Early Intervention System Transformation Task Force Meeting
2/16/2012

Present: Beth Tolley, Jeff Beard, Patti Davidson, Debra Holloway, Mary Anne White, Mary Lou Hutton, Rosalind Cutchins, Jennifer McElwee, Margaret Johnson, Tracey Miller, Susan Sigler, Chris Gregory, Kathy Pierson, Nancy Butts, Jan Jessee, Tammy Whitlock, Catherine Hancock, Brian Campbell, Bernita Sykes

Quality Management Reviews (QMRs)

Jeff told the group that the ***intent of the Quality Management Reviews is to review quality, not to retract funds***. In fact, the reviewers may identify opportunities the local system or providers missed. The reviewers look at the providers' documentation to be sure the policies and procedures are followed and billing was done appropriately. Jeff indicated that in some cases hard and fast rules cannot be applied because individual circumstances require a level of judgment during reviews. The purpose of today's discussion is to provide guidance about the requirements, including what requires retraction of funds. Quality Management Reviews include identification of technical assistance needs and may also result in a requirement that the local system and/or provider/provider agency develop and implement an improvement plan. Jeff reviewed the elements below that are reviewed during QMRs. Some of the following elements are retractable and some are technical assistance and improvement plan issues, but all are related to the quality of care for the child and the family.

Personnel

1. Current and appropriate EI Certification of practitioner who rendered the service that was paid by DMAS.
2. Current License / Discipline Certification of practitioner who rendered the service that was paid by DMAS.
3. If EI Specialist, is there documentation that the individual was supervised?

Eligibility & IFSP Info & Support

1. Parent Signature with Date on the IFSP?
2. Physician Certification present.
    - Is Certification dated within 30 Days of first paid visit by the service provider?
3. Does the number of sessions provided and documented during the review period match the number expected per the IFSP? Does the number of Sessions reimbursed during the review period match the number expected during the review period per the IFSP?
    - Reviewers compare the number of sessions provided, documented and billed to the number expected based on the IFSP. Documentation of any discrepancies (missed sessions due to child illness, make-up sessions, etc.) is critical. It is ok to make up sessions in advance for therapist going on vacation ***as long as*** that meets the child and family needs.
4. Is there a difference between the number of units paid & the number of units documented? *(Paid - Documented = units retract)*
5. Does the number of units paid match the number of units expected based on the IFSP? *(Paid - IFSP = units retract)*

Contact Notes

1. Did the service provider bill the same Service Date(s) documented on the Contact Note? *(The note should be written within 5 days. If using an electronic billing system and the note is entered into the system after 5 days, there needs to be documentation of the date the note was written by the practitioner. The electronic system will only indicate the date the note was entered into that system.)*
2. Is there documentation of the Parent/Caregiver present during the session?
3. Is the child's name on the note (and on each page if more than one page)?
4. If applicable, is it clear that it was a face-to-face visit?
5. Is the signature of the practitioner on the note?
6. Is the *Intensity (length of the service visit)* of the Session(s) documented in minutes?

7. Is the documentation clear about what the provider did/provided during the session?

ASP IFSP Development

1. Do the minutes billed for the ASP match the minutes/time that is documented? *(If unknown, also retract)*
2. Is the IFSP Meeting Date documented - to correspond with service date(s) paid for the IFSP?
3. Does the IFSP Review Meeting Date match the service date paid (for reimbursement of IFSP Review)?
4. Is the parent/guardian's signature and date on the ASP?
5. Was the Addendum completed and parent signature obtained (or, in the case of an IFSP review, was it revised with a new signature if new services added)? *(If there is a change of service that requires an update to the IFSP, there must be the appropriate revisions to the IFSP and signatures.)*
6. Is the number of minutes documented for the IFSP Meeting the same, more or less than the number of minutes paid for the IFSP Meeting?

Retractions of reimbursement are necessary if requirements are not met. Jeff emphasized the critical role of thorough, timely documentation. If the Infant & Toddler Connection of Virginia staff have questions about particular issues (such as whether the contact note meets the requirements), they consult with Jeff. The review team has a list of every paid claim during the review period (3 month period).

- If the practitioner who provided the reimbursed services did not have the required discipline specific qualification or the EI Certification, then reimbursement for all services provided by that practitioner during the review period will be retracted
- Reimbursement for services for which no documentation can be located will be retracted.
- In general, services provided during the 3 month review period are subject to possible retraction. However, if there is a major issue, such as services provided by a practitioner who is not licensed, then the retractions could include services provided before or after the 3 month review period.
- Absence of physician certification requires retraction of reimbursements.
- There is an element of judgment applied during reviews. For example, an isolated documentation omission may not result in a retraction, whereas a pattern of missing documentation would.

