Medicaid Stakeholder Group Meeting
3/14/08
Tuckahoe Library, Richmond, Virginia

Attendance:
Sue Mackey Andrews, SOLUTIONS Consulting Group, LLC
Nancy Bailey Infant & Toddler Connection of Lenowisco
Joann Boise, Child and Adolescent Health, VDH
Nancy Butts, Private Provider
Brian Campbell, EPSDT Coordinator, DMAS
Molly Carpenter, Policy Analyst
Mary Ann Discenza, Virginia Part C Coordinator
Jill Donaldson, Public Provider, Infant & Toddler Connection of Rappahannock Area
Jim Gillespie, MR Director, Rappahannock Area CSB
Karleen Goldhammer, SOLUTIONS Consulting Group, LLC
Carol Hagen, Family Involvement Project
Debra Holloway, Family Involvement Project
Jennifer McEllwee, Infant & Toddler Connection of Virginia Beach
Tracy Miller, Rehab Associates
Phyllis Mondak, 619 Coordinator, DOE
Allan Phillips, Infant & Toddler Connection of Fairfax
Kathy Phillips Infant & Toddler Connection of MPNN
Anne Simmons Infant & Toddler Connection
Eva Thorpe, George Mason University
Beth Tolley, Technical Assistance Coordinator, Infant & Toddler Connection of Virginia
Tera Yoder, Partnership for People with Disabilities

Welcome and Introductions

Sue reviewed the Briefing Document (handout). The document has been presented to and discussed with Frank Tetrick, Associate Commissioner for Community Services, DMHMRSAS. Sue stated that changes in any of the components of the system transformation (rates, Medicaid, data, family cost participation) would impact everything else.

Sue informed the group that they, as stakeholder representatives are expected to work with their constituents in the 2 weeks following receipt of the minutes of this meeting.

Sue and Karleen updated the group on the work of the three other stakeholder groups.

Rates and Allocation Stakeholder Meeting

The term "allocation" will no longer be used because the proposed mechanism for funding will be through a service reimbursement for reimbursable services/functions and through Part C funding for the Part C system components and unfunded services. This will include a variety of fund sources available to Part C and result in equity and parity for providers and for families and will include integration of family cost participation. Steps to move to this funding mechanism include work with Medicaid (plan amendments, etc.) and work with private third party payors.

There seems to be sufficient funding match (through DMAS and DMHMRSAS funding) in the system so it will not be necessary to request funding for this from the General Assembly.

With the new system of funding, service coordination and certain administrative functions will be reimbursed through administrative claiming; other services will be reimbursed through EPSDT and DME will be reimbursed through the current (EPSDT) mechanism. SOLUTIONS will be working with Medicaid regarding reimbursement for screening.

It is expected that these funding changes will result in greater system capacity through increased funding and additional providers to serve more children.

DMAS will not pay for service coordination that is implemented through the blended model (per CMS directive at the federal level). Medicaid can reimburse either the service or the service coordination when the same person provides both services to the same child, but it can't pay for both. Local systems can choose to use local funds to pick up the balance of payment for these "blended" people, but cannot use Part C Federal funds, to continue to use the blended model of service coordination because use of Part C funds would violate the payor of last resort requirement. Also, Medicaid will not reimburse for both the system work (through administrative claiming) and the direct service work (reimbursement) done by a system manager. Local systems will need to decide if they want to change how they are structured to maximize reimbursement options. Systems will not be required to change how they are configured, but they will need to figure out how they will fund the unreimbursed functions if they elect to stay with a configuration that is not within the definitions for reimbursement of the Medicaid EI initiative.

The consultants believe that the Office of Management and Budget (OMB) prohibits billing for admin claiming and reimbursement for services provided by the same individual. There could be an audit funding and a payback situation to the locality if a local system bills for reimbursement and also uses administrative claiming for other functions provided by same person. There are two different mechanisms for accessing administrative claiming and the fee for service (15 minute increments) for direct services. Admin claiming is based upon a random time study approach and actual costs; fee for service is an amount reflecting all of the costs involved in a face:face encounter with a child and family/caregiver. Local funds could be used to support one or the other or the local structure can be reconfigured. The consultants made it clear that any realignment of staff functions would be a locally-determined decision.

