Concept Discussion
Collection of Delivered Service information
ITOTS Stakeholder Group Recommendation

PURPOSE

This document broadly defines a new proposed delivered service data collection component for the Infant & Toddler Connection of Virginia, the Commonwealth's Part C Early Intervention system. The intent of this paper is to solicit provider comment, input and suggestions with respect to this proposed change. It is important to say that this is only one component of change in a compendium of proposed changes for early intervention data collection currently being discussed by the ITOTS Stakeholder Group. This one, the most significant of the items being discussed, is being singled out for comment because of its broad impact.

This change must companion with two other elements of change. First, a provider registry must be created for all practitioners who might be named as a child's service provider. Secondly, the current ITOTS system does not allow for data entry for anything beyond the initial IFSP. It is imperative for the system to capture the history of services for enrolled children. The timeline for implementation of the proposed change will be as soon as is practical after approval to proceed.

Development of this concept paper was represents the recommendation of the ITOTS Stakeholder Group. Comments, questions, support or concern about the content of this document may be submitted via e-mail to Karleen Goldhammer at kgoldhamm@aol.com before 3/6/2008 for them to be brought to the Stakeholder meeting on 3/12/2008.

BACKGROUND

There are a total of forty (40) Local Lead Agencies (LLAs) with responsibilities throughout the Commonwealth for the delivery early intervention services for eligible children, birth through two, and their families. The 40 catchment areas mirror those of the Community Service Boards (CSBs). Historically, the CSBs had the "first right of refusal" to assume LLA responsibilities for Part C.

Local Lead Agencies vary with the majority being Community Service Boards (CSBs) (N=30), two (2) health departments, four (4) universities, two (2) local governments, and two (2) local education agencies. There is a Local System Manager at each LLA who is responsible for the general oversight, ITOTS data entry, reporting and management of the system in coordination with the LLA administration. The majority of LLAs are the provider of some EI services for children and families they serve, and subcontract for the remainder of services.

The mix of providers delivering early intervention services includes LLA employees as well as other public and private agencies, and private providers through contracts with the LLAs. Contracts are de-

veloped between the LLA and provider to ensure payment for services that are not third-party, where Federal and/or state Part C, or local funds are used as whole or partial reimbursement.

Based upon multiple sources of service planning data, children receive about 30 hours of service annually and there are about 5,000 children in service on any given day. This means that there are roughly 150,000 service transactions annually, given that most services last 60 minutes in duration. In addition, evaluation services are provided to children entering the system and team meetings occur for service planning that are likely to account for an additional 35,000 transactions for an estimated total of 185,000 transactions annually.

There is no precise count of the number of sub-contracted provider organizations in the EI system. Most LLAs are providers of service, accounting for 40 providers. In addition, most LLAs have sub-contracts for the provision of direct services. Specific data from 25 LLAs shows relationships with 53 different organizations. Given that relationship we could speculate that there might be 100 sub-contracted providers for a total (including the LLAs) of 140.

Without considering service coordination and assistive technology, it appears that 50% of EI service is delivered by personnel within the LLAs with the balance of service delivered through sub-contractors, such as public and private agencies and private providers. Of the non-LLA providers, three (3) organizations emerge as the most significant in volume. Rehab Associates is the largest in volume, followed by The Chesapeake Center and then the Children's Center. There are 15-17 LLAs who account for about 80% of all children with 5-7 of those delivering a fair amount of delivered service.

ITOTS

The current web base ITOTS data system in use for the Virginia Infant and Toddler Connection System Virginia relies on data entry of information from the Individual Child Data Form ICDF Form 402 upon entry of a child into the system. A key data entry point occurs again after development of the Individualized Family Service Plan (IFSP). There is an annual LLA requirement to update the primary service setting as this is a required Federal reporting obligation. Exit information is added when the child transitions out of Part C. The referral, eligibility, some IFSP information, including planned services and child outcome data, are captured within the system. These three (3) new components must be in some way tied to this existing system.

KEY PRINCIPLES

Minimize or Eliminate Double Data Entry: To the degree that service providers already have this information entered in an electronic system, there should be a way to avoid additional data entry.
Create Consistent Process For Sub-Contracted Providers To Bill: Currently, providers who contract with more than one LLA must submit billing information in multiple ways. The intent of this process is to create a uniform reporting and billing process for all providers regardless of the volume of service that they provide, or the geographic area(s) they serve.

Family Cost participation (FCP): A review of this procedure will have to occur once the FCP process has been re-defined.

Methods collection:

1. A data extract allowing providers a vehicle using existing data.
2. A data entry portal across the internet similar to, or as part of the existing ITOTS.
3. Use of the universal billing process defined by the Electronic Data Interchange (EDI) requirement of the Health Insurance Portability and Accounting Act (HIPAA). These requirements provide guidelines for billing that all organizations billing medical transactions in an electronic format must follow. The specifics detailed in X12 837, Health Care Claim: Professional or Institutional.
4. It is the recommendation of the Stakeholder Group to require electronic data collection. However, there is some question as to whether or not a paper process must be offered since organizations paying for medical services must accept the CMS 1500 paper or the UB92 claim forms, both of which are used for the paper billing process.