A comment was made that providers who are accustomed to the DMAS rehabilitation audits are working to understand the requirements for EI Medicaid Services Quality Management reviews and the differences between these reviews.

Requirement to Bill Number of Minutes

- Stakeholders asked if there could be reconsideration of the requirement that early intervention services be billed by number of minutes and instead allow the "8 minute rounding"* practice that is accepted by Medicare and private payors. [*less than 8 minutes are not billed; 8 or more minutes are billed as a unit].
- Billing minutes is problematic especially when a child has Medicaid as the secondary payor; for a 55 minute session, 4 units can be billed to the primary payor, but only 3 units can be billed to DMAS. Adding minutes together at the end of the month has been problematic and not workable for many agencies.
- DMAS will be looking into the possibility of adopting the Medicare "8 minute rule" for each session. The Part C Office will notify system managers of the outcome of the Medicaid's decision.

System Manager Meeting March 27, 2012

- Quality Management Reviews was the top priority topic listed by System Managers for this meeting. DMAS staff will participate in the QMR presentation at that meeting.

Discussion of Issues

- New practitioners do not always understand and follow the Part C Requirements
- Meeting documentation requirements is an ongoing issue

- The requirements to be certified as an Early Intervention Practitioner (Professional, Specialist, and/or Case Manager) does not mean that an individual is qualified to provide services (including assessment and ongoing services) for all populations. Specialized expertise goes beyond basic EI requirements. The Local Lead Agency must assure that the practitioners' expertise and experience match the needs of the child and family.
- Unintended impact of the standard EI rates
    - The standard EI rate has resulted in high Part C costs in situations where insurance is paying little or nothing and/or the family has a $0 or low family cost share.
        - SLP rates are low in part because reimbursement is not time based. This is something that would need to be addressed by SLPs through ASHA (as a start).
    - The rate was based on the average cost (time and $$) for travel; practitioners and agencies that will only travel self-determined distances negatively impact the local lead agency's ability to serve all children and negatively impact the cost of services for the local lead agency
    - Practitioners/provider agencies who agree to only serve children with specific payor negatively impact the local lead agency's ability to serve all children and negatively impact the cost of services for the local lead agency
    - There continue to be some challenges with practitioners/agencies willingness to participate in the non-direct activities that are captured in the standard rate – such as teaming, personnel development.
    - Independent contractors do not have the same costs that contacting agencies have.
    - Discussion followed about possible ways to address these issues including:
        - Development of contract templates for contracting agencies and for independent contractors that spells out the expectations (teaming, being in payor networks, participation is local system personnel development activities, serving children throughout the locality, etc.). Recognize (and reflect in contract) the difference in services and costs when contracting with an agency vs. independent practitioner. (Susan Sigler offered to be a resource with this).
        - Directing practitioners to contacted agencies rather than contracting directly with them.
            - Tammy noted that independent practitioners were included in order to be able to address the need for practitioners to serve all areas
        - Assess local systems' mechanism for assigning children (when parents request "first available provider" to assure that it is not a set up for "cherry picking". One mechanism is to send the list of children to be scheduled **first** to agencies/practitioners who are in all of the networks.
        - Hold contractors to meeting the requirements. End contracts of providers who do not comply.
    - There is a perception that the Infant & Toddler Connection of Virginia Practice Manual does not allow different rates be paid to individuals vs. agencies. Guidance was requested about how to calculate the "cost" of the services the local lead agency provides (that are a part of that standard rate).
        - A suggestion was made to add this topic to the March 27, 2012 System Manager/Infant & Toddler Connection of Virginia meeting.
- A report listing the intake date for individual children was requested to give Local System Managers a mechanism for monitoring whether intake dates are being entered in ITOTS.
- Rare instances of physicians refusing to sign certification. Ideas were brainstormed including
    - Personal meetings with the physician
    - Contact from another physician (Colleen Kraft; Fairfax physician)
    - Family chose another physician
- Paperwork requirements have increased
- Local systems unable to get into all of the commercial payor networks

Positive Impact of the Medicaid EI Initiative:

- There are more providers in the system (as was intended)

- Need to continue to work through the growing pains; some problems have been resolved through the initiative, new issues are being addressed;
- Need to continue to focus on quality
- Note: there are some localities (SW Virginia) that continue to have provider shortages