Admin claiming is just for public system and will be done at the state and local level. The rates include consideration of private provider costs for recruitment and training.

The work done by SOLUTIONS in 2003 was updated to determine costs and thus rates for services. The cost for intervention service was determined to be $126/hour for face-to-face contact. (The rate factors in some reasonable consideration of no shows and travel time based upon the updated cost and time study activities.) In looking at the salary information, it was clear that there were two groups – therapists in one and service coordinators and special instructors for the other. At this time, $150/hour is being considered for therapy rate and $104 for service coordination and special instruction.

Now that it has been determined that Part C will seek service coordination reimbursement from Medicaid through administrative claiming, additional work needs to be done on the rate for developmental therapy. There has been a lot of discussion about having one rate, but because of the way Virginia's local service delivery system is configured now, the providers can't be sustained with the lower rate and service coordination and special instruction would be reimbursed at rate higher than cost if a single rate was used. The system structure may be

aligned in the future for a single rate, but isn't now. Tweaking will need to continue. Work with DMAS regarding the rates and reimbursement structure will start next Friday. The requirement that the MCO rates be at least what the fee for service rates is written into the MCO contracts.

It is expected that the rate change will have a positive impact on the provider shortage, which is a factor in child counts lower than expected. This is an important consideration from the perspective of meeting the needs of children and families and from the perspective of compliance with OSEP and Title XIX requirements.

Other questions arose related to billing requirements that may be in conflict with Medicaid billing requirements in the transformed system for Medicaid reimbursement. Sue asked stakeholders to forward questions to her. She and Karleen will work with Tammy Whitlock to develop a document that addresses the scenarios presented from the stakeholders.

The potential that providers may opt to leave therapy agencies and function as independent providers was discussed. The providers in the group did not believe that this would be an issue. Management of the requirements associated with Part C is an incentive for providers to work in an agency rather than independently. Providers can do both.

SOLUTIONS Consulting Group recommends doubling the funding for the administrative functions at the state level of Part C in order to be successful with the transformation. The increased funding is needed for the data system work and for development and implementation of provider/service coordinator training as well as training and support for local system managers, on-going technical assistance and monitoring/supervision activities. A complete review of all Part C policies, forms, guidance documents and creation of new guidance is required. When OSEP finalizes the Part C regs, Virginia regs must then be developed.

January 1, 2009 is the target date for implementation. The current plan is to submit the state plan amendments (for Medicaid and FAMIS) between April 1 and June 30. There is a 90-day window for CMS to ask questions. Questions from CMS restart the 90-day clock. Implementation of the changes for MCOs is expected to occur about 90 days after the changes are implemented for fee for services. Work with the private third party payors will follow. The data indicates that about 42% of the children served by Part C have private insurance. Healthnet (federal) is included in the 42%. It is estimated that services for about half of these children are reimbursed under the EI rider and half are under ERISA.

SOLUTIONS is confident that at least 45% of the children served in part C are Medicaid eligible, based on a review of DMAS and ITOTS data. Nearly every community is aligned with the % of children in Part C matching the % of children with Medicaid in that community. However, we expect a higher percentage of children with Medicaid to need early intervention that the percentage in the general population, so there is an opportunity to increase the number of Medicaid covered children served through Part C.

This leaves about 20% (for children who have no insurance/no reimbursement as well as for the non-billable Part C functions such as child find and IFSP development) to be funded with funds other than Medicaid or private insurance.

Part C is working with the Office of Administrative Services to extend the current contracts for six months.

Family Cost Stakeholder Group

The stakeholder group recommended a uniform annual participation cost based on taxable income. SOLUTIONS will do some modeling for the group to look at some different amounts for the cost participation. The average family fee now is about $100/month. Family cost participation will integrate use of insurance. If a family consents to use of insurance, they will not be charged a participation fee. Collection of family cost will be determined on a local lead basis.

