

State of Indiana
Family and Social Services Administration
Division of Disability and Rehabilitative
Services
First Steps
Revenue Analysis
Recommendations Report
Public Consulting Group, Inc.

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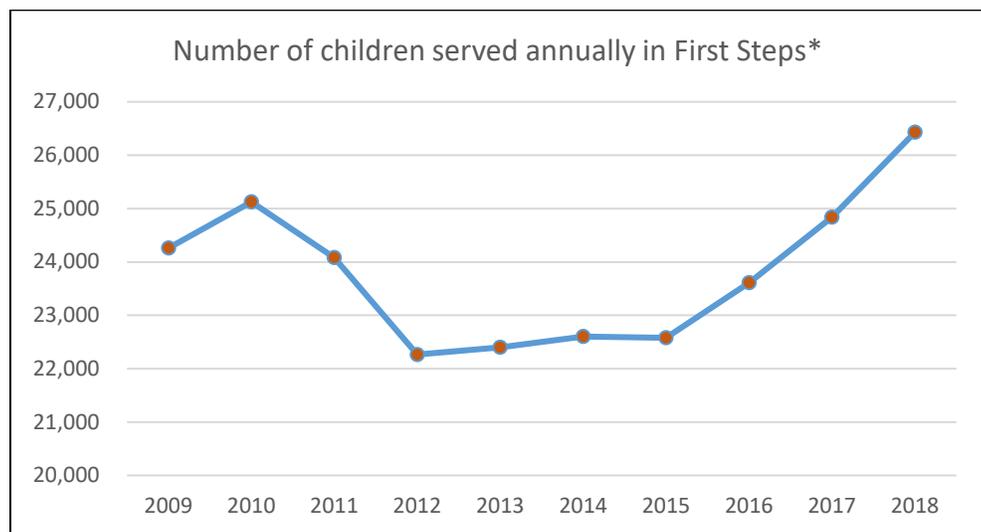
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EXECUTIVE SUMMARY

First Steps is Indiana's early intervention program under Part C of the Individuals with Disabilities Education Act (IDEA). First Steps serves young children, birth to age 3, with developmental delays or disabilities and their families. In the first three years of a child's life, more than one million new neural connections form every second. These early years are a time of great opportunity and great vulnerability, as early experiences literally shape the brain's architecture to support either a strong or fragile foundation for all future learning, health, and success. The purpose of First Steps and early intervention is to promote young children's lifelong success by supporting the optimal development of infants and toddlers and enhancing the capacity of families to meet the needs of their young children.

First Steps is a program of the Division of Disability and Rehabilitative Services (DDRS) in the Indiana Family and Social Services Administration (FSSA). The program provides services primarily in a child's home or other natural environments. Services such as assistive technology; developmental therapy; family training, counseling, and home visits; nutrition services; occupational therapy; physical therapy; service coordination (i.e., case management); social work services; speech therapy; psychological services; and vision services are examples of some of the 17 services required at a minimum by Part C regulations. As a federal entitlement program, First Steps serves families at all income levels; however, more than half of the families served fall below 250 percent of poverty.

As an entitlement program, First Steps does not have a wait list for services. Referral rates continue to rise with no signs of abatement and while this has allowed children in need to receive vital services, it has also created service delivery and fiscal challenges First Steps received 27,952 referrals in 2017—an 8 percent increase from the previous year and a 23 percent increase since 2012. The total number of children served in 2017 with an individualized family service plan, or IFSP, was 20,775. The growth of First Steps is illustrated not only in rising referral rates, but also in the rising proportion of children who are eligible for services. This includes children who have been exposed pre- or postnatally to drugs, alcohol, or other toxic substances and are eligible for First Steps on the diagnosis of exposure alone.



¹ Annual, unduplicated count of children served regardless of IFSP. This includes eligible children who received an IFSP and early intervention services as well as children who were referred to First Steps and received evaluation and assessment services but were not eligible for early intervention services.

During Indiana's 2018 legislative session, House Bill 1317 was introduced with a requirement that FSSA/DDRS conduct a study of First Steps service provider and service coordinator reimbursement rates. In total, HEA 1317² required:

- A comprehensive rate and time study for First Steps providers and System Point of Entry (SPOE) personnel,
- A comprehensive analysis of First Steps revenue sources and fund recovery systems,
- The identification of new or improved ways to leverage available funding for early intervention services,
- Consultation with other state agencies on the projected number of children who will need early intervention services as a result of drug exposure, and
- The identification of service gaps statewide and the number of early intervention professionals needed to provide First Steps services over the next five (5) years.

This report examines ways in which DDRS can improve utilization of available funding sources for early intervention and is one of three reports compiled in response to the requirements of HEA 1317. The second report, on the rate and time study, provides the results of the study and recommendations for DDRS around reimbursement rates. A third report addresses projected program growth, First Steps service gaps, and anticipated personnel needs moving forward.³ FSSA hired Public Consulting Group, Inc. (PCG) to complete the rate study and revenue source analysis. The report on program growth and service gaps was compiled independently by FSSA/DDRS.

