Part C System of Payments Study:

Consultant Overview and Next Steps

Virginia Interagency Coordinating Council (VICC)
September 12, 2007

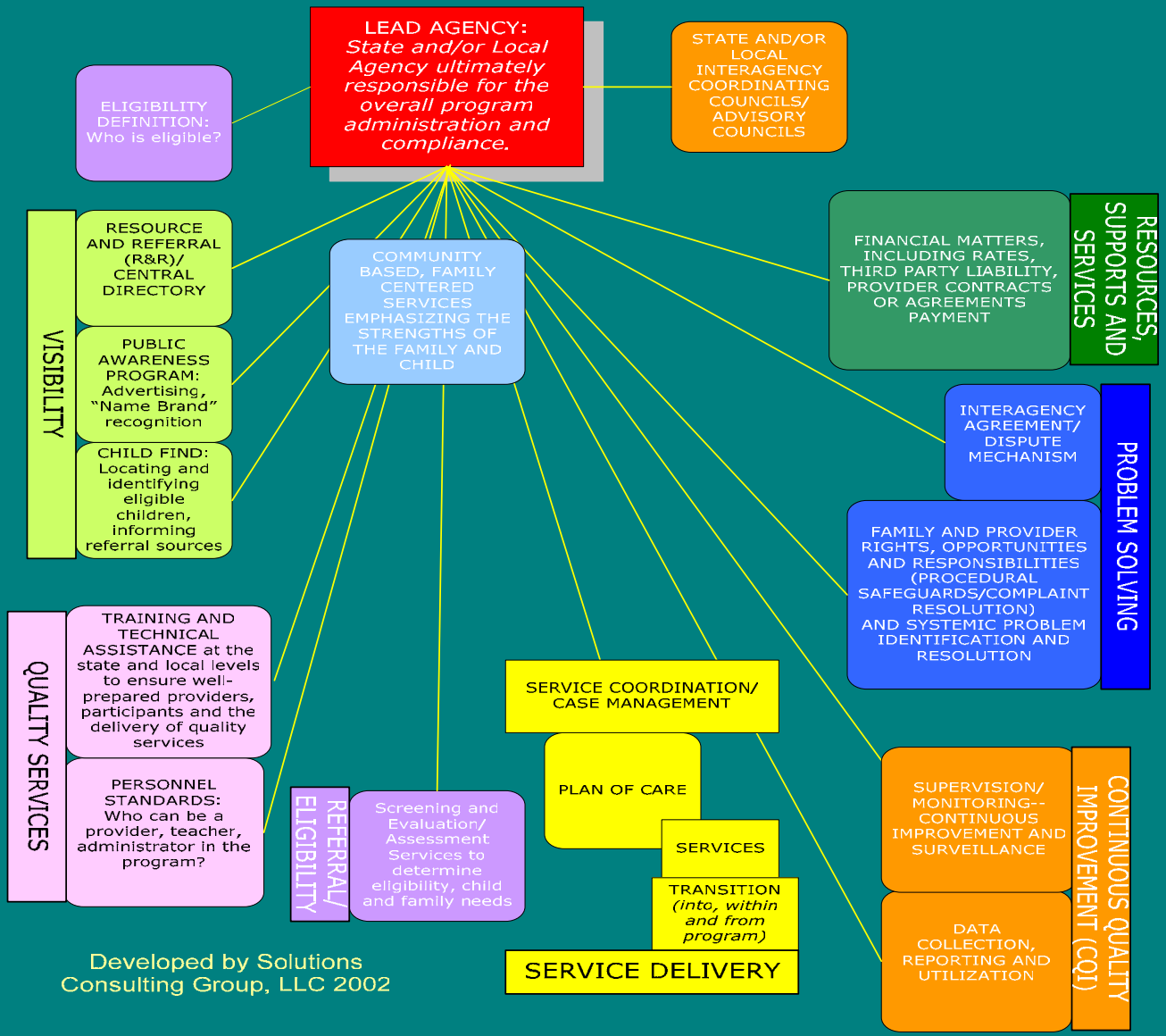
System of Payments Study Outcomes

- Provide recommendations and documentation required for the Commonwealth's Family Cost Participation (FCP) policies, procedures and practices (formerly Ability to Pay or ATP);
- Assist state agency administrators in the dialogue about approaches and options to financing early intervention services through Medicaid, including considerations of the Deficit Reduction Act (DRA), managed care, etc., and
- Provide findings and recommendations related to the Virginia Part C allocation approach, including the potential for a rate methodology template designed for local implementation.

Consultant Commitment

- Think SYSTEMS: Research and study the issues comprehensively.
- Ask probing, sometimes “hard” questions and listen to answers.
- Give you my honest opinion and options based upon research, other state experiences, etc.
- Honor that you make the decisions about what you will do, regardless of what I advise.
- In finance work, construct policy and procedures which avoid any possibility of recoupment or payback.
- In all services, produce outcomes that keep both the state administrators and stakeholders and us out of jail.

Components of Quality Early Childhood Systems



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System of Payments (SOP) Study Consolidated Recommendations

- Finalize the Family Cost Participation (FCP) section within the System of Payments.
- Finalize the Rate Methodology Template with provider and state-agency input, development of instructions for local use and consideration of training approaches for the Virginia state office staff team in the utilization of this template locally. Specific attention will be directed to projecting total cost differences anticipated between the current and proposed rates approaches at the local level.
- To assist state agency administrators in the dialogue about approaches and options to financing early intervention services through Medicaid, including considerations of the Deficit Reduction Act, managed care, etc.
- Evaluate the current Allocation Methodology for state and Federal funds integrating the outcomes of the Prevalence Study and Cost Study into the final recommendations which will be contained in the System of Payments Summary Report.

How Did We Get Here?

