between centralized reimbursement or centralized billing. Rather, the options are here for the task force to discuss.)

Note: Areas in which this alternative differs from Alternative 2a are italicized.

Role of the State Lead Agency

In this model, the role of the state lead agency remains the same as in Virginia's current infrastructure. The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. The Lead Agency is also responsible for supervision and monitoring and provides technical assistance to the regional lead agency, the regional ICC, and providers.

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the regional Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the regional interagency coordinating council; provision of financial support; etc).

Role of the Regional Lead Agency

Responsibilities of the regional lead agency include ensuring that a regional system of early intervention services is in place and meets all Part C regulations and state Part C Policies and Procedures (including those related to public awareness, child find, evaluation and assessment, IFSPs, personnel, data collection, natural environments, monitoring, procedural safeguards, etc) and that all Part C fiscal and program assurances are met. In addition, the entity selected as regional lead agency receives Part C funds from the state lead agency, contracts or otherwise arranges for services directly with providers, prepares and submits budget and expenditure reports, etc. The entity that serves as the regional lead agency may also be a service provider in the system.

The regional lead agency operates a centralized reimbursement or centralized billing system for the region.

The entity that will serve as regional lead agency is selected by the State Lead Agency through an RFP process. The responsibilities of the regional lead agency are outlined through a contract between DMHMRSAS and that entity.

Role of the LICC

LICCs are no longer required. Instead there is a regional interagency coordinating council (RICC) in each of the regions. The role of the RICC is to advise and assist the regional lead agency in implementing the regional Part C early intervention system. Membership of the RICC would include parents as well as representatives from a range of service providers across the region.

Role of Participating Agencies/Providers

The participating Part C agencies/providers carry out the responsibilities outlined in contracts with the regional lead agency and/or in interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the regional interagency coordinating council. In addition, all participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel

standards, procedural safeguards, etc.). *Participating agencies/providers will also have responsibilities related to documentation for the centralized reimbursement or billing system.*

Flow of Part C Funds

Part C funds are allocated from the state Lead Agency to each of the regional lead agencies. The entity serving as regional lead agency may also be a provider of services. The regional lead agency provides budget and expenditure reports to the Lead Agency.

The regional lead agency enrolls local/regional service providers as part of their regional Part C system. Enrollment agreements (or contracts) are signed between the regional lead agency and the enrolled providers to specify programmatic requirements, billing procedures, etc.

Billing System

The regional lead agency operates a centralized Part C reimbursement or billing system for the region. In the case of a centralized reimbursement system, the enrolled provider continues to bill Medicaid, private insurance and families in accordance with current Virginia Part C Policies and Procedures. The provider then bills the regional lead agency for the remaining cost – the regional lead agency pays the provider using Part C funds as payor of last resort and up to the maximum rates established for reimbursement. If a centralized billing system is used, then the regional lead agency (or a contractor) also would do all Medicaid and private insurance billing for the region’s Part C system (they might also collect family fees).

PROs	CONs
<ul style="list-style-type: none"> • Allows for allocation of funds through use of a valid, legal contract between the state lead agency and the regional lead agency. • Simplifies administration for the state lead agency since they now work with only 4-8 contracts instead of 40. • Facilitates regional planning for public awareness, child find, service delivery, monitoring, etc. • Simplifies contracting process for those providers who work across current LICC boundaries and currently must sign contracts with multiple fiscal agents. • <i>Allows funds to “follow” the child rather than the provider.</i> • <i>With centralized billing, may be able to negotiate higher reimbursement rates with third party payors (strength in numbers)</i> • May facilitate collaboration with other groups in the state that operate regionally (e.g. some health initiatives) • RFP process is a mechanism by which the state can require certain aspects of the system be in place or planned for (such as providing an avenue for continued employment of well-qualified personnel who are already in the system). • May improve consistency in the Part C system across the state, while still allowing flexibility to meet regional needs 	<ul style="list-style-type: none"> • If not carefully planned, this model could simply add an extra administrative layer (would have to deal with local, regional and state levels). • Places a large administrative burden on the regional lead agency to coordinate services and systems components for the region, <i>operate centralized reimbursement or billing system (or manage a contract to implement such) – will anyone be willing to take on this role?</i> • Potential perception of conflict of interest if the regional lead agency is also a provider of Part C services (since they are in charge of deciding who is awarded money) • <i>Significant start-up costs associated with regionalized billing (though this may vary depending on the agency selected and billing mechanisms already in place)</i>

ALTERNATIVE 3

Provider Enrollment through the State Lead Agency

Alternative 3a: Provider Enrollment with Centralized Reimbursement Through the State Lead Agency

Role of the State Lead Agency

The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. The Lead Agency is also responsible for supervision and monitoring and provides technical assistance to the LICC and service providers.

In addition, the state lead agency enrolls local/regional service providers as part of the statewide Part C system and operates a centralized reimbursement system for the entire state.

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the statewide Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the LICC; provision of financial support; etc).

Role of the LICC

The LICCs would work to coordinate services, public awareness, child find and data collection in their locality.

Role of Participating Agencies/Providers

The Part C participating agencies/providers carry out the responsibilities outlined in contracts from the state lead agency and/or in interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the LICC. In addition, all participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.).

Flow of Part C Funds

Through an RFP process, the state lead agency enrolls local/regional service provider agencies as part of the statewide Part C system. Enrolled provider agencies must meet minimum requirements related to licensure, personnel standards, etc. Enrollment agreements (or contracts) are signed between the state lead agency and the enrolled provider agencies to specify programmatic requirements, billing procedures, etc. Part C funds then go to agencies/providers based on the services they provide, as documented on the child's IFSP.

Billing System

The state lead agency operates a centralized Part C reimbursement system for the state. In that way, Part C funds are not used to fund agencies/providers/services but to fund children's IFSPs. The enrolled provider continues to bill Medicaid, private insurance and families in accordance with current Virginia Part C Policies and Procedures. The provider then bills the state lead agency (the centralized billing office) for the remaining cost – the state lead agency pays the provider using Part C funds as payor of last resort and up to the maximum rates established for reimbursement.

PROs	CONs
<ul style="list-style-type: none"> • Allows for dissemination of Part C funds for services through a valid, legal mechanism – contract with provider agencies • State is better able to monitor many aspects of the statewide system, including but not limited to the following: kinds of services used, frequency, and intensity; whether we are running out of funds; payor of last resort • Eliminates the potential conflict of interest issues that are present in the other 2 models. • May increase consistency in the Part C system statewide 	<ul style="list-style-type: none"> • Reduces local flexibility • Dissemination of Part C funds for systems components, such as child find and public awareness, may be more difficult, especially if there is a desire to maintain interagency participation in these aspects of the Part C system. • There will need to be training for all local personnel responsible for submitting reimbursement documentation to the state. • This model requires the most changes from the current infrastructure and at all levels of the system • This model seems least in line with Virginia’s traditionally de-centralized way of doing business. • Significantly increases the administrative burden (and potentially cost) at the state level in 2 ways: <ul style="list-style-type: none"> ○ Managing close to 100 contracts with provider agencies ○ Managing centralized reimbursement system • Will require tremendous efforts to ensure coordination and non-duplication of services since individual provider agreements with the state may facilitate “everyone doing his/her own thing.” – how does central point of entry work, service coordination, who does evaluation, etc.

** Note: It is difficult to say whether this model really streamlines the Part C system administratively. While the state would contract directly with providers and operate a centralized reimbursement system, localities and/or local service providers would still need to submit paperwork to the state for reimbursement; would still be doing their own billing for Medicaid, private insurance and family fees.

**Alternative 3b: Provider Enrollment with Centralized Billing
through the State Lead Agency**

Note: Areas in which this alternative differs from Alternative 3a are italicized.

Role of the State Lead Agency

The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. The Lead Agency is also responsible for supervision and monitoring and provides technical assistance to the LICC and service providers.

In addition, the state lead agency enrolls local/regional service providers as part of the statewide Part C system and *operates a centralized billing system* for the entire state.

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia’s Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the statewide Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the LICC; provision of financial support; etc).

Role of the LICC

The LICCs would work to coordinate services, public awareness, child find and data collection in their locality.

Role of Participating Agencies/Providers

The Part C participating agencies/providers carry out the responsibilities outlined in contracts from the state lead agency and/or in interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the LICC. In addition, all participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.).

