REPORT OF THE

JOINT SUBCOMMITTEE STUDYING EARLY INTERVENTION SERVICES FOR INFANTS AND TODDLERS WITH DISABILITIES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 107

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

Members

Delegate Mary T. Christian, Chair
Senator Yvonne B. Miller, Vice-Chair
Delegate Dwight C. Jones
Delegate M. Kirkland Cox
Delegate Kenneth R. Plum
Delegate Marian Van Landingham
Senator Malfourd W. Trumbo
Senator William C. Wampler, Jr.
The Honorable Emilie F. Miller
Dr. Miriam Carmichael
Helen Daniel

Staff

Division of Legislative Services

Amy Marschean, Staff Attorney
Gayle Vergara, Research Associate
Iris A. Kincaid, Operations Support Staff

House of Delegates

Dawn Smith, Committee Operations

TABLE OF CONTENTS

I. EXECUTIVE SUMMARY

The joint subcommittee found that early intervention services are of vital importance because they can prevent or mitigate problems for infants and toddlers with disabilities and their families. Also, it endorsed the Commonwealth's continued participation in the "Virginia Babies Can't Wait!" early intervention federal grant program under Part C of the Individuals with Disabilities Education Act. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is the lead agency for the development and implementation of this program, which is required to be a statewide, comprehensive, coordinated and interagency system. Virginia moved into statewide implementation of the program on September 30, 1993.

Since 1990, the joint subcommittee has made a number of recommendations that have facilitated the implementation and effectiveness of the Commonwealth's early intervention services program. The joint subcommittee:

- recommended a definition of eligibility that is as inclusive as possible and included children at risk of developmental delay when economically feasible;
- endorsed cultural diversity in all aspects of the early intervention program and recommended strategies to alleviate early intervention personnel shortages;
- established a program infrastructure in the Code of Virginia, § 2.1-760 et seq.;
- worked to ensure that infants and toddlers with disabilities eligible under the early intervention program receive medically necessary services through Medicaid Managed Care Organizations; and
- recommended and witnessed the passage of legislation that mandated coverage of early intervention services under the State Employees Health Care Plan and by private insurers and health maintenance organizations.

Despite the many accomplishments of the Virginia Babies Can't Wait! early intervention program, the joint subcommittee identified various actions that need to be taken to improve the early intervention system. The joint subcommittee recommended that:

- the state agencies involved in the early intervention system obtain a data system that will collect, analyze, and report on Part C services, consumers, and funding on a consistent and comparable basis across agencies and localities statewide;
- the methodology and projections for Part C-eligible children under the current eligibility definition, which does not include children at risk of developmental delay, be updated;
- equitable and reasonable fees for early intervention services and consistent mechanisms to determine ability to pay be developed and implemented;
- the lead agency complete the development of standardized forms, data collection, and assessment instruments and strengthen the role of Part C coordinators;

- the coordination of interagency participation in the early intervention program be strengthened;
- the lead agency and the Virginia Interagency Coordinating Council (VICC) should continue their efforts to expand cultural diversity in early intervention services; and
- should the Governor transfer the lead agency responsibilities from the DMHMRSAS to another state agency, such a change must not disrupt local service planning, delivery, and funding and must involve extensive planning and public input.

II. AUTHORITY

House Joint Resolution (HJR) 164, agreed to by the 1990 General Assembly, established a joint subcommittee to study the programmatic and fiscal impact of the Commonwealth's implementation of Part H of Public Law (P.L.) 99-457, the Education of the Handicapped Act, which was subsequently reauthorized by Congress as Part H of P.L. 101-476, the Individuals with Disabilities Education Act (IDEA). After a year of intensive study and testimony from the lead agency, other state agencies, parents, the Virginia Interagency Coordinating Council (VICC), local councils, community services boards, other service providers, and experts in fiscal and other Part H matters, the Joint Subcommittee Studying Early Intervention Services for Handicapped Infants and Toddlers produced an interim report, House Document No. 59, 1991, which contained a number of recommendations, including continuation of the joint subcommittee. The General Assembly continued the joint subcommittee in 1991 with HJR 380, in 1992 with HJR 187, in 1993 with HJR 627, in 1994 with HJR 196, in 1995 with HJR 511, in 1997 with HJR 581, and in 1999 with HJR 725 (Appendix A). The change in the name of the Act reflected the preference for the use of "disabled" instead of "handicapped" and the joint subcommittee voted to change its name to reflect this preference. Clearly, the General Assembly has continued to be concerned about and interested in early intervention services for the past decade. This report summarizes the joint subcommittee's activities and presents its final findings and recommendations.

III. BACKGROUND

The federal Education of all Handicapped Children's Act of 1975 (Act), P.L. 94-142, intended that all states serve children with disabilities starting at age three and required states to set as a goal the availability of services beginning at birth. In 1986, Congress heard testimony that only one-half of the states had implemented mandates for services starting at age three and only five states had birth mandates. In response, Congress amended the earlier Act through Part H of Public Law 99-457 in 1986 to establish a program of special education beginning at birth, even though Congress recognized that the downward extension of special education law was perhaps not the best approach for serving infants and toddlers with disabilities.

Section 671(b) of Part H of P.L. 99-457 states that it is the policy of the United States that each state:

- develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for handicapped infants and toddlers and their families;
- facilitate the coordination of payment for early intervention services from federal, state, local, and private sources (including public and private insurance coverage); and
- enhance its capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to handicapped infants and toddlers and their families.

The Act specifies that "handicapped infants and toddlers" are individuals from birth through age two who need early intervention services because of actual developmental delays in certain areas or because of a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. The law charged each state with defining developmental delay, recognizing that the more broadly developmental delay was defined, the larger the number of children who would be served and the more costly the program would be. Because Part H is an entitlement program if a state elects to participate in it, all children found eligible under the definition are entitled to services. Not all Part C-entitled services are free of charge to families. As seen in Appendix B, only child-find activities, multidisciplinary evaluation and assessment, Individualized Family Services Plan (IFSP) development, service coordination, and mediation and due process are provided at no cost to families. For services identified on the child's IFSP, fees are charged. These services, however, cannot be denied due to a family's inability to pay. Therefore, ability to pay mechanisms must be in place. Even though the Part H (later Part C) program is discretionary, all 50 states have chosen to participate in it. [1]

State participation in the Part H program required the designation of a Part H lead agency. On June 3, 1987, Governor Gerald Baliles designated the Department of Mental Health, Mental Retardation and Substance Abuse Services as Virginia's lead agency because of its long history of supporting the provision of early intervention services through Community Services Boards (CSBs). State participation in the Part H program further required the establishment of a governor-appointed state interagency coordinating council for providing advice and assistance to the lead agency for the implementation of Part H. In March 1988, the Governor appointed the initial members of the VICC. The Council is comprised of parents, service providers, agency representatives and representatives from the state legislature, in accordance with federal law. The VICC chairs from 1988 through the present have been Frances Dunston, Gerry Desrosiers, John Frederick, Cheri Takemoto, and Anne Stewart.

The lead agency and the VICC have worked together to establish an organizational structure and framework for planning and service development. Together,

[1] In 1997, Public Law 105-17 amended the Individuals with Disabilities Act (IDEA) and changed Part H to Part C designation.

they established a planning sequence for the accomplishment of the following 16 federally-mandated components of an early intervention program.

1. Definition of Developmental Delay
2. Central Directory of Services, Providers, and Programs
3. Policy on Timetables for Serving All Eligible Children
4. Public Awareness Program
5. Comprehensive Child Find and Referral System
6. Evaluation, Assessment, and Nondiscriminatory Procedures
7. Individualized Family Services Plan (IFSP) and Service Coordination Services
8. Comprehensive System of Personnel Development
9. Policies and Procedures for Personnel Standards
10. Procedural Safeguards
11. Supervision and Monitoring of Programs
12. Lead Agency Procedures for Resolving Complaints
13. Policies and Procedures Related to Financial Matters
14. Interagency Agreements and Resolution of Disputes
15. Policy on Contracting
16. Policies and Procedures for Data Collection

The interagency agreement was signed in July 1990 and again in 1996 by the Secretary of Health and Human Resources, the Secretary of Education, and the heads of the agencies represented on the VICC (Departments of Health; Education; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; Social Services; the Departments for the Deaf and Hard-of-Hearing, the Visually Handicapped, and Rights of Virginians with Disabilities; and the State Corporation Commission Bureau of Insurance).

At the community level, 40 Local Interagency Coordinating Councils (LICCs) for early intervention, corresponding to the community services board service areas, were established. Local community services boards serve as the fiscal agents for 34 LICCs, but six councils are staffed through other agencies.

To enhance family involvement at the state level, a parent of a child with disabilities has served as the State Family Representative to the VICC since 1995. In 1997, five part-time Regional Family Representatives were hired by the VICC Family Support and Advocacy Committee.

In 1997, P. L. 105-17 amended the IDEA for five years with an authorization level of $400 million dollars and changed Part H to Part C designation. Part C of the IDEA is a federal grant program to provide early intervention services to infants and toddlers with disabilities and their families. With the reauthorization of the IDEA in 1997, Congress included a seventeenth federal component of the Part C law, "natural environments." This new component specifies that all Part C early intervention services, to the extent feasible, must be provided in a child's "natural" setting (e.g., home, day care center, church, etc.) as opposed to clinical settings. When services cannot be provided in

natural environments, the child's IFSP must include documentation as to the reason. [2] The Commonwealth's Part C program is currently known as the Virginia Babies Can't Wait! early intervention system.

IV. AN OVERVIEW OF THE EARLY INTERVENTION PROGRAM AND JOINT SUBCOMMITTEE ACTIVITIES: 1990-2000

For a decade, the joint subcommittee has had the broad directive to study the programmatic and fiscal impact of the early intervention program as it has been implemented. The joint subcommittee has made numerous recommendations that were offered for the General Assembly's consideration. Recommendations addressed statewide implementation, personnel shortages and cultural diversity in the early intervention field, enhanced interagency collaboration, and improvements in early intervention services under both the Commonwealth's Medicaid program and private insurance coverage. The continuous legislative oversight has resulted in many improvements in early intervention service delivery and increasing public awareness of this program.

A. STATEWIDE IMPLEMENTATION

The joint subcommittee met frequently in the formative years of the program to review background information on the federal law and regulations and the accomplishments of the lead agency and the VICC in creating Virginia's early intervention program infrastructure. Early program accomplishments included establishing the VICC's mission statement[3] and philosophy of service delivery[4] and its

---

[2] In 1998, the Virginia Association of Community Services Boards reported to the joint subcommittee that, because Virginia Code § 32.1-162.7 requires any organization that provides health services in the home to be licensed as a home care organization, early intervention programs provided in the child's natural environment might require such licensure. The joint subcommittee recommended, and the 1999 Session of General Assembly passed, two bills, House Bill 2569 and Senate Bill 1196, attached as Appendix C, which clarified that early intervention services provided to infants and toddlers with disabilities in accordance with Part C of the IDEA are not home health services, and thus the organizations providing those services are not required to be licensed as home care organizations.

[3] The VICC's current mission statement is "To advise and assist in planning the comprehensive system of early intervention services defined in the Individuals with Disabilities Act and to assure the implementation and evaluation of the coordinated, statewide, interagency, interdisciplinary system of services which enhances the capacity of families to meet the needs of their infants and toddlers with disabilities." (www.dmhmrsas.state.va.us/vababiescantwait/default.htm)

[4] The current VICC philosophy is:

1. Infants, toddlers, and their families have unique needs. Meeting those needs is a fundamental human right and responsibility of all families and a responsibility of our society.
2. Infant, toddler, and family needs should be identified early and families should have access to services as soon as needed.
3. The needs of infants, toddlers, and their families can be so complex that they cannot be met effectively by a single agency, provider, or discipline.
4. In order for service delivery to be comprehensive and coordinated, agencies and service providers need the skills and support necessary to work as a team to pool information and resources.
5. Appropriate early intervention services should be consistent throughout the Commonwealth of Virginia.

committee structure and bylaws. The VICC also developed policies and procedures for the 16 federally mandated components of the early intervention system.

In 1990, the lead agency engaged a health planning consultant to conduct a study to estimate the need for Part H early intervention services under working definitions of "developmental delay" and "at risk" categories of eligibility developed by the VICC. According to the definitions used for the study, eligibility existed if a child was developmentally delayed, had one or more specified physical or mental conditions, or had three or more risk factors. The study data projected that approximately 15,000 children statewide would qualify under the definitions at some point during the first three years of their lives and about 7,500 children would be eligible on any given day. In addition, 40,000 to 45,000 children were projected as having a single risk factor at any given time. The study found that the need for early intervention services varied considerably across the Commonwealth and that services should be targeted to those areas that have high-risk populations. A copy of the study is attached to this report as Appendix D.

The joint subcommittee recommended in 1990 that the lead agency and the Department of Medical Assistance Services explore the feasibility of amending the State Medical Assistance Plan to expand Medicaid coverage of early intervention services and of encouraging all early intervention providers to become Medicaid certified. Further, the joint subcommittee recommended that local and state agencies involved with the early intervention program hire staff members of diverse cultural backgrounds to reflect the cultural diversity of the families served by the program and endorsed inclusion of cultural diversity in all aspects of the program.

In 1990, the joint subcommittee received information on the amount of money that state agencies were spending to provide early intervention services to developmentally delayed infants and toddlers from birth through age two. The figures were gathered from those agencies that provided direct services: the Departments of Health; Education; Mental Health, Mental Retardation and Substance Abuse Services; and Social Services; and the Department for the Visually Handicapped. However, data were inconclusive due to the lack of standardized interagency data collection and reporting formats. It was also difficult to identify the amount of Medicaid spending involved because Medicaid claims may be submitted by a number of providers and do not identify early intervention services as a specific procedure code. Therefore, the joint subcommittee was unable to project the cost of the early intervention program.

---

6. Service delivery personnel must be sensitive to the cultural diversity among families and responsive to their varying levels of ability to participate with and to advocate for their children.
7. Families have the right to define their membership, the right to privacy and confidentiality, and the right to respect for themselves and their values.
8. Families have the right to professional honesty and information so that they can best determine their needs and make informed choices for their children.
9. In order to provide for the needs of infants and toddlers and their families, the Commonwealth must actively recruit and train adequate numbers of personnel, maintain high professional standards, and provide continuing education for practicing interventionists. (www.dmhmrsas.state.va.us/vababiescantwait/default.htm)

The joint subcommittee recognized the many problems that can be prevented when children receive services early in their lives and therefore endorsed the broadest possible definition of eligibility in 1990. However, due to financial uncertainty and a lack of resources, the VICC and the lead agency ultimately adopted a definition that did not include children at risk of developmental delay in 1991. Appendix E is Virginia's definition of developmental delay and eligibility procedures.

In 1991, the joint subcommittee recommended and the 1992 Session of the General Assembly passed a resolution to declare November as early intervention month. In addition, the joint subcommittee recommended legislation, House Bill 817 (1992), attached as Appendix F, which established the early intervention program infrastructure in the Code of Virginia (§ 2.1-760 et seq.), and a budget amendment in the amount of $250,000 for the biennium earmarked for Part H services. The legislation passed by the General Assembly (Code of Virginia § 2.1-760 et seq.) required the Secretaries of Health and Human Resources and Education to work together to promote interagency participation in the implementation of a statewide early intervention system. The Departments of Health; Education; Medical Assistance Services; Mental Health, Mental Retardation and Substance Abuse Services; and Social Services; the Departments for the Deaf and Hard of Hearing; the Visually Handicapped; and the Rights of Virginians with Disabilities; and the Bureau of Insurance within the State Corporation Commission were defined as participating agencies and are required to work together to plan and implement the statewide system. An early intervention agencies committee, composed of the agency heads of the participating agencies, is required to meet at least twice a year and make annual recommendations to the Secretaries of Health and Human Resources and Education on issues that require interagency planning, financing, and resolution. The VICC was continued and codified. The duties of the local public agencies were enumerated and each locality was required to establish, either singly or in combination with one or more other localities, a local interagency coordinating council (LICC).

In 1992, the joint subcommittee heard testimony from a national consultant on the benefits of moving to full implementation of the Part H early intervention program. In anticipation of full implementation, the lead agency reported that it had provided guidance to the LICCs on implementing House Bill 817 to ensure local interagency collaboration that would increase service capacity, strategies for accessing and maximizing use of resources, and cultural diversity training. Further, the lead agency reported that all local early intervention providers were required to obtain Medicaid certification or make arrangements with already certified providers. The lead agency contracted for the development of a guidance manual to assist local early intervention agencies in meeting the Medicaid certification requirements as outpatient rehabilitation agencies.

In 1992, the joint subcommittee recommended and the 1993 Session of the General Assembly passed HJR 626, which requested that "the Governor take all actions to implement fully early intervention services to infants and toddlers with disabilities in the Commonwealth and to ensure that the Commonwealth moves into the fifth year of the grant participation in the Part H program in 1993." See Appendix G. The General

Assembly passed HJR 186, designating November as early intervention month, but failed to pass a budget amendment recommended by the joint subcommittee to support pre-service training of early intervention personnel in allied health professions.

Virginia moved into statewide implementation of the Part H early intervention program on September 30, 1993. The lead agency reported to the joint subcommittee on completion of an interagency study on the shortage of allied health personnel in local school divisions and early intervention programs. In 1993, the joint subcommittee recommended, but the 1994 Session of the General Assembly failed to approve, a budget amendment in the amount of $250,000 to support pre-service training on family-centered care and cultural diversity and incentives for training allied health personnel to work in early intervention.

B. PERSONNEL SHORTAGES AND CULTURAL DIVERSITY

In 1994 and 1995, the joint subcommittee focused its efforts on the issue of Part H provider personnel shortages and established an ad hoc committee to study the issue. The stated goal of the Personnel Shortages Meeting on September 29, 1995, was to identify and develop feasible strategies for expanding the number and diversity of persons providing early intervention services for infants and toddlers with disabilities and their families. The recommendations and strategies for implementation presented to the joint subcommittee are attached as Appendix H. The recommendations are listed below.

- Make scholarship funds available for individuals who commit to working in the field of early intervention.
- Determine and implement strategies to increase the number of culturally diverse service providers.
- Increase the number of slots available for students in early intervention-related programs at institutions of higher education. Examine the initial start-up costs and the costs of maintaining the slots, space, and faculty to support this endeavor.
- Encourage educational institutions to cross-train students. Expand pre-service and in-service training for existing personnel.
- Examine licensing barriers.
- Support the expansion of paraprofessionals through Virginia's high school vocational technical system and community college system.
- Expand professions to include an early interventionist credential for those who do not hold a state certification or license in an existing profession. The new credential would support the retention of highly skilled early intervention personnel currently employed in the field and the recruitment of prospective personnel wishing to enter the field.

The lead agency and the Personnel Training and Development Committee (PTDC) of the VICC continue to address these significant personnel issues to ensure adequate staffing within early intervention, the quality of services provided, and accountability. By 1997, the PTDC developed personnel standards and a Comprehensive System of Personnel Development for those working with infants and

toddlers with disabilities to meet the requirements of the IDEA. Tuition assistance has been made available by the lead agency. The PTDC developed competency statements, described roles and responsibilities, and identified the degree of supervision for a paraprofessional, establishing an Early Intervention Assistant position within the Part H system.

In April 1997, the PTDC reviewed preliminary results of a Diversity Questionnaire that was sent to persons working in early intervention programs. Of the 342 providers reporting:

- 85% were Caucasian
- 10% were African-American
- 2% were Hispanic; and
- 3% identified themselves as other.

Those respondents reported the following years of experience in early intervention programs:

- 31% have 0-3 years;
- 22% have 3-6 years;
- 17% have 7-10 years;
- 16% have 10-15 years; and
- 14% have more than 16 years of experience.

