



Infant & Toddler Connection of Virginia

Part C Infrastructure Task Force Report

April 30, 2004

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I. Executive Summary

In August 2003, a group of stakeholders was convened by the Department of Mental Health, Mental Retardation 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 General Funds for Part C have remained at \$125,000 per year; 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.
- The current administrative structure, which is based on local interagency coordinating councils (LICCs), 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 localities 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.

The pending Part C budget shortfall made it very difficult for the infrastructure task force to reach the point of consensus on any long-range vision for the Part C system despite the extensive effort and thought that the task force put into examining Virginia's Part C system and options for long-range re-structuring. However, the following steps have been taken:

- In light of the fiscal crisis in Virginia's Part C system, a state-level workgroup developed strategies that must be implemented immediately in order to maximize efficiencies in the use of each Part C dollar beginning in State Fiscal Year 2005.
- The infrastructure task force developed the following short-term recommendations for implementation in State Fiscal Year 2006:
 - DMHMRSAS shall remain the state lead agency for Part C in Virginia.
 - Responsibilities for ensuring that a local system of Part C early intervention supports and services is in place and meets all Part C regulations will shift from the LICC to a Local Lead Agency, which must be a public entity. This change will allow for a valid contracting mechanism between DMHMRSAS and the local level.
 - The LICC will advise and assist the Local Lead Agency in implementing the local Part C system.

- This public comment period is being used to solicit community input not only on the short-term recommendations described below but also on considerations for long-range planning. Work to further study elements of the long-range vision based on public input received through this comment period and to plan for implementation of that vision over time will continue.

II. Background

In August 2003, a group of stakeholders was convened by the Department of Mental Health, Mental Retardation 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 localities 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.

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).

Federal early intervention legislation was enacted by Congress 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 – 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) has 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, localities 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 localities 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 have been appropriated annually since 1992 to DMHMRSAS for the provision of early intervention services for unserved and under-served Part C eligible children.
- The allocation of Part C funds (federal and state) to Virginia's 40 local interagency coordinating councils includes \$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 are reviewed annually, and updated statistical data are entered into the formula each year to reflect current local needs.
- The Code of Virginia was amended in 1997 and 1998, respectively, to require the State Employee Health Benefits Plan (§ 2.1-20.1) and private insurers (§ 38.2-3418.5) to cover early intervention therapy services for Part C eligible children.
- 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) = 33%
- Local Revenue = 21%
- Insurance = 18%
- Medicaid = 15%
- Other State Funds = 8%
- Family Fees (through ability to pay) = 1%

(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 \$31.7 million. This total includes provider costs, local council costs, and state level costs.
- The annual cost per child for a full year of services is \$7,600.

Note: The complete Cost Study Report (Karleen Goldhammer, 2003) is provided in Appendix D.

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.
- 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 localities 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. There has been no increase since 1992 in the amount of State General Funds appropriated for Part C in Virginia.
2. 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.
3. Providers have experienced decreasing reimbursement rates from Medicaid and other third party payors.
4. Feedback from localities indicates that the formula used for allocation of federal and state Part C dollars does not equitably meet local needs.
5. Local dollars make up almost a quarter 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 task force reviewed the early intervention process from entry to discharge from the Part C system. For each step in the process, the group 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:

- A single point of entry into the Part C system in each area (e.g. council area or region).

- 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 an enforceable 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 group’s discussions and recommendations is included in Appendix E.

Strengths:

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.

Challenges:

1. Inconsistency across the state in how localities 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 that more is better, services in clinics are better
4. Variability in service coordinator training, skills, abilities, caseloads across the state

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 General Funds for Part C have remained at only \$125,000 per year; 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.
- 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 almost a quarter 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 localities 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 F. The table provided in Appendix F 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 G. 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

The pending Part C budget shortfall made it very difficult for the infrastructure task force to reach the point of consensus on any long-range vision for the Part C system. The information gathered from other states, the chart developed by the services subcommittee, and the infrastructure alternatives presented in the Appendices represent the effort and thought that the task force put into examining Virginia's Part C system and options for long-range re-structuring. However, the following steps have been taken:

- In light of the fiscal crisis in Virginia's Part C system, a state-level workgroup developed strategies that must be implemented immediately in order to maximize efficiencies in the use of each Part C dollar beginning in State Fiscal Year 2005.
- The infrastructure task force developed the following short-term recommendations for implementation in State Fiscal Year 2006.
- This public comment period is being used to solicit community input not only on the short-term recommendations described below but also on considerations for long-range planning. Work to further study elements of the long-range vision based on public input

received through this comment period and to plan for implementation of that vision over time will continue even as the following short-term infrastructure is put into place.

