Profile of States (updated 12/1/03)

	Virginia	Indiana	Maryland
Role of Lead Agency	Lead Agency is the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Their role: • 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.	Lead Agency is the Indiana Family & Social Services Administration (FSSA). Their role: · General Supervision and Monitoring · Technical Assistance to providers, LICCs and families · Contract Management · Central Reimbursement (Contracts with Covancis to do the billing.)	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. 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.

	Virginia	Indiana	Maryland
Local system and provider network	Local Interagency Coordinating Councils (LICCs) 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 and needs. Forty (40) local interagency coordinating councils have been established statewide to enable early intervention service providers to: • 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. Each LICC is composed of 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 Divisions. These designees designate additional members as follows: • At least one parent;	Local Planning and Coordinating Councils 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 Council, community resources are identified and service providers are invited to coordinate all available early intervention services for children. 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. State's provider networks · 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.	Local Service Delivery and Coordinating Councils 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 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. 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. Each LITP has a local interagency coordinating council (LICC) that advises and assists the local lead agency to implement the local system.

<table>
<tr><th></th><th>Virginia</th><th>Indiana</th><th>Maryland</th></tr>
<tr><td></td><td>Representatives from community providers that serve infants and toddlers with disabilities; and representatives from other service providers as deemed appropriate.
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.
State's Provider Network
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 councils employ service coordinators, therapists and educators within their own systems.</td><td></td><td>State's Provider Network
As stated above, services are delivered through local Infants and Toddlers Programs by employees of public agencies or through contracts with private providers. Services are provided at no cost to the family, as required by Maryland's birth mandate status.

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 coordination is provided by a service provider. Should the infant/toddler and family have complex needs, there is usually a designated service coordinator.</td></tr>
<tr><td>Service issues</td><td>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.</td><td></td><td>Data entry and system use
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.

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</td></tr>
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	Virginia	Indiana	Maryland
			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. 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. Parent Participation There is strong parent participation on State and local ICCs. Most ICCs are co-chaired by a parent.
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 be transitioned to the natural environment as deemed appropriate.	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 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	• State funds; • Medicaid; • Private insurance; and	State funds TANF Medicaid	Funds include State Federal

	Virginia	Indiana	Maryland
	• Family fees: o Implemented January 01, 2002 in accordance with Virginia Code whereby a system of payments for early intervention services was established by the Lead Agency; o 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). o A sliding fee scale establishes a uniform monthly cap based on taxable family income; and o A fee appeal process is made available for families experiencing identified hardships.	▪ 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.	Medicaid Local government funds Local Infants and Toddlers Programs are required to submit an interagency budget for all funding sources that support early intervention.
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, 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	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: ▪ All relevant state, federal and local resources available to support early intervention services and activities are identified and maximized ▪ Timely reimbursement to providers for early intervention services rendered ▪ Financial and data reporting needs	Medicaid billing is the only billing done for Part C services in Maryland. No Commercial insurance companies are billed. 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 in every jurisdiction does Medicaid billing for service coordination. Each local system determines how the money received from this billing is to be

	Virginia	Indiana	Maryland

	available to support early intervention services are identified and maximized.	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:
		  ▪ Common service descriptors, rates depending on discipline, and sites of service.
		  ▪ Provider enrollment.
		  ▪ Common authorization and invoice documents.
			used to support the early intervention system.
			
			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.

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 *Code of Virginia*, 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	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.		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.
Local system and provider network	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	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 were the Point of Entry offices are. Most of the offices are affiliated with either the local health department or the local	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.

	North Carolina	Kentucky	Louisiana
	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. Service coordination could in the past have been done by those who are also direct service providers, but the pilot programs are not functioning in this dual role. 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). 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. 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. 3. Can the central point of entry also be a provider of services?	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 been allowed, but is under consideration at this time. 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.	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. Responsibilities include: ¨ Receiving referrals and establishing the initial EI hardcopy and electronic record ¨ Conducting and completing the family intake ¨ 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 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