Flow of Part C Funds

Through an RFP process, the state lead agency enrolls local/regional service providers as part of the statewide Part C system. Enrolled providers must meet minimum requirements related to licensure, personnel standards, etc. Enrollment agreements (or contracts) are signed between the state lead agency and the enrolled providers to specify programmatic requirements, billing procedures, etc. Part C funds then go to agencies/providers based on the services they provide, as documented on the child’s IFSP.

Billing System

The state lead agency operates (or contracts out for operation of) a *centralized Part C billing system* for the state. *Enrolled provider agencies would submit billing documentation to the state lead agency (or its contractor). The state lead agency (or its contractor) would do all Medicaid and private insurance billing for the state’s Part C system (they might also collect family fees) as well as providing reimbursement using Part C funds for other allowable expenses.*

PROs	CONs
<ul style="list-style-type: none"> • Allows for dissemination of Part C funds for services through a valid, legal mechanism – contract with providers 	<ul style="list-style-type: none"> • Reduces local flexibility • Dissemination of Part C funds for systems components, such as child find and public

<ul style="list-style-type: none"> • State is better able to monitor many aspects of the statewide system, including but not limited to the following: kinds of services used, frequency, and intensity; whether we are running out of funds; payor of last resort • Eliminates the potential conflict of interest issues that are present in the other 2 models. • May increase consistency in the Part C system statewide • <i>Potential for state to negotiate higher reimbursement rates with insurance companies</i> • <i>State would be able to ensure that all revenues remain in the Part C system</i> 	<p>awareness, may be more difficult, especially if there is a desire to maintain interagency participation in these aspects of the Part C system.</p> <ul style="list-style-type: none"> • There will need to be training for all local personnel responsible for submitting billing documentation to the state. • This model requires the most changes from the current infrastructure and at all levels of the system • This model seems least in line with Virginia’s traditionally de-centralized way of doing business. • Increases the administrative burden at the state level • Significantly increases the administrative burden (and potentially cost) at the state level in 2 ways: <ul style="list-style-type: none"> ○ Managing close to 100 contracts with provider agencies ○ Managing centralized billing system • Will require tremendous efforts to ensure coordination and non-duplication of services since individual provider agreements with the state may facilitate “everyone doing his/her own thing.” – how does central point of entry work, service coordination, who does evaluation, etc.
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Hybrid Alternative 1

Role of the State Lead Agency

The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. In addition, the Lead Agency is responsible for supervision and monitoring and provides technical assistance to the Regional ICC and service providers. To meet these responsibilities, the state lead agency does the following:

- Enrolls and credentials service providers as part of the statewide Part C system and maintains an updated list of Part C service providers;
- Operates a centralized billing system for the entire state (or contracts with another agency/entity for such a billing system);
- Retains control of Part C funds to be used for child find, public awareness, and training;
- Implements utilization review/quality assurance mechanisms to ensure Part C supports and services are provided in accordance with the Part C supports and services guidelines disseminated in 2003;
- Uses focused monitoring to allocate resources and meet priority needs, based on priorities and benchmarks established by the State Lead Agency. Priorities may dictate that some funds go to certain regions to address a specific issue while other priorities may be addressed at the state level (e.g. if child find is identified by the state as a priority in one region, then Part C funds may be used by the state lead agency to target public awareness and child find efforts in that region. Those funds might be allocated to the region based on a plan of improvement or might be used by the state lead agency to develop public awareness materials that address regional needs. Similarly, if the state identifies that training on a particular topic is a priority statewide, then the state lead agency may use Part C funds to develop and implement that training across Virginia).

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the statewide Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the regional ICC; provision of financial support; etc).

Role of the Regional Interagency Coordinating Council

LICCs are no longer required. Instead there is a regional interagency coordinating council (RICC) in each region of the state. The role of the RICC is to assist the State Lead Agency in overall system coordination by facilitating regional planning, coordination and communication about the Part C system in that region. Membership of the RICC would include parents as well as representatives from a range of service providers across the region. A paid RICC coordinator is employed in each region (could be employed through a contract directly with the State Lead Agency or through regional central point of entry).

Central Point of Entry

The State Lead Agency contracts with a regional central point of entry in each of the regions across Virginia. This regional central point of entry is the single means for entry into the Part C system for that region. The responsibilities of the regional central point of entry include supervision of temporary service coordinators in the region, although there is no requirement that the temporary service coordinators be housed in one regional facility.

When a child is referred to the regional central point of entry, referral information is gathered, introductory information about the Part C system is given to the family, and a service coordinator from that family's part of the region is assigned. Initial information and support to families as they enter the

system comes from people who know their area of the state and its unique issues and resources. Further, the temporary service coordinator will know the family's specific area of that region and can pull together evaluation and IFSP team members (by accessing expertise from their area of the region and/or from other parts of the region) that best match each child's and family's unique priorities, needs, resources, and interests.

The responsibilities of the regional central point of entry are detailed through a contract between DMHMRSAS and the selected entity.

Role of Participating Agencies/Providers

The Part C participating agencies/providers carry out the responsibilities outlined in contracts from the state lead agency and/or in interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the RICC. In addition, all participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.), as detailed in provider contracts.

Overall System Coordination

The state lead agency ensures that there are an adequate number of providers enrolled in Virginia's Part C system to provide needed supports and services to all eligible children and families and to provide access to all possible funding sources. The RICC, whose coordinator works closely with the state lead agency, assists in the planning, coordination and implementation of the regional Part C system. Once children enter the regional Part C system through the regional central point of entry, service coordinators then pull the system together for each individual child and family (by facilitating planning for and provision of appropriate Part C supports and services to meet each child's and family's unique combination of priorities, needs, resources and interests).

Flow of Part C Funds

Through an RFP process, the state lead agency enrolls and credentials service providers as part of the statewide Part C system. Enrolled providers must meet minimum requirements related to licensure, personnel standards, etc. Enrollment agreements (or contracts) are signed between the state lead agency and the enrolled providers to specify programmatic requirements, billing procedures, etc. Part C funds then go to agencies/providers based on the Part C supports and services they provide, as documented on the child's IFSP.

Also through an RFP process, the state lead agency selects an agency to serve as central point of entry in each region. A contract is signed between the state lead agency and each selected regional central point of entry detailing programmatic responsibilities and requirements as well as procedures for fiscal accountability for the Part C funds received.

Billing System

The state lead agency operates (or contracts out for operation of) a centralized Part C billing system for the state. The entity (whether it is the state lead agency or its contractor) responsible for operation of this centralized billing system will be referred to here as the State Billing Office. The centralized billing system would involve the following (or similar) procedures:

- Once it is determined that a child needs a Part C evaluation, the service coordinator submits to the State Billing Office, the referral information and the family's insurance information.
- The State Billing Office determines if there is a need for insurance pre-authorization for the evaluation and begins that process with the insurance company, if needed. Once it is determined that there is money to pay for the evaluation (through Medicaid, Part C funds, or other funds), the State Billing Office notifies the service coordinator that the child is ready for evaluation.

- Following the IFSP meeting, the service coordinator submits the IFSP and the Part C *Financial Agreement Form* to the State Billing Office in order to request payment.
- The insurance pre-authorization process is repeated for those families with Medicaid and those who have agreed to have their private insurance billed. Part C funds may be used to ensure the timely start of services while the insurance process is followed. The State Billing Office also establishes a payment schedule for the family fees, if any, as determined through the ability to pay process.
- Once insurance benefits have been determined, the State Billing Office provides information to the service coordinator (and/or providers) on the number of visits approved.
- The State Billing Office prints out the actual bill to be submitted to the insurance company, along with any required supporting documentation.
- Service coordinators provide IFSP-related documents and enrolled service providers submit progress notes, as needed, to ensure insurance company’s re-authorization of services.
- The State Billing Office has ongoing responsibilities related to obtaining insurance re-authorizations, following up when benefits are denied, etc.
- Based on provider agreements and taking into account insurance benefits and family fees, the Regional Billing Office uses Part C funds, as appropriate and as payor of last resort, to reimburse the provider for remaining costs up to the maximum established rate.