Articulating the Issue At Hand

- Why is FCP/Ability to Pay important in the VA Part C system?
- How is it working in your region/program?
- What is working well? Why?
- What could be improved?
- How could it work better for you?

Why is ATP Important to the Commonwealth?

- VA Code requires this
  - Indicates strong belief in family cost participation
  - ATP protects families and children from being denied services due to cost (e.g., sliding fee scale)
- Increases family participation – what you pay for implies a value, importance
- Increases the financial base for the Commonwealth's Part C System
  - Serve more children with more resources
- General Assembly/Legislature "likes" fees

Virginia History, Philosophy and VA Code re: Family Service Payment

Ability To Pay: Policies, Procedures & Documentation

Covered VS. Uncovered Services

ATP Linkage with Private Insurance, Medicaid

VA Services and Supports Document

OSEP, VA General Assembly Monitoring and Reporting Requirements

Child/Family: Individual Eligibilities/ Resources Statewide Equity and Parity

Local Lead Agency And Provider: Timely and Adequate Reimbursement

Federal Requirements Re:POLR, MOE, Non-Supplanting

SYSTEM OF PAYMENTS

Key Principles and Tenets

Accessibility	Equity	Parity
Convenience	Evenhandedness	Equality
Ease of understanding	Fairness	Par
User-friendly	Impartiality	Uniformity
Openness	Justice	Similarity
Ease of use	Fair play	
Ease of access	Justness	

SYSTEM OF PAYMENTS STUDY: KEY FINDINGS

- Lack of consistency and uniformity in the application, determination and collection of family fees
- Ability to report finance data in a timely and accurate manner to the Virginia General Assembly and to OSEP
- Lack of Parity/Equity in Provider Reimbursement
- Impact upon Adequate Provider Capacity
- Federal Requirements:
  - Payor of Last Resort (POLR)
  - Nonsupplanting/Maintenance of Effort Requirement
- Infusion of State Funds without concurrent increase in enrollment
- No formal process for replacement of Local Lead Agencies
- Current state/federal funds allocation process and Medicaid reimbursement are not supportive of the programmatic directive

Findings:
Ability to Pay

Lack of Consistency and Uniformity in ATP

1 of 3

- ATP results in families declining services, especially special instruction, that their insurance does not cover and that they would have to pay for. The degree or frequency of this outcome is not known.
- Not sure how many families leave the system due to family fees.
- LLAs vary as to who completes the ATP documentation with the family and the consistency of these practices.
- Since providers collect the ATP, the majority of LLAs and the state Lead Agency have no information about what monies are collected, which families are declined services due to the lack of payment, and if payment is being consistently collected statewide.

Lack of Consistency and Uniformity in ATP - 2 of 3

- Only a select few of the LLAs can report the amount of money collected from family fees. It would be a major effort for the majority of LLAs to provide this data to the LA as they would have to collect these data from individual providers who actually collect these fees.
- No assurance that family fees are used as program income and, as required by EDGAR, must be committed back to the Part C system.
- ATP is assigned to different provider rates (full cost vs. negotiated cost) at the local level, resulting in a lack of equity for families and providers re: how much providers earn while collecting ATP, how "far" the family resources go (collection at full cost vs. negotiated rate). Some providers bill ATP and others never have this opportunity.

Lack of Consistency and Uniformity in ATP - 3 of 3

- Providers sometimes terminate services when ATP is not paid, resulting in disruption in services and additional work for the LLA in locating another provider.
  - This is a serious compliance issue and risks due process and compensatory services.
- The majority of families do not access the "appeals" process; not sure why.

What We Don't Know

- The number/% of families who decline or drop out of services due to ATP
- The number/% of families who lose services because of failure to pay
- How much is collected locally (local lead agencies, providers)
- How much is "forgiven" / uncollected
- How much time is spent on:
  - Fee assignment
  - Fee collection and chasing
- "Double-dipping" potential?
- How does ATP affect provider participation?

Findings:
Distribution of Resources
Provider Contracting and Reimbursement
LLA Compensation

Parity/Equity in Provider Reimbursement 1 of 3

Contractual arrangements between providers and the Local Lead Agencies (LLAs) are constructed locally using a variety of approaches to reimbursement.

- Varying methodologies for reimbursement used by LLAs
- Reimbursement ranges from unit rate (e.g., per hour) to a bundled monthly rate
- The reimbursement for evaluation/assessment services is equally diverse.
- In many instances, the LLA negotiated rate is less than the state Medicaid fee for service rate which is a compliance issue under Federal Medicaid regulations.
- Few LLAs reimburse providers for time spent in team meetings and consultation; activities which are required by Federal regulations.
- Associated costs are considered differently, with no reimbursement by some LLAs
- Some providers have contracts in multiple LLAs resulting in varying rates for the same service, different methods of documentation and billing, and payment schedules.

Result: Depending upon the reimbursement approach, there may be untoward implications regarding service delivery that would result in a compliance issue for the Commonwealth.

Examples would include insufficient rates to ensure adequate capacity of providers, influence of rate in the determination of the IFSP services for individual children, etc.

Adequate Provider Capacity 3 of 3

- Diversity in child, family needs, schedules and expertise.
- Requirement for Family Choice of Service Provider.
- Current reimbursement structure does not promote provider participation in many parts of the Commonwealth.
- Enrollment needs to “grow” in VA – provider capacity will be a tremendous issue for each locality.

What Does This Mean for Families?

- Lack of provider choice for families
- Regional disparities in service availability
-
-
-
-

Infusion of State Funds 1 of 3

There was a major infusion of state funds for Part C services which started for Fiscal Year 2004; culminating with $7,203,366 for Fiscal Year 2008. The purpose of these funds is to "serve additional children."

The Commonwealth also received a total of $10,280,066 in FY 2005 in Federal funds. These funds were slightly reduced in FY 2006 due to the impact of the decrease in 0-3 population in Commonwealth and totaled $10,127,614. The Federal funds are allocated based upon the state 0-3 population as compared to the national total.