NEED/REASONS FOR COLLECTING ACTUAL DELIVERED SERVICES

- **Cost Projections:** Actual delivered service information is one of the most viable ways to continue the work started by the Finance Group in order to look at the costs of the EI system in Virginia and to capture some of the most useful information about the System. The cost per hour of delivered service was computed through the Cost Study performed in 2003 and updated in 2007. The information may be adjusted with some inflation factor for a number of years to come. There is currently no systemic way for this update to occur.
- **Quality Assurance and Accountability to the Individualized Family Service Plan (IFSP):** The integrity of the service planning process can be measured against what actually happens for children and families in the Virginia Early Intervention system when delivered services actually occur. Monitoring of actual services received against the planned services is currently a manual process at many levels of the system. Automation in this fashion is a significant person power savings. Knowing why services did not occur is critical to understanding and managing the overall system. The Part C system, both locally and at the state level, has a responsibility to families of knowing the service requirements of the IFSP's and whether those requirements are met.
- **System Management:** Service detail provides important data to localities about staff shortages, cancellation rates, no show issues, etc. It also provides statewide information on enrollment and what kinds of services are being provided so that longer term planning can occur. This is critical to system planning and growth.
- **Contract Management:** Currently, local system managers create a mechanism for sub-contractors to bill services not covered by third party resources to each LLA. They look to be sure that the services are in accordance with the terms of the sub-contract and, if appropriate, verify that services are specified on the IFSP and they confirm that they have actually been delivered.

- **Required of the General Assembly Report:** The legislatively required reporting to the General Assembly cannot be completed, nor can true projections of cost be developed in order to support increased finding requests.
- **Allocation of Funds:** This data would allow for a more equitable distribution of funding between DMHRSAS and the LLAs since both the volume of services would be known as well as the funding sources. The common reimbursement structure, currently in development, could be applied to delivered services, fulfilling a number of regulatory requirements.
- **OSEP Indicators:** This process will allow the automatic computation of the time for the start of services which is one of the OSEP indicators. The localities are currently required to be compliant with a number of indicators with OSEP. Due to a lack of data, it is not possible to know where services really stand unless a thorough record review is done, which is very costly for staff time.
- **Outcomes Measurement:** Another missing and critical feature is the lack of ability to state that what was provided had the impact/result desired. The Commonwealth needs to be able to analyze what services were provided to what children and what were the children's outcomes when they left Part C. In addition, there should be some longitudinal study developed to see where children were enrolled in the Part B program in the "out" years which could provide data to support cost savings of early intervention.

WHAT TO COLLECT

Providers would submit information for all services delivered to a child and or family participating in Part C early intervention regardless of the funding source ultimately billed. The information should be centrally collected rather than making this the responsibility of the Local Lead Agency for two primary reasons. One, to eliminate the possibility of different protocols for providers who serve multiple LLAs; and two) and the information should be available back to the LLA. The timeline for collection should be specified as monthly or quarterly and should be tied to billing. The data would be required no later than the close of the quarter following the service delivery quarter. In other words data for the quarter ending September 30, 2007 would be due no later than December 31, 2007.

The State office will have to develop an application to import the delivered service information from any of the specified formats and will have to have a workable database that links with ITOTS data. In addition, a data entry capacity will have to exist for the paper CMS 1500 or UB 92 forms, if paper forms are allowed for submission.

DATA SPECIFICATIONS

1. ITOTS Child Id as it is used in ITOTS.
2. Child Name: First, Last, MI. The purpose is for verification of a match with the ITOTS child ID.
    a. A suggested business rule might be that-- records must match the ITOTS Child ID with the first three letters of the first and last names and the child's date of birth.
3. Child date of birth: mm/dd/yy. (The HCFA 1500 paper form does not have space for the full 4 digit year)
4. Date of service: mm/dd/yy (No date range is needed)
5. Service Code: At the option of the provider, this could be either the service codes aligned with ITOTS or relevant HCPC/CPT code(s) and modifier(s) (if applicable) from the appropriate code set in effect on the date of service. The field should accommodate the entry of up to four two-digit modifiers.
6. Duration: in Units: Using the definition of unit at the time of billing. The working assumption is that all services with the exception of Assistive Technology will be the 15-minute unit.
7. Funding Source: Original funding or supports expected to pay for the provided service. The listing would match that in ITOTS with the exception that the local system name would be an available option. This would be the trigger for billing to the local system.
8. Location of Service: Using the HIPAA/EDI place of service codes
9. Provider Organization and Practitioner Name: these two data items should be tied to the provider registry and to the child's IFSP. Some consideration should be given to using the National Provider Identification (NPI) that should already be in place with most providers.
10. Cancellation: This field would be used to submit service records for events that did not occur for a variety of reasons that would include staff cancellation, family cancellation and no-show. In addition to what actually occur, this allows for the full accounting of services specified on the IFSP.
11. Transaction type: This would allow for an original transaction to be voided or changed based on correction or subsequent action. Typical choices include Normal, Void or Adjusted. The concept is that if the original transaction is incorrect in any way it is marked as void and an exact negative transaction is created. In some instances a replacement transaction must be created to reflect the correct information. This would allow for services originally billed to Insurance but denied, for example, to in turn be billed to the LLA.
12. Charges: The amount billed for the service.