In 1998, the lead agency hired a cultural diversity specialist to develop, implement, manage, and evaluate activities designed to increase the diversity of Virginia's early intervention services provider workforce and enhance cultural awareness within all aspects of the early intervention system. A Cultural Diversity Advisory Committee was established by the lead agency in October 1998 to develop strategies to advance these goals.

In 1999, the Cultural Diversity Advisory Committee made the following recommendations:

1. Recognizing that Virginia universities that offer degrees in Early Childhood Special Education are not attracting minorities and in order to increase the number of minorities pursuing such degrees, Early Childhood Special Education pre-service training programs should be established in Virginia's historically black colleges and universities.
2. Extend and increase funding appropriated through the Virginia Department of Social Services to train welfare recipients in the Temporary Assistance to Needy Families program as early intervention paraprofessionals.

C. INTERAGENCY COLLABORATION

Beginning in May 1990, the Virginia Department of Health (VDH) joined resources with the lead agency to initiate the High Priority Infant Tracking Program Pilot Project. This pilot program would identify, follow, and refer for services infants and toddlers identified as being at risk for poor health or developmental outcomes. The VDH agreed to administer and oversee the development and implementation of the program as a component of child-find and service delivery for Virginia's Infant and Toddler Program under the IDEA. The goals of the program were:

- To help parents keep their infants and toddlers under the care of a primary health care provider;
- To promote early identification of infants and toddlers requiring further evaluation of service; and
- To assist in planning for the health and educational needs of the children of the Commonwealth.

In 1998, Dr. Donald Stern of the VDH reported that, as of October 30, 1998, program enrollments from three hospital newborn intensive care units at the Medical College of Virginia, the University of Virginia, and Fairfax Hospital totaled 1,819. Further, he reported that 401 children were being tracked in the program and an average of 30 children and families per month had direct contact from either program staff or local health department staff for follow-up. Finally, the VDH integrated and updated several infant registries, the High Priority Infant Tracking Program, the Virginia Hearing Impairment Identification and Monitoring System, and the Virginia Congenital Anomalies Reporting and Education System (VaCares).

The lead agency and the Virginia Department of Education (DOE) continue to collaborate on how responsibility should be delineated for two-year-olds who may be eligible for special education and early intervention services. The families of infants and toddlers in Virginia have the option of transitioning to Part B of IDEA (i.e., special education) to receive early intervention services following the child's second birthday or remaining in the Part C system until the child's third birthday. Collaborative efforts between these two agencies have focused on ensuring family-centered and supportive transitions between Part C and Part B, as well as educating service providers and families about transition requirements and procedures.

Beginning in 1998, the lead agency collaborated with the VDH, the DOE, and the Virginia Department for the Deaf and Hard of Hearing to implement Virginia's Universal Newborn Hearing Screening, pursuant to legislation passed during the 1998 Session of the General Assembly.

D. MEDICAID MANAGED CARE AND PRIVATE MANAGED CARE ORGANIZATIONS

Federal Part C regulations require that states facilitate the coordination of payment for early intervention services from federal, state, and local government and private sources (including public and private insurance coverage). With the advent of managed care technologies, Part C requirements have conflicted with reimbursement policies of Virginia's Medicaid Managed Care and Private Managed Care Organizations (MCOs).

1. Mandatory Medicaid Managed Care

Beginning in 1996, substantial interagency planning and negotiation occurred around Virginia's mandatory Medicaid Managed Care (Medallion II) initiative to ensure infants and toddlers with disabilities eligible under the Part C system received medically necessary services through Medicaid MCOs. The joint subcommittee began efforts to monitor the implementation of Medallion II, Virginia's mandatory Medicaid managed care program in the Tidewater region, and its impact on the early intervention system. In 1997, the joint subcommittee requested that the lead agency and the DMAS establish a Work Group to examine strategies for enhancing and integrating existing approaches for Medicaid coverage of early intervention services.

LICCs reported in 1997 that they were using other public and private early intervention funds to pay for services previously reimbursed by Medicaid because the Medallion II MCOs were denying medically necessary services. Early intervention service providers also reported that Medallion II MCOs reimbursed for services at significantly lower rates than the providers' usual and customary rates. As a follow-up to these reports, the lead agency, with support from the DMAS, conducted a Medallion II Impact Study to determine if there was any cost shifting or duplication of effort occurring. In 1998, the lead agency reported that the Part C Medallion II impact study could not substantiate problems reported by the LICCs and early intervention providers because "the complexity of the data collected in this study, the small sample available, as well as lack of comparability to existing data resources, limited accurate and meaningful analysis." See Appendix I.

In January 1999, Senator Trumbo reported back to the joint subcommittee that the following issues concerning access to Medicaid coverage of Part C services were identified by the Work Group created in 1997.

- The Early Periodic Screening Diagnosis and Treatment program (EPSDT) was underutilized for Part C services.
- Reimbursement rates for early intervention service providers under Medallion II are less than the rates provided under Medicaid fee for service, which has impacted the ability of providers to deliver the services required by Part C children. The Work Group suspected that the reduction in reimbursement resulted in cost shifting to Part C federal funding.

- Provider panels established by Medallion II MCOs limited family choice and created geographic barriers.
- Physicians need to be educated about early intervention and their involvement in the development of Individualized Family Service Plans (IFSPs). They are unfamiliar with the Part C system, eligibility determination, referral procedures, and timelines.

The report of the Work Group for Enhancing and Integrating Medicaid Coverage of Part C of IDEA Services for Infants and Toddlers with Disabilities is attached as Appendix J.

HJR 724 of the 1999 Session of the General Assembly (Appendix K), contained a recommendation of the joint subcommittee that requested the DMAS to report on (i) efforts to enhance and expand training on the availability of, access to, and use of EPSDT and (ii) contracts between MCOs and the DMAS to evaluate Part C provider participation in the managed care networks in order to meet access standards and to allow recipients greater choice. In addition, the report was to include an analysis of reimbursement rates across MCOs to ensure rates are sufficient to attract providers to the MCO networks. In House Document No. 40, 2000, the DMAS reported that it enhanced and expanded training on the availability of, access to, and use of EPSDT by conducting training sessions for physicians, school-based clinics, and Part C and MCO staff. The DMAS also indicated that it had improved training materials and provider manuals by making them available on the DMAS web site. While the Medallion II MCOs reimbursed Part C providers below their commercial rates initially, reimbursement was increased in 1997-1998 across most plans to their commercial rates. According to the DMAS, this resulted in an increase in providers leading to better access and more recipient choice of providers. The joint subcommittee heard from the DMAS and Deanna McGuire Buck, Richmond Infant Council Coordinator, in 1999 that the implementation of Medallion II in central Virginia on April 1, 1999, went more smoothly in large part because of the lessons learned from the Tidewater implementation.

To ensure that Part C recipients have access to needed early intervention services (physical therapy, occupational therapy, and speech-language pathology services), House Bill 2617 was introduced, upon the recommendation of the joint subcommittee, to develop an exception for Part C children to mandatory enrollment in MCOs. See Appendix L. This law allows Part C recipients to disenroll from MCOs if certain criteria are met in order to obtain the needed services.

2. Private Insurance Issues

In 1997, local early intervention providers reported to the joint subcommittee that private insurance companies were limiting coverage for children with developmental disabilities and providing low rates of reimbursement for early intervention services. The joint subcommittee supported legislation requiring coverage of early intervention services for infants and toddlers with disabilities by the state employee health insurance plan and by private insurers and health maintenance organizations.

House Bill 2716, introduced and passed in 1997, (attached as Appendix M), required the state employee health insurance plan to cover medically necessary early intervention services (speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices) for children from birth to age three who are certified by the lead agency as eligible for services under Part C of the IDEA. The law now provides a definition of medical necessity and also specifies that the cost of these medically necessary early intervention services cannot be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime. For persons previously covered under the plan, there can be no denial of coverage due to preexisting conditions. In 1997, the lead agency worked with Trigon/Blue Cross-Blue Shield to implement the mandated benefit for early intervention therapy services under the Virginia State Employee's Health Benefits Plan.

In 1998, the General Assembly passed House Bill 1413, which mandated health insurers, health maintenance organizations, and corporations providing accident and sickness subscription contracts to provide coverage for medically necessary early intervention services for children from birth to age three who are certified by the lead agency as eligible for services under Part C of the IDEA. This coverage is limited to a benefit of $5,000 per insured member per policy per calendar year. This bill provides a definition of medical necessity and requires that the cost of these medically necessary early intervention services not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime. Additionally, co-payments, co-insurance, or deductibles resulting from receiving early intervention services may be paid by federal, state, or local funds. The provisions of the law are applicable to policies, plans, and contracts delivered, issued for delivery, or renewed on and after July 1, 1998. See Appendix N.

At the recommendation of the joint subcommittee, Delegate Mary Christian and Governor George Allen provided written public comment in 1998 to the U. S. Department of Education, Office of Special Education Programs, on proposed Part C regulations pertaining to accessing private health insurance. See Appendix O. The proposed regulations specified that, if any costs were incurred, a family may refuse access to its health insurance coverage as payment for early intervention services. Given that the majority of, if not all, private insurers impose deductibles and co-pay amounts on policy holders, and that most cap or limit lifetime benefits and increase premiums for those policy holders requiring intensive medical care, it was unlikely that any family possessing private health insurance coverage would ever completely avoid financial costs when accessing their private insurance for early intervention services. Further, it was equally unlikely that families would allow their coverage to be accessed when informed of their rights to deny such access. Since Virginia required families to access private insurance for payment for early intervention services, such a regulation would have placed considerable burden on the already limited Part C dollars available to provide services for families with no insurance. Ultimately, the proposed federal regulation was withdrawn.

V. FINAL FINDINGS AND RECOMMENDATIONS

A. FUNDING

The total public dollars spent on early intervention services for infants and toddlers with disabilities cannot be accurately documented or estimated. Currently, funding for these services is provided through a myriad of funding streams, many which do not categorize, identify, or track funds or services as early intervention activities. However, data are available regarding federal Part C funds spent for these services.

Federal Part C Allocations to VA

FFY94	$5,660,050	**FFY97**	$6,814,652
FFY95	$7,199,945	**FFY98**	$7,695,736
FFY96	$6,930,714	**FFY99**	$8,164,038

Part C regulations specify that federal funds may not be used to satisfy a financial commitment for services that would otherwise have been paid by another public or private source. Such funds therefore may be used only for early intervention services that an eligible child needs, but is not currently entitled to, under any other federal, state, local, or private source. Part C regulations also specify that funds must be used to supplement and increase the level of state and local funds expended for Part C eligible children and their families, and in no case can Part C federal funds supplant other state and local funds.[5]

Because of the data problems and issues related to non-supplantation and federal Part C funding as the payor of last resort, the General Assembly in 1997 asked the lead agency and the Department of Medical Assistance Services (DMAS) to prepare a joint report on maximizing federal Medicaid funds for early intervention services. In response, the agencies indicated that Medicaid covers most early intervention health care and rehabilitation services for eligible children under the Virginia State Medical Assistance Plan. The lead agency and the DMAS reported that in 1996, $6,960,050 in federal Part H (Part C) funds were allocated to Virginia to supplement existing funding and to be used as payor of last resort. In addition, $125,000 in state general funds were allocated specifically for these services. Further, state general funds totaling $4,540,915 were expended by the Department of Mental Health, Mental Retardation and Substance Abuse Services for these services. In addition, $3,155,148 of local government funds were provided through community services boards for early intervention services.

The lead agency and the DMAS estimated that 40 percent of the 4,430 infants and toddlers with disabilities served under the early intervention system between December 2, 1995, and December 1, 1996, were Medicaid recipients. During 1996, Medicaid spent $154 million for medical services for roughly 106,000 children from birth to age two. However, the DMAS estimated only a small percentage of the 106,000 were likely to be Part H (now Part C) service recipients. The exact figure could not be determined from the Medicaid claims data. The report "estimated" that about $2.6 million may have

[5] 34 C.F.R. 303.527

reimbursed by Medicaid for Part H children. The lead agency and the DMAS reported that this "estimate" was most likely low because Medicaid might have served more than 40 percent of the 4,430 children who received Part C services in 1996.

Because the study could not document early intervention expenditures accurately for the Medicaid program, the joint subcommittee requested a report on the total state and federal funding sources being used to provide early intervention services in 1997. The lead agency and the DMAS contracted with researchers at George Mason University to evaluate use of Medicaid funds for Part C families and providers for the period December 2, 1996, through December 1, 1997. The study, titled "Analysis of Virginia Medicaid Expenditures and Services Provided to Part C Children December 2, 1996-December 1, 1997, " found that the Virginia Medicaid program spent $161.2 million for medical services for approximately 98,000 children. Of this amount, the DMAS spent $19.6 million (12 percent of total expenditures) for early intervention services for 1,625 children. The study could not identify expenses for children who received services through Medicaid MCOs at that time.

Table 1 displays the geographic distribution of Medicaid and Part C reimbursement for non-HMO children aged 0-3 by region during the study period.

Table 1: Medicaid and Medicaid Part C Reimbursement by Region
December 2, 1996 - December 1, 1997

Region	Part C	Medicaid
Central	$5,511,502	$35,488,264
Northern	$4,405,669	$41,966,264
Southwest	$4,145,821	$35,570,146
Tidewater	$3,759,700	$35,117,010
Valley	$1,727,589	$13,064,204

The geographic distribution of Virginia's Medicaid and Part C claims are identified by percentage in Table 2.

Table 2: Medicaid and Part C Claims by Region
December 2, 1996 - December 1, 1997

Region	Part C	Medicaid
Central	24.74%	21.62%
Northern	20.70%	25.49%
Southwest	27.89%	29.86%
Tidewater	18.70%	15.80%
Valley	7.98%	7.24%

Further, the nine state agencies participating in the Part C program in 1998 completed an assessment of the total funds provided by each to support early intervention services. Again, it was reported that the process of determining the exact amount spent by each agency is hampered by the difficulty of matching program dollars to children and the services they receive. Together, the agencies estimated that at least $17,000,000 was utilized for early intervention services.

Recommendation 1: *Introduce a budget amendment for the lead agency to hire a consultant to develop and implement an effective information strategy or for the lead agency to procure an interagency data system for the state agencies involved in the early intervention system that will collect, analyze, and report on Part C services, consumers, and funding (expenditures and revenue) on a consistent and comparable basis across agencies and localities statewide. This will promote more efficient and cost effective early intervention service delivery for infants and toddlers with disabilities. In the interim, the DMAS and the DMHMRSAS should implement procedures to share, analyze, and report data about recipients served by the Part C system through services funded by both agencies.*

B. CHILD FIND AND PUBLIC AWARENESS

From 1991 through the present, accurate data on early intervention expenditures, projected costs, number of children served, and number of children at risk for developmental delay have been lacking. Early on, the joint subcommittee received estimates in 1991 that roughly 7,500 children daily would be served under the current Part C eligibility definition. If the at-risk population were added, the estimate would have risen by approximately 40,000 children. In contrast, only 4,642 infants and toddlers and their families statewide received early intervention services under Part C between December 2, 1997, and December 1, 1998. The following chart tracks the child count since 1993.

Reported Changes in December 1st & Annualized Child Counts

December 1st Child Count		Annualized Child Count	
Year	**Child Count**	**Year**	**Child Count**
1993	1867	12/2/1993 to 12/1/1994	2999
1994	2086	12/2/1994 to 12/1/1995	3519
1995	2226	12/2/1995 to 12/1/1996	4178
1996	2191	12/2/1996 to 12/1/1997	4430
1997	2391	12/2/1997 to 12/1/1998	4642
1998	2651	12/2/1998 to 12/1/1999	5096
1999	3007	12/2/1999 to 12/1/2000	5850

To ensure children who need services receive them, a number of child-find and public awareness activities were recently implemented.

- Implementation of the Virginia Children's Medical Security Insurance Plan (CMSIP) and the new Family Access to Medical Insurance Security Plan (FAMIS) should identify children ages 0-3 who need services and increase public awareness.
- An evaluation of existing public awareness efforts and the development of a statewide marketing plan was completed by an independent contractor in

September 1999, which was reviewed and approved by the VICC. The marketing plan identifies additional activities (e.g., development of a consistent name recognition, brochures, news bulletins, press releases, radio and television public services announcements, etc.) for an effective and ongoing public awareness campaign. Implementation of this marketing plan will be ongoing under a contractual arrangement. The overall outcomes are to increase the number of children served and to coordinate consistent child-find activities statewide.

- The continuation and expansion of physician training should increase early identification and referral.
- The Virginia Babies Can't Wait! website (www.dmhmrsas.state.va.us/vababiescantwait/default.htm) and a toll-free telephone number (800-234-1448) were established.

While it appears that Virginia's efforts to identify and serve Part C eligible children and families are demonstrated by the increasing numbers receiving services since 1993, the number of Part C children served remains short of the 1991 projections.

Recommendation 2: *Introduce a budget amendment for the lead agency to hire a consultant to update the methodology and projections for Part C eligible children under the current eligibility definition and the at-risk population. Such methodology shall account for child finding under CMSIP and FAMIS. As the joint subcommittee recommended in 1991, it is highly desirable to include at-risk children in the early intervention definition of eligibility. The joint subcommittee continues to encourage localities and the Administration to make early intervention services under Part C available to infants and toddlers at risk of developmental delay.*

C. FEE SYSTEM AND ABILITY TO PAY

At the November 16, 1999, meeting of the joint subcommittee, families shared concerns about Part C fees and measures used to assess family ability to pay for services. Under the Part C requirements, only child-find activities, the multidisciplinary evaluation and assessment, Individualized Family Services Plan (IFSP) development, service coordination, and mediation and due process are provided at no cost to families. For services identified on the child's IFSP, fees are charged. These services, however, cannot be denied due to a family's inability to pay. Therefore, ability to pay mechanisms must be in place.

Several key issues raised by families included widely disparate fees across the state for similar services, inconsistent ability to pay measures imposed by local agencies across the state, the imposition of fees exceeding third party reimbursement rates, the impact of fees on accessing some or all early intervention services, and fees that families simply cannot afford to pay. Fees for early intervention services have been established at the local level based upon differing policies with the result that there is a lack of consistent statewide procedures for determining reasonable family fees.

The lead agency expressed its commitment in December 1999 to resolving issues associated with family fees in a timely manner and targeted the completion of any necessary policy and procedure changes by April 30, 2000. Substantive policy and procedure changes must be approved by the U. S. Department of Education. Therefore, implementation of any changes is now targeted for October 1, 2000.

Recommendation 3: *As proposed in HJR 294, offered in the 2000 Session of the General Assembly (Appendix P), the lead agency (DMHMRSAS), in cooperation with the other state agencies participating in the early intervention program and all stakeholders in the program to include, but not be limited to, representatives of LICCs, the VICC, the Early Intervention Management Team, parents, and service providers, should identify and resolve concerns related to parental liability for costs of Part C early intervention services (including federal requirements related to liability for the costs of various services and access to private insurance reimbursement), mechanisms to determine ability to pay on an equitable and consistent basis statewide, and extreme variations in the costs of services among different localities and report on the results of these activities by November 1, 2000, to the Governor and the General Assembly.*

D. PROGRAM IMPROVEMENTS AND CONTINUED OVERSIGHT

The Virginia Babies Can't Wait! early intervention system continues to develop a comprehensive and efficient system for infants, toddlers, and their families. The early intervention system of monitoring and improvement has been piloted in preparation for statewide implementation in 2000. Technical assistance efforts have helped localities on issues related to compliance, accountability, and continuous quality improvement. To enhance consistency in implementation of requirements, the lead agency reported in 1999 that a number of activities related to standardizing forms and procedures were implemented. Standardization of documentation for IFSPs and service delivery/family progress charting was a recommendation of the George Mason University researchers. A standardized IFSP form that meets the Medicaid plan of care criteria has been developed by the VICC. Standardized "procedural safeguards" forms pertaining to parental consent and prior notice requirements have also been developed. The George Mason University researchers also recommended that the role and performance of Part C Service Coordinators in the CSBs should be strengthened.