The comprehensive analysis of First Steps revenue sources and fund recovery systems examined closely the ways in which DDRS might improve existing fund recovery efforts in First Steps as well as realize additional funding options. Based on the review of the current system of payment as well as the research of other state's policies and procedures regarding early intervention funding, this report concludes with the following recommendations for Indiana's consideration:

- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid Claiming:**
Leverage federal Medicaid dollars for EI services, including Developmental Therapy-Special Instruction with a portion of current state appropriations via EPSDT provisions of Medicaid.
- **Additional forms of 1915i state plan amendments or 1915(b) and (c) Medicaid Waivers:**
Explore ways to deliver and pay for early intervention services through Medicaid Waivers, which allow states to access federal funding by waiving certain Title XIX requirements.
- **Expand/Enhance Access to Private Insurance Funding:**
Explore ways to expand or enhance access to private insurance to fund various early intervention services by creating statutory language centered on parental consent and parental risks, as well as other policy/procedural updates.
- **Expand Provider Cost Reporting Requirements**
Explore option to request more frequent cost reporting from providers to better understanding fiscal health and frame policy around reimbursement.
- **Enhance Case Management and Billing Technology Solution:**
Explore enhancements to reporting and billing functionality to improve access to real-time data essential to making policy decisions.

These recommendations were developed to help DDRS examine additional revenue options for early intervention services and identify the state funding being used, in order to better utilize federal funds and other funding sources. Supporting early intervention has a significant return on investment for the families

² <http://iga.in.gov/static-documents/4/2/2/4/4224a870/HB1317.06.ENRS.pdf>

³ All three reports can be found on the First Steps website at <https://www.in.gov/fssa/ddrs/4655.htm>.

served by First Steps and the state of Indiana as a whole. New research from James Heckman, Nobel Laureate in Economics, indicates a 13 percent return on investment for birth to five programming compared to the 7 to 10 percent return established for preschool investments alone.⁴ Research indicates that investing early is more effective and less costly than addressing problems later on, and investing in young children can improve numerous outcomes relating to health, crime, education, and income. By working to implement the recommendations in this report, Indiana can achieve its goal of promoting lifelong success for the young children and families served by First Steps.

I. PROJECT BACKGROUND

Indiana's First Steps early intervention program is a federal entitlement program provided under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. 1431 et seq. and 34 C.F.R. 303 et seq. First Steps provides services primarily in a child's home or other natural environments. Services such as assistive technology; developmental therapy; family training, counseling, and home visits; nutrition services; occupational therapy; physical therapy; service coordination (i.e., case management); social work services; speech therapy; psychological services; and vision services are examples of some of the 17 services required at a minimum by Part C regulations.

The Division of Disability and Rehabilitative Services, or DDRS, is Indiana's lead agency for IDEA Part C and as such is responsible for developing and implementing the required statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services known as First Steps. Implementing this system includes coordinating payment for early intervention services among a myriad of public and private sources. Early intervention services are typically funded through a variety of channels including Medicaid, private insurance, family fees (cost participation), and federally appropriated funds under Part C. In Indiana, early intervention services are funded by the aforementioned sources in addition to Temporary Assistance for Needy Families (TANF) funding, Social Services Block Grant (SSBG) funding, and State Part C appropriations. A breakdown of First Steps funding is as follows:

Funding Source	Percent of Total Funding
Temporary Assistance for Needy Families (TANF)	41%
Medicaid	18%
Federal Part C	17%
State Part C	10%
Private Insurance	7%
Social Services Block Grant (SSBG)	5%
Family Cost Participation	2%

Federal Part C regulations require that certain services be provided at no cost to families. Such services include child find and public awareness activities, evaluation and assessment activities (including eligibility determination), service coordination, administrative and coordinative activities related to the development, review, and evaluation of IFSPs and interim IFSPs, and the implementation of procedural safeguards. Family fees can be assessed on all other early intervention services, and this fiscal analysis project focused mainly on improved revenue services for actual services to children.

⁴ "13% ROI Research Toolkit." Heckman: The Economics of Human Potential. Retrieved from: <https://heckmanequation.org/resource/13-roi-toolbox/> on July 17, 2018.

The Indiana Family and Social Services Administration (FSSA), Division of Disability and Rehabilitative Services (DDRS) contracted with Public Consulting Group (PCG) to conduct a fiscal analysis of the First Steps program in alignment with the requirements of House Enrolled Act (HEA) 1317. HEA 1317 requires DDRS to conduct a comprehensive review, evaluation, and analysis of First Steps' current revenue sources, payment methodology, and fund recovery systems in order to identify potential opportunities to enhance or maximize the available funding resources.

The analysis was guided by the following three research questions:

- What is the “current state” of Indiana’s First Steps financial system, including revenue resources, payment methodology, and fund recovery systems?
- What are areas that Indiana First Steps can improve upon their financial system to maximize revenue and how would they do so?
- How do federal and Indiana-specific rules, regulations, and fiscal policies affect the current state regarding the program’s financial system and how would they affect a “future state?”