PROs	CONs
<ul style="list-style-type: none"> • Allows for dissemination of funds through a valid legal mechanism – contract with providers, regional central points of entry [ADMIN] • State is better able to monitor many aspects of the Part C system, including but not limited to the following: kinds of services used, frequency, and intensity; whether we are running out of funds; payor of last resort [ADMIN, MONITORING, TA] • By credentialing providers, will allow the Part C system to know who our providers are even if they move between agencies and would eliminate billing delay that happens now (because provider must get a new number each time they change agencies). [ADMIN, PROVIDERS] • Makes sense and reduces cost for those providers who currently must deal with multiple LICCs, fiscal agents. [ADMIN, PROVIDERS] • Regional points of entry, RICCs, and state enrollment of providers will facilitate access to specialized resources for children and families, since these resources may be found in only a few places a cross the state and local “boundaries” have been eliminated in this alternative [CHILDREN & FAMILIES] • With a smaller number of regional central points of entry instead of 40 local points of 	<ul style="list-style-type: none"> • Significantly increases the administrative burden at the state level for contract management – would be managing close to 100 contracts with provider agencies plus contracts with regional central points of entry [ADMIN] • Significantly increases administrative burden and cost at the state level for credentialing of providers [ADMIN] • Significantly increases the administrative burden and costs at the state level for managing (or contracting out for) a centralized billing system [ADMIN] <ul style="list-style-type: none"> ○ Estimated annual operating costs = \$650,000 ○ Estimated software costs = \$300,000 ○ Additional costs associated with development of the billing system, training of service coordinators and service providers in order to implement the documentation and other procedures required for centralized billing, etc. • Billing documentation will have to be maintained at both the state level and provider/agency level for audit purposes. [ADMIN]

<p>entry, more consistent message will be given to families statewide as they enter the Part C system. This will also facilitate a more streamlined and functional IFSP process and document since expectations (that are in line with supports and services guidelines) can be set more consistently with families [ADMIN, PROVIDERS, CHILDREN & FAMILIES, SYSTEM COORD]</p> <ul style="list-style-type: none"> • By keeping central points of entry and service coordination at the regional level, we build on the relationships that have been established over time. Initial information and support to families as they enter the system comes from people who know their area of the state and its unique issues and resources. [CHILDREN & FAMILIES, SYSTEM COORD] • In some areas of the state, councils and providers work across local boundaries already – this alternative builds on those existing regional efforts [ADMIN, SYSTEM COORD] • May be able to negotiate higher reimbursement rates with third party payors [PROVIDERS, ADMIN, CHILDREN & FAMILIES] • RFP process is a mechanism by which the state can require certain aspects of the system be in place or planned for (such as providing an avenue for continued employment of personnel who are already in the system – to minimize job loss as the infrastructure changes) [PROVIDERS, CHILDREN & FAMILIES] • With greater state control of funds, resources can be allocated and technical assistance focused on specific needs in different regions. [ADMIN, TA, MONITORING, SYSTEMS COMPONENTS] 	
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Hybrid Alternative 2

Role of the State Lead Agency

The state Lead Agency is responsible for ensuring a statewide system of early intervention services is in place for all eligible children and families in accordance with Part C of IDEA. In addition, the Lead Agency is responsible for supervision and monitoring and provides technical assistance to the Regional ICC and service providers. To meet these responsibilities, the state lead agency does the following:

- Enrolls and credentials service providers as part of the statewide Part C system and maintains an updated list of Part C service providers;
- Contracts with a regional central point of entry and a regional billing office in each region across Virginia;
- Retains control of Part C funds to be used for child find, public awareness, and training;
- Implements utilization review/quality assurance mechanisms to ensure Part C supports and services are provided in accordance with the Part C supports and services guidelines disseminated in 2003;
- Uses focused monitoring to allocate resources and meet priority needs, based on priorities and benchmarks established by the State Lead Agency. Priorities may dictate that some funds go to certain regions to address a specific issue while other priorities may be addressed at the state level (e.g. if child find is identified by the state as a priority in one region, then Part C funds may be used by the state lead agency to target public awareness and child find efforts in that region. Those funds might be allocated to the region based on a plan of improvement or might be used by the state lead agency to develop public awareness materials that address regional needs. Similarly, if the state identifies that training on a particular topic is a priority statewide, then the state lead agency may use Part C funds to develop and implement that training across Virginia).

Role of Other State Agencies Involved in Part C

The other state agencies involved in Virginia's Part C system remain involved in the Early Intervention Interagency Management Team and the VICC. They provide leadership and guidance to their local counterparts about ways in which they can be involved in the statewide Part C system (e.g. provision of supports and services; involvement with systems components like public awareness, child find or data collection; participation on the regional ICC; provision of financial support; etc).

Role of the Regional Interagency Coordinating Council

LICCs are no longer required. Instead there is a regional interagency coordinating council (RICC) in each of the state. The role of the RICC is to assist the State Lead Agency in overall systems coordination by facilitating regional planning, coordination and communication about the Part C system in that region. Membership of the RICC would include parents as well as representatives from a range of service providers across the region. A paid RICC coordinator is employed in each region (could be done through a contract directly with the State Lead Agency or employed through regional central point of entry).

Role of the Regional Central Point of Entry

The State Lead Agency contracts with a regional central point of entry in each of the regions across Virginia. This regional central point of entry is the single means for entry into the Part C system for that region. The responsibilities of the regional central point of entry include supervision of temporary service coordinators in the region, although there is no requirement that the temporary service coordinators be housed in one regional facility.

When a child is referred to the regional central point of entry, referral information is gathered, introductory information about the Part C system is given to the family, and a service coordinator from that family's part of the region is assigned. Initial information and support to families as they enter the

system comes from people who know their area of the state and its unique issues and resources. Further, the temporary service coordinator will know the family's specific area of that region and can pull together evaluation and IFSP team members (by accessing expertise from their area of the region and/or from other parts of the region) that best match each child's and family's unique priorities, needs, resources, and interests.

The responsibilities of the regional central point of entry are detailed through a contract between DMHMRSAS and the selected entity. (Note: The same agency/entity may serve as both regional central point of entry and regional billing office. This agency/entity may also be a provider as services in the regional Part C system.)

Role of the Regional Billing Office

A regional billing office is selected by the state lead agency for each region of the state through an RFP process. The regional billing office is responsible for development and use of consistent documentation and paperwork related to Part C billing, procedures to seek pre-authorization (and re-authorizations) for evaluations and services, procedures to generate and submit bills and supporting documentation to Medicaid and other third party payors, and procedures to follow-up with appeals and other details following determination of benefits. The specific responsibilities of the regional billing office are detailed through a contract between DMHMRSAS and the selected entity. (Note: The same agency/entity may serve as both regional central point of entry and regional billing office. This agency/entity may also be a provider as services in the regional Part C system.)

Role of Participating Agencies/Providers

The Part C participating agencies/providers carry out the responsibilities outlined in contracts from the state lead agency and/or in interagency agreements. Such responsibilities may include provision of supports and services; involvement in systems components like public awareness, child find and data collection; and participation on the RICC. In addition, all participating agencies/providers are responsible for meeting all Part C requirements (e.g. personnel standards, procedural safeguards, etc.), as detailed in provider contracts.

Overall System Coordination

The state lead agency ensures that there are an adequate number of providers enrolled in Virginia's Part C system to provide needed supports and services to all eligible children and families and to provide access to all possible funding sources. The RICC, whose coordinator works closely with the state lead agency, assists in the planning, coordination and implementation of the regional Part C system. Once children enter the regional Part C system through the regional central point of entry, service coordinators then pull the system together for each individual child and family (by facilitating planning for and provision of appropriate Part C supports and services to meet their unique combination of priorities, needs, resources and interests).

Flow of Part C Funds

The state lead agency contracts with a central point of entry and a billing office in each region. Providers, who are enrolled in the Part C system through the state lead agency, are reimbursed through the regional billing office for the Part C services they provide (using Medicaid and other third party payor reimbursement, Part C funds, etc.), in accordance with a contract between their agency and the state lead agency and based on each child's IFSP.

Billing System

A centralized Part C billing system for each region is operated through the Regional Billing Office. The centralized billing system would involve the following (or similar) procedures:

- Once it is determined that a child needs a Part C evaluation, the service coordinator submits to the Regional Billing Office, the referral information and the family’s insurance information.
- The Regional Billing Office determines if there is a need for insurance pre-authorization for the evaluation and begins that process with the insurance company, if needed. Once it is determined that there is money to pay for the evaluation (through Medicaid, Part C funds, or other funds), the Regional Billing Office notifies the service coordinator that the child is ready for evaluation.
- Following the IFSP meeting, the service coordinator submits the IFSP and the Part C *Financial Agreement Form* to the Regional Billing Office in order to request payment.
- The insurance pre-authorization process is repeated for those families with Medicaid and those who have agreed to have their private insurance billed. Part C funds may be used to ensure the timely start of services while the insurance process is followed. The Regional Billing Office also establishes a payment schedule for the family fees, if any, as determined through the ability to pay process.
- Once insurance benefits have been determined, the Regional Billing Office provides information to the service coordinator (and/or providers) on the number of visits approved.
- The Regional Billing Office prints out the actual bill to be submitted to the insurance company, along with any required supporting documentation.
- Service coordinators provide IFSP-related documents and enrolled service providers submit progress notes, as needed, to ensure insurance company’s re-authorization of services.
- The Regional Billing Office has ongoing responsibilities related to obtaining insurance re-authorizations, following up when benefits are denied, etc.
- Based on provider agreements and taking into account insurance benefits and family fees, the Regional Billing Office uses Part C funds, as appropriate and as payor of last resort, to reimburse the provider for remaining costs up to the maximum established rate.

