Implementing the New Federal Part C Regulations in Virginia:
Questions and Answers from the June 2012 Webinars

(Note: There were some technical difficulties in copying the chats, which contained the questions, from a couple of the webinars. We tried to remember and include as many of the questions from those sessions as we could.)

General:

1. Can we use up our current supply of forms and Rights documents before switching to the revised versions?
   Since the revisions to the forms are required in order to meet the new federal regulations, we are not able to wait until current supplies are exhausted to begin using the revised forms and Rights documents.
2. Should we start using the new forms with new families beginning July 2, 2012?
   Yes. If you have electronic records and need a little more time to make the changes to your electronic forms, then please complete that process and begin using the new forms as close to July 2 as possible.

Eligibility Determination

3. If you're establishing eligibility by records, does the person reviewing the records have to be from a different discipline than the person who wrote the report?
   No, they do not have to be from different disciplines. For instance, a PT from the local system could review a report from a PT at MCV to establish eligibility by records.
4. For the annual determination of eligibility, can the person who is reviewing the contact notes to determine eligibility be the same person who has been seeing the child?
   Yes, the EI Professional who has been providing services to the child may use the contact notes to establish eligibility by records at the annual.
5. Do you still have to give the family the Notice and Consent to Determine Eligibility if you're able to establish eligibility by records?
   Yes. You still need parent consent to move forward.
6. When you establish eligibility by records, do you have to complete the narrative section of the Eligibility Determination Form?
   No, you do not need to complete the narrative. You will only complete the top of the first page, through the Statement of Eligibility section, and then sign on page 2 of the form.

Assessment for Service Planning

7. Where do we have to write down the family's responses to the required set of questions that make up the family assessment tool? Do they have to be on page 2 of the IFSP?
   Although the family's responses must be documented, local systems have some flexibility in where they are documented. The responses might be recorded in a contact note, on a local form (e.g., an intake form or a local form created specifically for the family assessment questions), or through other mechanisms. The responses to the questions could be recorded on page 2 of the IFSP if the

family agreed, though a summary based on those responses (with the actual responses recorded elsewhere) may be effective in supporting the identification of outcomes and for service planning.

IFSP Implementation

8. Is aural habilitation to develop functional use of a cochlear implant allowed as a Part C service or is this excluded along with implementation, optimization, maintenance, and replacement?

   Aural habilitation to develop functional use of a cochlear implant would be considered an early intervention service under Part C if it is necessary to meet the child's outcome(s).

Transition

9. Can the family agree to send their directory information as part of the notification but wait until later to decide about the referral?

   No, the notification is a referral and will be handled as such by the local school system. If a family is not ready to decide about a referral, then the family could initially opt out of the notification. They can always change their mind later (and there's a place to indicate that on page 7 of the IFSP) and have the notification and referral sent.
10. Does the local school system representative now have to attend the transition conference and meeting to develop the transition plan or is the requirement still to invite them?

    They must be invited. If they are unable to attend, you will take the steps identified in Chapter 8 of the Practice Manual to ensure the family receives the required Part B information and that the family has the name and phone number of an individual they can contact in the local school division if they have questions.
11. For many children who are not going to Part B, it is going to be impossible to figure out 90 days+ prior to their discharge date in order to develop a transition plan. For example, we get a 2 month old in with torticollis. We don't know if we will have that child for 2 months in service or 8 months – and suppose we think it will be 8 months and, at 5 months, the child looks great and is ready for discharge – and we haven't done the transition plan. Then what do we do? For those kids with mild concerns who are likely going to be with us for a short while, it is going to be a challenge to develop a plan for at least some of them at least 90 days before discharge.

    In Virginia we would generally <u>anticipate</u> that children will either transition at age 2 (start of the school year in which they turn 2 by September 30) or at age 3. If the child exits outside of one of those anticipated transition points - in your example, because the child reached age level – then when you realize the child is exiting, you will offer the family an IFSP Review in order to develop a plan for transition (are there other community programs they would like to explore, are there materials or resources they would like to access in order to continue monitoring their child's development?). If the family does want to develop a plan, you would complete those steps that make sense given this child's and family's situation and mark the others N/A. This transition plan will have been developed more than 90 days before the child's anticipated date of transition (at age 2 or 3) even though it might be less than 90 days before the child actually transitioned. If

the family does not want to develop a plan, you would document that in a contact note. There will always be those children who exit without warning ... because the family declines all further services, the child moves, the family is lost to contact, etc. Unless that happens close to age 2 or 3, you probably won't have a transition plan in place, and your documentation of those exit circumstances will be sufficient to explain why there was no transition plan. We will be revising our record review forms for transition and will be sure to include a question/s or mitigating circumstance that allows you to clearly document these kinds of scenarios that might impact the existence or timing of a transition plan.

Procedural Safeguards

12. Is the 10-day timeline for responding to a parent's request to inspect and review records calendar days or business days?
    Calendar days
13. Since the surrogate parent cannot be a provider of any service to the child or a member of the child's family, does that exclude a guardian ad litem from serving as surrogate parents? What about foster parents?
    Foster parents are included under the definition of "parent" so no surrogate is needed in this situation. We are still investigating the question in relation to a guardian ad litem and post the response here once we have it. *Update 9/5/12: A guardian ad litem may serve as a surrogate parent as long as the child is not a ward of the state and the guardian ad litem meets the other criteria for a surrogate parent (see Chapter 3 of the Practice Manual)*.
14. How do you give prior written notice when the child is found not eligible?
    You use the Parental Prior Notice form and mark "Your child is not eligible for Infant & Toddler Connection of Virginia" and the reason.