The following report builds on preliminary findings by revisiting the analysis methodology, exploring various fiscal elements of the First Steps program, pinpointing strengths and opportunities for improvement, and identifying recommendations for DDRS and First Steps moving forward. This report is one of two reports published as part of the First Steps fiscal analysis. The other report centers on the rate and time study for early intervention service providers and service coordinators. Both reports can be found on the First Steps website at <https://www.in.gov/fssa/ddrs/4655.htm>.

III. METHODOLOGY

Three major activities were performed to provide a comprehensive review of First Steps' revenue:

- High-level Analysis of First Steps' Funding Sources,
- Deep Dive into Billing and Claiming Data, and
- Stakeholder Interviews

These activities informed the findings set forth in this report. The following section outlines the methodology used for each major project activity.

High-level Analysis of First Steps Policies, Procedures, and Available Information

The fiscal analysis project included a comprehensive review, evaluation, and analysis of the First Steps' current fund recovery system, including payment methodology and revenue sources like Medicaid, Temporary Assistance for Needy Families (TANF), private insurance, and family cost participation. Specifically, the review included:

- 2014 Indiana TANF State Plan;
- Indiana State Medicaid Plan and relevant waivers and amendments;
- Billing and claiming procedures and policies;
- Billing and claiming submitted/paid/denied data;
- Medicaid and TANF eligibility information,
- Child count data;
- Claim denial reports;
- Sample System Point Of Entry (SPOE) and Provider contracts;

- Various administrative policies including general fund recovery processes; and
- Historical revenue and financial reports.

Analysis of Billing and Claiming Data

The analysis included a review of historical billing and claiming data for private insurance, Medicaid, and TANF funding sources. This data was aggregated and analyzed for potential trends, gaps, and opportunities for improvement. Several claim denial reports that detailed duplicated claim counts by Current Procedural Terminology (CPT) code was also reviewed.

Stakeholder Interviews

Three Peer states were identified for stakeholder interviews: Kentucky, Wisconsin, and Missouri. These states were chosen based on a combination of factors including similar IDEA Part C program size and noted programmatic features (e.g., Medicaid eligibility population, similar administrative/fiscal policies.)

Peer states were interviewed to determine “what works” regarding their fiscal policies, administration, and management, and to determine “pain points” or challenges. Some sample questions included:

- What is the approximate amount of federal funding the state receives?
- How is funding allocated to providers? Describe the contract structure between the state and providers.
- What do you wish you could change regarding the fiscal administration of your program? What are your restrictions to achieving this?
- What are some other lessons learned you have experienced in your role?

In addition to interviewing administrative employees in the selected peer states, several state-level Indiana personnel were interviewed. A sample of interview questions included:

- What revenue sources are currently being utilized by IN First Steps to fund the services the program provides?
- What resources are available to First Steps, but are not being utilized?
- What is the lifecycle of an early intervention claim in Indiana?
- Is the current fund recovery system in Indiana a good fit for the system and does it maximize potential revenues?
- How do Indiana’s fiscal policies for early intervention affect different areas and stakeholders of the First Steps program?

The information gathered from these interviews was helpful. Each interview provided insights into data collection challenges, claiming issues, and other matters affecting the state of Indiana.

IV. RECOMMENDATIONS

The following key revenue categories are presented in the *Recommendations* section for Indiana's consideration:

- **Medicaid:**
 - Funding for early intervention services and special instruction/development therapy (DT) claiming – Many states currently successfully claim DT services via EPSDT Medicaid provisions
 - Creation of a special populations waiver, such as HCBS or Medicaid Managed Care waivers
- **Private Insurance:**
 - Statutory reform or system of payment policy development have supported many states in increasing/maximizing private insurance support for early intervention
- **Cost Reporting:**
 - Institute a regular, standardized cost reporting process for providers
- **Technology**
 - Enhanced data and fund recovery system functionality can increase data availability and reporting capabilities

A. Medicaid

Recommendation A: Improve and expand Medicaid reimbursement for First Steps early intervention services by leveraging Early Periodic Screening, Diagnosis and Treatment (EPSDT) provisions.

The first recommendation regarding the First Steps revenue analysis is for Indiana to consider improving and expanding its leveraging of federal Medicaid dollars for early intervention services, including developmental therapy, with a portion of current state appropriations. The intent of this recommendation is not to make a case for new state appropriations for the early intervention program. Rather, it is to have a thorough knowledge about resources in the system to deploy them as effectively and efficiently as possible. Additionally, fund expansion activities identify new sources of revenue, opportunities to leverage additional dollars, or expand service support through collaborative relationships.

The Medicaid fund expansion recommendation includes:

- Leveraging Federal Medicaid dollars for early intervention services, including developmental therapy (DT) with a portion of current State appropriations, and
- Developing a special population waiver.