PROs	CONs
<ul style="list-style-type: none"> • Allows for dissemination of funds through a valid legal mechanism – contracts between state lead agency and central points of entry and billing offices and between billing offices and providers. [ADMIN] • By credentialing providers, will allow the Part C system to know who our providers are even if they move between agencies and would eliminate billing delay that happens now (because provider must get a new number each time they change agencies). [ADMIN, PROVIDERS] • Makes sense and reduces costs for those providers who currently must deal with multiple LICCs, fiscal agents [ADMIN, PROVIDERS] • May be able to negotiate higher reimbursement rates with third party payors [PROVIDERS, ADMIN, CHILDREN & FAMILIES] • RFP is mechanism by which the state can require certain aspects of the system be in place or planned for (such as providing an avenue for continued employment of personnel who are already in the system – to minimize job loss as the infrastructure changes) [PROVIDERS, CHILDREN & FAMILIES] • This hybrid allows for greater flexibility to design more aspects of the system around regional needs and 	<ul style="list-style-type: none"> • There will be costs associated with training of service coordinators and service providers in order to implement the documentation and other procedures required for centralized billing [ADMIN, PROVIDERS] • Billing documentation will have to be maintained at both the regional level and provider/agency level for audit purposes [ADMIN] • Significantly increases administrative burden and cost at the state level for credentialing of providers [ADMIN] • Significant start-up costs associated with regionalized billing (though this may vary depending on the agency selected and billing mechanisms already in place)

<p>resources (e.g. billing system can complement service system) than does Hybrid 1[PROVIDERS, ADMIN, SYSTEM COORD]</p> <ul style="list-style-type: none"> • With a smaller number of regional central points of entry instead of 40 local points of entry, more consistent message will be given to families statewide as they enter the Part C system. This will also facilitate a more streamlined and functional IFSP process and document since expectations (that are in line with supports and services guidelines) can be set more consistently with families. [ADMIN, PROVIDERS, CHILDREN & FAMILIES, SYSTEMS COORD] • By keeping central points of entry and service coordination at the regional level, we build on the relationships that have been established over time. Initial information and support to families as they enter the system comes from people who know their area of the state and its unique issues and resources. [CHILDREN & FAMILIES, SYSTEM COORD] • In some areas of the state, councils and providers work across local boundaries already – this alternative builds on those existing regional efforts [ADMIN, SYSTEM COORD] • Regional points of entry, RICCs, and state enrollment of providers will facilitate access to specialized resources for children and families, since these resources may be found in only a few places a cross the state and local “boundaries” have been eliminated in this alternative [CHILDREN & FAMILIES] • Allows for consolidation of billing functions regionally, with improved consistency and standardization of forms and statements without creation of huge statewide billing system – could be interim step if we still wanted to move toward statewide billing system [ADMIN] • Builds on existing expertise by separating central point of entry and billing functions [ADMIN] • Doesn’t require one agency (e.g. regional lead agency) to do it “all” at the regional level [ADMIN] • With greater state control of funds, resources can be allocated and technical assistance focused on specific needs in different regions. [ADMIN, TA, MONITORING, SYSTEMS COMPONENTS] 	
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APPENDIX G:

Summary of Public Comments On Draft Report

PART C INFRASTRUCTURE TASK FORCE REPORT PUBLIC COMMENT INDEX

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PART C INFRASTRUCTURE TASK FORCE REPORT PUBLIC COMMENT

Comments were received from 16 individuals. Those individuals included providers, local council coordinators, families, and Directors of Mental Retardation Services. If more than one individual submitted the same comment, then a number in parentheses follows the comment to so indicate. Almost all comments are addressed in the final infrastructure task force report and/or the final local contract for SFY-06. A brief response is provided for each comment.

COMMENT RECEIVED	RESPONSE
Funding Issues:	
Federal Part C Fiscal Requirements	
This section states that federal funds will be used to <u>supplement and increase the level of State and local funds</u> expended for infants and toddlers. However, that does not appear to be the case in Virginia, and the Infrastructure Task Force should address this. Specific information needs to be provided about the exact meaning of this requirement and the implications and consequences of non-compliance with it.	The Office of the Attorney General was consulted regarding this issue when it arose in comments on the draft local contract. The OAG confirmed that the non-supplanting requirement is a federal requirement and cannot be changed by Virginia.
Virginia Policies, Procedures and Legislation	
Clarify that the Early Intervention Benefits only relates to certain classes of private insurance and is not a benefit that is available to all holders of private insurance policies.	Will be clarified in the final task force report
Revenue Sources	
If the total that is listed is estimated rather than exact, that should be stated. Also, if the “annual cost per child” is an average, that should be stated.	Language will be clarified to reflect the statements as given in the cost study report.
I recommend that the Ability to Pay Scale be reviewed and, after some data is gathered from localities about how the implementation of this scale has been working, consideration be given to adjusting the monthly cap amounts, perhaps on an annual basis. (4)	Review of the ability to pay policies and procedures is one of the recommendations of the task force and will be reflected in the final report.
The Ability to Pay Committee still needs to address the issue of assistive technology costs and how that fits with the Ability to Pay System. (2)	Please see above
Continual effort to increase our reimbursement from third party payors needs to be addressed. As you know, the Early Intervention Benefit does not guarantee reasonable reimbursement rates. (2)-(109)	The final report will reflect the task force’s recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates.
Many localities utilize other sources of private revenue, such as United Way funds, to assist with the cost of providing early intervention services. It would be important to include this source of revenue in the total of sources.	This is included now under private/other funding.

<p>...what about Part B guidelines to serve 2 year olds? Could that issue be looked at and spoken to? If it is a straight language delay and the child will be 2 by September 30, could those children be referred directly to the Part B system? Some assistance and clarification of these issues would be helpful.</p>	<p>Task force recommendations in the final report will address the need to determine whether families are being informed of their option to transition to Part B services if the child is 2 by September 30th and eligible under Part B. The task force does not recommend a change in the Part C definition of eligibility in Virginia since cost studies have shown no definite cost savings as a result of tightening eligibility.</p>
<p>I would like for us to be using a lot of time and energy in finding new funding sources so we can continue to be an asset to the families.</p>	<p>The final report will reflect the task force's recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates.</p>
<p>As long as providers are required to rely on insurance and fees to just keep the program afloat, we will continue to serve the same two masters.</p>	<p>The task force recognizes this challenge. A number of the recommendations in the final report will relate to this issue.</p>
<p>Providing TCM is in addition to Part C coordination. Limits caseload, increase of paperwork requirements for Service Coordinators. Other agencies do not understand how TCM will help children leaving Part C. Children that would benefit from TCM don't receive it because they do not have Medicaid coverage and there is no other funding source.</p>	<p>The final report will reflect the task force's recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates. Technical assistance is available from the Part C Office to assist in local implementation of TCM.</p>
<p>Greater cooperation between DMAS, insurance companies and providers; greater insurance reimbursement</p>	<p>The final report will reflect the task force's recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates.</p>
<p>More collaboration with VDOE to serve higher percentage of eligible 2 year olds in different community settings.</p>	<p>Task force recommendations in the final report will address the need to determine whether families are being informed of their option to transition to Part B services if the child is 2 by September 30th and eligible under Part B. The task force does not recommend a change in the Part C definition of eligibility in Virginia since cost studies have shown no definite cost savings as a result of tightening eligibility.</p>
<p>Look at the age requirement more carefully. It seems that we are getting more and more 2-2 1/2 year olds that are being referred for speech-only concerns. It is very labor intensive to perform a full evaluation, write an IFSP and begin services only to transition within a few months to the school system. Perhaps the temporary service coordinator should help the family make a school referral if they are greater than 2 1/2 years old.</p>	<p>Task force recommendations in the final report will address the need to determine whether families are being informed of their option to transition to Part B services if the child is 2 by September 30th and eligible under Part B. The task force does not recommend a change in the Part C definition of eligibility in Virginia since cost studies have shown no definite cost savings as a result of tightening eligibility.</p>
<p>Costs Associated with Part C</p>	
<p>We have one local provider...We cannot compete with the school systems and contracting agencies. We are such a rural area that our providers will not be willing to travel to outlying areas, without a huge increase in</p>	<p>Changes made in the final version of the local contract are intended to address this concern.</p>

