

**VIRGINIA INTERAGENCY COORDINATING COUNCIL
MEETING MINUTES
Skipwith United Methodist Church
Richmond, Virginia
January 30, 2008**

The Chair of the Virginia Interagency Coordinating Council (VICC), Rick Beaman, called the January 30, 2008 meeting to order. Karen Durst then called the roll. Ten (10) VICC members were present. (Please see the attendance sheet following the minutes).

Mary Ann Discenza then shared that Sue Mackey Andrews, along with Part C staff, met yesterday, January 29, 2008, with 34 of the 40 local system managers. The purpose of the meeting was to share, clarify and update information related to upcoming proposed changes within Virginia's Part C system; identify questions, issues and barriers regarding implementation of the proposed changes; and to work together through collaboration and partnering toward support of the proposed changes.

Mary Ann Discenza shared additional comments regarding the positive response from the Department of Medical Assistance Services (DMAS) regarding upcoming changes and specifically the support and collaboration of Tammy Whitlock. Appreciation and recognition was also given to Sue for the pro bono work that she has provided to the Part C System.

Sue addressed the VICC members and stressed the importance of today's meeting. She emphasized her role as being that of providing information on what is consistent with the law and providing guidance based on her knowledge, information and experiences from other states.

Sue continued with a review of the sequence of events related to Solutions involvement with the Part C System in Virginia. In 2005, Solutions provided technical assistance through the National Early Childhood Technical Assistance Center (NECTAC) when a key issue arose regarding what rate, provider cost or negotiated rate, should be used in the assignment of Part C Ability to Pay (ATP). The following issues were identified:

- Difference existed in parity and equity in how families were being charged;
- Differences existed related to contract relationships with providers;
- Associated costs were not being reimbursed to all providers;
- Parity of reimbursement across providers was an issue;
- It was unknown if family fees were being collected by all systems and/or providers; and
- Complete information on how much money was in the Part C could not be reported to the General Assembly and to the Office of Special Education Programs (OSEP).

It was identified that the issue of Family Cost Participation was intertwined within Medicaid, insurance and other issues within the Part C finance and service delivery system. Therefore, Family Cost Participation (FCP) could not be addressed in isolation.

A contract was developed with Solutions Consulting to identify areas within the Part C system in Virginia where issues existed and to propose methods to address those issues. A report was provided that included the following proposed initiatives:

- Update the 2003 Fiscal Study;
- Complete an evaluation of ITOTS;
- Revise the Family Cost Participation System;
- Develop an Early Intervention Medicaid Initiative; and
- Recommendations for the State Interagency Agreements.

Throughout Solution's first contract, six (6) on-site visits occurred culminating with the development of the System of Payments Report. Additionally, Solutions developed five (5) Q & A documents to provide clarification to the field subsequent to the recommendations made in this report. (This report is posted on the I&T Connections web site together with all appendices and the Q&As.) A second contract was developed with Solutions for the time period September 2007-December 2008. Five (5) on-site visits have occurred to date. This contract extends to December 2008 with the majority of the products produced prior to June 2008.

Through this work, the system is moving closer to the implementation of the proposed changes as recommended in the System of Payments report. All work under this contract is being conducted in a stakeholder structure through several groups.

An exact timeline is not available for actual implementation but rather a sequence of events. Sue stressed that funding will be changing. Through the change an opportunity exists to align the financing to support the system that is desired. The focus will be on what is good for children, families and providers.

The subject of family fees was addressed. Sue reported that at least 38 states now have systems including family fees though some states don't actually implement a charge. While policies may be clear, differences still exist in the practices. Additionally, it was reported that states typically use six to eight funding sources for their Part C systems.