State Lead Agency

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)

Role of the State Lead Agency

The role of the state lead agency remains largely 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 state Lead Agency is also responsible for statewide supervision and monitoring and statewide public awareness and provides technical assistance to the local lead agency, the LICC, and providers. Based on monitoring results and data review, the state Lead Agency determines priorities associated with and allocates funding for child find to local lead agencies, as appropriate.

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).

Process for Selecting the Local Lead Agency

In order to determine the local lead agency in each of the 40 local council areas, the state lead agency will send a letter to the public entity currently serving as the fiscal agent in that locality. That letter will detail the responsibilities of the local lead agency and will request that the fiscal agent have discussions with the local council core group to determine the local lead agency. A letter will also be sent from the state lead agency to the local council coordinator requesting that the LICC discuss the selection of the local lead agency and provide recommendations to the core group (the core group may accept or reject the council's recommendation). Following discussions between the current fiscal agent and the core group, the core group will send a letter to the state lead agency indicating what local public entity will be the local lead agency. If the locality is unable to determine a local lead agency through the process described above, then the state lead agency will work with the locality to make that determination.

Role of the Local Lead Agency

Responsibilities of the local lead agency 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 Part C local lead agency would be detailed in a contract between DMHMRSAS and the local lead 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 all fiscal and policy decisions would be 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 Part C contract with DMHMRSAS. As local lead agency, the CSB (or its designee) 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 is implemented.

NOTE: Since the task force report has not yet been finalized or presented to the Commissioner of DMHMRSAS, the task force recommended that for SFY-05 DMHMRSAS pursue use of a contract extension of the existing Local Contract for Continuing Participation. However, the Office of the Attorney General was not able to support that proposal since that would continue the use of an invalid contract. DMHMRSAS cannot contract with the LICC and cannot use the term “fiscal agent” in the contract (because legally that term means an agent of the LICC; and if the LICC cannot legally enter into a contract, neither can its agent). In order to address the need for a valid contract in this interim year (i.e., between the old contract and a new contract that reflects implementation of infrastructure task force recommendations), the SFY-05 local contract is between DMHMRSAS and the “local lead agency.” In this interim year, the local lead agency is responsible for the fiscal management of the Part C funds (the same responsibilities as the fiscal agent had in last year’s contract) and for assisting the LICC in carrying out its duties (since those duties must belong to the LICC, in accordance with the *Code of Virginia*). The scope of responsibilities for the local lead agency will change when the infrastructure task force recommendations are implemented in SFY-06.

APPENDIX A:

List of Task Force Members

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Virginia's Early Intervention System
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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 agency representatives shall be appointed by the member of their agency who serves on the early intervention agencies committee. 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) Licensure 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 agency representatives shall be appointed by the member of their agency who serves on the early intervention agencies committee.~~ *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:
2003 Cost Study Report

APPENDIX E:

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 for what is said to families and consistent forms for intake, intake 	<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 	<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
				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)	contacts to lay 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 • Use of existing test results • Strive for more true “team” approach, evaluating at same time • Consistency of evaluation tools • Increase awareness at referral sources and families about what will happen • 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 	<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 		

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			information about what 1) eligibility for Part C means and 2) what eligibility for specific service would mean	Virginia's 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>Federal: 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 their child 	<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)			<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 private school or 			

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			<p>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 of services being provided 	<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 contract language to require providers to follow 	<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 community in Virginia

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
			<p>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>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 orientation module • Include in contract language documentation requirement for service delivery for 		

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
				providers		
IFSP Reviews	Federal: 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 across Virginia • Great variability in SC caseloads across Virginia 			
Transition Activities	Federal: Prior Notice,	<ul style="list-style-type: none"> • Transition Technical Assistance 	<ul style="list-style-type: none"> • Confusion about requirements • There are different 	<ul style="list-style-type: none"> • Include in contract, requirement to adhere to 90 day 		