Steps and Functions to Implement EPSDT claiming

The following steps and functions are needed to implement EPSDT claiming:

- Step 1: Medicaid State Plan Amendment
- Step 2: Credentialing Process
- Step 3: Adherence to Requirements for Medicaid Billing

Step 1: Medicaid State Plan Amendment

Indiana's Medicaid statutes, regulations, and Medicaid State Plan will need to be updated in order to expand the use of Medicaid funds for early intervention services. Particular emphasis should be paid to gathering language utilized by other states. For an example of Virginia's State Plan language, included for its language regarding developmental therapy claiming, please reference **Appendix A** of this report.

Step 2: Credentialing Process for Developmental Therapy

Individuals who serve infants and toddlers need specialized knowledge and skills to work with the diverse young children, families, caregivers, and professionals involved in the early intervention system. They also must meet specific standards of competence. In order to realize Medicaid claiming for DT, states must define a credentialing program often referred to as infant-toddler personnel certification. This certification must then be required for specified providers of developmental therapy services in the early intervention program.

In general, state credentialing programs require that staff and providers submit an application that provides:

- Educational background,
- Continuing education credits covering specific competency areas, and
- Demonstrated competence in the field.

Individuals pursuing a certificate must earn all the required credits within a state-specified time period.

Indiana has the ability to construct a Medicaid approved credentialing system by utilizing available technical assistance and training resources. In many ways, a certification process approved by Medicaid would build on the foundation of the current training and technical assistance processes and tools. As part of the credentialing requirements, development therapists should also be required to obtain a National Provider Identifier (NPI). Indiana currently credentials their First Steps early intervention providers, but this system can be better aligned to meet Medicaid's requirements.

Step 3: Adherence to Requirements for Medicaid Billing

- Referrals **must** go through proper procedures to determine eligibility for services and to develop the Individualized Family Service Plan (IFSP).
- Developmental therapy services **must** be provided in accordance with IDEA Part C as indicated on the IFSP.
- Billing should be done directly to the state Medicaid agency via an electronic submission process.
- Billing must be done in a way that meets all federal CMS documentation requirements.
- Billing codes must be defined specifically in a way that accurately describes the service(s).

Service Documentation Requirements

Unless otherwise noted in the service definition, service documentation must include the following:

- Date of service provision,
- Name of service provided,
- Type of contact,
- Place of service,
- Purpose of the contact as it relates to the goal(s) in the IFSP,

- Description of the intervention provided,
- Duration of service,
- Assessment of the effectiveness of the intervention and the recipient's progress toward the goal,
- Signature and credentials or job title of the staff member who provided the service, and
- The service recipient's name, provider's Medicaid identification number and/or NPI, and record number.

More than one intervention, activity, or goal may be reported in one service note, if applicable.

Recommendation B: Consider additional forms of 1915(i) State Plan Amendments or 1915(b) and (c) Medicaid Waivers that could be used to target children and develop a coordinated set of services.

The Medicaid program is comprised of a State Plan and various Medicaid Waivers. A State Plan is a document that serves as an official agreement between the federal government and the State to administer the Medicaid program (Title XIX).

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(l) to the Social Security Act, which is similar to what is provided through 1915 (c) HCBS waivers. The significant difference, however, is that a 1915(i) does not require an individual to meet an institutional level of care in order to qualify for HCBS (at risk of institutionalization is a requirement for the waivers). States can apply for this option to offer services and supports before individuals need institutional care, while also creating a mechanism to provide these supports and services for qualifying individuals.

An August 2010 State Medicaid Director Letter (SMDL#10-015; ACA#6) describes some changes made to the 1915(i) section made by the Affordable Care Act (ACA).

In addition to a State Plan, a state can ask the federal government for opportunities to test new or existing ways to deliver and pay for health care services that require some flexibility to waive certain Title XIX requirements – these are called Medicaid Waivers. There are four primary types of waivers and demonstration projects:

- **Section 1115 Research & Demonstration Projects:** States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- **Section 1915(b) Managed Care Waivers:** States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- **Section 1915(c) Home and Community-Based Services Waivers:** States can apply for waivers to provide long-term care services in home and community settings.
- **Concurrent Section 1915(b) and 1915(c) Waivers:** States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly.

The 1915(c) waivers allow the provision of long term care services in home and community based settings. CMS allows for states to “offer a variety of services under an HCBS Waiver program”. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, and respite care. States can also propose ‘other’ types of services that may assist in diverting individuals from institutional settings.

- Indiana should consider implementing a Medicaid waiver for young children. A number of states have implemented 1915(c) Medicaid Waivers that Indiana can learn from. Many 1915(c) Medicaid Waivers are used to provide home and community based services for the developmentally and

physically disabled populations, but there is growing use of these waivers for children with early childhood mental health/behavioral health needs. Louisiana's Coordinated System of Care Waiver offers good model language for Indiana's consideration.

1915(c) Medicaid waivers can provide Indiana the flexibility to design a Medicaid program that meets the specific needs of the child population.