Various changes at the federal level are slated to have an impact upon Part C systems. Several Notices Proposal for Rule Making (NPRMs) have been issued by CMS, largely as a result of the Deficit Reduction Act (DRA). One significant change would result in revisions to the Rehab Services Option (RSO) which currently covers Part C services. Part C services are considered habilitation and consequently would not be eligible for reimbursement under the current RSO. Per the instructions by the Centers for Medicare and Medicaid (CMS) (which governs Medicaid) for the past several years now, many states moving their Part C programs to Early, Periodic Screening Detection and Treatment (EPSDT). This is the proposed plan for Virginia.

Regulations for Targeted Case Management (TCM) have also changed. Billing would be required in 15 minutes increments and restrictions would be placed on what specific activities would be covered. There are also restrictions about "blended" service coordination, which would not permit payment for a single provider who is doing service coordination AND the provision of a direct service. This affects the current I&T Connection system in Virginia.

Sue reminded the group that, under Education Department General Administrative Regulations (EDGAR), some revenue streams generated under Part C must go back to support Part C. This is part of the state's system of payments.

The Office of Special Education Programs (OSEP) also will be instituting financial monitoring. Several states have already participated in pilots. Those states have shared that the process is vigorous and includes monitoring of payor of last resort, non-supplanting and maintenance of effort.

Sue shared that changes related to the Medicaid NPRMs would be required to one degree or another in all states. She stressed that Virginia is already ahead of other states by a year and a half due to the work that has already been completed.

The focus of the meeting turned to the Medicaid Early Intervention Initiative. Sue shared the following information on of what is currently happening in Part C in Virginia related to Medicaid:

- There is no Medicaid reimbursement for Medicaid-related administrative services provided by Part C;
- Service coordination is a Medicaid covered service in the State Plan Option (SPO);
- Most early intervention services are covered under the Rehab. Services Option; and
- Different agreements exist with MCOs and local lead agencies including reimbursement, who provides the service, how referrals are received, etc.

The following are issues that are currently being focused upon with the proposed changes within the Medicaid Initiative:

- The development of an Administrative Claiming Agreement between the Part C Lead Agency and the Department of Medical Assistance Services (DMAS). Options would be:
 - Administrative Claiming for intake and possible ongoing service coordination;
 - Establishment of new targeted case management for early intervention; or
 - The inclusion of Service Coordination under Early Intervention Services Chapter in EPSDT.
- Related to Direct Services, establish an Early Intervention Chapter in EPSDT that:
 - Includes all Part C services; and
 - With reimbursement related to function, such as screening, multidisciplinary team evaluation, etc.

Information was provided on the sequence of events related to the Medicaid Initiative. The steps include the following:

- Complete the Conceptual Framework;
- Identify the current DMAS match;
- Develop a State Plan Amendment (SPA) in coordination with CMS;
- Develop cost estimates and determine the potential budget impact; and
- Submit the SPA to CMS.

Discussion focused on the use of state dollars for match. In an effort to determine State Match dollars, DMAS has been working with the Part C system to determine the number of Medicaid children who are receiving Part C services. It was reported that a second run of data has occurred and that 3,349 children were identified with 29 of those cases being duplicates and 500 not having valid identification numbers. This has resulted in 2820 matches. These data will be used in part to identify the current amount of DMAS “match” supporting Part C services for dually enrolled children. Sue and Karleen will be conducting a “gap analysis” using the information provided by the LLAs which focused on current provider contracted rates and the proposed rates for services, together with the DMAS information re: current state match.

Pending this “gap analysis,” if the dollars for match are available, it is anticipated that the changes with Medicaid could take place between July and September of 2008. The State Office could certify the match. If sufficient match is not available, the changes will not occur immediately and will require a wait until the next General Assembly meets in order to request additional funding.