Process Steps	Regulations	Facilitating Factors	Barriers	Proposed Actions		
				Infrastructure	Implementation	Training
	Procedural Safeguards	<p>Document has been disseminated</p> <ul style="list-style-type: none"> • Page 7 of the state IFSP form serves as a reminder of required transition activities 	<p>processes for each local school system – and some councils have multiple school systems within their council</p> <ul style="list-style-type: none"> • 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 • Children who turn 2 after September 30 may be seen by Part B in some parts of the state but not in others. 	<p>transition conference requirement</p>		
Discharge from Part C Services			<ul style="list-style-type: none"> • Families no longer have service coordination (unless they have targeted case management) 			

APPENDIX F:

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</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 Council, community resources are identified</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>based upon local resources 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 <p>representatives from other service providers as deemed appropriate.</p> <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</p>	<p>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.</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, 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.</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 coordination is provided by a service provider. Should the infant/toddler and family have complex needs, there is usually a designated service</p>

	Virginia	Indiana	Maryland
	for early intervention services. A few of the councils employ service coordinators, therapists and educators within their own systems.		needs, there is usually a designated service 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	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
	for services to 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.	<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
	<p>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 available to support early intervention services are identified and maximized.</p>	<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	<p>Private insurance, with the family's permission, is billed for eligible Part C services. Medicaid is also billed for eligible Part C services.</p>		
Policy and procedure vs. code and regs.	<p>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.</p>	<p>Indiana Administrative Code</p>	<p>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.</p>

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>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.</p>	<ol style="list-style-type: none"> Who employs the local interagency coordinator? If you are asking about the chair of the ICC it is a voluntary position. 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 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. 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 	<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

	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>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>	<ul style="list-style-type: none"> • 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 <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 enrollment as a Part C system provider. Family service coordinators are enrolled as providers.</p>

	North Carolina	Kentucky	Louisiana
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 teamwork? 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 reduce that to a ratio of 1:20. Service coordinators are not the providers of other</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 First Steps provider on the plan be represented by more than one agency. What</p>	<p>~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</p>

	North Carolina	Kentucky	Louisiana
	<p>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>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 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 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>	
<p>Natural environments</p>	<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 decision of whether to provide services in settings other than natural environments.</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 their notes and the setting is listed on the IFSP.</p> <p>3. How is the service paid for if the family makes the decision? First Steps will</p>	<p>~All decisions for natural environments are made by the team.</p> <p>~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</p>

	North Carolina	Kentucky	Louisiana
	<p>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>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.</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>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, what percent of your budget is used by the lead agency for operating costs? Lead</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>3. How many children are being served? The last number of children I have is</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>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>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? Some funding is provided by the program 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 part of their reorganization to 18 regional centers under the lead agency.</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 solve when you went to centralized billing? Data collection was the main reason for the</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 system to the network of SPOEs throughout the state. The SPOE is responsible for</p>

	North Carolina	Kentucky	Louisiana
	<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 bill is generated by the central office of the lead agency.</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>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>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 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</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 of insurance by providers. We do not currently have a policy in place that requires</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 mainly covers therapy services.</p>

	North Carolina	Kentucky	Louisiana
	<p>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)? 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? 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>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 those eligible families.</p>	
Policy and			

	North Carolina	Kentucky	Louisiana
procedure vs. code and regs.			

APPENDIX G:

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 	<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)</i> – 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) • <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>

<p>employment of well-qualified personnel who are already in the system).</p> <ul style="list-style-type: none">• May improve consistency in the Part C system across the state, while still allowing flexibility to meet regional needs	
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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 eval, 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 • 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> 	<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 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 eval, etc.

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) 	<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

<p>agencies). [ADMIN, PROVIDERS]</p> <ul style="list-style-type: none">• 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 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]• 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	<ul style="list-style-type: none">○ 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]
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<p>continued employment of personnel who are already in the system – to minimize job loss as the infrastructure changes) [PROVIDERS, CHILDREN & FAMILIES]</p> <ul style="list-style-type: none">• 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) 	<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]

<p>agencies). [ADMIN, PROVIDERS]</p> <ul style="list-style-type: none"> • 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 resources (e.g. billing system can complement service system) than does Hybrid 1 [PROVIDERS, ADMIN, SYSTEM COORD] • 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 	<ul style="list-style-type: none"> • Significant start-up costs associated with regionalized billing (though this may vary depending on the agency selected and billing mechanisms already in place)
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<p>boundaries already – this alternative builds on those existing regional efforts [ADMIN, SYSTEM COORD]</p> <ul style="list-style-type: none">• 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 across 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 H:

Summary of Public Comments On Draft Report

(Will be added after the public comment period and included in final task force report to the Commissioner)