Summary of Virginia Part C State Funding 2003-2008					
FY2003	FY 2004	FY2005	FY2006	FY2007	FY2008
$125,000	$3,125,000	$3,125,000	$3,125,000	$7,203,366	$7,203,366

Child Enrollment 2 of 3

Virginia 0-3 Enrollment (2002-2006): Annualized vs. Child Count					
Year	2002	2003	2004	2005	2006
Annualized Count	7,409	8,052	8,661	9,209	10,704
% Growth Annualized		8.68%	7.56%	6.33%	16.23%
December 1 Child Count	4,163	4,204	4,415	4,335	4,619
% Growth CC		0.98%	5.02%	(1.81%)	6.55%
Ratio: Child Count to Annualized	0.56	0.52	0.51	0.47	0.43

What Do These Data Tell Us?

The infusion of new state funds has had little impact on the number of children in service using the point in time count.

The 2005 number actually represents a small drop with the 2006 increase slightly more than the change in 2004.

EI CHILD REFERRAL, ENROLLMENT

Table 4: Comparison of 2006 Referrals: Calendar Year vs. Fiscal Year		
2006 (Calendar) Referrals "Not Moving to Service"		
Referral Outcome	**Count**	**Percentage**
Deceased	13	0.3%
Declined Screening/Evaluation	979	26.3%
Eligible/Chose Other Services	15	0.4%
Eligible/Declined Services	148	4.0%
Eligible/Unable to Contact	12	0.3%
Evaluated - Ineligible	1,178	31.7%
Screened - Evaluation Unnecessary	724	19.5%
Unable to Contact	650	17.5%
Total	3,719	100%
2006 (Fiscal) Referrals "Not Moving to Service"		
Referral Outcome	**Count**	**Percentage**
Deceased	7	0.2%
Declined Screening/Evaluation	1,135	25.8%
Eligible/Chose Other Services	28	0.6%
Eligible/Declined Services	166	3.8%
Eligible/Unable to Contact	21	0.5%
Evaluated – Ineligible	1,294	29.4%
Screened - Evaluation Unnecessary	861	19.6%
Unable to Contact	887	20.2%
Total	4,399	100.0%

What Do These Data Tell Us?

The number of children who are referred and do not move into services due to a variety of reasons totaled 45.0% for Fiscal year 2006. Major reasons for the Commonwealth as a whole were: ineligible 29.4%, family declined to participate 30.2%, and unable to be located 20.7%; 19.6% of children referred were screened, with evaluation unnecessary.

Average Age of Referral

We also reviewed data related to the “average age of referrals” which, from 2000 through 2006, indicated a fairly “flat” pattern of the average age of referral for the Commonwealth as a whole (16.39 months in 2001 as compared to 16.21 months in 2006).

Incomplete data for 2007 indicate the average age of referral at 15.46 months for the Commonwealth. The range of average age of referral for 2006 ranged from 13.05 months to 18.97 months.

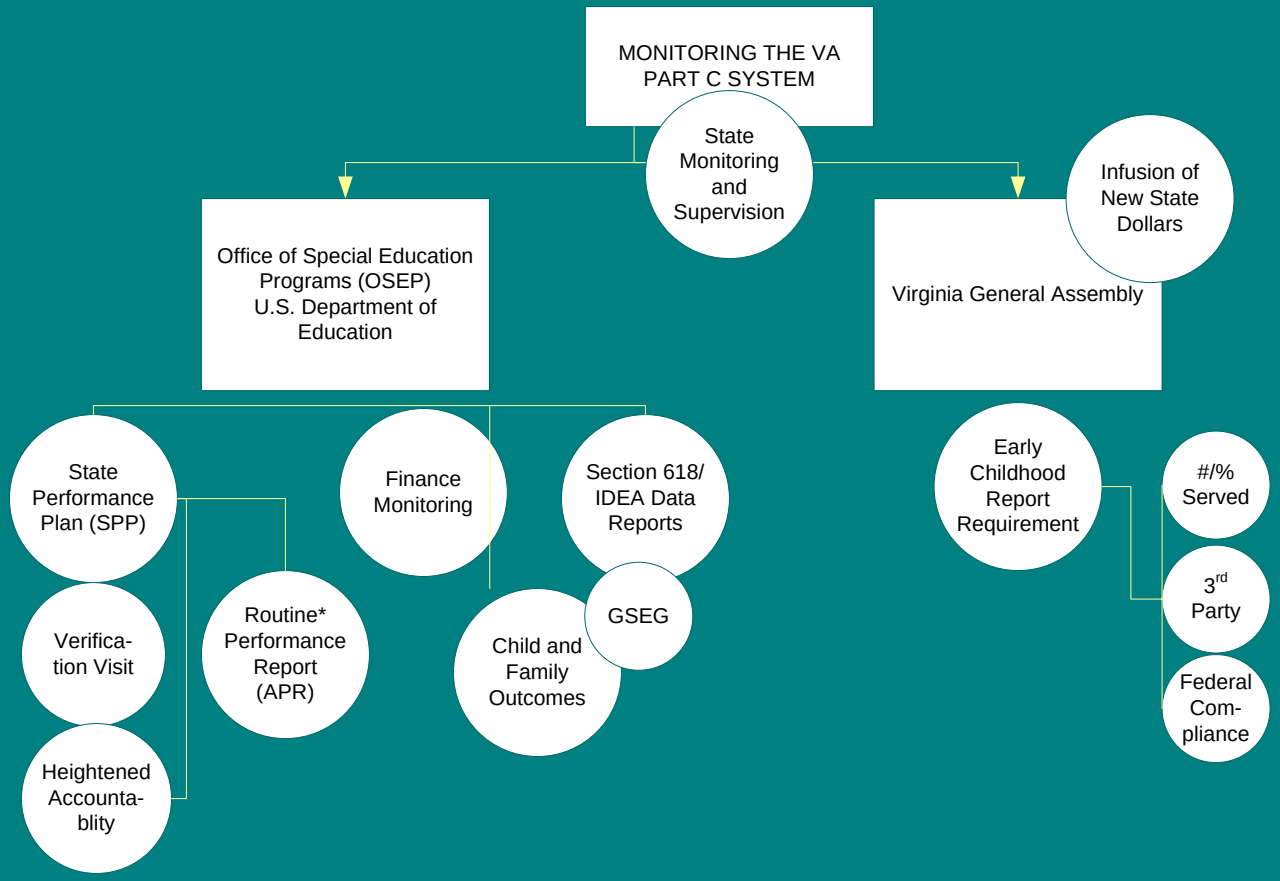
What Do These Data Tell Us?

