

**SUMMARY**  
**COMMITTEE TO DISCUSS INTERIM STRATEGIES**  
**(PLAN B)**  
**March 29, 2004**

**Waiting List:**

Essentially, a waiting list is defined as a listing of children/families identified as needing services but those services are not available. This includes listing of children/families referred and the referral is not being acted upon and those children/families who have an IFSP and services are identified but are not available and the child/family is waiting an inappropriate amount of time.

- There are strong feelings that a crisis may have to occur to stimulate support from the legislature. Waiting list and due process hearings may cause a recognition of the need.
- There were concerns that advocacy, though possibly strengthened by a crisis, will not be successful in time, if at all. Therefore, strategies to address the financial crisis still need to be established.
- There is also concern that such a major violation of substantial waiting list will threaten the program. OSEP could not allow continuance of major violations and the entire program could be lost while the advocacy efforts were proceeding.
- There were suggestions that the legislature will not just look at the crisis, but look at how you addressed the crisis. There is a need to show that everything possible has been done to address the need. Strategies implemented to address the financial crisis may not resolve the problem, there may still be shortfalls, but there will be documentation that everything possible has been done.
- There was interest in proceeding with the discussion on the strategies to see what impact they may have on the crisis.

**Definition:**

- General consensus was that a change in definition will take more study and should be considered by the big plan. Children under the definition have significant delays and it is not certain what modifications could be put in effect in the short term.
- Data from Karleen's study showed there would be little savings and this would not dramatically impact the crisis.

**Regionalizing core functions to effect cost savings and efficiencies:**

- General consensus was that this should be considered, but it will take more planning, a clear delineation of roles and functions and a great deal of transition time to make this happen. This too was referred to, what became to be known as, Plan A.
- There was a great deal of discussion around some of the core functions and whether there could be a more immediate savings by reducing the financial support of specific, low priority functions. Council coordinators provide public awareness and child find and some councils have full time staff. Is there a need for forty sites to do this? If these functions were reduced, could funding be lowered across the board for these positions?

No consensus could be reached because there is so much diversity of practice by the council coordinators. If a coordinator handled billing, data, etc. then reduction in the funding could jeopardize high priority functions. There was general consensus that some core functions could be reduced and a savings potential existed, but sorting out the payor and what level of local funding commitment existed and how much impact would occur is too difficult. No reductions were identified. However, it has been determined that targeted funding for the council coordinator would not continue and therefore a reduction in the total may be absorbed some through a reduction in staff time on these functions.

**Encourage evaluations and assessments and eligibility determinations to be conducted in center-based settings:**

- The idea is that by restricting the eligibility determination, evaluation and assessment to a site in stead of in the home and community that there would be a savings of staff time and travel. One area shared their success in doing this. Having the disciplines come to one site increased efficiency and saved funds.
- Concerns were raised about transporting child/family to site. In some areas public transportation is not available and the cost to support family travel would increase cost.
- The availability of a “center” site was raised. The suggestion was that it would not have to be a child development center, just a service site, a place, available to the disciplines. Consensus was that this should be considered and those areas that are doing all eligibility determinations, evaluation and assessments in the home and community should look into setting up a site if possible.

**IFSP team consider all pertinent evaluation information and make-up of team be as few disciplines as possible:**

- There was a consensus that these are already being done in most areas. No savings was anticipated from this.

**Cap payments to providers for eligibility determinations using a uniform statewide payment rate for point of referral, eligibility and evaluation:**

- There was consensus to cap evaluation rates. The state department should set a rate that is reasonable.
- Some concern was raised about the different charges around the state and that a set rate in one area may be too low and they would loose providers and in another area the set rate would be higher than what is presently paid. Consideration should be given to regional rates, but there is also a rule of usual and customary. If a set rate is higher than an existing rate only the lower rate could be charge.