Work tasks associated with this recommendation include:

1. Identify special population.
2. Identify related costs to the ITP and other Medicaid programs.
3. Review other states with waivers for similar populations and review Indiana's existing waivers.
4. Interview DRS staff, providers, and other community groups about service gaps for the specified special populations
5. Explore waiver development
 - a. Identify the waivers that must be requested
 - i. "State wideness"
 - ii. "Comparability"
 - iii. Income and resource requirements
 - b. Define the waiver program
 - i. Eligibility requirements
 - ii. Services to be offered under the waiver
 - iii. Types of providers under the waiver
 - iv. Licensure and certification standards for each type of provider
 - v. Level of care requirements
 - vi. Geographic areas under the waiver
 - vii. Recipient appeal rights if the desired service is not offered
 - c. Determine methods that will be used to satisfy CMS procedural requirements
 - i. Methods of informing recipients about waiver services
 - ii. Evaluating recipients' needs
 - iii. Documenting level of care
 - iv. Developing plans of care
 - v. Post-eligibility treatment of income and resources (applying excess income to the cost of waiver services)
 - vi. Independent assessments (often waived)
 - vii. Annual reports
 - viii. Quality assurance and standards enforcement
 - ix. Audits (may be covered through single state audit)
 - d. Determine the cost and impact of the waiver program
 - i. Projected caseloads
 - ii. Utilization of waiver and non-waiver services
 - iii. Average per capita costs
 - iv. Room and board exclusion
6. Prepare a written report with findings and recommendations for implementation

As an additional note, parental refusal to participate in medical assistance programs should be addressed through targeted awareness and information activities, as parental refusal is often based on under-informed decision-making. A comprehensive training and communication effort aimed at parents of qualifying children related to increasing medical assistance participation can further alleviate burden on state funds.

B. Private Insurance

Recommendation C: Consider expanding or enhancing System of Payment policies and/or pursuing statutory changes focused on the use of private insurance to support early intervention services.

Private insurance is identified in federal statute as an intended payor for early intervention services. As the need to create diverse funding structures for Indiana's early intervention services, it is recommended that Indiana move towards increasing access to private insurance support for early intervention services, as authorized in 34 C.F.R 303.520. Indiana might also consider seeking statutory language that addresses the parental consent and parental risk issues, such as parents refusing access to their insurance out of fear that they will max out their premiums. One of the more innovative approaches would be to establish a "First Dollar" pool from insurance carriers comparable to Massachusetts.

Work tasks associated with this recommendation include:

- Develop a set of recommended policy and procedure changes that will have positive impact on private insurance support for early intervention services. Particular attention should be paid to inform FSSA and DDRS leadership what options exist within the framework of IDEA Part C that has been successful in other states (see Massachusetts recommendation above).
- Develop draft and final policy letters based on DDRS accepted policy changes/choices.
- DDRS should coordinate closely with OSEP⁵ on the required steps to implement policies or policy changes-including System of Payment requirements or changes, requirements for public comment, and steps to receive OSEP approval.

Implementation tasks/functions associated with private insurance opportunities should focus on several key areas:

- Requiring and supporting the enrollment/credentialing of early intervention providers in private insurance networks,
- Developing detailed provider billing procedures,
- Training providers on proper documentation and claiming requirements, and
- Expansion of current First Steps fund recovery efforts to support or improve provider training/claiming/accounts receivables.

First Steps' current fund recovery system must be enhanced to improve the long-term statewide management of the finances for early intervention services:

- All relevant state, federal and local resources available to support early intervention services and activities are identified and maximized.
- Providers are reimbursed in a timely manner for early intervention services rendered.
- Financial and data reporting needs of various federal, state, and local funding sources are met.
- Duplication of effort to collect, maintain and report relevant data is minimized or eliminated.

⁵ The Office of Special Education Programs (OSEP) in the U.S. Department of Education is the lead federal agency for the Individuals with Disabilities Education Act, or IDEA, which includes Part C early intervention.

- Duplication of effort to collect data, manage third party billing, establish contracts is minimized or eliminated
- Efficiency and consistency across the state system is achieved as it relates to contracts, private insurance billing, documentation requirements, and accounting/reimbursement practices.
- A comprehensive data and financial system that can monitor and manage the level of early intervention resources is developed/implemented.
- Billing and documentation procedures are consistent statewide.

C. Cost Reporting

Regular and ongoing cost reporting from early intervention providers is recommended. This will provide essential financial information to DDRS, provide an impetus for EI providers to develop structures for data collection and reporting, and facilitate oversight and accountability within the EI program. There are several options for how to proceed with ongoing cost reports.

Three decision points for DDRS to consider are the structure, the frequency, and the universality of future cost reporting processes.