These data indicate pretty serious problems for the Commonwealth as a whole in locating and identifying children ≤12 months, as required in OSEP Indicator Five.

Given that Part B/ECSE assumes responsibility for services for children at age 2, this means that a majority of the children in the Commonwealth's Part C system are served for less than 8.5 months before exiting from the system.

Findings:
Monitoring and Supervision
Federal and State Reporting

Ability to Report Finance Data in a Timely and Accurate Manner to the Virginia General Assembly and to OSEP



Virginia Part C Reporting Requirements

- *By October 1 of each year, the department shall report to the Chairmen of the House Appropriations and Senate Finance Committees on the*
  - *(a) total revenues used to support Part C services, (b) total expenses for all Part C services,*
  - *(c) total number of infants, toddlers and families served using all Part C revenues, and*
  - *(d) services provided to those infants, toddlers, and families.*
- *OSEP Part C Fiscal Reporting Requirements*

Federal Monitoring
Components of a System of Payments

- Lead Agency
- Role of the SICC
- Interagency Agreements
- Dispute Resolution Process
- Assignment of Financial Responsibility in writing
- Payor of Last Resort
- Services to children and families in a timely manner
- Arrangements with providers – contracts, timely reimbursement
- Description of the Use(s) of Federal Funds (budget)
- Assurances, Reporting Requirements
- Compliance with a variety of federal regulations
- Non supplanting
- No commingling
- Equitable distribution of resources statewide
- Payments by parents reflecting consideration of their “inability to pay”

Federal Monitoring Components: Delineation of Responsibilities

Interagency Agreements – State and Local Levels

- Lead Agency
- Role of the SICC/LICC
- Dispute Resolution Process
- Assignment of Financial Responsibility in writing
- Payor of Last Resort
- Description of the Use(s) of Federal Funds (budget)
- Assurances, Reporting Requirements
- Compliance with a variety of federal regulations
- Non supplanting
- No commingling
- Equitable distribution of resources statewide

LLA/Provider Contracts and Provider Reimbursement

- Services to children and families in a timely manner
- Arrangements with providers – contracts, timely reimbursement
- Description of the Use(s) of Federal and State Funds (budget)
- Assurances, Reporting Requirements
- Compliance with a variety of federal regulations
- Non supplanting
- No commingling
- Equitable distribution of resources throughout the locality
- Payments by parents reflecting consideration of their “inability to pay”
- Data reporting and collection
- Confidentiality
- Assurance of Provider Qualifications, Part C regulations, policies and procedures

Payor of Last Resort (POLR)

The State is required to have formal interagency agreements that define the financial responsibility of each agency for paying for early intervention services (consistent with State law) and procedures for resolving disputes and that include all additional components necessary to ensure meaningful cooperation and coordination. (20 U.S.C. 1435(a)(10)(F)) and *The State is required to certify that the methods or arrangements to establish financial responsibility for early intervention services provided under Part C pursuant to 20 U.S.C. 1440(b) are current as of the date of this Application certification. (20 U.S.C. 1437(a)(2) and 1440).*

- **POLR requires that all other fund sources are used before Federal Part C funds are tapped to support direct services.**
- **Some states have extended this POLR requirement to include state general funds as well.**

Nonsupplanting/Maintenance of Effort Requirement

The State is required to ensure that the Federal funds made available under 20 U.S.C. 1443 to the State will not be commingled with State funds; and will be used so as to supplement the level of State and local funds expended for infants and toddlers with disabilities and their families and in no case to supplant those State and local funds. (20 U.S.C. 1437(b)(5))

- **DMHMRSAS has no data or ability to ensure and demonstrate to OSEP that Part C Federal funds are not being used to replace current resources in the system, such as CSB or other public funds at the local level.**

Replacement of Local Lead Agencies

- Considerable effort has been expended in the last couple of years to locate and “ready” a new LLA when a CSB decided they no longer wanted to perform these functions.
  - Potential for loss of local funds used to support EI services
- Leads to disruption in services for some families; timeline difficulties.
- Local contributions (maintenance of effort) have been lost when LLA changes.