The following information was also shared:

- A mix of service coordination options can be used;
- Administrative claiming need not be documented in 15 minute increments but is paid based on the number of Medicaid children being served using cost;
- MCO contracts can be adjusted mid-year in order to implement changes;
- The Initiative is constructed to work with other systems as partners, such as Care Connection, Baby Care, Healthy Families, etc.
- Some states use other partner programs for special instruction or service coordination, however, Medicaid will reimburse for only one case manager and will not pay for “blended” service coordination/direct service provision by the same person.
- DMAS will provide guidance on the process when everything is finalized; and
- There is currently no indication of what the rates will be as the process has not progressed to that point. We are using a stakeholder process for this activity; and
- Through the Medicaid Initiative, changes will occur with the MCOs with the expectation that changes will follow with insurance companies.
Eight states are currently operating with central billing systems and insurance legislation typically places a cap on traditional therapies with some proposing the payment of a set monthly amount per the number of children

In conclusion of the Medicaid Initiative portion of the meeting, Sue shared that the following is a list of responsibilities of DMAS in order for the implementation of the Initiative:

- Development of DMAS regulations;
- Development of an interagency agreement between Part C and DMAS;
- DMAS Software updates;
- Provide enrollment based upon Part C provider qualifications; and
- Training

Likewise, Part C has the following responsibilities in order for the Medicaid Initiative to be implemented:

- Revision and updating of I&T Connections forms;
- Updating of the Services and Supports document;
- Updating of the I&T Connections Policies and Procedures;
- Development of a provider database;
- ITOTS Software updates;
- Training and technical assistance for all localities, for all service coordinators, providers and opportunities for family informing.; and
- Statewide implementation in order to ensure access, equity, consistency and standardization.

The revision of the State Interagency Agreement was also discussed. While open ended related to expiration, the current Interagency Agreement needs revisions in order to address current issues and relationships between agencies. Issues of non-supplanting and maintenance of effort must be addressed. Once revised and signed, the Interagency Agreement will be sent by the state agencies to their respective local systems to implement at the local level, as well. LLAs will be required to develop parallel local agreements with agencies and entities which define how the state level agreements are implemented locally. These then should be folded into the monitoring process.

Mary Ann Discenza shared that the system also needs to look at partners among other programs serving children. She stressed the Governor's Early Childhood Initiative and the possible collaboration and partnership among those serving young children.

Sue then provided suggestions related to the infrastructure of the Part C system. She reported the following:

- The need exists for a close look at the current state Part C infrastructure;
- The state Part C infrastructure is under-funded and inadequate;
- In order to meet federal IDEA compliance requirements, training must be provided to all individuals in the system including providers and families; and
- Changes are needed within the Part C budget to address these issues.

The topic of the Services Pathway was discussed. Sue made the following points related to the Services Pathway:

- Reimbursement occurs for key events such as intake, evaluations, etc.;
- "Testing" is typically not needed in order to establish eligibility
 - Screening is included as a recognized component of the evaluation for eligibility process together with referral information, medical data, parent intake, informal observations, etc.;
- Assessment for service planning follows;
- Prior written notice should occur with the family in advance of the event;
- There is value to the family in having time between determining eligibility and developing the IFSP;
- Families cannot waive their rights to procedural safeguards including prior written notice; and
- The 45-day timeline is an issue of concern

- A federally proposed change has been made to consider the first day of the 45 day timeline as being at intake when parent consent to proceed to the evaluation for eligibility is obtained.

The role of VICC within the process of proposed changes was then discussed. Sue stated that public policy decisions must be made and that advice is needed from the VICC. Mary Ann Discenza stressed that policies should support best practice and what is best for children. It was decided that the role of VICC within the proposed changes would be included in the March VICC meeting agenda and discussed at that time. Sue stated that some policy issues, such as blended service coordination, would benefit from VICC review and discussion to provide input to the lead agency for decision making.

The area of the Fiscal Study Update was then addressed. The work in this area relates to common rates and the allocation formula. Sue shared that the gathering of data for the updated fiscal study had been completed and analyzed. A draft report will be developed followed by a phone conference among the Stakeholder Group and then a final meeting in March.

As part of updating the Fiscal Study, a request was made to local systems for the submission of 250 Individualized Services Plans (IFSPs). A total of 239 IFSPs were received for a submission rate of 96%. The following represents the additional participation levels:

- Encounter Forms, 343 requested with 199 received for a 58% return rate;
- Salary Survey, 110 requested with 34 received for a 31% return rate;
- Revenue Survey, 110 requested with 10 received for an 11% return rate; and
- Rate Survey, 40 requested with 25 received for a 63% return rate.