- Structure (agency providers): Develop and use a standardized cost reporting tool for agencies to complete on an annual basis.
- Structure (independent providers): The agency tool will not likely be an appropriate tool for independent providers, but other additional options are available:
 - Develop an online reporting tool. Since independent providers may have simpler structures than agencies, an online tool may facilitate quicker and easier cost report submission.
 - Use an Excel tool akin to the current agency tool, but simplified to eliminate irrelevant cost categories (e.g., indirect staff expenses).
- Frequency: Ideally, cost data would be collected yearly, but the process is labor-intensive for all involved. Two options are:
 - Yearly cost reporting.
 - Regular but less frequent cost reporting (e.g., every 2 to 4 years). The routine should be understood by providers so that they can plan accordingly.
- Universality: Again, ideally, all providers would fill out the cost report, but this is labor-intensive for both providers and for DDRS. Two options to consider:
 - All providers provide cost reports. This could be on a yearly basis or on a rotation (e.g., 1/2 of providers every two years or 1/3 of providers every three years).
 - A sample of providers provide cost reports. This lessens the work required from DDRS, but since all providers might be in any given year's sample, it still induces data collection and accountability.

If DDRS proceeds with regular cost reporting, the following recommendations apply to facilitate ongoing cost reporting efforts:

- Provide prior notice about cost reporting process and requirements to all providers by amending contractual arrangements to ensure notice and requirements. This will yield three benefits:
 - Providers will be able to collect and provide quality data on their cost reports.
 - Providers will be able to plan ahead for data collection and CPA engagement, which should lessen their burdens of time and money in completing the cost report.
 - DDRS will be able to proactively frame the purpose and process of the cost report.
- Maintain a structure for training and technical assistance. During the cost reporting undertaken as part of the First Steps fiscal analysis, providers had many questions about how to fill out the cost report. Although familiarity with the process may grow over time, turnover among personnel or

provider agencies will always mean that new people will be engaging with the cost report process. Available training and technical assistance both aid in the successful completion of the cost reports and provide another avenue for provider communication and feedback.

- Continually incorporate provider feedback into cost reporting process.

Please note that this report on the First Steps revenue analysis is one of two reports on the overall First Steps fiscal analysis. The second report includes information about the cost reporting referenced in this section.

D. System Enhancements

First Steps should consider implementing a fully integrated technology solution with enhanced reporting and time tracking functionality to ensure accurate real-time billing and claiming, case management record keeping, and the ability for the State and providers to perform valuable ad-hoc reporting and analysis. As an example, the data request associated with the completion of this project revealed that data related to eligibility was not available on a real-time basis and was not easily available through reports. Enhancing data entry and reporting functionality would ensure better access to real time data for the state and providers.

The availability of canned and ad-hoc reporting capabilities for the First Steps system should be expanded and guided to be easily configurable. Reporting should support both users who need quick and comprehensive program insights and users who need reports for mandated federal and state reporting. In addition, these reports should be available in multiple formats (such as PDF, Excel, and CSV) to fit the user's needs. Examples of reports that should be available to First Steps are:

- Monthly Core Reports
 - Provider agency state fiscal year payment history summary
 - Medicaid revenue
 - Family cost share revenue
 - Family cost share A/R
 - Bank reconciliation including inappropriate and/or incorrect payments
 - Helpdesk summary
 - Fiscal year summary
- Medicaid Claiming
 - Claims activity summary
 - Claims activity detail
 - Rejection and denial summary
 - Rejection and denial detail
 - Claims service line count
 - Service payment by service type and code
 - Actual claims versus planned levels of service
 - Other ad hoc reports
 - Summary and detail of Medicaid payments
- Commercial Insurance Claiming
 - Claims activity summary
 - Claims activity detail
 - Rejection and denial summary
 - Rejection and denial detail
 - Claims service line count
 - Service payment by service type and code
 - Actual claims versus planned levels of service

- Other ad hoc reports
- Summary and detail of Insurance payments

In addition to a comprehensive suite of reports that should be made available for First Steps and other users' access, the program should seek to implement a truly integrated system that is scalable, dynamic, and web-enabled. Ideally, it should seamlessly track children and families from referral through transition and discharge, while collecting all the information that is required to conduct HIPAA compliant billing and claiming to Medicaid and commercial insurance, and manage any family cost participation processes.

This ideal system should be a single, integrated web-based solution that manages child intake, document creation, early intervention service documentation, and reporting management. By having an integrated system, the state can provide and manage a continuum of services and care in one interface with one login. Furthermore, it will enhance reporting capabilities, mitigate audit risk, bolster security, and enable one source of training and support, and allow the state to clearly view and manage the entire early intervention process from referral and evaluation/eligibility to the development of the IFSP.

With this integration, EI agency, program, personnel, family, and child information can be tracked as one to allow for stronger reporting capabilities, and track service coordination, service authorizations, progress notes, and delivered services. With all of this information together, the state will then have the ability to track claims details by payer for each of the delivered services at a child-level.