Allocation, Service Reimbursement Supportive of the Programmatic Directive

- The funding for LLAs should promote the system services which are required and valuable to families, children and communities.
- The allocation of Federal and state funds should reflect consideration all other third party resources and promote their utilization.
- There is a distinct difference in Medicaid reimbursement between CSBs and other providers, resulting in lack of parity in payments for direct services which is sometimes significant.
- Providers have experienced revenue losses since the implementation of managed care.
  - Rates are individually negotiated
  - Not all providers are recognized in the MCO network
  - Can't be sure that families are referred to EI in a timely manner
  - Lack of clarity re: service coordination/case management is problematic

Consultant Findings and Recommendations

Action Plan and Timelines

Approach and Timelines

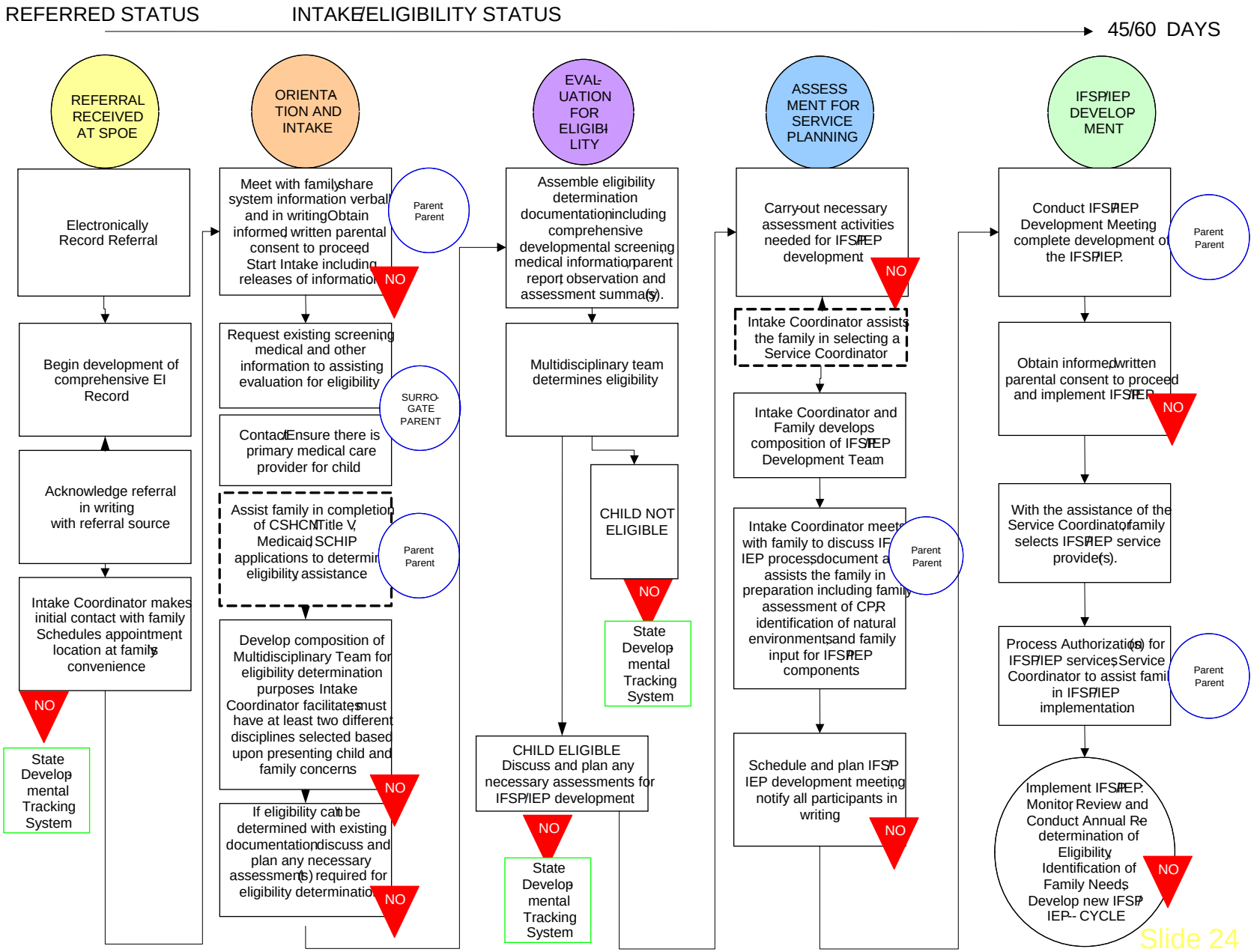
- A majority of the recommendations will rest upon the Part C state team, with assistance from Systems Managers and other stakeholders, for design and implementation.
- Stakeholder input is critical and will be solicited in a number of ways.
- Stakeholder groups will study the issues, review possibilities and develop recommendations for state agency consideration.
- Two phases are articulated:
  - P1: 3/1/07-2/28/08 (12 months)
  - P2: 3/1/08-7/1/08 (4 months)

Summary of Recommendations – Phase 1

- Resurface Supports and Services paper; update with definitions, examples – widely distribute
- Develop and provide broad based training in eligibility determination
- Develop and provide broad based training in assessment
- Develop and provide broad based training in IFSP outcomes development/teaming
- Develop and provide broad based training in the primary provider model
- Update EI Rate Study
- Revise MCO Contracts re: referrals, qualified personnel, reimbursement
- Study and develop method to reimburse for provider travel costs in a standard manner (DMHMRSAS, DMAS)