Copays and deductibles need to be considered in the context of family "inability" to pay. Some states include copays and deductibles in the determination of family cost share; others have policy that essentially states that by allowing access to private insurance, the family has met their cost-share in full and the co-pays and deductibles are the responsibility of the public system. This is a policy issue for DMHMRSAS.

Data System Stakeholder Group

Data system expansion is critical to success of the project. The Data Stakeholder group is supportive of everything that has been discussed. However, there are critical stakeholders who have not participated in the meetings and whose support is required.

Program data and utilization data are key parts of getting the changes made at DMAS.

Data must match practice. Adequate, appropriate data facilitates and/or supports:

- Local level management
- Desk monitoring and auditing
- Sharing data with DMAS.
- Monitoring expenses and expected funding needs.

Conscientious data entry by local systems is critical to ensure timely and accurate data for the system. It is expected that the changes in the data system will not result in increased time requirement because the data is already being collected. These changes will improve the accessibility of the data and decrease time needed to gather, sort and report data that is already required such as the data for OSEP indicators and improved compliance in general for Part C, and the funding partnerships with DMAS, and proposed partnerships with MCOs and private insurance. **Part C Service Pathway**

See diagram. The five distinct actions in the pathway do not necessarily mean 5 distinct or separate encounters with the family. There can be a coupling of events with the family and this would be determined individually, based upon family needs. The intent of the service pathway is to promote individualized planning, individualized services and implementation of the primary coach model of service delivery, as well as assure that federal regulations under IDEA and Title XIX are met. Every IFSP should look different. Prior written notice is a critical aspect of the service pathway. Different definitions are currently being used for evaluation and assessment. As indicated in the pathway, services are not determined based on the evaluation – eligibility is.

The chart will be modified based on discussions at the Family Cost Participation Stakeholder Meeting. Review of family cost participation will be inserted earlier in the pathway in the eligibility column for instances when authorization is required for assessment.

It is expected that eligibility will be determined for most children based on review of available documents and information (medical information, comprehensive developmental screening results, observation). Two different disciplines using at least 2 sources of information are required to determine eligibility. In many cases, the presence of a 25% delay can be determined through screening and the use of informed clinical opinion. If additional information is needed to determine eligibility, assessment can be a focused to obtain the necessary information. The assessment for eligibility and the assessment for treatment planning can be combined.

Considerable training will be needed, including use of selected instruments and the use of informed clinical opinion, along with work with medical homes.

The IFSP serves as the umbrella or broad plan for the child and family. Providers will develop individual (or team) treatment plans, which are more specific, include how the outcomes will be actualized, and serve as the billing documents. A treatment plan will also be required for service coordinators. SOLUTIONS can provide examples for these plans to the Part C team. It has not yet been determined whether the IFSP will be accepted as the plan of care.

Under the new regulations from CMS, Medicaid will not pay for Part C specific functions, which are child find, development and review of IFSP, and administration of IDEA procedural safeguards.

Service Descriptors Document

See document. "Family support and education" is listed as component under each service. It is expected that the intervention includes working with the child and with the family. We have removed this as a freestanding independent service.

Everyone will be called an early intervention specialist. Decisions need to be made re: associates and assistants and how they fit into the service provider "mix" and definitions.

Stakeholders commented that dysphasia treatment should be included in Speech Language Pathology and Occupational Therapy services. Discussion followed about which disciplines can provide this treatment. DMAS reimburses OT and SLP for feeding services.

Sue asked the stakeholders to email suggestions regarding the service descriptors to her by next Thursday.

The primary provider model was discussed. The consultants and the Part C Office are speaking with Dathan Rush and M'Lisa Shelden on model implementation, which they prefer to call the primary coach model. The reimbursement changes that are being proposed will better support implementation of the primary provider/primary coach model. Training, re-training, ongoing training and training embedded into supervision will be critical to successful implementation.