Recommendation 4: *The lead agency should complete the development and implementation of standardized forms, data collection formats and procedures, and assessment instruments and procedures for use by the LICCs to support a seamless, integrated and coordinated system of early intervention.*

Recommendation 5: *The lead agency should strengthen the role of Part C Service Coordinators throughout the Commonwealth by:*

- *Developing uniform job descriptions and professional qualifications for individuals serving as Part C Service Coordinators; and*

- *Developing uniform performance measures and expanding Part C Service Coordinators responsibilities to:*

    - *communicate with the child's medical home/primary care and specialist providers in order to coordinate and plan services across providers and agencies;*
    - *communicate with the DMAS to facilitate planning and problem solving for medically necessary services and advocate for families with concerns about plan enrollment, access and quality;*
    - *educate health providers and plans about the Part C Program and availability of non-medical services and programs available to families and individual children; and*
    - *facilitate referrals to programs, providers, and support services available to families after eligibility for Part C services ends (especially for children with chronic problems and disability related needs).*

The joint subcommittee acknowledged the ongoing efforts to increase interagency participation in establishing, providing, and funding early intervention services. In particular, it was noted that the lead agency and the DMAS have worked collaboratively to enhance awareness of Part C early intervention services and systems requirements among public and private health insurers, responded to legislative requests concerning the funding of early intervention services, and examined strategies for improving service availability and accountability under managed care. Nevertheless, interagency participation in the program must continue to be strengthened and coordinated.

Recommendation 6: *The lead agency and the DMAS should continue to improve interagency coordination to plan and problem-solve access to services and develop a Part C provider quality oversight program for all Medicaid plans. All state agencies participating in Virginia's Part C early intervention system should continue to provide assistance to the lead agency to enhance service delivery and provide long-term system planning and budgeting.*

Finally, the joint subcommittee continued to support efforts to ensure that traditionally underserved groups are meaningfully involved in the Part C early intervention system and have access to culturally competent services within their geographical areas.

Recommendation 7: *The lead agency and the VICC should continue their efforts to expand cultural diversity in early intervention services.*

E. TRANSFER OF LEAD AGENCY RESPONSIBILITIES

In 1999, questions arose concerning a possible change in lead agency designation for the Virginia Babies Can't Wait! early intervention system under Part C of the IDEA from the DMHMRSAS to the VDH. DMHMRSAS Commissioner Richard E. Kellogg reported that "any decision regarding a change in lead agency status would need to be

made by the Governor. Currently, there is no compelling reason to make an immediate change in the lead agency status, therefore, no decisions or recommendations are forthcoming from the Secretary of Health and Human Resources to the Governor. Should the matter of change in lead agency be revisited in the Spring, public input will be solicited through a public comment period." He further stated that the DMHMRSAS, "will be issuing a request for proposal for the evaluation of the Virginia Babies Can't Wait! early intervention system in 2000. Findings from this evaluation may provide compelling reasons for substantiating a change in lead agency status in the future."

Recommendation 8: *Should the Governor transfer lead agency responsibilities for Part C early intervention services from the DMHMRSAS to another state agency, such transfer must not disrupt local service planning, delivery and funding and must involve extensive planning and public input.*

VI. CONCLUSION

Because of the substantial benefits that accrue to the citizens of Virginia, the joint subcommittee endorsed continued participation in the Virginia Babies Can't Wait program and urged all state and local agencies involved to render any assistance to the lead agency to enhance and expand service delivery in this worthwhile program.

Respectfully submitted,

Delegate Mary T. Christian, Chair
Senator Yvonne B. Miller, Vice-Chair
Delegate Marian Van Landingham
Delegate Kenneth R. Plum
Delegate Dwight C. Jones
Delegate M. Kirkland Cox
Senator William C. Wampler, Jr.
Senator Malfourd W. Trumbo
The Honorable Emilie F. Miller
Dr. Miriam Carmichael
Helen Daniel

VII. APPENDICES

1999 SESSION

ENROLLED

HOUSE JOINT RESOLUTION NO. 725

Continuing the Joint Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities.

Agreed to by the House of Delegates, February 25, 1999
Agreed to by the Senate, February 23, 1999

WHEREAS, House Joint Resolution No. 164 (1990) established a joint subcommittee to study the programmatic and fiscal impact of the Commonwealth's implementation of Part H of the Education of the Handicapped Act; and

WHEREAS, the joint subcommittee was continued in 1991 by HJR No. 380, in 1992 by HJR No. 187, in 1993 by HJR No. 627, in 1994 by HJR No. 196, in 1995 by HJR No. 511 and in 1997 by HJR No. 581; and

WHEREAS, Part H of the Education of the Handicapped Act was subsequently reauthorized by Congress as Part H and then, in 1997, as Part C of the Individuals with Disabilities Education Act (IDEA); and

WHEREAS, the change in the name of the Act reflected the preference for the use of "disabled" over "handicapped" and the joint subcommittee voted to change its name to the Joint Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities; and

WHEREAS, Part C of IDEA is a federal grant program to provide early intervention services to infants and toddlers with disabilities and to their families; and

WHEREAS, the Department of Mental Health, Mental Retardation and Substance Abuse Services was designated by the Governor as the lead agency for the development and implementation of Part C, which is required to be a statewide, comprehensive, coordinated, and interagency system; and

WHEREAS, in September 1993 Virginia fully implemented a program for early intervention services for the Commonwealth's families with infants and toddlers with disabilities; and

WHEREAS, the joint subcommittee has seen evidence of how these early intervention services can prevent or mitigate numerous problems; and

WHEREAS, the success of the program requires substantial cooperation among the state agencies involved in services for infants and toddlers with disabilities, particularly agencies under the Secretary of Health and Human Resources and the Secretary of Education; and

WHEREAS, one recommendation of the joint subcommittee in 1997 was to request a report from the lead agency and the Department of Medical Assistance Services on the expanded use of capitated managed care plans for Medicaid services to Part C children; and

WHEREAS, the report from researchers at George Mason University which evaluated the use of Medicaid funds and service delivery satisfaction for Part C families and providers was due back to the joint subcommittee on November 15, 1998, yet was not received until January 12, 1999; and

WHEREAS, the joint subcommittee has made recommendations to further streamline the implementation of early intervention services in Virginia, particularly those regarding funding of services, and to encourage state and local interagency collaboration; and

WHEREAS, while such recommendations continue to be implemented, it would benefit the Commonwealth if the joint subcommittee continued to monitor the progress of those recommendations; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities be continued to monitor the recommendations it has made regarding (i) the interagency coordination of service delivery and funding sources to ascertain the most cost effective and appropriate manner for delivery of early intervention services; (ii) performance and outcome measurement pilots for Part C children; (iii) the standardization of forms, data collection and assessment procedures to support a seamless, integrated and coordinated Part C system; (iv) efforts to develop and implement technical assistance for localities; (v) training on the Part C program and using Early Periodic Screening and Diagnosis and Treatment; (vi) the early intervention fee system; (vii) ways of reaching populations that are underserved because of cultural diversity; (viii) child find activities and Part C public awareness campaigns; and (ix) Part C provider networks in HMO contracts.

The members duly appointed pursuant to House Joint Resolution No. 581 (1997) shall continue to serve. Vacancies shall be filled in accordance with the enabling legislation. Staffing shall continue to be provided by the Division of Legislative Services.

The indirect and direct costs for this study shall be assumed by federal grant funds to the Commonwealth under Part C of the Individuals with Disabilities Education Act.

The State Department of Health, and the Departments of Education, Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services, Planning and Budget, and Social Services; the Departments for the Visually Handicapped, for the Deaf and Hard-of-Hearing, and for the Rights of Virginians with Disabilities; and the Bureau of Insurance of the State Corporation Commission shall assist the joint subcommittee, upon request.

The joint subcommittee shall complete its work in time to submit its final findings and recommendations to the Governor and the 2000 Session of the General Assembly as provided in the procedures for the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Part H Early Intervention Services, Timelines, and Cost for Families

TIMELINES	SERVICE	CHARGE(S) FOR FAMILIES
N/A	**POINT OF IDENTIFICATION** The time at which a child is suspected of having either developmental delay(s) or diagnosed handicapping condition(s) with high probability of resulting in delay(s); delay or handicapping condition noticed by a physician, parent or other family member, neighbor, service provider, social worker, etc. Referral with parent consent must be made to local Part H early intervention system within 2 days of identification.	No
Within 2 Days of Identification	**REFERRAL** Contact established between child/family and the local Part H early intervention system via the local point of entry.	No
Within 45 Days of Referral	**ASSIGNMENT OF A TEMPORARY SERVICE COORDINATOR** To assist and enable eligible children and families to receive the rights, procedural safeguards, and the services that are authorized to be provided on the IFSP.	No
	MULTIDISCIPLINARY EVALUATION AND ASSESSMENT Conducted by a team of two or more professionals and the child's family in order to determine eligibility for Part H services.	No Medicaid may be billed for Medicaid-eligible children and for medically-necessary early intervention services covered under the Medicaid State Plan of Care.
	DEVELOPMENT OF THE INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) A process that includes negotiation among team members including the child's family, regarding outcomes and services that meet the developmental needs of the child and the needs of the family in enhancing their child's development. For eligible infants and toddlers, the law specifies certain requirements that must be included in the IFSP process and in the IFSP itself. The IFSP forms the plan of care for the child and family and is a fluid working document that changes with the needs of the child and family.	No
	ASSIGNMENT OF PERMANENT SERVICE COORDINATOR To provide ongoing service coordination throughout child's and family's Part H participation.	No

Appendix B

TIMELINES	SERVICE	CHARGE(S) FOR FAMILIES
As soon following IFSP development as possible	**PROVISION OF IFSP SERVICES** which may include: • assistive technology • audiology • family training, counseling and home visits • health services • medical services (for diagnostic and evaluation purposes only) • nursing services • nutrition services • occupational therapy • physical therapy • psychological services • respite care • social work services • special instruction • speech-language pathology • transportation • vision services	Yes Fees are charged based on the family's ability to pay. Medically-necessary services are billed to insurance when the recipient of Part H services has insurance (either public or private) and when the services provided are covered under the plan. (Parent permission is required for billing private insurance for medically-necessary Part H services.)
At Minimum Every 6 Months	**IFSP REVIEW AND REVISION** Conducted by the service coordinator and others providing services to the child and family; to evaluate progress of child and family, re-evaluate IFSP outcomes, and revise IFSP as needed.	No
As Needed	**MEDIATION AND DUE PROCESS**	No

VIRGINIA ACTS OF ASSEMBLY -- 1999 SESSION

CHAPTER 684

An Act to amend and reenact § 2.1-760 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 47 of Title 2.1 a section numbered 2.1-768.1, relating to early intervention services.

[H 2569]

Approved March 28, 1999

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-760 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 47 of Title 2.1 a section numbered 2.1-768.1 as follows:

§ 2.1-760. Definitions.

As used in this chapter, unless the context requires otherwise:

"Council" means the Virginia Interagency Coordinating Council.

"Early intervention services" means services provided through Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.) designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development, and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. *Early intervention services provided in the child's home and in accordance with this chapter shall not be construed to be home health services as referenced in § 32.1-162.7.*

"Participating agencies" means the Departments of Health, of Education, of Medical Assistance Services, of Mental Health, Mental Retardation and Substance Abuse Services, and of Social Services; the Departments for the Deaf and Hard-of-Hearing, for the Visually Handicapped, and for Rights of Virginians with Disabilities; and the Bureau of Insurance within the State Corporation Commission.

§ 2.1-768.1. Licensure as home care organization not required.

Notwithstanding the provisions of § 32.1-162.9, no person who provides early intervention services in accordance with this chapter shall be required to be licensed as a home care organization in order to provide these services in a child's home.

CHAPTER 640

An Act to amend and reenact § 2.1-760 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 47 of Title 2.1 a section numbered 2.1-768.1, relating to home health services.

[S 1196]

Approved March 28, 1999

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-760 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding in Chapter 47 of Title 2.1 a section numbered 2.1-768.1 as follows:

§ 2.1-760. Definitions.

As used in this chapter, unless the context requires otherwise:

"Council" means the Virginia Interagency Coordinating Council.

"Early intervention services" means services provided through Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.), *as amended,* designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition. *Early intervention services provided in the child's home in accordance with this chapter shall not be construed to be home health services as referenced in § 32.1-162.7.*

"Participating agencies" means the Departments of Health, of Education, of Medical Assistance Services, of Mental Health, Mental Retardation and Substance Abuse Services, and of Social Services; the Departments for the Deaf and Hard-of-Hearing, for the Visually Handicapped, and for Rights of Virginians with Disabilities; and the Bureau of Insurance within the State Corporation Commission.

§ 2.1-768.1. License not required.

Notwithstanding the provisions of § 32.1-162.9, no person who provides early intervention services in accordance with this chapter shall be required to be licensed as a home care organization to provide these services in a child's home.

Appendix D

EARLY INTERVENTION SERVICES IN VIRGINIA:

IMPACT, ISSUES, AND IMPLICATIONS OF IMPLEMENTATION

Presentation to the

Joint Legislative Subcommittee

Established Pursuant to HJR 164

George Barker

November 7, 1990

EARLY INTERVENTION SERVICES IN VIRGINIA:

STUDY ON THE IMPACT OF THE DEFINITION OF ELIGIBILITY

PURPOSE:

To develop information that is useful in planning early interventio programs and services for handicapped Virginia infants, toddlers, an their families.

PRESENTATION:

- Definition of Eligibility for Services
- Methodology of Study
- Results of Study
- Statewide Estimates
- Distribution of Need
- Issues Identified
- Long-Term Perspective

DEFINITION OF ELIGIBILITY

DEVELOPMENTALLY DELAYED

- 25% or Greater Deficit
- Atypical Development

DIAGNOSED CONDITION

- One or More of List of Specified Physical or Mental Conditions
- Similar Condition Deemed Qualifying by Local Team

MULTIPLE RISK FACTORS

- Three of More Specified Risk Factors
- Risk Factors Include:
    - Several Physical or Mental Factors
    - Child Abuse or Neglect
    - Existence of Social or Environmental Risk(s)
    - Existence of Major Congenital Anomaly(ies)
    - Very Low Birthweight (Less Than 1500 Grams)
    - Very Low Apgar Score (Less Than 4)
    - Very Low Maternal Age (Less Than 16)

METHODOLOGY OF STUDY

PROPECTIVE DATA COLLECTION

- Children Identified As Having A Condition Specified In The Definition
- Children In Early Intervention Programs

STUDY AREAS

- Urban High Risk	Richmond City
- Urban Low Risk	Hampton-Newport News
- Moderate Risk	Colonial (James City, York, Poquoson, and Williamsburg)
- Rural High Risk	Eastern Shore
- Rural Low Risk	Planning District 1

SOURCES OF INFORMATION

- Hospitals
- Physicians
- Health Departments
- Social Service Departments
- Community Services Boards
- School Systems
- Infant Intervention Programs
- Others

LEVELS OF SERVICE NEEDED

- Intervention
- Monitoring
- Tracking

RESULTS OF STUDY

NEWLY IDENTIFIED CHILDREN

Eligibility Category	Number of Children	Cumulative Total
Developmentally Delayed	95	95
Specified Diagnosed Condition	49	144
Multiple Risk Factors	38	182
"Other" Diagnosed Condition	114	296
Suspected Developmental Delay	45	341
Adjustment for Gestational Age (Gross Motor Only)	- 7	334
Limit on "Other" Diagnosed Condition	-67	267
Adjustment of Suspected Delay	-16	251
Others Identified	657	
Total		908
Sequential Effects of Broad Categories (After Adjustments)		
Developmentally Delayed	147	147
Diagnosed Condition	74	221
Multiple Risk Factors	30	251
Not Meeting Definition	657	908

RESULTS OF STUDY
(cont.)

CHILDREN IN INTERVENTION PROGRAMS

Eligibility Category	Number of Children	Cumulative Total
Developmentally Delayed	332	332
Specified Diagnosed Condition	20	352
Multiple Risk Factors	15	367
"Other" Diagnosed Condition	80	447
Suspected Developmental Delay	32	479
Adjustment for Gestational Age (Gross Motor Only)	-14	465
Limit on "Other" Diagnosed Condition	-39	426
Adjustment of Suspected Delay	-14	412
Others in Programs	155	
Total in Programs		567

Sequential Effects of Broad Categories
(After Adjustments)

Developmentally Delayed	350	350
Diagnosed Condition	46	396
Multiple Risk Factors	16	412
Not Meeting Definition	155	567

STATEWIDE ESTIMATES

Description	Meeting Definition	Total With Risk
Identified in Survey	251	908
Extrapolated to 3 Year Period	1,800	6,600
Projected to Total State	10,800	40,000
Adjusting for Undercount	14,400-16,200	60,000
Qualifying at a Given Time	7,200-8,100	40,000-45,000

Total Population Ages 0-2 276,000

Eligibility Factor	Sequential Percent of Total	Number Eligible (7,650 Qualifying at a Time)
Developmentally Delayed	58.6 - 84.9	4,481 - 6,499
Diagnosed Condition	11.2 - 29.5	855 - 2,255
Multiple Risk Factors	3.9 - 11.9	297 - 914

DISTRIBUTION OF NEED

Description	Planning District 1	Hampton-Newport News	Colonial	Richmond City	Eastern Shore
Number Newly Eligible	25	71	5	97	54
Adjusted to 3 Years	180	511	36	698	389
Population Ages 0-2	3,420	16,820	3,330	10,540	1,810
Percent Eligible	5.26	3.04	1.08	6.63	21.48

Note: Colonial Area had minimal participation in identifying newly eligible children.

ISSUES IDENTIFIED

From Definition

Limiting Issues

- age adjusted for gestation
- limit on "other" diagnosed condition
- limit on what constitutes social or environmental risk or major congenital anomaly
- multiple risks

Expanding Issues

- multiple social or environmental risks
- multiple congenital anomalies
- flexibility

Level of Service

- For Those Eligible
- For Those Not Eligible
- Tracking and Monitoring
- Screening and Evaluation
- Family Role

Funding

- Total
- Distribution

LONG-TERM PERSPECTIVE

Benefits

- To Children and Families
  - Resolving Problems
  - Helping Reach Potential
  - Prevention
- Savings

Structure

- To Meet Current Needs
  - Identifying Those Eligible
  - Serving Those Eligible
  - Tracking or Monitoring Where Risk
- To Develop System in Future
  - Problems Identified During Ages 3-5
  - Problems Occurring After Entering School

I. State Definition of Developmental Delay; Definition of Eligibility for Services

Virginia's definition of developmental delay and eligibility procedures ensure that all children from birth through age two who are developmentally delayed or who have a diagnosed physical or mental condition that has a high probability of resulting in delay are eligible to participate in the Part C program. The determination of eligibility for Part C services is documented in the child's Individualized Family Service Plan (IFSP). The Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), as Lead Agency, assures that these definitions and the eligibility requirements ensure uniform access to Part C services in Virginia. This component presents Virginia's definition of developmental delay, a list of conditions which have a high probability of resulting in delay, and the procedures for determining eligibility for the Part C program.