Further enhancements should be data-driven and process-based, compelling all users to enter all required data in a systematic manner compliant with the State's early intervention policies and with error checking and validation rules occurring throughout all related processes to ensure compliance and completeness at all levels. Billing and claiming portal enhancements should be related to the following:

- Credentialing—the system should track the status of provider credentialing. Using intelligent editing, the system should not bill claims if a provider has not completed the credentialing process.
- Enrollment with Medicaid—it should use intelligent payer controls and track the enrollment status of providers with Medicaid. This enrollment should be tracked both for claims and remittances.
- Licensure and Specialty—this system should have provider profiles that display the provider specialty, as well as licensure on file for the billing provider. It should also track rendering therapists associated with the billing provider.
- Duplicate Billing—Providers should be alerted to duplicate billing situations through front-end edits
- Electronic Funds Transfer (EFT) enrollment—Within the system's provider setup screens, a provider can access and maintain their EFT enrollment.

APPENDIX A. SAMPLE STATE PLAN AMENDMENT AND EI BILLING CODES

In the following section, please find the State Plan Amendment (SPA) language regarding EPSDT and the early intervention billing codes for the Virginia. It is recommended that DDRS use this information as the primary example should they consider updating their SPA language. The Virginia documentation is a great resource for DDRS because it centers on EPSDT and Developmental Therapy and received recent approval from CMS.

State Plan Amendment

12 VAC 30-50-131. Services provided by certified Early Intervention practitioners under EPSDT.

A. Definitions. The following words and terms when used in these regulations shall have the following meanings unless the context clearly indicates otherwise:

"DBHDS" means the Department of Behavioral Health and Developmental Services, the lead State agency for Early Intervention services appointed by the Governor in accordance with Chapter 53 of Title 2.2 (§ 2.2-5304) of the Code of Virginia.

"Early Intervention services" means services provided through Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.), as amended. Early Intervention services are specialized rehabilitative services covered in accordance with 42 CFR 440.130(d), which are designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and are provided to children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay.

"Individualized family service plan" or "IFSP" means a comprehensive and regularly updated statement specific to the child being treated containing, but not necessarily limited to, treatment or training needs, measurable outcomes expected to be achieved, services to be provided with the recommended frequency to achieve the outcomes, and estimated timetable for achieving the outcomes. The IFSP is developed by a multidisciplinary team which includes the family, under the auspices of the local lead agency.

"Local lead agency" means an agency under contract with the Department of Behavioral Health and Developmental Services to facilitate implementation of a local Early Intervention system as described in Chapter 53 of Title 2.2 (§ 2.2-5304.1) of the Code of Virginia.

"Primary care provider" means a practitioner who provides preventive and primary health care and is responsible for providing routine Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening and referral and coordination of other medical services needed by the child.

B. Coverage for Early Intervention services.

1. Early Intervention services shall be reimbursed for individuals younger than 21 years of age who meet criteria for Early Intervention services established by DBHDS in accordance with Chapter 53 of Title 2.2 (§ 2.2-5304) of the Code of Virginia.

2. Early Intervention services shall be recommended by the child's primary care provider or other qualified EPSDT screening provider as necessary to correct or ameliorate a physical or mental condition.

3. Early Intervention services shall be provided in settings that are natural or normal for an infant or toddler without a disability, such as the home, unless there is justification for an atypical location.
 4. Except for the initial and periodic assessments, Early Intervention services shall be described in an IFSP developed by the local lead agency and designed to prevent or ameliorate developmental delay within the context of the Early Intervention services system defined by Chapter 53 of Title 2.2 of the Code of Virginia.
 5. Medical necessity for Early Intervention shall be defined by the IFSP. The IFSP shall describe service needs in terms of amount, duration, and scope. The IFSP shall be approved by the child's primary care provider.
 6. Covered Early Intervention services include the following functions provided with the infant or toddler and the child's parent or other authorized caregiver by a certified Early Intervention professional:
 - a. Assessment, including consultation with the child's family and other service providers, to evaluate:
 - (1) the child's level of functioning in the following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development;
 - (2) the family's capacity to meet the developmental needs of the child; and
 - (3) services needed to correct or ameliorate developmental conditions during the infant and toddler years. EI services include, but are not limited to, PT, OT, and Speech Therapy as described in 42 CFR 440.110 and Developmental/Rehabilitative Services as described in 42 CFR 440.130(d). All licensed PT, OT, and Speech Therapy providers shall comply with requirements of 42 CFR 440.110. All EI providers are certified to provide EI services by the Virginia Dept. of Behavioral Health and Developmental Services.
 - b. Participation in a multidisciplinary team review of assessments to develop integrated, measurable outcomes for the IFSP.
 - c. The planning and design of activities, environments, and experiences to promote the normal development of an infant or toddler with a disability, consistent with the outcomes in the IFSP.
 7. Covered Early Intervention services include the following functions when included in the IFSP and provided to an infant or toddler with a disability and the child's parent or other authorized caregiver by a certified Early Intervention professional or by a certified Early Intervention specialist under the supervision of a certified Early Intervention professional:
 - a. Providing families with information and training to enhance the development of the child.
 - b. Working with the child with a disability to promote normal development in one or more developmental domains.
 - c. Consulting with the child's family and other service providers to assess service needs, plan, coordinate, and evaluate services to ensure that services reflect the unique needs of the child in all developmental domains.
- C. The following functions shall not be covered under this section:

1. Screening to determine if the child is suspected of having a disability. Screening is covered as an EPSDT service provided by the primary care provider and is not covered as an Early Intervention service under this section.
2. Administration and coordination activities related to the development, review, and evaluation of the IFSP and procedural safeguards required by Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1431 et seq.).
3. Services other than the initial and periodic assessments that are provided but are not documented in the child's IFSP or linked to a service in the IFSP.
4. Sessions that are conducted for family support, education, recreational, or custodial purposes, including respite or child care.
5. Services provided by a relative who is legally responsible for the child's care.
6. Services rendered in a clinic or provider's office without justification for the location.
7. Services provided in the absence of the child and a parent or other authorized caregiver identified in the IFSP with the exception of multidisciplinary team meetings, which need not include the child.

D. Qualifications of providers:

1. Individual practitioners of Early Intervention must be certified by DBHDS as a qualified Early Intervention professional or Early Intervention specialist and hold a valid Medicaid Early Intervention provider agreement.
2. Certified individuals or service agencies or groups who employ or contract with certified individuals may enroll with DMAS as Early Intervention providers. In accordance with 42 CFR 431.51, recipients may obtain Early Intervention services from any willing and qualified Medicaid provider who participates in this service, or for individuals enrolled with a Managed Care Organization (MCO), from such providers available in their MCO network.
3. Certified EI practitioners are qualified to provide a specialized rehabilitative service for young children with developmental delays. Certified individuals and agencies will enroll with DMAS and bill for this specialized rehabilitative service as an EPSDT Early Intervention provider rather than as a speech therapist, rehabilitation facility, or other designation. EI providers are certified or licensed to provide services within the scope of their practice as defined under state law. All licensed physical therapy and occupational therapy providers, and those providing services for individuals with speech, hearing, and language disorders shall comply with requirements of 42 CFR 440.110.

2 VAC 30-80-96. Fee-for-service: Early Intervention (under EPSDT).

A. Payment for Early Intervention (EI) services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) of 2004, as set forth in Supplement 1 to Attachment 3.1-A&B, Page 6.17 of 41, for individuals younger than 21 years of age shall be the lower of the state agency fee schedule or actual charge (charge to the general public). All private and governmental fee-for-service providers are reimbursed according to the same methodology. The agency's rates were set as of October 1, 2009, and are effective for services on or after that date. Rates are published on the agency's website at www.dmas.virginia.gov.

B. There shall be separate fees for:

1. certified Early Intervention professionals who are also licensed as either a physical therapist, occupational therapist, speech pathologist, or registered nurse and certified Early Intervention specialists who are also licensed as either a physical therapy assistant or occupational therapy assistant and
 2. all other certified Early Intervention professionals and certified Early Intervention specialists.
- C. Provider travel time shall not be included in billable time for reimbursement.
- D. Local Education Agency (LEA) providers provide Medicaid-covered school health services for which they are reimbursed on a cost basis pursuant to Attachment 4.19-B, pages 9a through 9f of 15. LEAs may also be certified as, and enrolled to provide, Early Intervention services. LEAs providing such services shall be reimbursed for EI services on a fee-for-service basis in the same manner as other EI providers. The fee-for-service rate is the same regardless of the setting in which LEAs provide EI services.

EI Billing Codes

EI Service Type		Reimbursement Category 2	Setting
Assessment for Service Planning and Development of IFSP Annual Renewal of the IFSP	T1023 U1	T1023	Natural environments or Center-based
Team Treatment activities, Team Meetings, Assessments done after the initial assessment for service planning	T1024 U1	T1024	Natural environments
Developmental Services provided for more than one child by one provider	N/A	T1027	Natural environments
Developmental Services provided by one provider for one child	N/A	T1027 U1	Natural environments
Center-based group developmental services	T1026	N/A	Center
Center-based individual developmental services	T1026 U1	N/A	Center
Center-based group developmental services	N/A	T1015	Center
Center-based individual developmental services	N/A	T1015 U1	Center
Congregate PT	G0151	N/A	NE
Individual PT	G0151 U1	N/A	NE
Congregate OT	G0152	N/A	NE
Individual OT	G0152 U1	N/A	NE
Congregate SLP	G0153	N/A	NE
Individual SLP	G0153 U1	N/A	NE
Congregate Nursing	G0154	N/A	NE

Scenario I-Center Based Services

If you are a physical therapist who is providing a group treatment session in a center-based environment, you will bill T1026 without a modifier. If you are a physical therapist providing an individual treatment session in a center-based environment, you will bill then bill T1026 with the U1 modifier because individual services are paid at a higher rate than group services.

Scenario II-Treatment Team

If you are a provider of developmental services (Reimbursement Category 2) participating in an IFSP team meeting with the family and child present, you would bill T1024 without the U1 modifier. If you are a physical therapist (Reimbursement Category 1) participating in a treatment team meeting with the family and child present, you would bill T1024 with the U1 modifier.



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