**Encourage local systems to implement the Supports and Services document and conform to frequency and intensity requirements:**

- There was strong consensus on implementation of the Supports and Service document. There was a great deal of discussion over the importance of routine based intervention and consultative approach. The discussion included a wonderful confirmation of this from a parent.
- The discussion led to enforcement. The S & S document does not include actual frequency and intensity limits. The question was raised, how can we know about violations if there is no measure of what a violation is and we have no data. There were concerns raised about establishing a number. How does this fit individualization and how do you determine the number? It was suggested a number would not be absolute and that an “approval” would have to be given for valid exceptions. For others exceeding the number, it should be fully understood that additional therapies may be desired, and even physician ordered, but that these are “Other” services (IFSP designation of service occurring but not responsibility of EI) and that other payors should be responsible. It was suggested that several other states do have a number established, based on professional judgment, and that this might provide some guidance. It was recommended that the council coordinator (or billing clerk if coordinator does not approve billing) be charged with the responsibility to screen the billings and question high frequency, and actually deny payments for continuous, high volume violators. It was shared that DD directors have stated that they do have service/billing data. Other non-DD entities might as well. Therefore, for purposes of oversight and monitoring for enforcement, the state program should draft an instrument to be used to gather data pertaining to frequency and intensity.
- It was also agreed that there needed to be a strong effort on parent awareness. Often parents do not understand that more is not necessarily better. Especially if the physician and other professionals are suggesting high levels of frequency. It is also difficult to understand the difference between medical approach and developmental, and the extent of EI responsibility. This has not been well defined and many professionals do not understand this concept.

**Conform to the primary service provider (transdisciplinary) model:**

- There was general consensus that this is appropriate, but that the implementation was beyond a short time-frame. The idea has been introduced for years. There are professional, legal issues and, most of all, training issues. Changing attitudes and practice approaches should be pursued, but that no savings could be gained immediately. This is also a data issue to determine to what extent a high level of multiple discipline involvement is occurring with in certain areas and/or agencies.

**Allocation of Funds:**

- There is available for allocation 9.04 million, approximately three million dollars less than last year. This is due to previous year’s carry-over funding no longer being available, and Social Service funds not likely to reoccur. Multiple scenarios have been considered and many of those were presented. Alarm accompany some of the options due to major impacts in several areas. Fairness is sought. There was a lot of discussion around how there is such a disparity of funding. A major factor is the grant allocations that have occurred over the last two years on a competitive basis. Some areas did not

apply or receive any additional funding and have had no additional funding since the formula distributions. Also, each year, emergency funding request have been honored and some areas increased their share. If total parity is sought through a method of allocation based on numbers of children served, several areas have unacceptable cuts. Cuts based on the percentage of shortfall leaves disparity. It was recommended that David clarify the options and everyone consider the most appropriate. Everyone knows that there is no good results, the cuts are extremely damaging to the program no matter what method is chosen.

### **Uniform statewide capitated rate for associated cost for Part C services:**

Failed to have time to consider.

Following the discussions it was determined that there was a need to re-convene. The group had not addressed the consideration of capitated rates, there was no recommendation on allocation, and there was still a feeling that waiting list and other major disruption to the system was going to occur and that there needed to be further discussion of strategies and guidelines. Therefore, Monday, April 5, 2004 was set for another meeting.

The proposed agenda is:

- Allocation recommendation
- Capitated rates
- Further guidance on:
  - Eligibility determinations, evaluations and assessments be done in center sites
  - Cap evaluation rates
  - Implementation of the Supports and Services document
  - Council coordinator (or billing clerk if coordinator does not approve billing) be charged with the responsibility to screen the billings and question high frequency, and actually deny payments for continuous, high volume violators.
  - State program should draft an instrument to be used to gather data pertaining to frequency and intensity
  - Strong effort on parent awareness
- Further discussion on:
  - Increase use of Medicaid
  - Regionalization of public awareness, child find, etc.
  - Other ideas shared by the group