A. Definition of Developmental Delay

1. Infants and toddlers who are functioning at least 25% below their chronological or adjusted age[1], *in one or more of the following areas*:

   a. *cognitive development*;
   b. *physical development (including fine motor, gross motor, vision, and hearing)*;
   c. *communication development*;
   d. *social or emotional development*;
   e. *adaptive development.* (34 CFR 303.16(a)(1))

- OR -

2. Children who manifest atypical development or behavior, which is demonstrated by one or more of the following criteria (even when evaluation does not document a 25% developmental delay):

   a. Abnormal or questionable sensory-motor responses, such as:
      (1) abnormal muscle tone;
      (2) limitations in joint range of motion;
      (3) abnormal reflex or postural reactions;
      (4) poor quality of movement patterns or quality of skill performance;
      (5) oral-motor skills dysfunction, including feeding difficulties

   b. Identified affective disorders, such as:
      (1) delay or abnormality in achieving expected emotional milestones;
      (2) persistent failure to initiate or respond to most social interactions;
      (3) fearfulness or other distress that does not respond to comforting by caregivers;

3. Behavioral disorders that interfere with the acquisition of developmental skills.

B. Children who have a *diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, even though no delay currently exists.* (34 CFR 303.16 (a)(2))

---

[1] For infants and toddlers born prematurely (gestation < 37 weeks), the child's actual adjusted age is used to determine developmental status. Chronological age is used once the child is 18 months old.

Those identifiable conditions include, but are not limited to:

1. seizures/significant encephalopathy (identifies the high risk group with low Apgars and/or asphyxia);
2. significant central nervous system anomaly;
3. severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage;
4. symptomatic congenital infection;
5. effects of toxic exposure including fetal alcohol syndrome, drug withdrawal and exposure to chronic maternal use of anticonvulsants, antineoplastics, and anticoagulants;
6. myelodysplasia;
7. congenital or acquired hearing loss;
8. visual disabilities;
9. chromosomal abnormalities, including Down Syndrome;
10. brain or spinal cord trauma, with abnormal neurologic exam at discharge;
11. inborn errors of metabolism;
12. microcephaly;
13. severe attachment disorders;
14. failure to thrive; or
15. other physical or mental conditions at the multidisciplinary/interdisciplinary/transdisciplinary team members' discretion.

C. Determination of Eligibility

In Virginia, all children are determined eligible for Part C services by the multidisciplinary/ interdisciplinary/transdisciplinary team, which includes the family. The following procedures are used to determine eligibility:[2]

1. Infants and toddlers whose development is delayed or atypical in one or more of the developmental areas identified in A.1. above must be determined eligible by either:

   a. determining the specific level of delay, as measured and verified by qualified personnel using appropriate criterion-referenced or standardized diagnostic instruments and procedures, informed clinical opinion, and information provided by the child's parents;

   -OR-

   b. determining the existence of atypical development by qualified professionals observing one or more of the atypical behaviors in the course of administering their evaluation/ assessment procedures.

[2] See policies and procedures in Component VI - Multidisciplinary Evaluation/Assessment for additional information regarding Virginia's procedures for evaluation/assessment techniques, decision-making processes used by multidisciplinary/interdisciplinary/transdisciplinary teams, procedures for resolving decisions where consensus of eligibility is not initially reached, and documentation of findings and results regarding eligibility.

2. Infants and toddlers who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay (such as those listed in B 1-15 above) must be determined eligible by identification of a specific condition with known etiologies and developmental consequences. Informed clinical opinion is used in determining such a diagnosed physical or mental condition.

D. Infants and toddlers at risk for developmental delay are not included in Virginia's current definition of eligibility for purposes of entitlement to Part C services. However, the Virginia Interagency Coordinating Council (VICC) and the Lead Agency recognize that infants and toddlers are at risk for developmental delays as a result of environmental and/or biological factors. These infants and toddlers can benefit from early intervention services and providers of early intervention services are encouraged to extend such services to them whenever circumstances allow.

The VICC and the Lead Agency may, on a periodic basis and as feasible and warranted, study the feasibility of including at risk infants and toddlers under the definition of eligibility for services. The results of such studies will be used to determine the appropriate scope and type of services needed to serve these infants and toddlers and their families.

LD0311148

HOUSE BILL NO. 817

Offered January 21, 1992

A BILL to amend and reenact §§ 2.1-1.7, 9-6.23, and 9-6.25:1 of the Code of Virginia and to amend the Code of Virginia by adding in Title 2.1 a chapter numbered 46, consisting of sections numbered 2.1-745 through 2.1-753, relating to early intervention services for infants and toddlers with disabilities.

Patrons—Christian, Connally, Cooper, Cox, Cunningham, J.W., Darner, Dillard, Grayson, Maxwell, Mayer, Munford, Plum, Stieffen and Van Landingham; Senators: Andrews, Hawkins, Lambert, Miller, Y.B., Scott and Woods

---

Referred to the Committee on General Laws

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.1-1.7, 9-6.23, and 9-6.25:1 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 2.1 a chapter numbered 46, consisting of sections numbered 2.1-745 through 2.1-753, as follows:

§ 2.1-1.7. State councils.—A. There shall be, in addition to such others as may be established by law, the following permanent collegial bodies either affiliated with more than one agency or independent of an agency within the executive branch:

Agricultural Council, Virginia

Alcohol and Drug Abuse Problems, Governor's Council on

Apprenticeship Council

~~Beach Erosion Council, Virginia~~

Child Day Care and Early Childhood Programs, Virginia Council on

Child Day-Care Council

Citizens' Advisory Council on Furnishing and Interpreting the Executive Mansion

Commonwealth's Attorneys' Services and Training Council

Developmental Disabilities Planning Council, Virginia

Equal Employment Opportunity Council, Virginia

Handicapped Children, Interagency Coordinating Council on Delivery of Related Services to

Health Services Cost Review Council, Virginia

Housing for the Disabled, Interagency Coordinating Council on

Human Rights, Council on

Human Services Information and Referral Advisory Council

Indians, Council on

Interagency Coordinating Council, Virginia

Job Training Coordinating Council, Governor's

Land Evaluation Advisory Council

Local Debt, State Council on

Long-Term Care Council

Military Advisory Council, Virginia

Needs of Handicapped Persons, Overall Advisory Council on the

Prevention, Virginia Council on Coordinating

Public Records Advisory Council, State

Rate-setting for Children's Facilities, Interdepartmental Council on

Revenue Estimates, Advisory Council on

State Health Benefits Advisory Council

Status of Women, Council on the

B. Notwithstanding the definition for "council" as provided in § 2.1-1.2, the following entities shall be referred to as councils:

Environment, Council on the

Council on Information Management

Higher Education, State Council of
World Trade Council, Virginia.

CHAPTER 46.

EARLY INTERVENTION SERVICES SYSTEM.

§ 2.1-745. Definitions.—As used in this chapter, unless the context requires otherwise.

"Council" means the Virginia Interagency Coordinating Council.

"Early intervention services" means services designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a twenty-five percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a handicapping condition, or who are at risk of developing a condition listed in (i), (ii), or (iii) and services provided to the families of such children.

"Participating agencies" means the Departments of Health, Deaf and Hard-of-Hearing, Education, Medical Assistance Services, Mental Health, Mental Retardation and Substance Abuse Services, Social Services, and the Visually Handicapped; the Department for Rights of Virginians with Disabilities; and the Bureau of Insurance within the State Corporation Commission.

§ 2.1-746. Secretaries of Health and Human Resources and Education to work together.—The Secretaries of Health and Human Resources and Education shall work together in:

1. Promoting interagency consensus and facilitating complimentary agency positions on issues relating to early intervention services;

2. Examining and evaluating the effectiveness of state agency programs, services, and plans for early intervention services and identifying duplications, inefficiencies, and unmet needs;

3. Analyzing state agency budget requests and any other budget items affecting early intervention services;

4. Proposing ways of realigning funding to promote interagency initiatives ar programs for early intervention services;

5. Formulating recommendations on planning, priorities, and expenditures for early intervention services and communicating the recommendations to the Governor and state agency heads;

6. Formulating joint policy positions and statements on legislative issues regarding early intervention services and communicating those positions and statements to the General Assembly; and

7. Resolving interagency disputes and assigning financial responsibility in accordance with Part H of the Individuals with Disabilities Act (20 U.S.C. 1470).

§ 2.1-747. Early intervention agencies committee.—An early intervention agencies committee shall be established to ensure the implementation of a comprehensive system for early intervention services. The committee shall be composed of the Commissioner of the Department of Health, the Director of the Department of Deaf and Hard of Hearing, the Superintendent of Public Instruction, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Commissioner of the Department of Social Services, the Commissioner of the Department for the Visually Handicapped, the Director of the Department for Rights of Virginians with Disabilities, and the Commissioner of the Bureau of Insurance within the State Corporation Commission. The committee shall meet at least twice each fiscal year and shall make annual recommendations to the Secretary of Health and Human Resources and the Secretary of Education on issues that require interagency planning, financing, and resolution. Each member of the committee shall appoint a representative from his agency to serve on the Virginia Interagency Coordinating Council.

§ 2.1-748. Duties of participating agencies.—The duties of the participating agencies shall include:

1. Establishing a statewide system of early intervention services in accordance with state and federal statutes and regulations;

2. Identifying and coordinating all available federal, state, local and private resources for early intervention services;

3. Developing and implementing formal state interagency agreements that define the financial responsibility and service obligations of each participating agency for early intervention services, establish procedures for resolving disputes, and address any additional matters necessary to ensure collaboration;

4. Consulting with the lead agency in the promulgation of regulations to implement the early intervention services system, including developing definitions of eligibility and services;

5. Carrying out decisions resulting from the dispute resolution process;

6. Providing assistance to localities in the implementation of a comprehensive early intervention services system in accordance with state and federal statutes and regulations; and

7. Requesting and reviewing data and reports on the implementation of early intervention services from counterpart local agencies.

§ 2.1-749. Lead agency's duties.—To facilitate the implementation of an early intervention services system and to ensure compliance with federal requirements, the Governor shall appoint a lead agency. The duties of the lead agency shall include:

1. Promulgating regulations to implement an early intervention services system, in consultation with other participating agencies; the regulations shall be promulgated in accordance with the provisions of the Administrative Process Act (§ 9-6.14:1 et seq.);

2. Providing technical assistance to localities in the establishment and operation of local interagency coordinating councils; and

3. Establishing an interagency system of monitoring and supervision of the early intervention services system.

§ 2.1-750. Virginia Interagency Coordinating Council: composition and duties.—A. The Virginia Interagency Coordinating Council is hereby continued to promote and coordinate early intervention services in the Commonwealth. The membership and operation of the Council shall be as required by Part H of the Individuals with Disabilities Education Act (20 U.S.C. 1470). The agency representatives shall be appointed by the member of their agency who serves on the early intervention agencies committee. Agency representatives shall regularly inform their agency head of the Council's activities and the status of the implementation of an early intervention services system in the Commonwealth.

B. The Council's duties shall include advising and assisting the lead agency in the following:

1. Performing its responsibilities for the early intervention services system;

2. Identifying sources of fiscal and other support for early intervention services, recommending financial responsibility arrangements among agencies, and promoting interagency agreements;

3. Developing strategies to encourage full participation, coordination, and cooperation of all appropriate agencies;

4. Resolving interagency disputes;

5. Gathering information about problems that impede timely and effective service delivery and taking steps to ensure that any identified policy problems are resolved;

6. Preparing federal grant applications; and

7. Preparing and submitting an annual report to the Governor and the U.S. Secretary of Education on the status of early intervention services within the Commonwealth.

§ 2.1-751. Duties of local public agencies.—Local public agencies are responsible for:

1. Participating actively on local interagency coordinating councils;

2. Designating a representative of their agency who is authorized to make policy and funding decisions for the agency to serve on the local interagency coordinating council;

3. Designating other members of the local interagency coordinating council as provided

in § 2.1-752;

4. Providing services as appropriate and agreed upon;

5. Maintaining data and providing information as requested to their respective agencies;

6. Developing and implementing interagency agreements;

7. Complying with applicable state and federal regulations and local policies and procedures; and

8. Following procedural safeguards and dispute resolution procedures as promulgated by the Commonwealth;

§ 2.1-752. Local interagency coordinating councils.—A. Every county and city shall establish, either singly or in combination with another political subdivision, a local interagency coordinating council to enable agencies to establish working relationships that will increase the efficiency and effectiveness of early intervention services. Public local agencies shall designate the members of local interagency coordinating councils, which shall include but not be limited to representatives of as many as possible of the following as practicable: parents, community services boards, departments of social services, departments of health, local school divisions, rehabilitative services, private providers of health, and mental health, and social services, and infant programs.

B. The duties of local interagency coordinating councils shall include:

1. Identifying existing early intervention services and resources;

2. Identifying gaps in the service delivery system and developing strategies to address these gaps;

3. Identifying alternative funding sources;

4. Facilitating the development of interagency agreements and supporting the development of service coalitions;

5. Assisting in the implementation of policies and procedures that will pro interagency collaboration; and

6. Developing local procedures and determining mechanisms for implementing policies and procedures in accordance with state and federal statutes and regulations.

§ 2.1-753. Existing funding levels.—Any federal funds made available through Part H of the Individuals with Disabilities Education Act and any state funds appropriated specifically for early intervention services, shall be used to supplement and increase the level of state, local, and other federal funds and in no case supplant those state, local and other federal funds.

§ 9-6.23. Prohibition against service by legislators on boards and commissions within the executive branch.—Members of the General Assembly shall be ineligible to serve on boards and commissions within the executive branch which are responsible for administering programs established by the General Assembly. Such prohibition shall not extend to boards and commissions engaged solely in policy studies or commemorative activities. If any law directs the appointment of any member of the General Assembly to a board or commission in the executive branch which is responsible for administering programs established by the General Assembly, such portion of such law shall be void and the Governor shall appoint another person from the Commonwealth at large to fill such a position. The provisions of this section shall not apply, however, to members of the Board for Branch Pilots, who shall be appointed as provided for in § 54.1-901, to members of the Commission on VASAP, who shall be appointed as provided for in § 18.2-271.2, to members of the Board on Veterans' Affairs, who shall be appointed as provided for in § 2.1-741, to members of the Council on Indians, who shall be appointed as provided for in § 9-138.1, ~~or~~ to members of the Board of Trustees of the Southwest Virginia Higher Education Center, who shall be appointed as provided in § 23-231.3 *or to members of the Virginia Interagency Coordinating Cour who shall be appointed as provided in § 2.1-750 .*

§ 9-6.25:1. Advisory boards, commissions and councils.—There shall be, in addition to such others as may be designated in accordance with § 9-6.25, the following advisory boards, commissions and councils within the executive branch:

Advisory Board for the Department for the Deaf and Hard-of-Hearing
Advisory Board for the Department for the Aging
Advisory Board on Child Abuse and Neglect
Advisory Board on Medicare and Medicaid
Advisory Board on Occupational Therapy
Advisory Board on Physical Therapy to the Board of Medicine
Advisory Board on Respiratory Therapy to the Board of Medicine
Advisory Board on Teacher Education and Certification
Advisory Commission on Mapping, Surveying, and Land Information Systems
Advisory Council on Revenue Estimates
Appomattox State Scenic River Advisory Board
Art and Architectural Review Board
Board of Directors, Virginia Truck and Ornamentals Research Station
Board of Forestry
Board of Health Professions
Board of Military Affairs
Board of Transportation Safety
Board of Trustees of the Family and Children's Trust Fund
Board of Visitors, Gunston Hall Plantation
Board on Veterans' Affairs
Catoctin Creek State Scenic River Advisory Board
Cave Board
Chickahominy State Scenic River Advisory Board
Coal Surface Mining Reclamation Fund Advisory Board
Council on Indians
Council on the Status of Women
Dual Party Relay Services Advisory Board
Emergency Medical Services Advisory Board
Falls of the James Committee
Forensic Science Advisory Board
Goose Creek Scenic River Advisory Board
Governor's Council on Alcohol and Drug Abuse Problems
Governor's Mined Land Reclamation Advisory Committee
Handicapped Children, Interagency Coordinating Council on Delivery of Related Services to
Hemophilia Advisory Board
Human Services Information and Referral Advisory Council
Industrial Development Services Advisory Board
Interagency Coordinating Council on Housing for the Disabled
Interdepartmental Board of the State Department of Minority Business Enterprise
Laboratory Services Advisory Board
Local Advisory Board to the Blue Ridge Community College
Local Advisory Board to the Central Virginia Community College
Local Advisory Board to the Dabney S. Lancaster Community College
Local Advisory Board to the Danville Community College
Local Advisory Board to the Eastern Shore Community College
Local Advisory Board to the Germanna Community College
Local Advisory Board to the J. Sargeant Reynolds Community College
Local Advisory Board to the John Tyler Community College
Local Advisory Board to the Lord Fairfax Community College
Local Advisory Board to the Mountain Empire Community College
Local Advisory Board to the New River Community College
Local Advisory Board to the Northern Virginia Community College
Local Advisory Board to the Patrick Henry Community College

Local Advisory Board to the Paul D. Camp Community College
Local Advisory Board to the Piedmont Virginia Community College
Local Advisory Board to the Rappahannock Community College
Local Advisory Board to the Southwest Virginia Community College
Local Advisory Board to the Thomas Nelson Community College
Local Advisory Board to the Tidewater Community College
Local Advisory Board to the Virginia Highlands Community College
Local Advisory Board to the Virginia Western Community College
Local Advisory Board to the Wytheville Community College
Long-Term Care Council
Medical Advisory Board, Department of Motor Vehicles
Medical Board of the Virginia Retirement System
Migrant and Seasonal Farmworkers Board
Motor Vehicle Dealer's Advisory Board
Nottoway State Scenic River Advisory Board
Personnel Advisory Board
Plant Pollination Advisory Board
Private College Advisory Board
Private Security Services Advisory Board
Psychiatric Advisory Board
Radiation Advisory Board
Rappahannock Scenic River Advisory Board
Reforestation Board
Retirement System Review Board
Rockfish State Scenic River Advisory Board
Shenandoah State Scenic River Advisory Board
Small Business Advisory Board
St. Mary's Scenic River Advisory Committee
State Advisory Board on Air Pollution
State Advisory Board for the Virginia Employment Commission
State Building Code Technical Review Board
State Council on Local Debt
State Health Benefits Advisory Council
State Insurance Advisory Board
State Land Evaluation Advisory Council
State Networking Users Advisory Board
State Perinatal Services Advisory Board
State Public Records Advisory Council
~~State Health Benefits Advisory Council~~
Staunton Scenic River Advisory Committee
Tourism and Travel Services Advisory Board
Toxic Substances Advisory Board
Virginia Advisory Commission on Intergovernmental Relations
Virginia Coal Research and Development Advisory Board
Virginia Commission for the Arts
Virginia Commission on the Bicentennial of the United States Constitution
Virginia Council on Coordinating Prevention
Virginia Equal Employment Opportunity Council
Virginia Interagency Coordinating Council
Virginia Military Advisory Council
Virginia Mine Safety Board
Virginia Public Buildings Board
Virginia Transplant Council
Virginia War Memorial Board

Virginia Water Resources Research Center, Statewide Advisory Board
Virginia Winegrowers Advisory Board.

Official Use By Clerks	
Passed By The House of Delegates	**Passed By The Senate**
without amendment ☐	without amendment ☐
with amendment ☐	with amendment ☐
substitute ☐	substitute ☐
substitute w/amdt ☐	substitute w/amdt ☐
Date: _____	Date: _____
_____	_____
Clerk of the House of Delegates	Clerk of the Senate

HOUSE JOINT RESOLUTION NO. 626

House Amendments in [ ] - February 4, 1993

Expressing the sense of the General Assembly that the Governor should undertake all actions [~~neeessary~~ to ~~fully~~ implement fully] early intervention services for infants and toddlers with disabilities and their families in the Commonwealth.