	North Carolina	Kentucky	Louisiana
	Central points of entry, under their lead agency, will be providers of service coordination. 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.		evaluation is helpful to DHH when new proposals are solicited for SPOE services. 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 enrollment as a Part C system provider. Family service coordinators are enrolled as providers.
Service issues	NC currently serves “at risk” children, including those with a history of founded child abuse or neglect. Their definition of eligibility is being reviewed. Issues identified in the 1999 document include the following: - 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 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?	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	~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
	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. 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 reduce that to a ratio of 1:20. Service coordinators are not the providers of other early intervention services. 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. 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.	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. 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 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. 3. Has trend data been collected on frequency, intensity, and location of services? Several years ago the First Steps Program was audited by the Legislative Review Committee. 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	

	North Carolina	Kentucky	Louisiana
		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. 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.	
Natural environments	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. 1. Who makes the decision to provide a service in a setting other than the natural environment? Service coordinators make the 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. 2. How is this (setting other than natural environment) documented? On the IFSP. 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.	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. 2. How is this (setting other than natural environment) documented? Each service provider documents in their notes and the setting is listed on the IFSP. 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 most of these services are paid for by KCHIP, medicaid or EPSDT. 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. 5. Has your state been monitored by OSEP with respect to natural environments? Was your	~All decisions for natural environments are made by the team. ~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 reimbursement rates include a charge for three "billing categories" – natural environments is one of these categories. ~cited by OSEP in previous configuration, but has not been monitored with since the change in Lead Agency.

	North Carolina	Kentucky	Louisiana
	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. 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.	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.	
General finance	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. 2. Of the total early intervention costs, 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). 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. 4. How is the local interagency council	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.. 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. 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 4. How is the local interagency council funded? How is the local interagency coordinator paid for? Some funding is provided by the program for the local DEIC's no funding is provided for the ICC. 5. How is service coordination paid for? Is it reimbursed by child or by contact hour	~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.

	North Carolina	Kentucky	Louisiana
	funded? How is the local interagency coordinator paid for? Little funding is provided for the LICC, as much is "in kind" by collaborating agencies. 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. 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. 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. 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.	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 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. 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? 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.	
Billing system	1. Does your state have centralized billing? Yes, under their new model which is being piloted. 2. What problem were you trying to solve when you went to centralized billing? This is part of their reorganization to 18 regional centers under the lead agency. 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 bill is generated by the central office of the lead agency.	1. Does your state have centralized billing? Yes, CBIS the Centralized Billing and Information System is housed at the University of Louisville. 2. What problem were you trying to solve when you went to centralized billing? Data collection was the main reason for the billing change from state government. 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	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 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

	North Carolina	Kentucky	Louisiana
	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. 5. Is a per child cost established? Cost is per service. 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. 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. 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. 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". 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.	to provide billing and data collection. 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? Yes 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?	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. ~trying to solve problems of providers having to bill multiple sources, of payor of last resort, of Medicaid billing and other insurance billing. ~contract with CFO for billing is approximately $500,000-$600,000.
Insurance, Medicaid, Payment	NC does not currently have a state-wide 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 requesting an insurance bill through their General Assembly to assist with private insurance coverage. 1. Is insurance accessed for Part C services in addition to Medicaid? If so, how is this done	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 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.	~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. ~EPSDT is part of the Medicaid billing and mainly covers therapy services.

	North Carolina	Kentucky	Louisiana
	(re: need for authorization and getting therapists to have provider numbers with insurance companies)? 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. 2. Are families giving permission for their insurance to be billed? What is the success rate in accessing insurance? Not currently in place. 3. What problems have surfaced (re: private insurance billing)?Not applicable at this time. 4. Are families responsible for co-pays and deductibles? They do have family fees, but are not billing private insurance. 5. Does your state have an ability-to-pay policy? They will have this in place soon. 6. Who is responsible for collecting fees through ability-to-pay? Billing is done through the 18 regional offices. 7. Does your state use the ISFP as the medical plan of care? Did not ask – not applicable at this time for private insurance. 8. What role does EPSDT play in funding EI services? This is a source of payment under Medicaid. 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. 10. How else is Medicaid funding used? What other methods are used to seek Medicaid funding? See #9.	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. 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. 4. Are families responsible for co-pays and deductibles? Yes, but we deduct these amounts from family share. 5. Does your state have an ability-to-pay policy? We have a sliding fee scale for family share. 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. 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. 8. What role does EPSDT play in funding EI services? No part. 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. 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 those eligible families.	
Policy and procedure vs. code and regs.			