PHASE ONE

Virginia 0-3 EI Service Delivery Model



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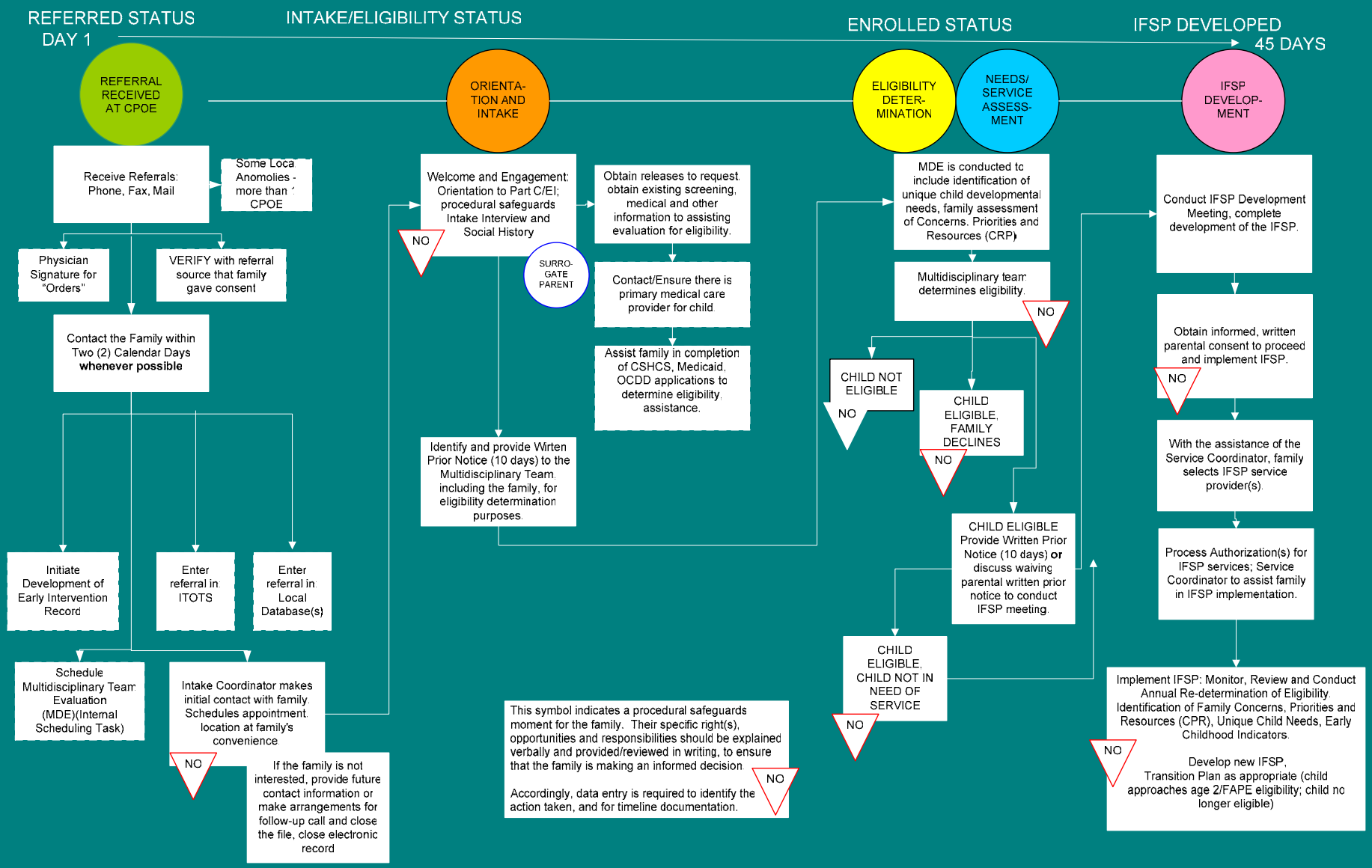


Consultant Recommendations - Family Cost Participation: Phase 1 (1 of 2)

- ****Current ATP configuration stays "in place"**
  - **Use the negotiated contract rate as the base for family fee assignment and collection.**
- **Location of family financial information**
  - At the Local Lead Agency in a separate file (not the EI Record)
  - Noted for family access in safeguards; not subject to general FERPA access

Consultant Recommendations - Family Cost Participation: Phase 1 (2 of 2)

- **Collect and report FCP/ATP from all LLAs, includes:**
  - # of families assessed
  - # of families who decline to participate due to FCP/ATP
  - # of families who decline to pay
  - # of families where FCP/ATP influences the services on the IFSP
  - Amount billed
  - Amount collected
  - # of Families referred to collection agency

Long Term Outcome: FCP

- ****Implement a one-step process which includes extraordinary circumstances**
  - Performed with all families including Medicaid-covered
  - Linked to utilization of private insurance, TRICARE
  - Document collection incorporates an interview to confirm family income
  - Includes resource case management
  - Develop Assistive Policy Procedures for implementation

Consultant Recommendations – Interagency Agreements: Phase 1

- Revise the current state-level interagency agreement to be an “umbrella” agreement across all state agencies
  - Develop the sequence (listing) of individual state agency agreements with DMHMRSAS defining the joint Part C relationship, and timelines
- Identify incentives to encourage local lead agencies to foster, cultivate and develop interagency relationships