Patrons—Christian, Connally, Cox, Mayer and Plum; Senators: Miller, Y.B. and Wampler

Referred to the Committee on Health, Welfare and Institutions

WHEREAS, the Joint Subcommittee Studying Early Intervention Services for Handicapped Infants and Toddlers was established in 1990 by House Joint Resolution No. 164 to study the programmatic and fiscal impact of the Commonwealth's implementing Part H of the Education of the Handicapped Act; and

WHEREAS, the joint subcommitee was continued in 1991 by House Joint Resolution No. 380 and in 1992 by Resolution No. 187 and the joint subcommittee will ask the 1993 General Assembly to continue its existence for an additional year; and

WHEREAS, Part H of the Education of the Handicapped Act, was subsequently reauthorized by Congress as Part H of the Individuals with Disabilities Education Act; and

WHEREAS, Part H is a discretionary federal grant program of early intervention services to infants and toddlers with disabilities and their families and is required to be a statewide, comprehensive, coordinated, and interagency system; and

WHEREAS, the joint subcommittee has carefully studied the complex budget and service delivery issues involved in the Part H Program and has determined that Virginia should fully implement the Part H Program in 1993 by moving into the fifth year of participation in the federal grant program; and

WHEREAS, studies show that early intervention programs for infants and toddlers with disabilities reduce expenditures for special education, residential placements, and other human services; and

WHEREAS, early intervention services provide substantial support for the families of infants and toddlers with disabilities and enhance the quality of life not only for the child with disabilities but for all of the members of the child's family; and

WHEREAS, Virginia currently has waiting lists of children who need early intervention services but are not able to receive them because of a lack of resources; and

WHEREAS, by moving into the fifth year of grant participation the Commonwealth would receive in September, 1993, $3.95 million in federal money and possibly an additional $1.25 million, and would receive not less than $ 4.7 million in September 1994; all with no state or local match required; and

WHEREAS, because early intervention works and saves money, the federal grant funds should be obtained as quickly as possible so that services can be expanded and more lives can be impacted; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That it is the sense of the General Assembly that the Governor should undertake all actions to [~~take whatever steps are necessary to fully~~ implement fully] early intervention services to infants and toddlers with disabilities in the Commonwealth and to ensure that the Commonwealth moves into the fifth year of grant participation in the Part H Program in 1993.

Recommendation 1: Make scholarship funds available for individuals who commit to working in the field of early intervention (priority given to those already working in the field but who do not reach a highest standard, minorities, family members of children with disabilities, individuals with disabilities, and those from underserved areas.)
Strategies
1. Ask the General Assembly to appropriate scholarship funds for early intervention disciplines a. Use successes of other scholarship programs as basis (i.e., the rural physicians and occupational therapists scholarship programs) to establish participatory criteria.
2. Request the Part H Office to increase funding and reevaluate eligibility requirements for the state tuition assistance program.
3. Encourage hospitals/private sector/community to develop and offer scholarships.
4. Encourage all agencies involved in Part H to establish a tuition assistance program for early intervention disciplines.
5. Encourage existing and potential employers to fund full scholarships for staff.

Recommendation 2: Determine and implement strategies to increase the number of culturally diverse service providers.
Strategies
1. Continue to increase the *Be Someone Special* efforts, a recruitment project co-sponsored by the DOE and DMHMRSAS targeting minority communities.
2. Encourage DOE to make minorities aware of early intervention fields through Career Day, flyers, brochures, electronic bulletin boards, etc.
3. Make educational programs more flexible (weekends, nights, part-time, etc.)
4. Request a meeting at traditionally black universities to discuss minorities entering early intervention field and strategies to help them complete early intervention program.
5. Discuss early intervention with college advisors to increase awareness.
6. Encourage development of paraprofessional programs and make efforts to have them recognized by private insurance, Medicaid and Medicare for reimbursement.
7. Identify organizations that support minority professionals entering early intervention related fields and develop ways to utilize them to recruit minorities. a. Allocate Part H funds to professional organizations for their use in recruiting minorities and funding scholarships.
8. Determine the number of minorities who apply to, are accepted to, enter, and complete degree program in early intervention related fields.
9. Encourage grant writers at universities to access minority scholarship funds offered through the universities, foundations and corporations.

Recommendation 3: Increase the number of slots available for students in early intervention related programs at institutions of higher education. Examine the initial start-up costs and the costs of maintaining the slots, space and faculty to support this endeavor.

Strategies

1. Continue to analyze shortages in selected professions in Virginia.
2. Make a recommendation to the Joint Commission on Health Care to earmark funds to ensure the availability of slots in programs.
3. Develop Virginia doctoral program(s), which will prepare individuals for university faculty position (currently under development at VCU).
    a. Develop fellowships to support these doctoral candidates.
4. Provide line-item funding (funds specified) for faculty in Occupational Therapy (OT), Physical Therapy (PT) and Speech and Language Pathology (SLP).
5. Develop strategies and incentives for sites to supervise fieldwork exercises.
    a. Encourage more early intervention programs to increase the number of fieldwork students they take.
    b. Encourage innovative fieldwork models (i.e., consumer friendly hours: part-time, weekend and evening hours).
    c. Encourage sites to supervise more than one student at a time.

Recommendation 4: Encourage educational institutions to cross-train students. Expand pre-service and inservice training for existing personnel.

Strategies

1. Establish a balanced exchange between disciplines so that all departments/schools get credit for FTEs.
2. Hire adjunct faculty (or offer them other benefits) to teach existing personnel (using clinicians to teach clinicians).
3. Re-examine curriculum to establish cross-disciplinary courses that meet each discipline's requirements in certain areas (not add to requirements).

    For example: In the past four years 24 physical therapy trainees as well as students from disciplines of social work, psychology, OT, SLP, and nursing have been enrolled in interdisciplinary training in infant and family services administered by the Virginia Institute for Developmental Disabilities, a state-wide university affiliated program currently housed at VCU. Students who receive this specialized training and related field experience are much more likely to become employed in early intervention.

    a. Open up courses to students not enrolled in grant programs so that it increases university enrollment.
    b. Find ways for students to complete requirements for cross-disciplinary programs within the confines of requirements for traditional professional program (perhaps as part of fieldwork assignments).
    c. Market the program as a recruitment strategy for the university in order to leverage university funds.
4. Access funds to continue support of cross-disciplinary training programs.
    a. Ask the General Assembly to appropriate any available federal "block grants" to sustain and expand cross-disciplinary training programs such as the existing program at VIDD.
    b. Provide line-item funding to sustain and expand cross-disciplinary training programs.
    c. Access multiple funding sources to locate student support.
    d. Share this program as a model for other institutions of higher education to emulate. (Requires funding.)
    e. Provide summer institute opportunities for more intensive training - either self-supporting or with state funds.
    f. Offer program to professionals currently working (will require funding).

Recommendation 5: Examine licensing barriers.
Strategies
1. Encourage communication between licensing boards, state agencies and advocacy groups before beginning the evaluation of these licenses.

Recommendation 6: Support (i.e., funding) the expansion of paraprofessionals through Virginia's high school vocational technical system and community college system. Representatives from the Department of Education, Department of Mental Health, Mental Retardation and Substance Abuse Services and the Virginia Community College System could work together on this.
Strategies
1. Explore, examine, and target funds to support faculty positions and expand degree programs at community colleges for vocational, technical, and adult education in early intervention related fields.
2. Include early intervention competencies within specific high school vocational technical and community college training programs. a. Provide technical assistance to parents and paraprofessional/professional service providers to help foster the programmatic shift from the medical model to the developmental model. b. Get private insurance, Medicaid and Medicare to reimburse for services provided by paraprofessionals.

Recommendation 7: Expand professions (i.e. early interventionist) for those who do not hold a state certification or license in an existing profession. This new credential will support 1) the retention of highly skilled early intervention personnel currently employed in the field and 2) the recruitment of prospective personnel wishing to enter the field.
Strategies
1. Authorize the Department of Mental Health, Mental Retardation and Substance Abuse Services to grant an early interventionist "credential" to applicants with the appropriate demonstrated competencies being developed by the Personnel Training and Development Committee (PTDC) of the Virginia Interagency Coordinating Council (VICC).
2. Inform the General Assembly and the public of this new profession, which is currently being developed by the PTDC.
3. Seek the endorsement of the General Assembly so that it may assist with any legislative action or funding that may need to occur in order to successfully create a new profession recognized by the Commonwealth of Virginia.

Medallion II Mini-Study: Determining the Impact of Medallion II on Part C Early Intervention Services for Infants and Toddlers with Disabilities

Summary of Purpose, Methodology and Limited Findings

Richard E. Kellogg, Commissioner
Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Dennis G. Smith, Director
Virginia Department of Medical Assistance Services

November 3, 1999

Medallion II Mini-Study: Determining the Impact of Medallion II on Part C Early Intervention Services for Infants and Toddlers with Disabilities

Summary of Purpose, Methodology, and Limited Findings

INTRODUCTION AND PURPOSE

The Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), the Part C lead agency , with consultation from the Virginia Department of Medical Assistance Services (DMAS), designed and piloted a mini-study in two (2) local interagency coordinating councils in the Tidewater region of Virginia. The purpose of the study was to determine if there was any negative impact of Medallion II on early intervention services provided to Part C eligible children and their families. Specifically, the purpose of the study sought to identify changes in the cost, quantity and/or quality of services provided both prior to and following the November 1997 expansion of Medallion II in the counties of Suffolk, Isle of Wight, James City, York, and Gloucester and the city of Williamsburg.

STUDY METHODOLOGY

The mini-study was conducted over a period of eighteen (18) months beginning January 1, 1997 through June 30, 1998. The length of the study was chosen to ensure that at least six (6) months of data were available both prior to and following the November 1, 1997 expansion of Medallion II in Tidewater and to ensure that service costs could be isolated based on state fiscal years. The study was broken into four (4) data collection periods: *Period One* - January 1, 1997 tp June 30, 1997; *Period Two* - July 1, 1997 to October 31, 1997; *Period Three* - November 1, 1997 to February 28, 1998; and *Period Four* - March 1, 1998 to June 30, 1998.

Western Tidewater Interagency Coordinating Council and Colonial Interagency Council for Young Children, both located in the Tidewater Medallion II expansion areas, agreed to participate in the mini-study. Children and families from these two (2) sites were selected for participation based on residency and their eligibility for both Part C and Medicaid during the study period. A total of ninety-three (93) children, birth to age three (3), and their families were initially included in the mini-study. However, not all of these children and families received Part C early intervention services throughout the entire study period. Therefore, to present an accurate picture of pre- and post- Medallion II implementation, the final study sample included only twenty-four (24) children and families for whom information was obtained for the entire length of the study. Of these twenty-four (24) children and families, ten (10) were served by Colonial Interagency Council for Young Children and fourteen (14) by Western Tidewater Interagency Coordinating Council.

Western Tidewater Interagency Coordinating Council and Colonial Interagency Council for Young Children collected the following data during each of the four (4) periods of the mini-study:

1. **Provider Data:**

   1.1 Administrative Time and Costs - Administrative time associated with obtaining reimbursement from each Medicaid source (Medicaid and Medallion II HMOs) and private insurers were collected per-child. Administrative activities reported reflected such activities as obtaining preauthorization, completing and submitting paperwork required to receive reimbursement, filing appeals and following the appeals process to conclusion, and negotiating entry into participating Medallion II HMO networks.

   1.2 Reimbursement Rates - Reimbursement rates were compiled for each Part C early Intervention service per Medicaid payor.

2. **Individual Consumer Data:**

   2.1 Medicaid Program Payment Source per Consumer - For each consumer, enrollment in individual Medicaid Programs including Waivers, Medallion I, Medicaid fee-for- service, OPTIONS, EPSDT, State Plan Option, Medallion II HMOs were identified.

   2.2 Consumer Service Information - For each consumer, information on the intensity and frequency of each Part C early intervention service as listed on the IFSP and as provided were collected in order to tract access to care and the quantity and quality of Part C services provided.

   2.3 Reimbursement for Services - For each consumer, the total dollar amount billed to third party sources was recorded along with the amount received and remaining amount outstanding. This information was collected from private insurance, Medicaid, and other sources including Part C funds for each service.

   2.4 **Service Authorization, Denial and Appeal** - For each consumer, data on the authorization of each service, including denials and appeals was reported.

DATA ANALYSIS AND FINDINGS

Overall, the data gathered in this mini-study proved to be quite complex and the sample size too small to draw significant conclusions. In fact, the data collected was not comparable to Medicaid payment data, as was initially hoped, and therefore had limited meaning. Specifically, DMAS

reimbursement methodology differs significantly from reimbursement methodologies of Medallion II HMOs. In fact, payment methodology differs within each HMO. For example, Medicaid reimburses rehabilitation agencies (the providers for both Western Tidewater Interagency Coordinating Council and Colonial Interagency Council for Young Children are certified as such) based upon a cost settlement. Some Medallion II HMOs reimburse rehabilitation services in accordance with modality-based service codes while others pay per unit of service delivered. Such differences resulted in an inability to compare reimbursement rates with the actual cost of providing the service.

In addition, due to small number of children (24) in the study, the results were insufficient for the purposes of determining the overall impact of Medallion II on access to care and the quality and quantity of early intervention services provided to Part C eligible children and families. However, the data suggested several interesting and global findings:

1. This mini-study, while limited in scope, provided no evidence to suggest that services to children and families were impacted by the implementation of Medallion II in the two (2) participating Tidewater localities.

2. The overall-cost of providing early intervention services did not appear to have changed significantly as a result of Medallion II.

3. Administrative costs were impacted differentially by the various HMO's participating in Medallion II program. Overall, the administrative cost changes were determined to be associated with the cost of doing business.

In summary, the complexity of the data collected in this study, the small sample available, as well as lack of comparability to existing data resources, limited accurate and meaningful analysis. DMHMRSAS and DMAS have provided on-going technical assistance and support to local interagency coordinating councils regarding the implementation of Medallion II for Part C eligible children and remain committed to resolving any implementation issues identified.

HJR 581 Work Group for Enhancing and Integrating Medicaid Coverage of Part C of IDEA Services for Infants and Toddlers with Disabilities

Report Compiled by

Department of Mental Health, Mental Retardation and Substance Abuse Services
and
Department of Medical Assistance Services

on behalf of the

Work Group Evaluating Part C and Medicaid

January 1999

Preface

This report has been prepared at the request of the Joint Legislative Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities (HJR581), which during the 1998 Session of the Virginia General Assembly instructed the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and the Virginia Department of Medical Assistance Services (DMAS):

> [to] establish a work group to examine strategies for enhancing and integrating existing approaches for Medicaid coverage of Early Intervention Services for Infants and Toddlers with Disabilities. The membership of the work group shall include two members of [the Joint Legislative Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities] and representatives of Local Interagency Coordinating Councils (LICCs), the Virginia Interagency Coordinating Council (VICC), Community Services Boards (CSBs), and [the Virginia] Department of Education (DoE). The two members shall be a member of the House Appropriations Committee and a member of the Senate Finance Committee who also serve on this [Joint Legislative] Subcommittee. As part of its study, the work group shall provide, no later than December 15, 1998, a report on how to better coordinate and implement Part H [Part C, effective 7/1/98] services. The report should address the extent to which the program can be modified to resolve administrative problems while delivering cost effective and appropriate services to all who are in need of early intervention services for infants and toddlers with disabilities.

This report does not reflect policy of DMAS and DMHMRSAS. Both agencies participated in good faith in facilitating and documenting the activities of the work group. Furthermore, both DMAS and DMHMRSAS continue to work collaboratively to assure that services for eligible infants and toddlers with disabilities are provided and that the system is improved where indicated.

Blank

Introduction

This report, prepared at the request of the Joint Legislative Subcommittee Studying Early Intervention Services for Infants and Toddlers with Disabilities (HJR581), provides recommendations pertaining to enhancing and integrating existing approaches for Medicaid coverage of early intervention services for infants and toddlers with disabilities, as well as for addressing the extent to which the Virginia Part C program can be modified to resolve administrative problems while delivering cost-effective and appropriate services to all infants and toddlers in need of early intervention services.

The recommendations provided herein are in response to five (5) primary issues identified by the Work Group Evaluating Part C and Medicaid (the Work Group), which was formed in May 1998 in accordance with specifications provided in the legislation. In brief, the issues identified by the Work Group were:

- Under-utilization of the Early Periodic Screening Diagnosis and Treatment Program (EPSDT) for Part C services;
- Impact of reimbursement rates under Medallion II on Medicaid coverage of early intervention services;
- Impact of reimbursement rates under Medallion II on Medicaid coverage of medically-necessary services to meet the developmental outcomes of children in accordance with the Individualized Family Service Plan (IFSP);
- Impact of provider networks under Medallion II, which may limit family choice and create geographic barriers, on Medicaid coverage of medically-necessary services to meet the developmental outcomes of children in accordance with the IFSP; and
- Level of physician knowledge of, and involvement in, the Part C early intervention system, specifically in the development of IFSPs.

Background

In 1996 the Early Intervention Interagency Management Team (EIIMT) formed a small work group to follow developments in Virginia's development and implementation of managed care. The membership of this EIIMT work group was expanded, in accordance with the instructions of the Joint Legislative Subcommittee, in order to assume the responsibilities of the work group as dictated by HJR581. The membership of the Work Group is listed and included as Appendix A.

Five (5) Work Group meetings were held between May 1998 to September 1998. The purpose of each meeting was as follows:

- May 18, 1998 – A comprehensive overview of Medicaid-covered services as related to Part C early intervention was provided in order to increase participants' knowledge of Medicaid in Virginia, including the State Plan for Medical Assistance Services (the State Plan), waivers, Medallion, Medallion II, etc. (A second training meeting was held in July to assist members in understanding Medicaid services).

- June 15, 1998 – A national perspective on the impact of Medicaid managed care on state Part C systems was shared, including the successes and barriers encountered in other states and approaches for Virginia to consider. The presentation included information on how Medicaid is used to fund Part C early intervention systems.

- July 13, 1998 – Work Group participants were provided opportunities to identify issues pertaining to securing Medicaid coverage of early intervention services. Questions that were presented and responses received are included as Appendix B.

- August 24, 1998 – Preliminary data collected and analyzed by George Mason University (via contract with DMAS and DMHMRSAS) pertaining to the use of Medicaid funding and managed care implementation in other states as related to Part C early intervention was presented. The presentation included preliminary data analysis of Medicaid payments for the birth through 2-year-old (0-36 months) population in Virginia and for Part C eligible children. (The full report of the study will be submitted to the Subcommittee once complete.)

- September 14, 1998 – Work Group participants provided recommendations for the top five issues identified.

Medicaid Coverage of Part C Early Intervention Services

Currently in Virginia, Medicaid covers most health care and rehabilitation Part C services for eligible children under the State Plan, as long as those services are deemed to be medically necessary for the child. For the purposes of obtaining services under the State Plan, *medically necessary services* are those services designed to "correct or ameliorate a [child's] medical condition" when the service is a Medicaid covered service and the child meets the specific service criteria. This definition supports the provision of services per Virginia's mandated private health insurance legislation, which includes HMOs, for early intervention therapies, which defines *medically necessary early intervention services* as "those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and

shall include services that enhance functional ability without effecting a cure. However, Medicaid does not cover services solely for purposes of maintenance.

Children who are both Medicaid recipients and eligible for Part C early intervention services may obtain Medicaid coverage of early intervention services via various State Plan Medicaid Services. The Medicaid-covered services utilized most frequently for the provision and coverage of Part C early intervention services include:

- Outpatient Rehabilitation Services (physical, occupational, and speech-language therapies);
- Durable Medical Equipment (DME) (assistive technology and supportive services i.e. nursing);
- Home Health Services; and
- Community Rehabilitation Services (mental health and mental retardation services).

Refer to Appendix C for a complete listing of State Plan Medicaid Services and the equivalent Part C early intervention services.