Review of the UPDATED Medicaid EI Services Initiative

An Interagency Agreement for Administrative Claiming is being developed. DMAS is moving forward with 2 State Plan Amendments (Medicaid and SCHIP) to EPSDT. The intent is to apply the rates determined through this work to MCOs (possibly 90 days after implementation of the State Plan Amendment) and to revise the Commonwealth's current insurance legislation initiative to promote insurance reimbursement for all Part C services consistent with the model

developed for Medicaid (possibly a year after implementation of the Medicaid changes). DMAS is developing document now that they will be able to use to help educate the MCOs. Regarding reimbursement by private insurers, Sue mentioned the Massachusetts insurance model that pays average amount per child based on the annual average cost/child, divided into 12 month payments based upon actual enrollment.

Medicaid "Match"

DMAS will continue to provide "match" for existing services under EPSDT. Part C will provide the "match" for Administrative Claiming and Developmental Therapy (now termed "developmental promotion."). "Match" arrangements are being explored now. The match must be state funds.

A handout was provided that listed the Part C components and indicated which ones would fall under administrative claiming. ***This handout will be sent to the stakeholders electronically.*** Boxes with checks are the activities that DMAS would pay for (cost based reimbursement) under administrative claiming. Parameters will be developed. Reimbursement is determined based on the Medicaid percentage of the early intervention population x 50%. It hasn't yet been determined whether the reimbursement will be based on local or state calculations of the Medicaid percentage of the early intervention population.

Interagency collaboration, meeting the needs of all eligible children, quality services, qualified providers and quality data are all very important to Medicaid.

Sue will verify reimbursement for translation. It is currently included in the overall EIS service descriptors. If it were not included in the services covered by DMAS, then it would have to be reimbursed by Part C.

Service Coordination

Service coordination will be incorporated under Administrative Claiming, including initial/intake and ongoing. This will require random time sampling to document time spent; and this will be invoiced at actual cost. The details for time sampling have not yet been determined. The locality will determine the service coordination approach for their system. Medicaid will likely not reimburse for any "blended" service coordination (e.g., provided by a direct service provider). This doesn't mean a local system can't employ this model; they just won't get Medicaid or state or federal Part C reimbursement for it because the payor of last resort federal requirement applies. Lack of local dollars may limit local choices in this determination.

The administrative claiming provides reimbursement for children in Medicaid. Part C dollars will support non-Medicaid kids for administrative functions.

It is expected that Targeted Case Management will no longer be an option for Part C. This will be further explored and confirmed by DMAS. Reimbursement should not be an issue because the reimbursement will be cost based. A question arose concerning children receiving intensive case management through early intervention, and continuing to need this intensity of case management when they turn three. Currently the same case manager can continue with the child. SOLUTIONS will continue to work on this with DMAS.

Covered early intervention services would include:

- Screening

- Assessment for IFSP planning
- IFSP Teaming/Collaboration including The Evaluation for eligibility
- Team Activities including plan (IFSP and clinical) development and evaluation meetings, consultation and coaching

Covered EI Services

- Assistive technology services
- Assistive Technology devices would remain reimbursable under the existing EPDST chapter
- Audiological Services
- Developmental Promotion Intervention
- Health services
- Family Counseling
- Interpreter Service
- Medical services for diagnostic or evaluation purposes only
- Nursing services
- Nutrition/dietician services
- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Speech-language pathology services
- Sign language and cued language services
- Vision services

Reimbursement

- 15 minute unit = billable unit for all services
- Individuals likely cannot be reimbursed under both Administrative Claiming and 15 minute, fee for service reimbursement
- Requires documentation for each unit billed

Qualified Providers

- Preferred Term: Early Intervention Specialists
- Reference: Provider Grid document
- Consideration of Associates and Assistants in the service delivery "mix"
- Individualized services
    - Impact on Primary Coach (Provider) Model
    - ASD

Integration of Stakeholder Recommendations

- Integration of Rates/Allocation Stakeholder Group Recommendations
- Budget Realignment is essential – State, Local Lead Agency Level
- Match Requirements/Current Match Identification
- Integration of Family Cost Participation Stakeholder Group Recommendations