Family Cost Share

15. For our current families, do we use the revised Family Cost Share Agreement form at the next IFSP review or annual or do we have to update everyone's now?
    For most families, you will move to the revised Family Cost Share Agreement form at their next annual though you may do so at the next IFSP review if you wish. You do need to remember, though, that families who are using their private insurance and whose services increase at an IFSP review will need to complete the new box on page 9 of the IFSP and will need to complete a new Family Cost Share Agreement form if they decide to decline use of their private insurance now that their services have increased.
16. Do all families check the Flexible Spending Account box on the Family Cost Share Agreement form even if they don't have a flexible spending account?
    Yes, all families check the Flexible Spending Account box on the Family Cost Share Agreement form. Since families' flexible spending account status may change during the time the Family Cost Share Agreement is in place, this checkbox ensures all families have been informed about the policy related to payment of co-pays, co-insurance and deductibles if they have a flexible spending account that automatically pays their family or the provider for those costs.
17. If the family started a Medicaid application before we interact with them and they check the box on the Family Cost Share Agreement allowing us to routinely check for

Medicaid coverage, then we don't have to use an agency-specific release to do this, correct?

That's correct. You do not need to use an agency-specific release in this situation. The statement on the Family Cost Share Agreement gives you the consent you need to routinely check for Medicaid coverage.

18. What if there are not extenuating circumstances for the family not providing income information at the initial or annual IFSP, do we still use the same process and form?

    Even if the family just forgot to bring their income information, you will use the Temporary Family Cost Share Agreement form to document the family's choices about starting services and to ensure they understand their responsibilities for providing the financial information and for paying for services if they choose to begin services prior to determining a monthly cap.

19. If a family opts to start services and receives one month of services then declines further services how are the costs determined? Full fee?

    If, at the end of the 30 days, the family declines further services and declines to provide the income information necessary to access the sliding fee scale, then the family would be responsible for paying the full early intervention rate for services that were delivered during that 30-day period (or the full amount of co-pays and deductibles if they had consented to use of private insurance to pay for covered early intervention services).

20. If the family has private insurance but is not able to provide their income information would we use the top section of the Family Cost Share Agreement form and the Temporary Family Cost Share Agreement form?

    Yes, you can use the Family Cost Share Agreement form to document the family's consent to use their private insurance and the Temporary Family Cost Share Agreement form to document that they are unable to provide income information to access the sliding fee scale. Once you receive the income information, you will revise the Family Cost Share Agreement form accordingly.

21. Is it possible to add a box on the Temporary Family Cost Share Agreement form stating that I agree to have my private insurance billed?

    Since the forms have been available for several days now and since we had encouraged folks to start making changes in their electronic health records and to copies of the forms, we will not add that box right now. However, we will have the opportunity over the next year to make additional changes to the forms as needed to ensure consistency with the state regulations we'll be developing and with any additional interpretation or guidance that may come from the federal level and to ensure the forms are working well for families and providers. We will consider this suggested change as continue to review forms in the coming months.

22. If the family wants to delay services until they can provide their income information, how does that impact the 30-day timeline for starting services?

    This would be a family reason for a delay in the timely start of services and will not negatively impact the local system's compliance with the 30-day timeline requirement.

23. If the family's Medicaid ends and they have signed a Family Cost Share Agreement because of the change in Medicaid coverage do we return and tell them they pay full fees?

    If the family's Medicaid coverage ends, then a new Family Cost Share Agreement form must be completed to document not only the family's loss of Medicaid coverage but also the family's new monthly cap, if that has changed. While the family had Medicaid, they could check the box in the Charges section

of the Agreement form showing that their family cost share was $0 because they had Medicaid. They will now need to provide income documentation or a statement that they have no income in order to determine their monthly cap. They would only be at full fee if they declined to provide any income documentation.

24. Please explain again what happens at the IFSP Review if the family's cost share is $0.

    The family's monthly cap does not change at the IFSP Review. The only time you need to do anything related to family cost share at the IFSP Review is if the family is using their private insurance to pay for early intervention services and services are increasing as a result of the IFSP Review. If that's the case, then the family must document on page 9 of the IFSP whether they continue to consent to use of their private insurance or if they now decline use of their private insurance since services have increased. If they now decline use of their private insurance, then a new Family Cost Share Agreement must be completed, indicating that the family declines use of their private insurance to pay for early intervention services. This does not mean that their monthly cap changes. *The only time you need to re-evaluate the monthly cap is at the annual IFSP and any time the family lets you know that their financial situation has changed (e.g., income, family size).*

25. If a family has Medicaid and private insurance, can they opt out of having private insurance billed thus only having Medicaid billed? Does this meet the requirement of Medicaid being provider of last resort?

    A family may decline use their private insurance and Medicaid will still pay for the service as long as the Family Declining to Bill Private Insurance form (also called the TPL form) is completed. This does meet the requirement for Medicaid to be the payor of last resort.

26. If you do the Family Cost Share Agreement at intake, is it valid for 365 days or until the annual IFSP, which will be more than 365 days later?

    It is valid until the annual IFSP.

27. Why has the Fee Appeal Form not been included with the new Rights document or Family Cost Share Agreement form.

    The Fee Appeal Form is a separate form that may be used in conjunction with the Family Cost Share Agreement. There have been no changes to the Fee Appeal Form. Notice of Child and Family Rights and Safeguards Including Facts About Family Cost Share still covers the fee appeal procedures.