Targeted Case Management (the State Plan Medicaid Service that is equivalent to Service Coordination under Part C) is available to individuals with MH/MR and high-risk infants up to age 2 (through the Baby Care Program).

In addition, Part C early intervention services may be provided to infants and toddlers with disabilities under Medicaid waivers. Waivers are optional programs that afford states the flexibility to develop and implement alternatives to institutionalizing Medicaid-eligible individuals. States may request waivers of certain federal rules that may impede the development of Medicaid community-based treatment alternatives. The programs recognize that many individuals at risk of institutionalization can be cared for in their homes and communities at a cost no higher than that of institutional care. To receive approval to implement a waiver, a state Medicaid agency must assure the Health Care Financing Agency (HCFA) that it will not cost more to provide home- and community-based services than providing institutional care would cost. States seeking waivers must also assure HCFA that there are safeguards to protect the health and welfare of recipients.

In Virginia, Home and Community Based Care program waivers can be used to provide early intervention services to Part C eligible infants and toddlers with disabilities. Virginia currently has six (6) Home and Community Based Care program waivers:

- AIDS;
- Adult Care Resident (ACR) Intensive Assisted Living;
- Elderly and/or Disabled (E&D);
- Consumer Directed Personal Attendant Services (CDPAS);

- Mental Retardation (MR); and
- Technology Assisted.

For children who qualify, the E&D, MR, and Technology Assisted waivers are those used for the provision and coverage of Part C early intervention services.

The target population of the E&D Waiver include individuals who are 65 years of age or older and/or individuals who are disabled, in either case who meet screening criteria and who are at imminent risk of nursing facility placement. Services available under this waiver include adult day health, respite care, and personal care.

Individuals with mental retardation or related conditions and individuals under the age of 6 at developmental risk who have been determined to require the level of care provided in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) may be eligible for services under the MR Waiver. Such services include day support, supported employment, residential support, therapeutic consultation, personal assistance services, respite care, and nursing services.

For those in need of both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care, the Technology Assisted Waiver may be of benefit. Services provided under this waiver include: private duty nursing, respite care, durable medical equipment, personal care, and environmental modification.

In order for an infant or toddler with disabilities to receive services under any of these three waivers, however, the child must be a Medicaid recipient and meet eligibility criteria, and the child's income cannot exceed set limits. The current limit is 300% of the SSI payment limit for one person ($1,414/month).

The Early Periodic Screening Diagnosis and Treatment Program (EPSDT) is another mechanism for providing and covering some services for Part C eligible infants and toddlers who receive Medicaid. EPSDT is a federally mandated program under Medicaid that provides medically necessary health care for children ages birth to 21. EPSDT is characterized by a series of periodic health screenings that include:

- an unclothed physical examination;
- immunizations;
- lab work;
- a health history;
- developmental screenings;
- anticipatory guidance; and
- vision, hearing and dental screenings.

Any child under the age of 21 with a Medicaid card is eligible for EPSDT screenings. Federal regulations require that DMAS assure that all Medicaid recipients are:

- informed of the availability of EPSDT services;
- provided the screening service when requested; and
- receive any medically necessary service discovered as a result of the screening, as long as that service is covered under Section 1905 (a) of the Social Security Act.

Both Part C and EPSDT are entitlement programs, but they differ in their eligibility requirements. When family income meets financial criteria set by Medicaid or another program that triggers Medicaid eligibility (such as TANF or SSI), children under the age of 21 are eligible for EPSDT. Part C eligibility is based on the child's developmental needs as defined by federal and state laws, without regard to family income.

Participation in EPSDT and Part C is voluntary on the part of Medicaid recipients and providers. However, participation should be encouraged because:

- EPSDT is a way for at-risk infants and toddlers in low-income families who may or may not be in the Part C early intervention system to be identified and connected to a network of services if a medical problem arises; and

- Children identified with developmental delay or diagnosed handicapping conditions through EPSDT can be referred to the Part C system for a comprehensive developmental assessment, which is the diagnostic step of EPSDT and is reimbursable by Medicaid.

National Strategies

States across the nation have implemented differing strategies for ensuring that Medicaid is maximized as a source of funding for Part C early intervention services. For example, some states have provided for Part C services by making all of the mandatory and optional services available under Section 1905 (a) of the Social Security Act as state plan covered services. Other states have expanded the use of the Early Periodic Screening Diagnosis and Treatment Program (EPSDT) or allowed all services described in the child's IFSP to be reimbursed by Medicaid. Still others utilize waivers specific to children eligible for Part C (e.g., some Part C children have been included in Mental Retardation and Developmental Disabilities (MR/DD) waivers to maximize the federal participation for long-term community supports and family preservation services.)

Virginia is currently attempting to identify the extent to which Medicaid is maximized as a source of funding for Part C early intervention services statewide and potential strategies for improvement. To this

end, a study is underway at George Mason University (via contract with DMAS and DMHMRSAS) which will help to isolate Medicaid payments for the birth through 2-year-old (0-36 months) population in Virginia and for Part C eligible children. Furthermore, the study will provide greater detail on mechanisms employed by other states as related to Part C early intervention and obtaining Medicaid coverage of these services.

Issues and Recommendations
Pertaining to Medicaid Coverage of Part C Early Intervention Services

Although there was general agreement among Work Group participants that Medicaid coverage for many Part C early intervention services (notably therapies, transportation, and assistive technology services and devices) has proven to be adequate over the years, issues regarding access to Medicaid coverage of Part C early intervention services were identified nonetheless. Issues and recommendations include:

- Utilization of the Early Periodic Screening Diagnosis and Treatment Program (EPSDT) for Part C Services

  It appears that EPSDT is under-utilized in Virginia by the Part C service system for either child find or for coverage of early intervention services. Work Group members suggest that this is due to a lack of education about the program. According to the workgroup members, families and service providers may be unfamiliar with how to access EPSDT, and not all physicians are familiar with early intervention and EPSDT.

  - **Recommendations -**

    - Request DMAS to enhance and expand training to Part C on the availability of, accessing and using, EPSDT; and

    - Part C providers assist DMAS in educating recipients on EPSDT services.

      [NOTE: DMAS has already developed a new outreach process to educate recipients regarding EPSDT. Language was added to the managed care contracts to ensure that the EPSDT screenings are done. DMAS will continue to work with DMHMRSAS to ensure that Part C staff and providers understand EPSDT. EPSDT services are listed in the recipient handbook, which is given to all recipients and is available to everyone on the Internet at the DMAS site.]

- Reimbursement Rates

  - Impact of reimbursement rates under Medallion II on Medicaid coverage of early intervention services – Reimbursement rates for early intervention service providers under Medallion II are less than the rates provided under Medicaid fee for service, which has impacted the providers' ability to provide the services required by the Part C children.

    [NOTE: The providers negotiated and voluntarily agreed to contract with the HMOs at a certain rate. HMOs report that Part C providers are requesting rates much higher than industry standards.]

  - Impact of reimbursement rates under Medallion II on Medicaid coverage of medically-necessary services to meet the developmental outcomes of children in accordance with the Individualized Family Service Plan (IFSP) – In some instances there is a major decrease from fee for service Medicaid where rehabilitation agencies are cost settled. The group felt the reduction in reimbursement results in cost shifting to Part C.

    [NOTE: This study did not seek to verify rates or identify cost shifting. The agencies are aware that there are instances when the providers reduced services and/or used Part C funding when they felt the reimbursement under their contract with the HMO was insufficient. As these issues were discussed with HMOs, rates and agreements with network providers have been modified.]

  - **Recommendations –**

    - DMAS should monitor rates of reimbursement across HMOs for Part C providers and ensure rates are sufficient to attract providers to the networks; and

    - DMHMRSAS should develop and provide technical assistance to localities that identifies flexible alternatives for the provision of services to support local cost-saving strategies and local provider efforts to implement alternative and cost-effective methods for providing services.

- Impact of provider networks under Medallion II, which may limit family choice and create geographic barriers, on Medicaid coverage of medically necessary services to meet the developmental outcomes of children in accordance with the IFSP.

- **Recommendations –**

  - DMHMRSAS should: a) develop and implement technical assistance for localities that encourages and ultimately requires LICCs to expand local service provider networks; b) work with localities to identify (i.e., "map") current local networks; and c) have LICCs share these maps with HMOs and other LICCs statewide; and

  - DMAS should continue to monitor contracts to ensure a variety of providers in the networks in accordance with contracts to meet access standards.

    [NOTE: DMAS instituted contract language specifically addressing children with special needs and network requirements.]

- Level of physician knowledge of, and involvement in, the Part C early intervention system, specifically in the development of IFSPs – Physicians need to be educated about early intervention and their involvement in the development of IFSPs. They are unfamiliar with the Part C system, eligibility determination, referral procedures, and timelines.

  - **Recommendations –**

    - Continue current efforts of DMHMRSAS and LICCs to educate physicians, specifically, and the State's populace, generally, about Part C early intervention services for infants and toddlers with disabilities (i.e., public awareness efforts); and

    - DMAS should continue its efforts to require participating physicians and other health providers to refer children to Virginia's Part C early intervention system.

      [NOTE: Specific language requiring referrals to Part C was added to the HMO contracts.]

Conclusion

Throughout the workgroup sessions, the members were reminded by DMAS and DMHMRSAS staff that the charge from the Subcommittee encompassed all Medicaid covered services for Part C children. Questions that were posed to the workgroup to identify issues covered all Medicaid services. At the final meeting, it was again brought to the attention of the group that the issues prioritized by the group did not identify any administrative issues related to Medicaid covered services, including waivers. The Work Group did not find issues related to Medicaid coverage of Part C early intervention services. Two of the five issues prioritized focused on Medallion II and reimbursement rates to Part C providers, and another

focused on Medallion II and whether or not Part C providers are sufficiently represented and included within Medallion II provider networks. DMHMRSAS has initiated technical assistance to assist localities in mapping and expanding Part C provider networks.

One of the five identified issues related to EPSDT. DMAS has already developed a new outreach process to educate recipients regarding EPSDT. Language has been added to managed care contracts to ensure that the EPSDT screenings are completed. Furthermore, DMAS will work with DMHMRSAS to ensure that Part C staff and providers understand EPSDT.

The other issue addressed physician knowledge regarding Part C and the IFSP. DMHMRSAS contracts for continued provision of physician training will be renewed.

DMAS has made a number of changes in the HMO contracts since the inception of Medallion II in January of 1996 to address the needs of special populations and will continue to monitor issues and provider networks and will make changes as necessary.

Blank

Workgroup for Enhancing and Integrating Medicaid Coverage of Part C of IDEA Services for Infants and Toddlers with Disabilties

Legislators

Delegate Mary T. Christian P.O. Box 1892 Hampton, VA 23669	(757) 723-6060 (757) 723-6068 F
Senator Malford W. "Bo" Trumbo P.O. Box 448 Fincastle, VA 24090	(540) 473-6781 (540) 473-2188 F
Delegate Marian Van Landingham City Hall 301 King Street Alexandria, VA 22314	(703) 549-2511 (703) 548-0733 F

Participants

Mary Allen	(757) 552-7292 (757) 552-7149 F
Leslie Anderson Virginia Department of Social Services (DSS) 730 East Broad Street Richmond, VA 23230	(804) 692-1273 (804) 692-2215 F
Cynthia Banks	
Kate Bishop-Peusner Chartered Health Plan 4701 Cox Road, Suite 101 Glen Allen, VA 23060	(804) 418-6626 (804) 418-6647 F

Betty Beruard
MAMSI
11 Taft Court
Rockville, MD 20850
(301) 545-5864
(301) 545-4780 F

Nancy Bivens
MAMSI
4 Taft Court
Rockville, MD 20855
(301) 545-5864
(301) 545-5897 F

Cathy Bodler

Linda Bradford
Virginia Department of Education (DoE)
Regional Services
P.O. Box 2120
Richmond, VA 23216
(804) 225-2675
(804) 371-8796 F

Christy Bruns
MAMSI
11 Taft Court
Rockville, MD 20850
(301) 545-5862
(301) 545-5893 F

Deana Buck
Richmond Infant Council
VCU Box 843020
Richmond, VA 23284-3020
(804) 828-2742
(804) 828-0042 F

Debbie Burcham
Henrico Parent-Infant Program
10299 Woodman Road
Glen Allen, VA 23060
(804) 261-8520
(804) 261-8469 F

Jamie Clark
Southern Health Insurance
9881 Mayland Drive
Richmond, VA 23233

Richard Corbett
Virginia Part C Office
c/o DMHMRSAS
P.O. Box 1797
Richmond, VA 23218-1797

(804) 786-5817
(804) 371-7959 F

Anita Cordill
Virginia Department of Medical
Assistance Services (DMAS)
600 East Broad Street
Richmond, VA 23218

(804) 371-8855
(804) 371-4981 F

Bob Craig
MAMSI
3951 Westerre Parkway, #260
Richmond, VA 23233

(804) 270-7732
(804) 967-0844 F

Tracey Cramer
Alexandria Parent-Infant Education
517 North St. Asaph Street
Alexandria, VA 22314

(703) 838-5067
(703) 838-5070 F

Brenda Crockett
Chesapeake Infant Program
1417 N. Battlefield Blvd.
Chesapeake, VA 23320

(757) 547-8929
(757) 547-3595 F

Ann de Strowlinski
MAMSI
4 Taft Court
Rockville, MD 20855

(301) 545-5855
(301) 585-5893 F

Kathleen Dickerson
Virginia Department of Medical
Assistance Servcies (DMAS)
600 E. Broad Street
Richmond, VA 23219

(804) 786-7956
(804) 786-0972 F

Mary Ann Discenza
Virginia Part C Office
c/o DMHMRSAS
P.O. Box 1797
Richmond, VA 23219
(757) 259-0302 (v/F)

Debbie Dutton
Priority Health Care
621 Lynnhaven Parkway
Virginia Beach, VA 23452
(757) 431-5767
(757) 340-2329 F

Jeanne Fink
Priority Health Care
621 Lynnhaven Parkway, Suite 450
Virginia Beach, VA 23452
(757) 431-5765
(757) 340-2329 F

Cathy Gregory

Dr. Richardson Grinnan
2221 Edward Holland Drive
Richmond, VA 23229

Jeff Harlow
Virginia Part C Office
c/o DMHMRSAS
P.O. Box 1797
Richmond, VA 23219
(804) 786-8336
(804) 371-7959 F

Jean Hearst
Rehabilitation Associates
933 First Colonial, Suite 204
Virginia Beach, VA 23454
(757) 425-8835
(757) 425-5803 F

Elisabeth Hutton
Virginia Department of Health (VDH)
1500 East Main Street
Richmond, VA 23218
(804) 371-4099
(804) 371-6031 F

Francis Imobisa
MAMSI
3951 Westerre Parkway, #260
Richmond, VA 23233
(804) 270-2700
(804) 270-6479 F

Kim Jeremiah
Richmond Area ARC/Infant Intervention Services
1901 Westwood Avenue
Richmond, VA 23228
(804) 358-1874
(804) 353-0163 F

Barbara Klear
Norfolk Public Schools
P.O. Box 1357, Room 1002
Norfolk, VA 23501
(757) 441-1471
(757) 441-2197 F

Amy Kradel
MAMSI
4 Taft Court
Rockville, MD 20850

Bob Levin
Richmond Area ARC/Infant Intervention Services
1901 Westwood Avenue
Richmond, VA 23228
(804) 358-1874
(804) 353-0163 F

Marie E. Louis-Jeune
1976 Wellsford Drive
Virginia Beach, VA 23454
(757) 721-5222 (v/F)

Anne Lucas
Virginia Part C Office
c/o DMHMRSAS
P.O. Box 1797
Richmond, VA 23218-1797
(804) 371-6592
(804) 371-7959 F

Amy Marschean
Division of Legislative Services
General Assembly Building, 7th Floor
Richmond, VA 23219
(804) 786-3591 / x 224
(804) 371-0169 F

Joanna G. Ogbonna	(757) 827-2347 (757) 827-2340 F
Alan Phillips Fairfax-Falls Church ICC 3750 Old Lee Highway Fairfax, VA 22030	(703) 246-7170 (703) 246-7307 F
Geri Pratt Chesapeake Center (Tidewater)	(757) 565-1570 (757) 565-4431 F
Wanda Pruett HCR 67, Box 2050 Jamaica, VA 23079	(804) 758-3351 (804) 758-8060 F
Hubie Register Peninsula Health Care 606 Denbigh Boulevard, Suite 500 Newport News, VA 23602	(757) 875-5195 (757) 875-5785 F
Tammi Rittenhouse The Children's Center 700 Campbell Avenue Franklin, VA 23851	(757) 562-6806 (757) 562-2992 F
Lisa Rogers Thomas Child Development Resources P.O. Box 280 Norge, VA 23127-0280	(757) 566-3300 (757) 566-8977 F
Pat Rogers Chesapeake Center 6506 Loisdale Road Springfield, VA 22150	(703) 924-4100 (703) 922-5048 F
Chris Rowe Infant Intervention Services 1901 Westwood Avenue Richmond, VA 23227	(804) 358-1874

Alfreda Smith
HealthKeepers Plus
621 Lynnhaven Parkway, Suite 450
Virginia Beach, VA 23452

(757) 431-5263
(757) 340-0317 F

Carol Smith
Peninsula Health Care
606 Denbigh Boulevard, Suite 500
Newport News, VA 23602

(757) 875-5791
(757) 875-5785 F

Clarissa Sweeney
Sentara Family Care
4417 Corporation Lane
Virginia Beach, VA 23462

(757) 552-8916
(757) 552-7396 F

Tammy Whitlock
Virginia Department of Medical
Assistance Services (DMAS)
600 East Broad Street
Richmond, VA 23218

(804) 786-0167
(804) 225-4393 F

Nancy Wilson
2090 Strawberry Run
Crozier, VA 23039

(804) 784-2337
(804) 784-3365 F

Blank

Issues

The goal of this exercise was the identification of successes and barriers to accessing Medicaid funding for Part C early intervention services for infants and toddlers with disabilities.