Implementation Sequence

- State Plan Amendments – Development/ Submission
- Development of DMAS Regulations
- Confirmation of DMAS Rate(s)

    - Recommendation/Methodology Review provided by Consultants
- Development of an Interagency Agreement to include administrative claiming as well as ensuring collaboration related to the Early Intervention Services reimbursement between DMHMRSAS and DMAS
- Part C System Operations/Data Review/Revisions
    - ITOTS
    - Documentation/Forms
    - Supports and Services
    - Part C Policies and Procedures (eventually Regulations)
- Training and Technical Assistance System (CSPD)
- Application to MCOs
- Proposal to Insurance Commission
- Potential for General Assembly action if we determine there is insufficient state funds for "match"

Global issues are being addressed at this stage in the process. Details about the billing process, forms, etc will be worked out as the process unfolds.

Sue emphasized the need to routinize the requirements and practices so people are not doing different things for different reimbursement streams, which is more likely to result in audit findings due to poor documentation, mixed or inconsistent clinical practices, staff attrition, etc.

Implementation Considerations: Brainstorming

Sue asked the stakeholder group to think about what a paradigm shift this is for all the people in the field who have not been a part of these discussions and to brainstorm what needs to be considered or addressed for successful implementation. The group generated the following list of changes and challenges:

- Change in the process for determining eligibility
- Other practice changes
- The Service Pathway: people are having trouble understanding it and accepting change
- Figuring out what the local system will need to do, what can be decided locally and what the consequences are for the choices. Making sure all the players who collaborate with the local infant system understand what is being done and why
- Desire for specific details – what can be blended and what can't; what must be tracked and documented
- Concern about what will be able to be done and what will not "fly" with Medicaid.
- Concern about reimbursement methodology and rate for case management and potential loss of funds compared to current reimbursement
- Questions about data changes – Options are being studied including extracting data or direct entry of data. Do you stay with ITOTS and enhance it or go with a new system. Decisions and implementation are targeted for January 2008. There will be conversion time, testing time, training time, etc. Expect to be starting the process in the fall. Will need a provider enrollment and credentialing module so info can be provided to DMAS monthly.
- Diversity of local lead agencies – local lead personnel in agency are not in the loop and may throw up roadblocks. Need to plan for potential negative reaction from local lead agency personnel who are at different levels
- Budget personnel in local lead agencies have questions; they need to understand how the money will flow

- Something very clear needs to be communicated to the people at the local level who hold the purse strings. This needs to come from the state, not just from local system managers
- Need to consider the possibility that some local lead agencies may drop out.
- Questions about extending the contract for 6 months.
  - Mary Ann said that it is expected that allocation would be based on 6 months.
  - The additional funds that went to local systems are not put into the base.
- Local lead agencies may ask for additional funds to implement changes including new requirements (such as data entry).
- Suggest that presentations to CSB and other execs be made by people higher in the organization than the Part C office
- Will need $ amount of what the changes will be
- Need “no losers” with the changes.
  - There is a big fear that changes will result in less money for the agency.
  - “No losers” means that local systems need to be assured that they will receive the same amount of funding next year that they are getting this year.
  - Extra responsibilities can be added but systems are locked onto the funding amount.
  - Fear is the issue.
    - Suggest that the statement that revenue will not be less when the reimbursement and funding mechanisms change.
    - Will be paid for things that are not currently reimbursed, rates expected to be higher
- Funding is needed for start up costs
- Need to state that administrative time for data management will not be increased.
  - Time will just be spent differently.
  - Need to realize that improved data system will get us closer to compliance.
  - New data collection methodology will likely decrease doing things twice
- People need to understand their responsibilities – they need to realize what they have been accountable for all along so it is clear what is already required vs. what are new requirements
- Need lots of lead-time to implement local requirements (such as RFP for providers). Not all localities require an RFP.
- Need to offer families choice of providers and for those local lead agencies that are the only provider in locality will need to demonstrate that they are recruiting.
- Intense up front training is essential.
  - This will be very expensive for private providers (loss of revenue while providers are in training, etc.).
  - Sue reported that SOLUTIONS has implemented similar initiatives in 15 states and there has never had issues with the time for the training of providers.
    - Providers were not paid to attend the training.
    - No providers were lost because of the training requirements.
  - Training has to be more than a one-day training.
    - Need to include modeling and coaching and mentoring.
- “Need people in positions of power to inform and educate.
- Stakeholders have not had details to share and are worried that the leaders will resist out of fear.
  - Another stakeholder reported that the stakeholders have received document after document that explains what is happening.

