Early Intervention System Transformation Implementation Task Force Meeting
Henrico MHDS/Teleconference Call
10/12/2010

Attendance: See participation list

Topic	*Discussion and preliminary decisions and next steps*	Final Decisions
Medicaid MCO Decision	DMAS made the decision that EI will remain carved out at least for now. This is expected to be a win-win decision that will allow reimbursement of service coordination/case management for all children with Medicaid/FAMIS coverage and will allow a meshing of Medicaid and early intervention requirements related to case management as has been done for early intervention services. Task force members expressed appreciation for the decision.	Early Intervention will continue to be carved out of Managed Care. In order for EI to remain carved out, an early intervention case management model to include all children must be developed and implemented.
Early Intervention Case Management	DMAS is working with a small group to draft a proposal for EI case management. This group has four meetings scheduled throughout October. After each meeting a decision grid listing issues, discussion and decisions will be sent to the Implementation Task Force members. EI ITF members can provide input back to the members of the small group. Tammy described the early intervention case management as providing managed care outside of a formal managed care organization. Tammy reported that this concept (which is new across the country) was presented by Cheryl Robertson at a National meeting and was met with positive comments. The three service coordination models are being looked at as this early intervention case management is being developed: blended, dedicated and independent. At this point, the early intervention case management model is in the process of being developed, so there are not answers to specific questions about what it will look like. The intent is to reimburse for services (service coordination/case management) that being provided and to mesh Medicaid and EI requirements. Quality measures will be incorporated, such as well child visits and immunizations in order to demonstrate/measure the value of Early Intervention case management beyond coordination of developmental services. It is very important that local systems continue to access MR/ID and MH TCM in the meantime. DMAS and DBHDS are planning joint training/TA sessions on these in the near future.	

Celebration: One Year Anniversary of Implementation	October 1, 2010 marked the one year anniversary of the implementation of the Early Intervention Medicaid Initiative (as well as implementation of the service pathway and EI Practice Manual).	
Data Report	Jeff provided handouts summarizing the change in enrollment over the year as well as the early intervention services reimbursement during the past year. ***Enrollment:*** • Enrollment changed from **2,968** in October 2009 to a high of **3,570** in August 2010. Enrollment for September 2010 dropped to **3,289** as a result of a high number of children transitioning out of early intervention into the school system. • Initially, it was expected that the percent of children in early intervention who had Medicaid or FAMIS would be around 40%. Currently 51% of the children in early intervention have Medicaid or FAMIS and this number has been as high as 54% in one month • It was suggested that this higher percentage may be a reflection on the current economy ***Reimbursement:*** • According to the Medicaid Information system (VAMMIS), $6,690,945 has been paid for early intervention services (not including case management) for data pulled according to date of service. • $8,100,699 has been paid for early intervention services (not including case management) from October 2009 through August 2010. • September data is not yet available. A question arose about the amount of Medicaid/FAMIS reimbursement prior to October 2009. Jeff and Mary Ann will see if they can provide this information. It is known that prior to 10/09, Medicaid/FAMIS did not cover developmental services or IFSP meetings and that there were not standard EI rates that captured the cost of providing services in natural environments. In addition, one participant reported that they'd had to use Part C funds for children who had Medicaid coverage in situations where they could not find a Medicaid Provider (and this is no longer an issue). ***Practitioners*** • The number of certified individuals has increased from **926** in February 2010 to **1198** today (includes EI Professionals, EI Specialists and EI Service Coordinators). This is an increase of 272 practitioners (29% increase).	

	A request was made for a report that includes the locations the various disciplines are practicing.	
Timeline Requirement Changes	The change in the timeline requirement (to 30 calendar days) for children who receive Medicaid or FAMIS at some point after they are referred to early intervention was reviewed. The 10 business day timeline requirement for entry of the Medicaid information into ITOTS for children who have Medicaid/FAMIS when they are referred to early intervention has not changed. With the current ITOTS system, the 10 business days is measured from the date of the IFSP. Participants were encouraged to get in the habit now of entering the information within 10 business days of the date eligibility was determined as this will be required when ITOTS 1.8 is implemented. There are a variety of ways local systems learn when Medicaid/FAMIS has been made effective retroactively including: • The Family tells the service coordinator • DSS informs the service coordinator • Part C staff include this information in response to inquiries from the field when a child newly receives Medicaid or FAMIS –or when child's coverage is restored. • The Monthly Report from Part C will have the Medicaid/FAMIS EI benefit begin date, end date and EI disposition date. In this case the EI disposition date refers to the date an entry was made for the EI benefit. This report will be in excel format and can be sorted according to the EI disposition date. The local system can then view which children have had the EI benefit added that month; and then look at the begin date for the benefit for those children. Plan: A webinar will be scheduled to explain/review the new Medicaid reports. Jennifer McElwee will collect specific questions that participants would like to have included as part of the webinar. Target Date: November. The webinar will include information about when and for what purpose the enrollment reports are used versus the eligibility verification reports.	A webinar will be scheduled (tentatively in November) to explain the new enrollment report. A separate webinar will be scheduled at a later date for the new claims report.
Eligibility Verification	Some local systems were checking eligibility weekly in order to meet the 10 business day timeline. With the change in requirements for children who receive Medicaid/FAMIS coverage after they are referred to Part C, it is expected that monthly verification will suffice. Participants discussed whether their locality is checking eligibility for all children or just for those they know had Medicaid/FAMIS or	

	were in the process of applying for Medicaid/FAMIS. Some are checking all children to assure that they do not miss children. **270/271 Reports** All states are required to make the 270/271 reports available. The 270 report is a request for information and the 271 report is the response to the request. Jeff sent members the "Companion Guide for 270/271) as well as a list (provided to him from ACS, the company that handles the 270/271 reports) of vendors who can provide the reports. Jeff explained that local systems must contract with a vendor that will write a code for the specific data that the local system specifies they want to have included on their 271 report. The local system pays to have that code written, then pays a per child amount ($.25 - /$.50) each time a report is generated. The local system will provide a list of children using an excel format on the 270 report. The vendor sends the request to ACS (who operates Medicaid's data system) using the code they created for the local system. The 271 report is generated within 24 hours. Local systems are not required to use the 270/271 reports. They can verify eligibility using the ARS system. The drawback for ARS is that children must be entered one at a time and only up to 10 children can be submitted at a time. The 270 report allows unlimited batching. Discussion followed about why ACS has provided a list of so many vendors and only 4 vendors were listed on the memo sent out by DMAS. In addition, one of the vendors on the DMAS memo was not included in the list from ACS. Jeff will follow up to learn the difference or relationship between the clearing house list (sent to Jeff by ACS) and the 4 that were listed on the Medicaid Memo. In the meantime, local systems may choose to pursue working with one of the 4 vendors listed on the Medicaid Memo.	
Claims Denial Codes	Jeff will put a list of the codes in a table in word or excel and send to the group.	
Update on Team Treatment Cap	The Medicaid/FAMIS claims system is applying the annual limits on a monthly basis for the team treatment codes. Brian Campbell has put in a request to have this fixed.	
Billing Question – Two providers using same code and same NPI	When billing for a service in which 2 providers are using the same billing code (such as team treatment) and have the same NPI number (in the same agency), the total number of units need to be added together on one line rather than listing the two providers separately because the Medicaid Claims system will see two separate lines with the same billing codes as duplicate billing.	

Next Meeting: October 25, 2010 at 9:30 AM at the VACSB.