Current effective undertakings that are already occurring for coordinating and integrating Part C and Medicaid –

NOTE: Med FFS = Specific comment about Medicaid Fee-for-Service; HMO = Specific comment about Health Maintenance Organizations; an asterisk (*) indicates repeated response

1. Which early intervention services do you feel are sufficiently covered by Medicaid?

    a. early intervention services [are] covered sufficiently, except service coordination
    b. testing, therapies, and durable medical equipment [are well covered] [Medicaid FFS; HMOs]

2. Identify five successful strategies that are currently being used in identifying and referring potentially eligible Part C children between Medicaid and early intervention systems.

    a. [Allows for] child find through non-traditional means
    b. [Enables] early identification and coordination with primary care physicians for services; children are being adequately identified [HMOs]
    c. Pre-authorizing process [helps to] identify other services [needed by child]; education of physicians in early intervention in holistic manner - increasing child find [HMOs]
    d. DMAS has identified specific people to help with Part C, coverage issues, etc.
    e. Getting public health nurse out early to assess newborns (early identification) [Med FFS]

3. What are some effective undertakings for transitions of children to carved-out Medicaid services such as waivers or long-term care institutions?

    a. Pre-natal case managers can identify the need for services early and provide continuity of care for [...illegible] [HMOs]

4. What are some successes related to securing waiver services such as private duty nursing, personal care, respiratory therapy, and respite care for medically fragile children under either the Technology Assisted Waiver, the MR Waiver, or the Elderly and Disabled Waiver?

    a. Children exit hospitals with needed services in place (few need these services, but for those who do, they are ready) [Med FFS]
    b. Waiver(s) provide options for families (*) [Med]
    c. [MR Waiver] effective tool for families ineligible for Medicaid

5. What are some examples of children accessing services (i.e., referral, provision of evaluation and treatment services) under EPSDT?

    a. [HMOs] are promoting education efforts specific to EPSDT-type programs (e.g., TOTTS)

6. What are some practices being used by Medicaid that ensure coverage of medically necessary services to meet the developmental needs of the child in accordance with the IFSP?

   a. Cost reporting under waiver includes transportation, etc. (*) [Med FFS]
   b. IFSP = a tool to ensure services are being coordinated [HMOs]
   c. Cost settlement allows services that are needed in whatever environment the child needs [Med FFS]

7. Can you identify successes for families receiving psychological or psycho-therapy services related to Medicaid reimbursement for these services?

   a. If Medicaid eligible, reimbursement successful under FAPT (Family Assessment and Planning Team)
   b. Primary care physicians' relationship with Mental Health – need to work closely for referrals to CSBs and/or Part C – early intervention – providing information to insurance companies (providers list, LICCs)

8. What are some efficient and effective procedures being used in pre-authorizing medically necessary early intervention services under Medicaid?

   a. Experience with Part C helps to facilitate the pre-authorization process [HMOs]
   b. After 24th visit, process over time has become clearer, consistent, assists with controlling the kinds of services provided [Med FFS]
   c. [Pre-authorization for] 24 visits [is] efficient and effective
   d. Case managers have been knowledgeable about accessing early intervention providers
   e. [It is] important for case managers to be involved with pre-authorization and to have experience with Part C early intervention
   f. Pre-authorization helps case managers to develop a clearer picture of the child's total needs

9. Give three examples of linkages between Medicaid transportation providers and early intervention services.

   a. Medicaid has provided funds to provide transportation [Med FFS]

10. What is your experience with involving primary care physicians in the development of IFSPs?

    a. Role of primary care physician in referral and approval of plans

11. General comments–

    a. Effective communication, education between early intervention [Part C system], Medicaid and concerned case managers in Medicaid health systems
    b. [These] Medicaid meetings have been educational and successful

Concerns about Medicaid coverage of early intervention services –

Refer to the attached charts for a summary of issues and concerns identified by workgroup participants.

Question 1 What are your concerns about Medicaid coverage of early inte .ion services?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - most urgent & feasible Green (G) - 2nd most urgent & feasible Yellow (Y) - 3rd most urgent & feasible**
1. **Process for referral**	Streamline the process for referrals to early intervention services.	⇦ No dots	
2. **Coordination and continuity of care**	Information needs to be available on services that have been received from other HMOs.	⇦ No dots	
3. **Identification**	Need more Part C providers. Who are the current providers? Which ones are interested in participating in an HMO network (if not already)?	⇦ **R-2**	
4. **Reimbursement**	Issues regarding rates for early intervention service providers need resolution. Rates are down between 30%-80%. DMAS includes for fee-for-services (cost settlement) into HMO capitation rate.	⇦ **R-4, G-3, Y-2**	
	Other states reimburse early intervention services broadly rather than by specific services. Virginia needs to look at other states' approaches (i.e., developmental therapy).	⇦ **G-1**	
5. **Services covered**	Service coordination not consistently covered.	⇦ No dots	
	Lack of clarity regarding payment for non-medically necessary travel in order to cover natural environment.		
	HMOs drop coverage when a child transitions from early intervention to school programs (not covering additional therapy over what's on the IEP).		
	Medicaid coverage is based on services for whole population and other populations. Early intervention children are funded by various Medicaid sources.		
	Limited amount of resources for services from Medicaid and HMOs.		

Response Themes	Specific Issues	Concern Factor	Red (R) - most urgent & feasible Green (G) - 2nd most urgent & feasible Yellow (Y) - 3rd most urgent & feasible
6. Education	Knowledge deficit regarding benefits (providers, HMOs, primary care physicians, etc.)	⇦ **R-1**	
7. Preauthorization	There is misinformation regarding the purpose.	⇦ No dots	
	Early intervention providers are finding the process to be burdensome.		
	A lack of consistency.		
	Need for clearly-focused, short-term goals to determine progress.		
8. Access	Access to early intervention providers is limited in some areas (i.e., some HMOs have only one early intervention provider who must cover a large area).	⇦ No dots	
	Babies (during 1st 90 days) do not have access to Medicaid reimbursement for early intervention services (under mother's Medicaid plan).		
9. General	Families dis-enrolling (changing HMOs) frequently.	⇦ No dots	

Question 2	hat are your concerns about coordination between local Med	programs and early intervention systems?	
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Education**	There is a lack of education to early intervention providers on Medicaid managed care (i.e., HMO processes such as billing and contracting).	⇦ R-1, G-2	
	(?) does not understand or even like Part C.		
	HMOs cannot access Part C funds.		
	Medicaid managed care needs education to better know Part C requirements (e.g., natural environments)		
2. **Direct services**	Length of therapy sessions; duration of services; profit motive affecting decisions; continuity of care; not enough providers in networks; lack of physician involvement	⇦ Y-1	
3. **Communication**	Lack of communication between systems (e.g., DSS should play bigger role in child find).	⇦ G-1, Y-1	
4. **Coordination**	Lack of coordination between systems (i.e., children not identified; fragmented services; fragmented reauthorization.	⇦ Y-1	
5. **Service coordination**	Not assertive enough; service coordinators are connected to service providers (conflict of interest); Part C service coordinators do not know how to access Medicaid programs; providers trapped between service coordinators and HMOs; exclusionary attitude toward HMO case managers.	⇦ No dots	

Question 3 → What are your concerns about state-level coordination between the Lead Agency (DMHMRSAS) and the Department of Medical Assistance Services (DMAS)?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Communication**	Poor communication between the agencies.	⇦ **R-2, G-1, Y-1**	
	Dissemination of information and knowledge.	⇦ **G-1**	
2. **Conflicts between agencies**	There is inherent conflict between the rules and regulations of the agencies	⇦ **Y-2**	
	The goals of agencies are in conflict.	⇦ No dots	
3. **Decision making**	Are decisions being made based upon political philosophies vs. reality of the needs of families and current laws?	⇦ **R-1, G-2**	

Question 4 → ...at are your concerns about accessing waiver services under ei... the Technology Assisted Waiver, MR Waiver, or Elderly and Disabled Waiver?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Access "how-to's"**	Existence of waivers needs to be advertised.	⇦ No dots	
	Qualifications for waiver are unclear.		
	There is a need for a manual and/or clear protocol.		
	There is no known central point of contact for the waiver programs.	⇦ **G-1, Y-4**	
2. **Waiver issues (general)**	Service gaps.	⇦ **G-1**	
	Local match for funding prevents utilization.	⇦ No dots	
	Coordinating services via physicians (?)		
	Demoralization of families due to long wait.		
	Lack of political support for waiver programs.		
	Two-tiered system when waivers drive service provision.		
3. **Waiting lists**	Significant waiting list for the MR waiver.	⇦ **R-1**	
	No emergency plan for access.	⇦ No dots	
4. **Criteria for participation**	Stringent criteria for Tech waiver results in limited access to program and providers.	⇦ No dots	
	Need different standards for adults and children.	⇦ **R-1**	
5. **Timelines**	Timelines for screening, implementation unclear.	⇦ No dots	
	Lengthy screening process and insufficient staff.		
	Responsibility during lengthy transition time is unclear.		
	Need dedicated case managers for waiver participants.		

Question 5 → What are your concerns about accessing services under the Early Periodic Screening and Diagnostic Tool?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Education**	Who is responsible for screening?	⇦ R-4, G-8, Y-3	
	Training needed on: tracking, screening and continuity of care; follow-up treatment; funding of diagnostic services and treatment; and accessing EPSDT.		
	Efforts to educate DMAS, HMOs, and providers are needed.		
	Ongoing technical assistance is needed.		
	Encounter data coding (?)		
	There is a lack of information and advertising about EPSDT.	⇦ Y-1	
2. **Fragmented services**	Transfer between HMOs, variety of providers, and eligibility; continuity of services affected.	⇦ No dots	
3. **Quality control**	Quality control	⇦ Y-2	

Question 6 → What are your concerns about Medicaid's pre-authorization process?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Obtaining preauthorization**	Pre-authorization for services is obtained, additional information is requested, and then, after services are provided, the claims department denies.	⇦ No dots	
	Authorization by telephone only; calls averaging 20 minutes.		
	Timeliness of preauthorization (providers and HMOs); too many hoops to jump through.		
	Provider provides inadequate clinical information and/or paperwork is lacking.		
	Frequency of on-going authorization; PT vs. OT vs. SLP authorized differently.		
	Inconsistency among Medicaid HMO preauthorization procedures.		
	HMOs need to look at each child individually and care should be authorized differently.		
2. **Reimbursement**	Change in Medicaid preauthorization system that does not allow retroactive reimbursement.	⇦ No dots	
3. **Case management**	Consistency and access to/of HMO case managers.	⇦ **R-1**	
	Case managers need education regarding all early intervention services.	⇦ **Y-2**	
4. **Eligibility criteria**	Eligibility criteria for developmental delay vs. medically necessary.	⇦ No dots	
5. **Communication**	Communication between providers and HMOs (assumptions are made).	⇦ **R-3, G-2**	
6. **Method for identification**	Preauthorization should be a method for identifying children and avoiding fragmentation.	⇦ No dots	

Question 7 → What are your concerns about transitions of children to carved-out Medicaid services?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Coordination**	Coordination of Part C and other services, such as carved-out services (e.g., school-based services) and waivered programs.	⇦ G-1, Y-1	
2. **Continuity of care**	From managed care to fee-for-service	⇦ Y-1	
3. **Communication**	Between case managers	⇦ R-1	
4. **Waiting lists**	Waiver enrollment wait time.	⇦ No dots	
5. **Education**	Of all players.	⇦ G-1	

Question 8 → What are your concerns about Medicaid coverage of medically-necessary services to meet the developmental outcomes of children in accordance with the Individualized Family Service Plan (IFSP)?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Definition of *medical necessity***	Who defines *medical necessity*?	⇦ **Y-1**	
	How can the definition be applied consistently?		
	Where does developmental delay fit into the definition?		
2. **Provider networks**	Provider networks limit family choice; geography is a barrier.	⇦ **R-2, G-3, Y-2**	
3. **Reimbursement rates**	Major decrease from fee-for-service to Medallion II. Cost shifting to Part C. Emphasis on cost containment.	⇦ **R-5, G-2, Y-1**	
	Virginia Department of Medical Assistance Services (DMAS) is spending the same amount on the system, but children are receiving fewer services. What is the benefit?		
4. **Natural environments**	• Part C and medical models are incompatible.	⇦ No dots	
5. **Fragmentation of services**	• Who is ultimately responsible for the coordination of service?	⇦ No dots	
6. **Sharing of information on the IFSP**	• Medallion II case managers do not receive information; identification of Part C children	⇦ No dots	
7. **Small size of Part C population; costs**	• HMOs are concerned that Part C services are very expensive and eligible children are a small percentage of the total numbers served.	⇦ No dots	

Question 9 → What are your concerns about physician involvement in the development of Individualized Family Service Plans (IFSPs)?			
Response Themes	**Specific Issues**	**Concern Factor**	**Red (R) - of most concern Green (G) - of stronger concern Yellow (Y) - of strong concern**
1. **Education**	Physicians are unfamiliar with the Part C system (e.g., eligibility, referral procedures, timelines.)	⇦ R-2, Y-4	
	Who is responsible for providing the training? (State or localities? Initial? Ongoing? What are the best strategies?)		
	Expanding training to include staff.		
2. **Time**	Physicians have little or no time to be trained, to identify children, and to participate in IFSP process.	⇦ No dots	
	Meeting Part C timelines; impact of pre-authorization process.		
3. **How physicians participate**	Physicians are not pulled in early enough.	⇦ No dots	
	Physicians are consulted for IFSP sign-off only.		
	Physicians need to understand the importance of "team" membership and their roles in comprehensive IFSP development.		
4. **Systems issues**	Who is responsible for ensuring physician participation and involvement?	⇦ G-1, Y-1	
	Physicians concerned about over-prescribing services.		
	Disincentives for referral to Part C (?)		

Concerns about Medicaid Coverage ırly Intervention Services

Participants were asked to place red, green, and yellow dots beside those items that they felt were most urgent and feasible (to address) as identified by workgroup participants.

Red = most urgent and feasible
Green = 2nd most urgent and feasible (i.e., just behind red)
Yellow = 3rd most urgent and feasible (i.e., right behind red and green)

Listed below are the five topics/issues identified by workgroup participants most frequently as "urgent and feasible" –

1. **Question 5** (page 9) - What are your concerns about accessing services under the Early Periodic Screening Diagnosis and Treatment Program (EPSDT)?

   Response Theme(s) - Education / Dots - Red (4), Green (8), Yellow (3) [Total = 15]

2. **Question 1** (pages 4-5) - What are your concerns about Medicaid coverage of early intervention services?

   Response Theme - Reimbursement / Dots - Red (4), Green (3), Yellow (2) [Total = 9]

3. **Question 8** (page 12) - What are your concerns about Medicaid coverage of medically-necessary services to meet the developmental outcomes of children in accordance with the Individualized Family Service Plan (IFSP)?

   Response Theme(s) - Reimbursement Rates / Dots - Red (5), Green (2), Yellow (1) [Total = 8]

4. **Question 8** (page 12) - What are your concerns about Medicaid coverage of medically-necessary services to meet the developmental outcomes of children in accordance with the Individualized Family Service Plan (IFSP)?

   Response Theme(s) - Provider Networks / Dots - Red (2), Green (3), Yellow (2) [Total = 7]

5. **Question 9** (page 13) - What are your concerns about physician involvement in the development of IFSPs?

   Response Theme(s) - Education / Dots - Red (2), Yellow (4) [Total = 6]

Workgroup participants are encouraged to provide in writing their ideas and suggestions for potential strategies for addressing these topics/concerns. Please respond to this by September 1, 1998. A compilation of suggestions received will be shared at the final workgroup meeting in September. Responses should be sent to:

DMHMRSAS - Early Intervention
c/o Richard Corbett
Madison Building - 10th Floor
P.O. Box 1797
Richmond, Virginia 23218-1797
(or you may fax your recommendations to (804) 371-7959)

Blank

State Plan Medicaid Services	Early Intervention Services	Description & Limitation of Services
Outpatient Hospital Services	Medical/Health	Preventive, diagnostic, therapeutic, rehabilitative
Inpatient Hospital Services	Medical/Health	Inpatient medical & surgical services. Also includes: transplants, kidneys, corneas, liver, heart, bone marrow and other medically necessary transplants for children under 21
Home Health Services	PT/OT/SLP/Health/Nursing	Nursing services, home health aides, 32 visits; DME, PT/OT/SLP-audiology, 24 visits without preauthorization
Dental Services	Medical/Health	Dental services for all enrollees under age 21, orthodontics when preauthorized
Early, Periodic, Screening, Diagnosis & Treatment	Evaluation/Assessment	See periodicity schedule. Note: all Medicaid covered services require some type of assessment and evaluation to determine medical necessity
Medical Care	Physicians/Medical/Health/ Vision	Podiatrists-diagnostic, medical or surgical treatment for disease, injury or defects of the human foot Optometrists-diagnostic examination & Optometry treatment procedures and services covered for all recipients
Physicians Services	Physician/pediatricians, psychologists etc. Psychological/Individual & Family Counseling	Outpatient Psychiatric services, psychological testing. Psychotherapy limited to 26 visits in the first year without preauthorization Pediatricians, family practice physicians
Therapies	PT/OT/SLP/audiology	PT/OT/SLP-audiology 24 visits without PA
Drugs, dentures, prosthetic devices and eyeglasses	Medical/Health/Assistive Technology/Vision	Pharmacy services, dentures for recipients under 21, Prosthetics-artificial arms, legs and items necessary for attaching Eyeglasses for children under 21
Rehabilitative Services	PT/OT/SLP/ Health/Nursing Psychology/ Social Work	Inpatient skilled rehab nursing, PT, OT, SLP, cognitive rehab, prosthetic-orthotic services, psychology, social work and therapeutic recreation with preauthorization
Durable Medical Equipment	Assistive Technology	Medically necessary equipment and supplies excluding home modifications and non-medical equipment

State Plan Medicaid Services	Early Intervention Services	Description & Limitation of Services
Case Management	Service Coordination	High Risk Infants up to Age 2
Long Term Care	Medical/Health	Nursing facility placement for individuals who cannot be cared for in the community, may include specialized care.
Laboratory & X-ray Services	Medical/Health	All medically necessary
Transportation	Transportation	All medically necessary transportation

Note: Consult the provider manuals for details regarding limitations, preauthorization requirements etc.

MEDICAID WAIVER PROGRAMS	Early Intervention Services	Description & Limitation of Services
Elderly & Disabled Waiver	Health	Provides Personal Care & Respite Care for individuals at risk for nursing facility placement without these services.
Technology Assisted Waiver	Health/Assistive Technology	Personal Assistance, Private Duty Nursing, Respite Care, Respiratory Therapy, DME for individuals who are technology dependent
Aids Waiver	Health	Diagnosis of AIDS or ARC & score >70 on Karnofski scale
MR Waiver	Health/Assistive Technology	Crises stabilization, Day support, Residential Support, , Personal assistance, Respite care, Assistive technology, Environmental modifications, Supportive employment , Nursing services, and Therapeutic consultation for individuals who meet ICF/MR criteria

STATE PLAN OPTION SERVICES	Early Intervention Services	Available through CSBs only
Community Behavioral Health Services/Clinic Services	Health	Intensive In-Home Services, limited to 26 weeks annually. (Under 21 only)
		Therapeutic day treatment, 789 units annually (unit is 2 or more hours) Under 21 only
		Day Treatment/Partial Hosp 2+hrs per day-limited to 780 units includes diagnostic, medical, psychiatric, psychosocial & psychoeducational treatment modalities for individuals who require coordinate, intensive, comprehensive & multidisciplinary outpt treatment
		Psychosocial rehab 2+hrs per day limited to 936 units include assessment, education to teach about MI and Meds
		Crisis Intervention-limited to 180 hrs immediate MH care
		Intensive community treatment 26 sessions ICT defined as medical psychotherapy, psychiatric assessment & medication mgmt offered to outpt outside the clinic, hospital or office setting
		Crisis Stabilization-limit 8 hrs per day, 60 days per yr
		Mental health support services, 31 units per month
		Case Management-MI & MR

MANAGED CARE MEDICAID PROGRAMS	Early Intervention Services	
Medallion	All the above	PCP care coordination, provides State Plan covered services
Medallion II	All the above	Health Maintenance Organizations, mandatory enrollment, provides State Plan covered services
Options	All the above	Health Maintenance Organizations, optional enrollment, provides State Plan covered services

*Exclusions from participating in "**MEDALLION**", individuals who are:*

a) inpatients in mental hospitals and skilled nursing facilities
b) receiving personal care
c) in foster care or subsidized adoption programs, who are members of spend down cases, or who are refugees
d) receiving Medicare

*Exclusions from participating in **Medallion II**, individuals who are:*

a) inpatients in state mental hospitals
b) approved by DMAS as inpatients in long-stay hospitals, nursing facilities, or intermediate care facilities for the mentally retarded
c) placed on spend-down
d) participating in federal waiver programs for home and community-based Medicaid coverage
e) in foster care or subsidized adoption
f) in the third trimester of pregnancy
g) reside outside their area of record for greater than 60 days except those individuals placed there for medically necessary services funded by the HMO
h) in a Medicaid approved hospice program
i) ave any other comprehensive group or individual health insurance coverage

1999 SESSION

ENROLLED

HOUSE JOINT RESOLUTION NO. 724

Requesting the Department of Medical Assistance Services to report on early intervention services for infants and toddlers with disabilities.