associated costs.	
Inadequate Funding	
Some options include contracting out for certain services (i.e. lead agency responsibilities, centralized billing / reimbursement and central point of entry). This option will take more of our fiscal resources for administration, when we need those monies to pay for direct services.	The task force agrees and their recommendations will include not pursuing these options at this time, due to cost concerns and the need for more data. These concepts may be revisited in the future if conditions in the system change.
Concerns: Lack of funding to hire staff meeting the highest standard; lack of qualified personnel in our region; contractual providers moving into and out of system, requires constant training; and taking time to bring new providers up to new philosophy standards.	The final report will reflect the task force’s recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates.
State ITOTS data system is not completed, this results in local programs manually collecting data and trying to answer Part C requests. Short sighted decision on how to spend Part C dollars. Spending on Phase II of the ITOTS data system will save the state time and effort, as well as reduce cost in the locality.	Task recommendations will include the following: A comprehensive data system will be developed and implemented to manage and monitor the Part C system.
Caseloads are increasing without funding to hire additional staff.	The final report will reflect the task force’s recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates.
I would like to have any additional information that could be provided concerning any or all of the attempts to increase the budget through legislative processes. Specifically in a year where Part B has been successful in receiving additional funds, do we feel that enough is being done in the legislature to pursue the necessary and the possible money saving changes that would help alleviate some of the financial concerns? And with respect to that point, are there concerns at the state level, as there are with me, that reducing services and streamlining where appropriate documentation is given to justify additional services and support, will only “hurt” our cause in needing to rally support from legislators and families that ultimately are the ones that often provide the necessary support for change and increased funding?	The final report will reflect the task force’s recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates. Both the task force and the Part C Office support individualization of supports and services to meet the needs and priorities of children and families.
Under the implementation column (pg. 4 of Appendix E), “provide adequate funding so there is not a conflict between how services are to be provided and what is required from a reimbursement perspective”. Who is providing these funds? Because I believe this is the key-again, if we sell ourselves short we are going to find it difficult for the legislatures to buy into what we do or what we say.	The final report will reflect the task force’s recommendation that DMHMRSAS will continue efforts to seek additional revenue sources and to improve reimbursement rates.
The eligibility criteria could be tightened in order to save money, but still provide services to those most in need.	The task force does not recommend a change in the Part C definition of eligibility in Virginia since cost studies have shown no definite cost savings as a result of tightening eligibility.

Service Issues:	
Training and Support	
A significant amount of training and support is needed across the state to address the service delivery issues facing Virginia’s early intervention system at the same time that there is a decrease in training funds. (2)	Changes to the final version of the local contract include a category in the local budget for training. At the state level, the Integrated Training Collaborative will be planning training in ways that minimize costs to local providers and local Part C systems while providing effective information and support. Technical assistance consultants remain available to provide information and support as well.
In the Challenges chart: add statement about needing to “close the loop” with technical assistance, building into the process a way to gather feedback on an ongoing basis from those who were provided technical assistance.	The Part C Office will be working with stakeholders to determine a process for evaluation of TA that results in constructive information for all parties.
Rather than moving to regionalization as an attempt to solve the problems of the Part C system, I suggest that, first, sufficient data be gathered to determine exactly what the problems are. There is a good chance, with effective support and training, that our current system of 40 localities could successfully and efficiently provide even better early intervention services than we currently do. (2)	The task force agrees and has made a number of recommendations in the final report that address this issue – keeping local Part C systems, improving data and quality assurance mechanisms, etc.
Consider combining the MIMS and TA positions to create 5 MIMS/TA staff and then equally divide the state into five regions instead of three. (3)	The task force decided that consideration of the organization of the Part C Office, with regard to MIMS and TA staff, is to be managed within the office, with recognition that organizational structure is being reviewed.
We need some help with the 90-day conferences. If consistent messages from the state DOE on the 90-day conferences were given to all school divisions so that they could work with us in ensuring this were done, this would help us meet that requirement. (3)-(103; 109)	This has been identified in Virginia’s annual performance report to OSEP as a priority for the coming year. A state plan of improvement will be developed and submitted to OSEP by August 2004 detailing the steps Virginia will take to ensure statewide compliance with the 90-day conference requirement.
Local Part B systems vary across our planning district. Lack of collaborative training between Part C and Part B staff about the federal regulations regarding transition. No money to actually provide this training. The VA Board of Education and the Part C office should develop the standard training... It needs to be a local event required by both Part B and Part C.	State Part B staff has begun providing training to all LEAs regarding transition requirements. Part C and Part B staff worked together on developing this training, as well as the technical assistance document on transition that was disseminated to Part C and Part B providers in August 2003.
In spite of all the improvements and changes, there are still questions that go unanswered. For example, the IFSP outcomes are family driven, but frequency and intensity of services are restricted by the state. What do we do when a family disagrees with the allowable services? (2)	There is no restriction from the state on the frequency and intensity of supports and services. Decisions regarding these issues are made by the IFSP team and must be individualized based on the interests, priorities and needs of each child and family.
Training must be available for new employees as well as updated for current employees as changes occur. What are the costs of changing formats again? Who will bear them? Who will pay for local contractors to attend trainings?	Changes to the final version of the local contract include a category in the local budget for training. At the state level, the Integrated Training Collaborative will be planning training in ways that minimize costs to local providers and local Part C systems while providing effective information and support. Technical assistance consultants remain available to provide

	information and support as well.
Need timely clarification as questions arise about medical vs. Part C responsibility for complex medical needs, i.e. auditory-verbal, FM systems, hearing aids, nutrition services, etc.	Technical assistance is available from the Part C Office to assist with answers to such questions. There are times when answers cannot be provided instantly because clarification is needed from OSEP (often these issues are coming up in other states as well and there is a need to ensure accurate, up-to-date information based on recent court cases or other interpretation from the federal level). The goal is to ensure an accurate response and to do that as quickly as possible.
Ensure that funding is available to provide any training.	Changes to the final version of the local contract include a category in the local budget for training. At the state level, the Integrated Training Collaborative will be planning training in ways that minimize costs to local providers and local Part C systems while providing effective information and support. Technical assistance consultants remain available to provide information and support as well.
Unserved and Underserved Children	
In the Challenges chart: it is critical to add a statement about the “looming waiting lists of unserved and underserved children eligible for Part C services in some areas of the state”.	While the task force realizes the critical nature of the current fiscal crisis, the focus of our work was to be on the infrastructure that needs to be in place in order to most effectively serve children and families. The Plan B Workgroup addressed issues related to the fiscal crisis.
Due to the large number of ESL families in our area we use interpreters frequently. I realize that this is not a problem unique to Harrisonburg but it does affect how we spend our revenue.	Although the task force did not address issues as specific as the need for and cost of interpreters, the infrastructure recommendations in the final report will reflect the group’s belief that local systems of service are essential so that funds can be used as needed to meet local needs.
For us another question to raise is the issue of what is considered a language delay for a 2-year-old ESL child. Many of them have several languages spoken at home and may take longer to understand and speak those languages. I understand that we need to make sure we are not overlooking hearing loss in these children, but I think a two year old ESL preschool program through the city schools might be more cost effective and appropriate for these children than trying to serve them all individually.	Task force recommendations in the final report will address the need to determine whether families are being informed of their option to transition to Part B services if the child is 2 by September 30 th and eligible under Part B. The task force does not recommend a change in the Part C definition of eligibility in Virginia since cost studies have shown no definite cost savings as a result of tightening eligibility. Part C technical assistance consultants can help in interpretation of Virginia’s Part C eligibility criteria.
Natural Environments	
In the Challenges chart #3: clarify that the perceptions that more is better and that services in clinics are better are “in some areas”.	Clarification will be made
Bullet #1: clarify that services in natural environments increase costs to <u>Part C providers</u> . It is important to keep in mind that Clinic-based services are more costly to <u>parents</u> , which should be a consideration, particularly if Part C should be responsible for transportation.	Since the natural environments requirement is a federal requirement, the task force chose to document issues related to implementing that requirement (rather than those related to not implementing it – since that’s not an option).
I agree that services in the home are usually better. However, we have found	The natural environments requirement is federal. In accordance with Part C