The information submitted by local systems indicates that children receive an average of 30 hours of service per year. This number is low in comparison to other states. The data does indicate the use of the primary provider model with more intensive services being provided initially and then being decreased. Additional information obtained from the data indicates the following:

- Seventy Percent (70%) of children receiving services are male as compared to 30% being female;
- Personnel are staying in the Part C system with more than 47% having been in the system for more than five (5) years;
- The comparable quantity of salaries for the years 2003 and 2007 are \$9.2 million and \$9.6 million respectively;
- The 2007 average hourly costs for direct service personnel with benefits is \$35.46;
 - This amount includes employees and contractors and represents a mix of personnel types;
- The cost for one hour of direct service for 2007 including personnel costs, administrative and support costs and based on a 37% event/occasion percentage of time for the personnel is \$126.10.
 - The amount of \$126.10 will be used to configure a reimbursement system that is intended to be a common rate across Virginia and includes what is now the associated cost;

- Costs for service coordination and developmental therapy (special instruction) are less than the therapy services;
- The consensus of the Stakeholder Group is that:
 - Reimbursement must be configured in 15 minute increments;
 - There should be two different rates since market wages cluster in two groups such as therapists and special educators/service coordinators;
 - Even though salary differences and travel times do vary across the Commonwealth, neither creates a significant enough difference to include a differential in rate reimbursement; and
 - Those systems that have fewer Medicaid children would receive more dollars from Part C.

Discussion then moved to the Infant and Toddler Online Tracking System (ITOTS). Sue shared that a data review of ITOTS is occurring. She stressed that in order to make sound fiscal decisions that it is necessary to have good data. The Data Evaluation Work for ITOTS includes four (4) parts. They are:

- Part I which is an evaluation of what currently exists in ITOTS;
- Part II which focuses on enhancing the integrity of the data and other low-level changes;
- Part III which will create a vision for the data system and will identify critical success factors; and
- Part IV which will identify necessary interfaces for a more complete data picture
 - The need exists for capturing actual delivered services.

Work that has been completed includes:

- The development of a Concept Paper by Solutions related to ITOTS and the presentation of that Paper to the leadership of DMHMRSAS and
- A data swap/sharing with DMAS which has resulted in the identification of children with Medicaid numbers listed in ITOTS that were active anytime during Fiscal Year 2007.

Next steps related to ITOTS include:

- Detailing additional needs;
- A review with DMHMRSAS IT personnel to evaluate how to best support the need;
- Gain and continue to develop leadership support; and
- The creation and implementation of a plan for the data system.

Members then discussed the data related to actual services versus planned services. The following information was shared:

- Differences may be a result of mitigating circumstances for family reasons such as child illness, family cancellations, etc.;
- What would be considered a reasonable rate for mitigating circumstances;
- Systems are at risk for having to provide compensatory services if system reasons exist for planned services not matching actual services; and
- This information should be monitored at the local level.

Sue then discussed information related to Family Cost Participation (FCP). She shared that one (1) meeting of the FCP Stakeholder Group has been held. The general consensus of the group

was that not having family fees would be desirable. Some members did disagree and it was recognized that Virginia Code designates fees and that FCP is generally supported by legislators.

Members of the Stakeholder Group identified the priorities in redesigning the FCP as being easy to administer and not influencing whether families participate in Part C and what services are received. The following issues were discussed:

- The Family Fee Scale in Virginia is very high in comparison to other states;
- Does the cost effect enrollment;
- Data is not available for those families who declined Part C services regarding whether the fee system was involved in their decision not to participate; and
- Does the charging of family fees cost more than it brings into the system?