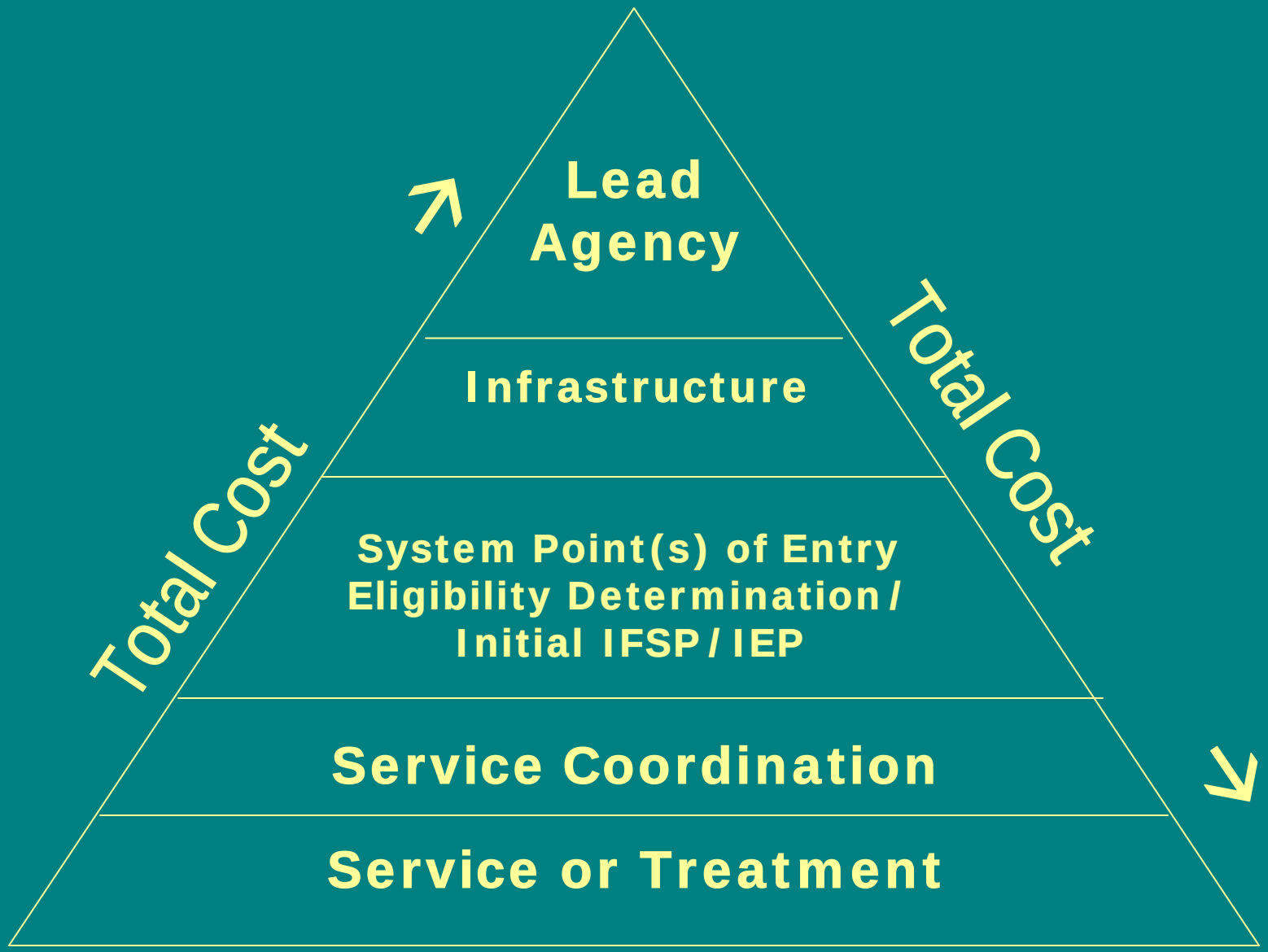
UPDATE

Consultant Recommendations – Service Delivery Model: Phase 1

- **Resurface Supports and Services document; update with definitions, examples – widely distribute**
  - Integrate Service Pathway chart in the Supports and Services document
    - Identify minimal vs. good vs. best practice in the flow chart
  - Potential impact of new Part C Federal Regulations (e.g., screening)
- **Develop and initiate broad based training, linked to Part C credentialing, to include all practitioners in:**
  - Eligibility Determination
  - Assessment
  - IFSP outcomes development/teaming
  - Primary Provider Model
- **Conduct a broad-based discussion re: service coordination, caseloads and options/opportunities for increasing capacity**

Consultant Recommendations – Finance and Data: Phase 1

- Update EI Rate Study
- Continue to work with DMAS to identify current Medicaid support for Part C
  - Initiate the collection of data re: delivered services, funding, etc., from LLAs
- Collect general revenue and service data from LLAs for General Assembly reporting purposes
- Revise LLA 2008 Contracts re: ChildFind, referrals, qualified personnel, reimbursement, data reporting to include finance, OSEP indicators and determination, participation in training
- Create a competitive bid process to secure new CPOEs should current LLAs decide they no longer want to participate. Effective for and prior to July 1, 2007.


Lead Agency
Infrastructure
System Point(s) of Entry
Eligibility Determination/
Initial IFSP/IEP
Service Coordination
Service or Treatment
Total Cost
Total Cost

Update EI Cost Study

- This process will be an abbreviated version of a cost study process used for twelve states including Virginia in 2003.
- Four (4) key elements of the study
  1. Revenue Data
  2. Salary Data
  3. Practitioner Direct & Travel Time
  4. Service Data
     - Planned through the IFSP
     - Actual through a documented service log

Method (1 of 3)

- A random sampling of 250 children currently enrolled in Virginia's EI System will be selected.
  - The ITOTs data system may be the source for sampling.
    - Children who will be three years of age before the end of October will not be selected.
  - Planned service levels for selected children will be tallied from the IFSP service summary page and quantified using daily, weekly and annual service levels.

Method (2 of 3)

- Service providers (about 400-600) for the selected children will be identified and asked to participate in an abbreviated recording of time
- They can use existing data or use new forms to record the following:
  - Service contact with selected children
  - For a defined period of time (either retrospectively or prospectively) they must be able to account for:
    - Total work time,
    - Direct Service time (Face to Face)
    - Travel time

Method (3 of 3)

- Providers will be asked to identify the funding/revenue sources for the selected children based on actual payments.
- Two pronged approach in that the initial information will come from the IFSP.
  - Follow-up work will be done to verify actual payments from providers.
- The intent is to spread the activity across the Commonwealth to limit the burden on any one entity.
  - Not collecting or reporting data by individual locality

Time Line

- Letter to the LLAs announcing the project by 9/17/2007
- Select child records by 9/17/2007
- Request the individual child IFSP service summary page by 9/27/2007
- Notification to practitioners by 10/5/2007
- Time detail submitted by 10/26/2007
- Data Entry and Analysis by 11/26/2007
- Draft Summary by 12/15/2007

Consultant Recommendations – Finance and Data: Phase 1 (1 of 2)

- **Develop and submit a Medicaid State Plan Amendment (SPA) to CMS for EI Services through Home and Community Services under EPSDT:**
  - Early Intervention Specialists
  - Expand eligibility for this HCBS to 300% FPL with consistent premiums, co-pays and deductibles to coordinate with EI FCP
  - Covered Services:
    - Screening
    - Evaluation/Assessment
    - IFSP Teaming
    - Early Intervention Services
    - Service Coordination
  - Utilize updated Cost Study information to determine state "match" requirement as well as projected revenue, based upon cost findings and rate recommendations.