<p>that some of our families have legitimate reasons that services should sometimes be held outside of the home. I would like for there to be leeway to individualize service delivery, if it is documented and the team agrees that is the way to go.</p>	<p>federal regulations and Virginia’s Part C Policies and Procedures, supports and services may be provided outside of a natural setting if there is written justification for why the outcomes cannot be met in a natural setting. In that situation, a written plan must be developed to specify steps that will be taken to move services back into a natural setting.</p>
<p>“Perceptions that more is better and services in clinics are better” (pg 10). More is not always better but sometimes it is and services outside the home is not always better but sometimes they are. I feel that using clichés over and over again cause a real sense of frustration to me. Again, I feel that this is where there appears to be a lack of trust and support for individualization (which I have always deemed as the foundation of our Part C system). This lack of support seems to be not only for those serving but those being served. The use of clichés and generalized exaggerations are not helpful or constructive in this process.</p>	<p>As detailed in <i>Individualizing Part C Early Intervention Supports and Services in Everyday Routines, Activities and Places</i>, individualization is key to effective service delivery. That document was very carefully developed to ensure that there were no “always” and “nevers.” The philosophy and guidelines reflected in that document also are based upon the latest research in the field of early intervention.</p>
<p>Natural environments were 65% in 2000 and 95% in 2003. Are we willing at all to take partial responsibility for the increased need for monies and growing deficits based on the fact that these services cost more even when (as stated above) there are generalizations to indicate that they are always better?</p>	<p>While the task force recognizes the additional costs associated with provision of Part C supports and services in natural environments, the natural environments requirement is federal and cannot be changed by Virginia. This requirement must be met if Virginia is to continue receiving federal Part C funds.</p>
<p>Services & Supports:</p>	
<p>I am concerned that while services and supports are supposed to be family driven, frequency and intensity are restricted by the state.</p>	<p>Frequency and intensity are not now and never have been restricted by the state. These concerns were addressed in changes made to the local contract.</p>
<p>Individualization appears to get lost in proposed capitations and pre approvals. While, clearly the intent is to ensure compliance with best practices. Some of the proposed changes will effectively dictate a cookie cutter approach to services delivery.</p>	<p>These concerns were addressed in changes made to the local contract.</p>
<p>I am concerned that we are, because of limited and inadequate funds, being asked to give families information of the amount of services offered that do not reflect our true professional opinions. For some, certainly not all, children a consult from a therapist is just not enough. I am also concerned that most therapists would not, indeed could not ethically, treat some children in this manner and will leave the Part C system.</p>	<p>Frequency and intensity are not now and never have been restricted by the state. These concerns were addressed in changes made to the local contract.</p>
<p>I wonder if withholding service is the way to face our inadequate funding. This is sending a message to our funding sources that we do not believe that what we do is important. Do we want these sources to believe that we recommend more services if we have funding and less if we do not? I would like for the monitoring team to really look at each individual chart and not just the number of services.</p>	<p>Frequency and intensity are not now and never have been restricted by the state. These concerns were addressed in changes made to the local contract.</p>
<p>I would like for the Part C folks to trust us to make decisions with the families and their doctors and give the services that are needed. If our</p>	<p>Frequency and intensity are not now and never have been restricted by the state. These concerns were addressed in changes made to the local contract.</p>

<p>services are truly individualized then there cannot be a set amount of time and services. I am very concerned that we are giving lots of time and energy to the funding and the system and not enough consideration to children and families. (2)</p>	
<p>The constant changes to documents, policies and procedures, and recommended practice present difficulties in getting providers to feel committed to the system. (2)</p>	<p>Some change is inevitable as practices evolve based on research in the field and data available within Virginia. The task force hopes that the time spent to develop these recommendations will ensure an infrastructure model that meets the needs of children, families and providers across Virginia.</p>
<p>Danger of Part C office to want a rubber stamp program, not looking at local needs or supports available to families. ...without regard to local needs or challenges.</p>	<p>The recommendations of the task force reinforce the need for local service delivery systems that have the flexibility to meet local needs and the needs of the children and families in that area.</p>
<p>No current standards for service coordination caseloads.</p>	<p>The task force feels that a consistent service coordination caseload size is difficult to determine on a statewide basis because of the variety of models of service coordination that are used, size of areas served, as well as other factors.</p>
<p>Hard to meet varied time demands from Medical reviews, Insurance requirements and Part C.</p>	<p>The task force recommendations will include continued study of additional economies of scale and other efficiencies. These may include consistent forms, contracts, etc.</p>
<p>I don't really understand the perceived difference between developmental and medical. I do understand that there are some children whose medical needs do not impact their developmental course (for example, a child with diabetes may not experience any effects on his/her development-although it could if their treatment was so intense that it effected their activities and participations in everyday activities-however, a child with C.P., seizures, or Down syndrome will have a number of developmental challenges secondary to and because of the direct impact of their medical diagnoses). A ruling in Michigan indicated that "developmental and neurological issues are not mutually exclusive, but both may exist in relation to a diagnosis". I strongly believe that the seeming dismissal of this fact again is indicative of an underlying distrust in the abilities and knowledge of those working in the system, as well as the families. There are many conditions-even by the risk factors list that the state provides-that dispute this continuing attempt to divide these two concepts (developmental and medical) and I feel that not honestly looking at the relationship does a disservice to all. I do acknowledge that in some situations these two concepts can be teased out-but it requires a lot of time and a relationship with the family-not something that can usually be teased out at the onset or during the first 1-2 visits (eval and IFSP) with the family.</p>	<p>The task force did not address issues as specific as this in their recommendations. However, the recommendations will include implementation of individualized services, data systems, benchmarks for services (to be developed with stakeholders), and appeal/review procedures to support implementation of the supports and services TA document. Part C TA consultants are available to assist providers in understanding the process for determination of Part C supports and services.</p>
<p>With respect to that point as well. (Comment above) I wonder how physicians feel when they read the state's document. Indicating that they are</p>	<p>Physicians are critical members of the IFSP team. They are equal to all other team members, including the family, in determining outcomes and then</p>

<p>need for reimbursement and for continuation of services (and monies) but that their professional opinion with respect to level and intensity is not welcomed -and even listed as a barrier (pg 31 of the appendix E).</p>	<p>supports and services. Part C has a process by which a decision is made by the team regarding entitled Part C supports and services. Outcomes are determined first and are based on evaluation and assessment in all areas of development and on the family's priorities, resources and concerns. Entitled Part C supports and services are those determined by the TEAM to be necessary and appropriate to meet the IFSP outcomes.</p>
<p>The comment about insurance companies compromising evaluation and service delivery because of discipline specific evaluations is nothing more than hypocrisy because the state requires and is holding us accountable for doing multidiscipline evaluations.</p>	<p>It is required that at least 2 individuals from different disciplines participate in the evaluation. The selection of those participants should be based on the needs of the child and priorities and concerns of the family, not on what disciplines can be reimbursed.</p>
<p>Using evaluations that are 6 months old to determine eligibility may very well increase numbers rather than decrease them.</p>	<p>It is a federal Part C requirement that each child's evaluation and assessment include a review of pertinent records less than 6 months old related to the child's health and medical history. In addition, Virginia Part C Policies and Procedures state the following: The evaluation team, with the permission of the parent, is responsible for reviewing any evaluation data less than 6 months old to determine if they are appropriate for inclusion in determining eligibility in order to prevent children and families from undergoing unnecessary evaluation and duplication of existing evaluation information. However, given the rapid changes in growth and development in infancy, evaluation teams need to ensure that all information used to determine eligibility accurately reflects a child's current status. The goal is to accurately identify children in need of Part C supports and services, not to increase or decrease a number.</p>
<p>PLEASE, PLEASE allow us to provide written explanation for why children are receiving high levels of service and frequency-I applaud this attempt and would strongly support it. I do believe in accountability and because of this, I believe we can provide adequate documentation on any child that is receiving services at higher levels. I would have to point out that the very fact of doing this (though I support it as a means of compromise) does again not reflect a service that truly supports individualization and supports the knowledge and judgment of those who work in the system.</p>	<p>There are no state limits on frequency and intensity. Supports and services must be determined on an individual child and family basis.</p>
<p>I don't understand the comment about "Lack of clarity about Part C's responsibility for children with complex medical needs". Are we now deciding who we are going to serve based on how severe or complex they are? Or how much money it may cost to serve them?</p>	<p>This comment related not to whom the Part C system will serve or how much that will cost, but to what supports and services for these children are covered under Part C and what services are medical in nature and listed under "Other Services" on the IFSP. These are issues and questions in many states, not just Virginia.</p>
<p>"Differences in services can range from 1 hour per month to 20 hours per week"-this is unconscionable. Either the state is using extreme situations (such as with a child who has ASD) or it is not certain to me how these areas would be able to continue this. Why would MIMS not be targeting these</p>	<p>Certainly these service frequencies do represent the extremes and the need for training, technical assistance and continued monitoring.</p>