  - Suggestion that the steps in the process for implementation be shared as a way to inform all of the people who will be impacted by the changes.
- Concern that credentialing might not be able to be done as soon as the plans are coming together. (Response: Interim credentialing would be done).
- Fear about what will happen with Targeted Case Management and funding for this.
- Concern about 5 CSBs who are invested in terms of local funds in EI program.
  - Have been providing early intervention even prior to Part H/C.
    - Concern that the concerns and needs of these local systems need to be met.
  - This was followed with a comment that these local systems may find that being the lead agency for the local Part C System is no longer a good fit for the agency
  - Discussion about making decisions based on the history of the local lead agencies in the Part C system or on the basis of current requirements and needs.
- Concern that the Child and Family services at the CSBs are out of the loop.
  - Jim said that the MR counsel provides information to the Child and Family service personnel.
- Concern about what will happen or not with reimbursement from private payors.
- Suggested that the issues all be identified so that the people who are being informed realize the questions have arisen and are being addressed.
- Implementation timeline is scary because don't know implications in order to plan.
- Include in the information that anyone currently providing service will have interim credentials.
- Request that info be provided to system managers about what is negotiable, what is required by what body, what is recommendation vs. requirement.

Sue stated that January 1 is the anticipated/planned implementation date. There are things that may impact this, but planning for January 1, 2009 should proceed. The changes that are being planned and will be implemented are critical for meeting OSEP requirements.

Sue urged stakeholders to email her any barriers they identify so strategies can be developed to overcome the barriers.

A request was made that whatever is sent to Frank Tetrick be sent to the stakeholders. The private provider stakeholders requested that the Part C office request that system managers forward all information to their providers along with the contact information for Tracy and Nancy and Pat Rogers since there is not currently a list of all of the Part C providers.
One stakeholder expressed concern that roadblocks were being thrown up and suggested that the focus shift to what is needed to meet the needs of children and families including seeing more children, meeting timelines, etc. The changes are not about individual local systems; it is about serving children and families.

In other states, SOLUTIONS has done local forums for providers talking about the "now" and "then". This may be a strategy for Virginia to consider. They could be done in partnership/collaboration with individuals who served on the stakeholder groups.

Challenges in communication about the work that has and is being done were shared including:

- Lack of interaction with people in leadership roles in their agency
- "Gag order"
- Not having details to share
- Not having contact information for other stakeholders (private providers)

Local lead agencies are the arm of the state lead agency and are responsible for ensuring compliance with part C and EDGAR (all funding streams). Some local lead agencies are not playing by the rules (not collecting family fees or providers not collecting family fees) and this is an exposure issue for potential class action suit against the state lead agency and locality as well.

The local system must be assured that no family is denied services on the basis of inability to pay. Each system must know why each family declines services. The local system must assure payor of last resort and non-supplanting.

There needs to be a meeting with local lead agencies to be sure they understand their requirements, so they understand what they are agreeing to.

It was recommended that persons closest to the process (service coordinators) enter the data and that data entry be from the source documents, not from the ICDF. Consider how the indicator data requirements can be built into data collection. It is expected that data entry time will take the same or less time than is now used in the review and data collection from the paper documents.

Next Steps:

The minutes will be sent to stakeholders in about a week. Stakeholders will have 2 weeks from the time they receive the minutes to work with their constituency groups.

Stakeholders are email questions, suggestions, etc. to Sue.

Sue will prepare information from upcoming meetings with the executive directors and the MR counsel. The MR Directors are meeting with Frank Tetrick on March 27, we believe.