Sue shared that it was requested of those participating local system managers who were involved in the Stakeholder Group to gather data on the time involved within their systems related to Family Cost Participation. This information will be reported at the next FCP meeting which is scheduled for March 13, 2008.

Information was provided on potential methods for assigned family fees. The options include:

- Maintaining the fee structure as it now is including a cap;
- Establishing a general IFSP fee based on income;
- Charging an annual enrollment fee with quarterly or monthly payments being made;
- Implementing a fee per chargeable services; and
- Classifying early intervention as a “prevention” service and not charging a fee.

Information was also provided regarding the Parent Survey Results from the Family Involvement Project. Approximately 4,500 surveys were sent to families. Over 730 families responded. Approximately 100 individuals requested that the Family Involvement Project contact them for further follow-up. The following findings from the survey were reported:

- 51.9% of the families reported completing the Ability to Pay (ATP) process
 - It was noted that many families may not have recognized the term “ability to pay”;
- 27% of the families paid a fee;
- 5% of the families used the appeals process
 - Many families reported that they did not know about the appeals process;
- 4.2% stated that their fee was reduced following an appeal;
- Private insurance was billed in 48.5% of the cases;
- Medicaid was used in 30% of the cases; and
- Many of the respondents provided written comments with the surveys.
 - Some comments were positive and
 - Others expressed concerns about the primary provider model, missed appointments, communication, etc.

Sue shared the following additional information and concerns related to family fees:

- A large number of children are lost to the system after eligibility is determined without a reason why
 - Is the charging of fees a contributing factor;

- Many systems do not like the current method of having to verify a family's income through obtaining a copy of their tax form ;
- Visual regard could be considered rather than obtaining a copy of a tax form;
- Some report that the paperwork is cumbersome related to family fees; and
- Are families choosing services based on cost?

The following next steps and timelines were shared:

- The next meeting of the FCP will be in March;
- The Stakeholder Group will study the options and alternatives;
- This information will be integrated with the final rate recommendations;
- Policies and Procedures will need to be revised;
- Training and orientation must occur; and
- Data will be collected on the fee amounts paid, billed and unpaid, and the number of families who decline services or decline to participate in Part C due to fees.

Following Sue's presentation, the VICC members discussed the upcoming VICC meetings. The recognition of the need to make decisions quickly was expressed. The impact of the upcoming changes on the state regulations was identified.

Mary Ann Discenza shared that the Senate has confirmed Mr. Tracy Justenson as the new director of OSEP and that he has stressed that promulgation of the federal regulations would be a priority.

The VICC members were reminded that the Virginia Office of the Attorney General has stated that the Part C system of Virginia should develop regulations rather than policies and procedures. This will occur following the completion of the federal regulations.

It was also decided that the February 13, 2008 meeting of the VICC would focus on the issue of autism. Dr. Colleen Kraft will be asked to provide a presentation.

The meeting was then adjourned.

Attendance

VICC Members

Frederick Beaman
 Joanne Boise
 Virginia Heuple
 Mary Lou Hutton
 Lyndell Lewis
 Phyllis Mondak
 Sheila Nelson
 Glen Slonneger
 Dr. Eva Thorpe
 Tammy Whitlock

Part C Staff

Beverly Crouse
 Mary Ann Discenza
 Karen Durst
 Bonita Grifa
 David Mills

Local System Managers

Nancy Bailey, LENOWISCO
 Deana Buck, Richmond
 Rhonda Lusk, The Highlands

VICC Members Not in Attendance

Delly Greenberg
Dina Kirby
Jacqueline Fagan Myal
Corinne Garland
Leslie Hutcheson Prince
Dr. Colleen Kraft
Martha Kurgans
Rev. Brenda Laws
Laura Miller
Jeannie Odachowski
Sharon Osborne
Yolanda Tennyson
Delegate Shannon Valentine
Sandra Binns Whitaker

Anne Simmons, Central Virginia
Kim Taylor, Mount Rogers

Family Members

Debra Holloway

Audience Members

Jim Gillespie, Rappahannock Area CSB