<p>areas if they were truly seeing children that did not need to be seen 20 hours a week? It has been interesting to watch some of the lawsuits, particularly in Washington, concerning the state’s responsibility with families of children who suffer from these very difficult and isolating issues. I again applaud any effort on the state’s part to censure and pull in any area that would be misusing the system in such a way-I do wonder if this statement is used out of context?</p>	
<p>“More services will make the child progress more and faster”-we often have families ask us if we believe this (that their child will be fine or that the service will help him/her be okay) and we often respond that we understand their concern and their need to ask but we simply can not look into the future. Again, using statements like this (that more is not better and that children will not benefit from more intense services) seem to be divisive because withholding services from one group of children/people while giving to another group is completely unethical and that is why there is not any real data on this-on either side of the argument.</p>	<p>The service considerations presented in <i>Individualized Part C Supports and Services in Everyday Routines, Activities and Places</i> reflect evidence-based practice. Individualizing supports and services is not about giving more or less; it’s about providing what’s necessary and appropriate to meet the IFSP outcomes for that child and family at that particular time.</p>
<p>I believe that individualization is used multiple times in the state’s documents. I applaud this because I too believe in individualization of services. I hope that this foundation is a true one, allowing for families to have input and allowing for teams to determine appropriate services for a particular child in a particular setting and community. I fear that any shift to a state-driven system that is removed from the individual will result-now or later-into a system of rules, regulation, and guidelines that will support the system and not the individual.</p>	<p>The changes in the local contract and the recommendations from the infrastructure task force reflect a commitment to individualization and local flexibility with an appropriate level of monitoring and supervision by the state lead agency.</p>
<p>Contract Language:</p>	
<p>In the section on the “Flow of Part C Funds”, the second sentence states “As local lead agency, the CSB (or its designee) contracts...” which is not accurate. It should just say “The local lead agency contracts...”</p>	<p>Thank you for noting this error -- it will be corrected in the final report</p>
<p>It was difficult to understand many of the comments on Attachment E because they seemed to be written in an abbreviated form. (2)</p>	<p>This is a working document developed by the service delivery committee of the task force. A summary of the committee’s findings and recommendations is provided in the body of the report.</p>
<p>Possible Infrastructure Alternatives:</p>	
<p>Regionalization</p>	
<p>Of noticeable concern is the potential loss to the system of local funds...(4). As a representative from a very rural area, my concern is that any further stretching of the resources or coordination away from our locality would even more severely limit access to care for children and families in our community.</p>	<p>The task force agrees and recommendations in the final report reflect members’ and commenters’ strong belief in local service delivery systems.</p>
<p>I would urge that data be gathered to see if a regional system would be more cost effective and exactly how it would provide better services to families. (3)</p>	<p>Please see above</p>

Centralizing some of the administrative functions will most likely enable you at the state level to have more control and better fiscal management, but centralizing or regionalizing service delivery will have a negative impact on the very people we are trying to serve—infants and toddlers and their families. (4)	Please see above
I have heard at meetings that the Part C system is being urged to regionalize. I would like an understanding of why this is happening when Virginia still has 32 Health Districts, 40 CSBs, 121 local Departments of Social Services, and 132 school divisions. (2)	Please see above
I would argue that localized coordination offers a better chance at consistency than regionalization. (2)	Please see above
Regionalization will be highly costly to administer...	Please see above
To regionalize activities like the Central Point of Entry depersonalizes the system; this can impact on the relationships that have been developed, and referral may drop. (9)	Please see above. The final report will also reflect the task recommendation for a <u>single</u> point of entry in each local Part C system.
There may be a way to encourage a modified regional approach and to try this approach in one region to see if it provides costs savings—it may be that some of the structures do not need to be “repeated” in 40 localities, however, 5 or 7 regions may be too few. Is there a population threshold that is optimal (like areas that are 200,000 to 500,000) and could areas “merge” to form a region, rather than having lines drawn by CSB areas?	The recommendations in the final report offer the following options with regard to consolidating local Part C systems: If there is a reason that the number of local lead agencies becomes different than 40, then local determination will drive the decision as to why current local Part C systems might combine; thus, any number that is appropriate at a particular time is allowed. Some activities, such as public awareness, may occur at a regional level as occurs now among some local Part C systems. It is also noted that some activities, such as public awareness, may occur at a regional level, as they do now among some local Part C systems.
I hope that given each locality’s unique needs, Part C can allow individual councils to decide how best to use their resources. (2)	Changes in the local contract and recommendations in the final report of the infrastructure task force both reflect the need for local flexibility.
The proposed “overall system of coordination” process looks to be cumbersome and likely to create unnecessary delays in services to families (2) and potentially to create significant delays in the billing/ reimbursement process to contracted providers.	The task force agrees and will recommend local systems and no centralized billing.
Local service coordinators currently present the families with all IDEA Part C information applicable to the intake process. They have an extensive understanding of local contacts and resources. The scripted format is fine, but families should not be forced to listen to someone sit and read the information verbatim. The script must allow for local info. to be added.	The script is not something to be read to a family. It is intended to ensure that all families entering the system receive consistent information about what Part C is and is not.
Regionalization or centralization of some of the overlapping duties of the council would benefit a small rural council.... One example...is in the preparation of contracts.... Common billing practices...have service coordinators supervised, trained and mentored regionally to enhance skill	The recommendations in the final report offer the following options with regard to consolidating local Part C systems: If there is a reason that the number of local lead agencies becomes different than 40, then local determination will drive the decision as to why current local Part C systems

<p>development and improve service delivery to our families.</p>	<p>might combine; thus, any number that is appropriate at a particular time is allowed. Some activities, such as public awareness, may occur at a regional level as occurs now among some local Part C systems. It is also noted that some activities, such as public awareness, may occur at a regional level, as they do now among some local Part C systems.</p>
<p>Regionalization or centralization of revenue would not benefit our council. Small, rural councils with higher than average costs of providing services due to geographical boundaries and staff costs need to retain administrative responsibility of their revenue.</p>	<p>The task force report will reflect that centralized billing is not recommended at this time.</p>
<p>Do not agree with some of the projected ideas about regionalizing the central point of entry to cut down on overhead ... worked very hard to have a personal relationship with our referral sources. We also serve a large Mennonite population. It is just in the last few years where we have seen an increase in referrals. Most of these referrals come by word of mouth. They feel comfortable taking this major step because they know they will be served by people from their own community that know about their concerns and lifestyle. I do not think they will respond positively to a phone call from Richmond or Roanoke.</p>	<p>The task force agrees and the final report will indicate the recommendation for local service delivery systems including a single point of entry for each local Part C system.</p>
<p>Look carefully at infrastructure changes, the re-grouping of early intervention programs according to likeness versus differences.</p>	<p>The recommendations in the final report offer the following options with regard to consolidating local Part C systems: If there is a reason that the number of local lead agencies becomes different than 40, then local determination will drive the decision as to why current local Part C systems might combine; thus, any number that is appropriate at a particular time is allowed. Some activities, such as public awareness, may occur at a regional level as occurs now among some local Part C systems. It is also noted that some activities, such as public awareness, may occur at a regional level, as they do now among some local Part C systems.</p>
<p>Local Lead Agencies</p>	
<p>The strengths of having diversity in local lead agencies appears to far outweigh tying all local lead responsibilities to one system or department. It actually seems to defeat the intent of the law to limit or designate early intervention to one system at the local level. This made the comment on page 13 under “flow of Part C funds” confusing – “as local lead agency, the CSB (or its designee) contracts....” In the future, as this issue continues to be discussed, it would seem that an RFP process that clearly defines the responsibilities of “local lead” would be preferable and more equitable than – designating based on the state lead.</p>	<p>The task force recommendation related to selection of a local lead agency will read as follows: The local lead agency must be a public agency. In order to determine the local lead agency in each area, the agency currently serving in that role will be given the opportunity to continue. If that agency is not willing to continue as local lead agency, then other local public agencies will be considered by the local Part C system. If the local Part C system is unable to determine a local lead agency through the process described above, then the state lead agency will work with the local Part C system to make that determination.</p>
<p>There appears to be a conflict of interest when the local lead agency is also a provider of services. Is this effective practice? There may be some services</p>	<p>The task force recommendation related to conflict of interest will read as follows: Since the local lead agency may also be a service provider in the local Part C system, the local contract between DMHMRSAS and the local</p>