- Success of the initiative has empowered the EI System to tackle new challenges (commercial insurance)
  - There is a VICC Insurance Committee that is addressing this.
- Localities are getting the signed physician certifications as well as the Health Status Indicators back from the physicians

DMAS Reports

- Jeff emphasized the importance of reviewing the monthly Medicaid reports sent from DBHDS to local systems.
  - Local systems should let Irene Scott (Irene.scott@dbhds.virginia.gov or 804-786-6848) know if there are children listed for their system who do not belong in their system – AND if there are children with Medicaid/FAMIS coverage in their system who are not showing up on the report for their system.
- DMAS will be providing a report to Local Lead Agency Executive Directors of the percentage of children with the Medicaid EI Benefit for whom claims were filed.

Timeline Requirements for ITOTS Data Entry for Children with Medicaid/FAMIS

The following information was provided for the group and will be sent to System Managers and also included in the March Infant & Toddler Connection of Virginia Technical Assistance Update:

For Children New to Early Intervention in Virginia

The intake date and the Medicaid/FAMIS number must be entered in ITOTS within 10 business days of the intake date. If both of these timeline requirements are met, the intake date is used as the start date for the Medicaid EI benefit.

If there is no intake date, the eligibility date can be used as the start date for the Medicaid EI benefit if both the Medicaid/FAMIS number and the eligibility date are entered within 10 business days of the eligibility date. *Please note that Service Coordination Services (Early Intervention Targeted Case Management) that occur prior to the eligibility date cannot be billed to DMAS if the eligibility date is used as the start date for the Medicaid EI benefit.*

If the Medicaid number or the eligibility date is entered in ITOTS more than 10 business days after the eligibility date, the date that the last one of these to be entered is used as the start date for the Medicaid EI benefit. *Please note that Service Coordination Services (Early Intervention Targeted Case Management) that occur prior to the start date for the EI benefit cannot be billed to DMAS.*

For Children Who Transfer from one Local EI System to Another Local EI System in Virginia

The referral date (which is after the discharge date from the previous local system) is used as the start date for the Medicaid EI benefit. *Please note that the EI Benefit cannot be added for the new EI system until the transferring system has entered the discharge date in ITOTS followed by the new EI system entering their information in ITOTS. Delays in data entry will impact the new EI local system's ability to bill DMAS.*

For Children Discharged from previous EI Services for the reason "IFSP Completion Prior to Age Three"

The rules listed under "Children New to Early Intervention in Virginia" apply.

For Children Who Receive Medicaid/FAMIS After Intake or Eligibility Determination

If the Medicaid number is **entered within 60 days of the Medicaid/FAMIS "disposition" date**:

- The intake date is used as the start date for the Medicaid EI benefit if it is after the start date for the Medicaid/FAMIS coverage
- The eligibility date is used as the start date for the Medicaid EI benefit if there is not an intake date and if the eligibility date is after the start date for the Medicaid/FAMIS coverage.
- The start date for the Medicaid/FAMIS coverage is used as the start date for the Medicaid EI benefit if it falls between the intake and eligibility date when an intake date is present, or if it is after both the intake and eligibility date.

If the Medicaid number is **entered more than 60 days after the Medicaid/FAMIS "disposition" date**, the date the Medicaid number was entered in ITOTS is used as the start date for the Medicaid EI benefit.

For Children Whose Medicaid/FAMIS Coverage Was Lost, Then Restored

If the Medicaid/FAMIS number was re-entered into ITOTS – or if the local system notified the Part C Office - **within 60 days** of the Medicaid/FAMIS "disposition" date, the start date for the Medicaid/FAMIS coverage is used as the start date for the EI Benefit.

If the Medicaid/FAMIS number was re-entered into ITOTS – or if the local system notified the Part C Office – **more than 60 days** after the Medicaid/FAMIS "disposition" date, then the date the Medicaid number was re-entered into ITOTS – or the date the local system notified the Part C Office – is used as the start date for the Medicaid EI benefit.

The following training and technical assistance needs were identified:

- What to expect with Quality Management Reviews
- Documentation
- Contracts – what to include
- Calculating cost to local lead agency of the functions included in the standard rate that are provided by the local lead agency

Future Planning

- Task Force members agreed that meeting every six months could be helpful.
- The EI TCM Task Force may be combined with this task force in the future
- Focus of future meetings can include:
    - Assessment of how things are going
        - Are there opportunities for streamlining
    - Review of themes from Quality Management Reviews

The next meeting will be scheduled for approximately 6 months from now.