Consultant Recommendations – Finance: Phase 1 (2 of 2)

- Work with DMAS to revise MCO contracts to reflect Part C responsibilities and reimbursement (referrals, qualified providers, policies and procedures).
- **Study and develop method for DMHMRSAS to reimburse for Associated Costs in a standard manner.
  - **Modified by SOP Stakeholder Group** to be targeted to LLAs where associated costs are currently not reimbursed and/or rates were woefully insufficient to meet provider costs.

Consultant Recommendations – ITOTS Analysis: Phase 1 (1 of 4)

- To craft a strategy to move VA from the current Data Reporting System (ITOTS) to a comprehensive data system supporting management and decision making for all business practices – state and local levels.
- To identify needed data interface structures.
- Review the existing data system analysis completed in February 2006 by Synigent Technologies.
  - To compliment the processes used by the consultants and to limit redundancy.

Consultant Recommendations – ITOTS Analysis: Phase 1 (2 of 4)

Long Term Outcome

Support the development of a comprehensive data system.

- State and Federal reporting requirements
- State and Local operations requirements
- Day to Day process management
- Accountability reporting

Consultant Recommendations – ITOTS Analysis: Phase 1 (3 of 4)

Short Term Outcome

Make “what is” a more stable source.

- Move to a place of consistency, integrity and accuracy with what is currently collected.
- Assist with the development of meaningful reports.
- Assist with the development of meaningful policies and data training opportunities.

ITOTS Analysis: Timeline (4 of 4)

- Develop full plan for the analysis by 9/24/2007.
- Data and policy review complete 10/15/2007
- Work with current IT staff to complete report development
- Identify options for implementation of a management system.
  - Moving ITOTs to that system
  - Evaluation of other VA systems
  - Identification of other Part C data systems that could support VA
- Complete analysis by 11/30/2007

PHASE TWO

Consultant Recommendations – Family Cost Participation: Phase 2 (1 of 2)

- Family fee is reconstructed to incorporate the EI Service organization in the Medicaid SPA, anticipated to be provided by any recognized EI provider* who will be called an Early Intervention Specialist or Assistant
- Family Cost Participation is implemented for all new families to the EI System, and completed with families at the annual IFSP Evaluation.
- Who conducts FCP process with families?
  - Service Coordinator **OR**
  - Local Lead Agency Individual with finance skills
- Who collects the fee?
  - Local Lead Agency or some other Third Party Administrator

*May have implications for Part C credentialing and training systems

Consultant Recommendations – Family Cost Participation: Phase 2 (2 of 2)

- Training for and monitoring of the FCP process for Service Coordinators and Local Lead Agency Staff
  - Statewide standardization
    - Ensures key principles: Accessibility, Equity and Parity
      - Local Lead Agencies
      - Families
      - Providers
    - Ensures reporting capacity
    - Ensures appropriate use of revenue
- May include “incentives” for Local Lead Agencies pursuant to the expansion of local resources, interagency agreements

Consultant Recommendations – Service Delivery Model: Phase 2

- Confirm design of service coordination model to include credentials, caseloads, approach (designated vs. blended).
  - Design incorporated into the whole financing approach.
  - Training to be developed and implemented to support model approach, to include documentation.
- Create expanded and comprehensive training initiative to include all practitioners and administrators, to include supervision training.

Consultant Recommendations – Medicaid Utilization: Phase 2

- Implement the approved Medicaid State Plan Amendment (SPA) for EI Services.
  - Early Intervention Specialists and Assistants
  - Covered Services:
    - Screening and Intake
    - Evaluation/Assessment
    - IFSP Teaming
    - Early Intervention Services
    - Service Coordination
- Expand eligibility for this HCBS to 300% FPL with consistent premiums, co-pays and deductibles to coordinate with EI FCP.
- There is also the need for DMAS to craft accompanying regulations and create provider manuals, documentation (as needed), etc. as this is rolled-out for implementation, once approved by CMS.

Consultant Recommendations – Finance and Data: Phase 2

- Implement revised allocation formula to reflect third party revenues as well as conform with Medicaid reimbursement approach.
- Revise MCO Contracts re: referrals, qualified personnel, reimbursement structure (to match SPA approach).
- Establish billing approach to mirror Medicaid reimbursement for the (five (5) covered services functional services).

Consultant Recommendations – Interagency Agreements: Phase 2

- Develop individual state agency agreements with DMHMRSAS defining the joint Part C relationship.
- Implement incentives to encourage local lead agencies to foster, cultivate and develop interagency relationships.
- Assist Local Lead Agencies to develop and implement local interagency agreements with community resources.
  - Incorporate into the LLA contract a sequence and timeline for Interagency Agreement development.
  - LLAs to monitor local interagency partnerships by collecting resource data, identifying compliance and barriers to compliance with local interagency agreements, etc.

Stakeholder Meeting Schedule

- Medicaid Reconfiguration:
  - September 2007 and January 2008
- Rate Methodology/Allocation:
  - January and March 2008
- ITOTS
  - Telephone conferencing and emails
  - November 2007
- Family Cost Participation
  - January and March 2008

Solutions Consulting Group, LLC

Karleen R. Goldhammer
725 Riverside Drive
Augusta, ME 04330

KGoldhamm@aol.com
Tel: 207-623-8994
Cell: 207-446-8994
Fax: 207-623-9793

Sue Mackey Andrews
Post Office Box 218
Dover-Foxcroft, ME 04426

sdmandrews@aol.com
Tel: 207-564-8245
Cell: 207-408-8040
FAX: 207-564-7175