that become exceptions, however, this does not seem to be a practice that should be encouraged. If the local lead agency is responsible for ensuring that Part C services are explained to all families, can they also provide services and still be clear about roles?	lead agency will specify safeguards to minimize any perception of conflict of interest in budgeting and use of Part C funds.
With the change from local fiscal agency to local lead agency, it may be a good time to look more closely at the responsibilities of the local lead agency and the role of the LICC (and the core group—for this next year). The agency that is the local lead will have responsibility for fiscal and policy decisions—how can these functions be merged with the LICC, a group that has experience and expertise in early intervention?	The final report will reflect the responsibilities of the local lead agency and the LICC and their relationship to each other. The recommendations also include the need to revise the <i>Code of Virginia</i> to reflect the infrastructure changes.
Provider enrollment at the state level should be explored to ensure consistency – local lead agencies could still “contract” for services.	The task force recommendations will include continued study of additional economies of scale and other efficiencies, including provider enrollment.
Putting pressure on local providers to work without adequate funding will result in the local lead agency to question if they want or can afford to continue to support staff salaries, travel expenses, space and other support services at a loss.	Changes in the local contract have been made to address these concerns.
If the proposed changes to the infrastructure are implemented to increase the responsibilities of the lead agency, all the gains in working together to develop a cohesive interagency council would be weakened with the role of the council reduced to advise and to assist the lead agency.	The task force believes the LICC still has a very important role in the local Part C system. Interagency collaboration and relationships have been developed and maintained at the state level, where the infrastructure of lead agency and ICC is the same as that proposed at the local level. The task force feels there is strong local commitment to maintaining public-private partnerships and interagency collaboration.
Local Interagency Coordinating Councils	
A challenge for the Regional Interagency Coordinating Councils: A concern is that it will be challenging for the Regional Coordinators to get adequate representation on the new RICCs. Without adequate representation, and without truly understanding the needs of the various parts of the region, the issue mentioned before of having less control over how EI services are delivered may be among the results. (3)	The task force will recommend local service delivery systems, so there will be no RICCs.
Very few of the alternatives discuss having a local LICC. The type of personal relationships that have been established over the years would be jeopardized by a regional system. (2)	The final report will reflect the task force recommendation that LICCs be maintained and provide advice and assistance to the local lead agency.
Parents’ input and interagency coordination will be lost.	The task force believes the LICC still has a very important role in the local Part C system. Interagency collaboration and relationships have been developed and maintained at the state level, where the infrastructure of lead agency and ICC is the same as that proposed at the local level. The task force feels there is strong local commitment to maintaining public-private partnerships, parent-professional partnerships and interagency collaboration.
If the LICCs are no longer comprised of a core group, which not only informs and advises the Lead Agency, but also presents resources needed to provide	While a local Part C system may certainly choose to use a core group, one will not be required.

complete services and alternative funding, then there will be no incentive to bring these groups to the table.	
Networking was a particular subject that our committee said would fall short on if the council was dismantled. Most of our current parents will not be able to attend any kind of meeting based on personal costs to them.	The final report will reflect the task force recommendation that LICCs be maintained and provide advice and assistance to the local lead agency.
Council Coordinators	
It is not quite clear to me exactly what the new role of the local councils will be and how this will fit with the role of the local lead agency. Or is the intent of the Infrastructure Group to eliminate the local Council Coordinators regardless of the model chosen? (2)	The final report will reflect the task force recommendation that LICCs be maintained and provide advice and assistance to the local lead agency.
None of the options refer to or discuss the role of the local council coordinator. Eliminating local coordinators from the system creates a contract that is unmanageable. (4)	This issue was addressed in the local contract public comment table and in changes to that document.
The council coordinator is responsible for the Public Awareness projects, Child Find, Parent and staff trainings, state communication with the 6 schools, social services and health districts among others. How will we be able to do more with less?	Please see above
To have a Regional Coordinator who could understand those differences would be a tremendous challenge.	The task force will recommend local service delivery systems, so there will be no regional coordinator.
Regional or State Level Billing	
Sending all this information from the local level to the regional/state level will add red tape to each local provider's workload and may well result in a process that is cumbersome, inefficient, and time-consuming both locally and at the regional/state level. (3)	The task force agrees and their recommendations will not include pursuing these options at this time, due to cost concerns and the need for more data. These concepts may be revisited in the future if conditions in the system change.
If Virginia moves to a regional or state billing system, understanding the infrastructure from a state that is successfully billing all three (families, private insurance, Medicaid) would be essential. (2)	Please see above
It is recognized that there, might be some benefit to a centralized system of billing and provider enrollment for some of the councils. A regional or statewide provider approval process would be helpful.	Please see above.
More centralized billing systems should also be explored and not dismissed as being too costly—it is a long term idea and may not work in Virginia, however, it does not seem like this idea has been fully examined.	Please see above
Perhaps there is a way to centralize billing that would streamline some of the costs.	Please see above. Also, the task force recommendations will include continued study of additional economies of scale and other efficiencies, including provider enrollment, consistency of forms, consistency of contracts, etc.
General:	
...how to raise public awareness about the Part C situation. ...Suggested that	Thank you for your suggestions. The infrastructure task force did not make

we look into the Tobacco and Lottery money and also get a national or state spokesperson.	recommendations as specific as this, but your ideas have been shared with the Part C Office.
Some of the beauty of Part C comes from having many agencies, organizations, community leaders, and others work together to blend families (who have children with delays and disabilities) into communities. When any one agency takes too much responsibility, the system ends up pulling the family too far into the programs and services, risking reliance on the system rather than on more natural community resources. The balance can be attained; this current struggle is part of the greater balance.	The final report will reflect the task force recommendation that LICCs be maintained and provide advice and assistance to the local lead agency. The task force believes the LICC still has a very important role in the local Part C system. Interagency collaboration and relationships have been developed and maintained at the state level, where the infrastructure of lead agency and ICC is the same as that proposed at the local level. The task force feels there is strong local commitment to maintaining public-private partnerships, parent-professional partnerships and interagency collaboration.
Our recommendation is that the State pursue those courses of action that: 1) create the least amount of disruption to processes that are currently in place and working well; 2) Allow for the maximum amount of funds to remain in direct services, 3) Do not create unnecessary barriers for families to services and systems. And, 4) Provide adequate resources for localities to meet required administrative responsibilities. Proposals that make drastic changes in systems before any adequate deliberate, focused efforts have been made to identify and remedy problem areas does not seem to be a most prudent decision.	The task force agrees and believes they have accomplished these goals with the recommendations reflected in the final report.
Monitoring requests by the Part C office must not be shifted to localities without insuring local MIS systems can be integrated in the state's MIMS and ITOTS. Expecting localities to invest in duplicative systems is unwise.	Task force recommendations will include the development of a comprehensive system of data collection to manage and monitor the Part C system.
If certain localities are going around the system, censure them. Do not charge all programs with redundant reporting and monitoring without reason.	The task force agrees.
Thank you for sharing all of the financial information and the specific budget concerns. I have heard in several venues that these changes are not related to budget or money-as I feel many of us understood they were, and I truly appreciate the honesty involved in brining this to the forefront and even listing it as one of the two main purposes of this document.	It is not clear which changes are being referred to here, so the task force in not able to comment.
Is there any information on how the states were chosen (Indiana, N.C., Kentucky, Louisiana and Maryland)? I attended a conference in TN recently an spent much of my time (in between sessions) interviewing other providers from other states (CA, TN, NC, MD, MI, FL, KY and others) and found that those I spoke to have varying ideas and implementations as well. It is interesting that some information is presented as though it is statewide and I am wondering if that is an accurate representation.	The five states were selected based on discussion with the National Early Childhood Technical Assistance Center (NECTAC) and chosen to reflect a variety of billing systems, lead agencies, and administrative structures (e.g. local councils, regional systems, etc.).
My recommendation is to establish a plan of action for five years and stick with it (instead of constantly shifting the ground beneath us).	The recommendations of the task force are intended to be long-term.
More accountability through the use of state-level interagency agreement	Although the task force did not address this specific issue, the Part C Office is aware of the need to review and revise the state level interagency agreement.

More time to problem-solve as opposed to changing the rules to accommodate the problem

The task force recommendations are intended to maintain and improve supports and services for children and families.