Agreed to by the House of Delegates, February 25, 1999
Agreed to by the Senate, February 23, 1999

WHEREAS, Part C of the Individuals with Disabilities Act is a federal grant program to provide early intervention services to infants and toddlers with disabilities and to their families; and

WHEREAS, Virginia entered into full implementation of the Part C program in 1993 and it soon became evident that early intervention services are of vital importance to Virginia's families with infants and toddlers with disabilities and that, because early intervention services can prevent or mitigate numerous problems, the expansion of early intervention services will ultimately benefit all citizens of the Commonwealth; and

WHEREAS, because of the expanded use of capitated managed care plans for Medicaid beneficiaries, the Department of Medical Assistance Services in 1998 undertook an evaluation of the impact of managed care on Virginia Medicaid expenditures, providers, and beneficiaries of services to Part C children; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services be requested to report on early intervention services for infants and toddlers with disabilities. The report shall discuss (i) efforts to enhance and expand training on the availability of, access to and use of Early Periodic Screening and Diagnosis and Treatment and (ii) contracts between HMOs and the Department to evaluate Part C provider participation in the network in order to meet access standards and to allow recipients greater choice. The report shall include an analysis of rates of reimbursement across HMOs to assure the rates are sufficient to attract providers to the HMO networks.

All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

The Department shall complete its work in time to submit its findings and recommendations by December 1, 1999, to the Governor and the 2000 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

VIRGINIA ACTS OF ASSEMBLY -- 1999 SESSION

CHAPTER 878

An Act to amend and reenact § 32.1-325 of the Code of Virginia, relating to medical assistance services.

[H 2617]

Approved March 29, 1999

Be it enacted by the General Assembly of Virginia:

1. That § 32.1-325 of the Code of Virginia is amended and reenacted as follows:

§ 32.1-325. Board to submit plan for medical assistance services to Secretary of Health and Human Services pursuant to federal law; administration of plan; contracts with health care providers.

A. The Board, subject to the approval of the Governor, is authorized to prepare, amend from time to time and submit to the Secretary of the United States Department of Health and Human Services a state plan for medical assistance services pursuant to Title XIX of the United States Social Security Act and any amendments thereto. The Board shall include in such plan:

1. A provision for payment of medical assistance on behalf of individuals, up to the age of twenty-one, placed in foster homes or private institutions by private, nonprofit agencies licensed as child-placing agencies by the Department of Social Services or placed through state and local subsidized adoptions to the extent permitted under federal statute;

2. A provision for determining eligibility for benefits for medically needy individuals which disregards from countable resources an amount not in excess of $2,500 for the individual and an amount not in excess of $2,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by (i) the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources and (ii) the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses;

3. A requirement that, in determining eligibility, a home shall be disregarded. For those medically needy persons whose eligibility for medical assistance is required by federal law to be dependent on the budget methodology for Aid to Families with Dependent Children, a home means the house and lot used as the principal residence and all contiguous property. For all other persons, a home shall mean the house and lot used as the principal residence, as well as all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the state plan for medical assistance *services* in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value;

4. A provision for payment of medical assistance on behalf of individuals up to the age of twenty-one, who are Medicaid eligible, for medically necessary stays in acute care facilities in excess of twenty-one days per admission;

5. A provision for deducting from an institutionalized recipient's income an amount for the maintenance of the individual's spouse at home;

6. A provision for payment of medical assistance on behalf of pregnant women which provides for payment for inpatient postpartum treatment in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Payment shall be made for any postpartum home visit or visits for the mothers and the children which are within the time periods recommended by the attending physicians in accordance with and as indicated by such Guidelines or Standards. For the purposes of this subdivision, such Guidelines or Standards shall include any changes thereto within six months of the publication of such Guidelines or Standards or any official amendment thereto;

7. A provision for payment of medical assistance for high-dose chemotherapy and bone marrow

transplants on behalf of individuals over the age of twenty-one who have been diagnosed with lymphoma or breast cancer and have been determined by the treating health care provider to have a performance status sufficient to proceed with such high-dose chemotherapy and bone marrow transplant. Appeals of these cases shall be handled in accordance with the Department's expedited appeals process;

8. A provision identifying entities approved by the Board to receive applications and to determine eligibility for medical assistance;

9. A provision for breast reconstructive surgery following the medically necessary removal of a breast for any medical reason. Breast reductions shall be covered, if prior authorization has been obtained, for all medically necessary indications. Such procedures shall be considered noncosmetic;

10. A provision for payment of medical assistance for annual pap smears;

11. A provision for payment of medical assistance services for prostheses following the medically necessary complete or partial removal of a breast for any medical reason;

12. A provision for payment of medical assistance which provides for payment for forty-eight hours of inpatient treatment for a patient following a radical or modified radical mastectomy and twenty-four hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate;

13. A requirement that certificates of medical necessity for durable medical equipment and any supporting verifiable documentation shall be signed, dated, and returned by the physician and in the durable medical equipment provider's possession within sixty days from the time the ordered durable medical equipment and supplies are first furnished by the durable medical equipment provider;

14. A provision for payment of medical assistance to (i) persons age fifty and over and (ii) persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a twelve-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen; and

15. A provision for payment of medical assistance for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, and one such mammogram annually to persons age fifty and over. The term "mammogram" means an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

B. In preparing the plan, the Board shall:

1. Work cooperatively with the State Board of Health to ensure that quality patient care is provided and that the health, safety, security, rights and welfare of patients are ensured. ~~The Board shall also~~

2. Initiate such cost containment or other measures as are set forth in the appropriation act. ~~The Board may~~

3. Make, adopt, promulgate and enforce such regulations as may be necessary to carry out the provisions of this chapter.

4. ~~Before the Board acts~~ *Examine, before acting* on a regulation to be published in the Virginia Register of Regulations pursuant to § 9-6.14:7.1, ~~the Board shall examine~~ the potential fiscal impact of such regulation on local boards of social services. For regulations with potential fiscal impact, the Board shall share copies of the fiscal impact analysis with local boards of social services prior to submission to the Registrar. The fiscal impact analysis shall include the projected costs/savings to the local boards of social services to implement or comply with such regulation and, where applicable, sources of potential funds to implement or comply with such regulation.

5. ~~The Board's regulations shall~~ Incorporate sanctions and remedies for certified nursing facilities established by state law, in accordance with 42 C.F.R. § 488.400 et seq., "Enforcement of Compliance

for Long-Term Care Facilities With Deficiencies."

C. In order to enable the Commonwealth to continue to receive federal grants or reimbursement for medical assistance or related services, the Board, subject to the approval of the Governor, may adopt, regardless of any other provision of this chapter, such amendments to the state plan for medical assistance services as may be necessary to conform such plan with amendments to the United States Social Security Act or other relevant federal law and their implementing regulations or constructions of these laws and regulations by courts of competent jurisdiction or the United States Secretary of Health and Human Services.

In the event conforming amendments to the state plan for medical assistance services are adopted, the Board shall not be required to comply with the requirements of Article 2 (§ 9-6.14:7.1 et seq.) of Chapter 1.1:1 of Title 9. However, the Board shall, pursuant to the requirements of § 9-6.14:4.1, (i) notify the Registrar of Regulations that such amendment is necessary to meet the requirements of federal law or regulations or because of the order of any state or federal court, or (ii) certify to the Governor that the regulations are necessitated by an emergency situation. Any such amendments which are in conflict with the Code of Virginia shall only remain in effect until July 1 following adjournment of the next regular session of the General Assembly unless enacted into law.

~~B.~~ *D.* The Director of Medical Assistance Services is authorized to*:*

1. Administer such state plan and to receive and expend federal funds therefor in accordance with applicable federal and state laws and regulations; and to enter into all contracts necessary or incidental to the performance of the Department's duties and the execution of its powers as provided by law.

2. ~~C. The Director of Medical Assistance Services is authorized to~~ Enter into agreements and contracts with medical care facilities, physicians, dentists and other health care providers where necessary to carry out the provisions of such state plan. Any such agreement or contract shall terminate upon conviction of the provider of a felony. In the event such conviction is reversed upon appeal, the provider may apply to the Director of Medical Assistance Services for a new agreement or contract. Such provider may also apply to the Director for reconsideration of the agreement or contract termination if the conviction is not appealed, or if it is not reversed upon appeal.

3. ~~The Director may~~ Refuse to enter into or renew an agreement or contract with any provider which has been convicted of a felony.

4. ~~In addition, the Director may~~ Refuse to enter into or renew an agreement or contract with a provider who is or has been a principal in a professional or other corporation when such corporation has been convicted of a felony.

E. In any case in which a Medicaid agreement or contract is denied to a provider on the basis of his interest in a convicted professional or other corporation, the Director shall, upon request, conduct a hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) regarding the provider's participation in the conduct resulting in the conviction.

The Director's decision upon reconsideration shall be consistent with federal and state laws. The Director may consider the nature and extent of any adverse impact the agreement or contract denial or termination may have on the medical care provided to Virginia Medicaid recipients.

F. When the services provided for by such plan are services which a clinical psychologist or a clinical social worker or licensed professional counselor or clinical nurse specialist is licensed to render in Virginia, the Director shall contract with any duly licensed clinical psychologist or licensed clinical social worker or licensed professional counselor or licensed clinical nurse specialist who makes application to be a provider of such services, and thereafter shall pay for covered services as provided in the state plan. The Board shall promulgate regulations which reimburse licensed clinical psychologists, licensed clinical social workers, licensed professional counselors and licensed clinical nurse specialists at rates based upon reasonable criteria, including the professional credentials required for licensure.

~~D.~~ *G.* The Board shall prepare and submit to the Secretary of the United States Department of Health and Human Services such amendments to the state plan for medical assistance *services* as may be permitted by federal law to establish a program of family assistance whereby children over the age of eighteen years shall make reasonable contributions, as determined by regulations of the Board, toward the cost of providing medical assistance under the plan to their parents.

~~E.~~ *H.* The Department *of Medical Assistance Services* shall*:*

1. Include in its provider networks and all of its health maintenance organization contracts a provision for the payment of medical assistance on behalf of individuals up to the age of twenty-one who have special needs and who are Medicaid eligible, including individuals who have been victims of child abuse and neglect, for medically necessary assessment and treatment services, when such services are delivered by a provider which specializes solely in the diagnosis and treatment of child abuse and neglect, or a provider with comparable expertise, as determined by the Director.

2. Amend the Medallion II waiver and its implementing regulations to develop and implement an exception, with procedural requirements, to mandatory enrollment for certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

~~F.~~ *I.* The Director is authorized to negotiate and enter into agreements for services rendered to eligible recipients with special needs. The Board shall promulgate regulations regarding these special needs patients, to include persons with AIDS, ventilator-dependent patients, and other recipients with special needs as defined by the Board.

J. Except as provided in subsection I of § 11-45, the provisions of the Virginia Public Procurement Act (§ 11-35 et seq.) shall not apply to the activities of the Director authorized by ~~this~~ subsection *I of this section*. Agreements made pursuant to this subsection shall comply with federal law and regulation.

2. That the Board of Medical Assistance Services shall promulgate regulations to implement the provisions of this act within 280 days of its enactment.

VIRGINIA ACTS OF ASSEMBLY -- 1997 SESSION

CHAPTER 468

An Act to amend and reenact § 2.1-20.1 of the Code of Virginia, as it is currently effective and as it may become effective, relating to health and related insurance for state employees; coverage for early intervention services.

[H 2716]

Approved March 16, 1997

Be it enacted by the General Assembly of Virginia:

1. That § 2.1-20.1 of the Code of Virginia, as it is currently effective and as it may become effective, is amended and reenacted as follows:

§ 2.1-20.1. Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. 1. The plan shall include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

2. The plan shall include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. The plan shall include coverage for postpartum services providing inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. The plan shall include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services which enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The assets of the fund shall be held for the sole benefit of the employee health insurance program. The fund shall be held in the state treasury. Any interest on unused balances in the fund shall revert back to the credit of the fund.

D. For the purposes of this section, the term "state employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.16:24.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

§ 2.1-20.1. (Delayed effective date) Health and related insurance for state employees.

A. 1. The Governor shall establish a plan for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The Department of Personnel and Training shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. The Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

2. Such contribution shall be financed through appropriations provided by law.

B. 1. The plan shall include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age thirty-five through thirty-nine, one such mammogram biennially to persons age forty through forty-nine, one such mammogram annually to persons age fifty and over and may be limited to a benefit of fifty dollars per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally. The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

2. The plan shall include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. The plan shall include coverage for postpartum services providing inpatient care and a home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or

Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. The plan shall include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services which enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The assets of the fund shall be held for the sole benefit of the employee health insurance program. The fund shall be held in the state treasury. Any interest on unused balances in the fund shall revert back to the credit of the fund.

D. For the purposes of this section, the term "state employee" means state employee as defined in § 51.1-124.3, employee as defined in § 51.1-201, the Governor, Lieutenant Governor and Attorney General, judge as defined in § 51.1-301 and judges, clerks and deputy clerks of district courts of the Commonwealth, interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Medical College of Virginia Hospitals Authority as provided in § 23-50.15:25.

E. Provisions shall be made for retired employees to obtain coverage under the above plan. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Personnel and Training which utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

VIRGINIA ACTS OF ASSEMBLY -- 1998 SESSION

CHAPTER 625

An Act to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.3, relating to accident and sickness insurance; coverage for early intervention services.

[H 1413]

Approved April 15, 1998

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.3 as follows:

§ 38.2-3418.3. Coverage for early intervention services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for medically necessary early intervention services under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on and after July 1, 1998. Such coverage shall be limited to a benefit of $5,000 per insured or member per policy or calendar year and, except as set forth in subsection C, shall be subject to such dollar limits, deductibles and coinsurance factors as are no less favorable than for physical illness generally.

B. For the purpose of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). "Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services" shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

C. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer, corporation or health maintenance organization to or on behalf of the insured or member during the insured's or member's lifetime.

D. "Financial costs", as used in this section, shall mean any copayment, coinsurance, or deductible in the policy or plan. Financial costs may be paid through the use of federal Part H program funds, state general funds, or local government funds appropriated to implement Part H services for families who may refuse the use of their insurance to pay for early intervention services due to a financial cost.

E. The provisions of this section shall not apply to short-term travel, accident only, limited or specified disease policies, policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1~~, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2,~~ *through 38.2-3418.3,* 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500,

38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

MARY T. CHRISTIAN
P.O. BOX 1892
HAMPTON, VIRGINIA 23669
NINETY-SECOND DISTRICT

COMMITTEE ASSIGNMENTS:
EDUCATION
CONSERVATION AND NATURAL RESOURCES
LABOR AND COMMERCE
MILITIA AND POLICE

January 15, 1998

The Honorable Judith Heumann
Assistant Secretary of Education
United States Department of Education
400 Maryland Avenue, S.W.
Washington, D.C. 20202

Dear Secretary Heumann:

On behalf of the Virginia General Assembly's Joint Subcommittee Studying Early Intervention for Infants and Toddlers with Disabilities (Joint Subcommittee), I am writing to comment on the proposed regulations issued on October 22, 1997, pertaining to the reauthorization of Part H of the Individuals with Disabilities Education Act (IDEA).

Specifically, the Joint Subcommittee members are concerned by the proposed language in 34 CFR § 303.520(d)(2) which would prohibit Part H lead agencies from requiring families to use their private health insurance to pay for early intervention services if these insured families would incur a financial cost. Given that the majority of, if not all, private health insurers impose deductibles and co-pay amounts on policy holders, and that most capitate lifetime benefits and increase premiums for those policy holders requiring intensive medical care, it appears unlikely that any family possessing private health insurance coverage would ever completely avoid financial costs when accessing their private insurance for early intervention services. Therefore, it is also unlikely that families would allow their coverage to be accessed for early intervention services when informed of their rights to decline such access.

Limited access to private insurance for the provision of early intervention services will undoubtedly place additional financial burdens on Virginia. Although the proposed regulations specify that States may use Part H funds to replace insurance proceeds lost, the Joint Subcommittee fears that Part H funding received by the Commonwealth is insufficient to both fully replace the insurance revenue projected to be lost and maintain Virginia's early intervention system at its current level of success.

The proposed regulations bring about additional concerns. Private insurers impose deductibles and co-pays in order to manage costs and hold beneficiaries responsible for making informed decisions regarding the use of medical care. First, private insurers also require that providers within their networks make every effort to collect co-pays and deductibles from the *beneficiary*. Therefore, the use of Part H funds to cover co-pays and deductibles for families who have refused the use of their private insurance may not be acceptable to private insurers.

Also, 34 CFR § 303 states that efforts must be made by participating states to maximize all potential sources of revenue, including federal, state, local, and private sources (which includes both public and private insurance) for the provision of early intervention services prior to utilizing federal Part H funds. Sections of the Part H regulations would therefore conflict with one another should the proposed language be adopted.

Virginia has worked diligently to ensure that an array of resources are accessed in order to meet federal Part H payor-of-last-resort provisions, including the use of private insurance when feasible. The Joint Subcommittee respectfully requests that the U.S. Department of Education modify the language of the proposed regulations in order to promote the continued successful utilization of private insurance for the provision of Part H early intervention services.

If you have any questions or would like to discuss this matter further, please contact Amy Marschean, Staff Attorney, Division of Legislative Services, at (804) 786-3591.

Sincerely,

Mary T. Christian

cc: Thomas Hehir, Ph.D., Director, Office of Special Education Programs
Tom Irving, Office of Special Education and Rehabilitative Programs
Members of the Joint Subcommittee Studying Early Intervention Services for Infants and Toddlers With Disabilities (HJR 581)

2000 SESSION

003629668

HOUSE JOINT RESOLUTION NO. 294

Offered January 24, 2000

Requesting the Department of Mental Health, Mental Retardation and Substance Abuse Services to study parental liability for costs of early intervention services.

Patrons—Christian, Baskerville, Brink, Cox, Darner, Hall, Plum, Spruill, Van Landingham and Watts; Senator: Miller, Y.B.

Referred to Committee on Rules

WHEREAS, Part C of the Individuals with Disabilities Education Act creates a federal grant program to provide early intervention services to infants and toddlers with disabilities and to their families; and

WHEREAS, Virginia entered full implementation of the Part C program in 1993. It soon became evident that early intervention services are of vital importance to Virginia's families with infants and toddlers with disabilities and that, because early intervention services can prevent or mitigate numerous problems, the expansion of early intervention services will ultimately benefit all citizens of the Commonwealth; and

WHEREAS, federal law mandates free early intervention eligibility screenings, evaluations, and service coordination for eligible children, yet allows service providers to charge for physical, occupational, and speech therapies, parent-infant education, assistive technology, respite care, audiology and other services; and

WHEREAS, early intervention providers in Virginia are charging fees for most services, and families and many service providers are reporting that these fees cause hardship, resulting in some families refusing services because of the fees; and

WHEREAS, the 40 local interagency coordinating councils that oversee federal Part C program funds administer their local programs and set their own fees, which have resulted in inequities and inconsistencies; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Mental Health, Mental Retardation and Substance Abuse Services be requested to study parental liability for costs of early intervention services. The Department of Mental Health, Mental Retardation and Substance Abuse Services, in cooperation with the other state agencies participating in the early intervention program and all stakeholders in the program to include, but not be limited to, representatives of the local interagency coordinating councils, the Virginia Interagency Coordinating Council, the Early Intervention Management Team, parents and service providers, shall identify and resolve concerns related to fees for Part C program services, including federal requirements related to liability for the costs of various services and access to private insurance reimbursement; mechanisms to determine ability to pay on an equitable and consistent basis statewide; and extreme variations in the costs of services among different localities.

All agencies of the Commonwealth shall provide assistance to the Department of Mental Health, Mental Retardation and Substance Abuse Services for this study, upon request.

The Department of Mental Health, Mental Retardation and Substance Abuse Services shall complete its work in time to submit its findings and recommendations by November 1, 2000, to the Governor and the 2001 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.