COMMONWEALTH of VIRGINIA

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November 5, 2015

The Honorable Walter A. Stosch, Co-Chair
The Honorable Charles Colgan, Co-Chair
Senate Finance Committee
10th Floor, General Assembly Building
910 Capitol Street
Richmond, VA 23219

Dear Senator Stosch and Senator Colgan:

Item 308. H2. of the 2014 Appropriations Act requires the Department of Behavioral Health to report on Part C Early Intervention Services in Virginia. In accordance with those requirements, this report includes data on the total revenues used to support Part C services, total expenses for all Part C services, total number of infants and toddlers and families served using all Part C revenues, and services provided to those infants and toddlers and families.

Please find enclosed the report in accordance with Item 308.H2. Staff at the department are available should you wish to discuss this request.

Sincerely,

Jack Barber, M.D.

Enc.

Cc: William A. Hazel, Jr., M.D.
Joe Flores
Susan E. Massart
Mike Tweedy

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November 5, 2015

The Honorable S. Chris Jones, Chair
House Appropriations Committee
General Assembly Building
P.O. Box 406
Richmond, VA 23218

Dear Delegate Jones:

Item 308. H2. of the 2014 Appropriations Act requires the Department of Behavioral Health to report on Part C Early Intervention Services in Virginia. In accordance with those requirements, this report includes data on the total revenues used to support Part C services, total expenses for all Part C services, total number of infants and toddlers and families served using all Part C revenues, and services provided to those infants and toddlers and families.

Please find enclosed the report in accordance with Item 308.H2. Staff at the department are available should you wish to discuss this request.

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Report on Virginia's Part C Early Intervention System (Budget Item 308 H.2., 2015 *Appropriation Act*)

July 1, 2014 – June 30, 2015

to the Chairs of the
House Appropriations and Senate Finance Committees of the General Assembly

November 15, 2015

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Report on Virginia's Part C Early Intervention System

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EXECUTIVE SUMMARY

In the 2015 *Appropriation Act*, paragraph H.2. of Item 308 directs the Department of Behavioral Health and Developmental Services (DBHDS) to report the following information to the Chairmen of the Senate Finance and House Appropriations Committees by November 15 of each year: (a) total revenues used to support Part C services, (b) total expenses for all Part C services, (c) total number of infants and toddlers and families served using all Part C revenues, and (d) services provided to those infants and toddlers and families.

Overview of Fiscal Climate for Part C in FY 2015 and Beyond

The state funds allocated by the Governor and the General Assembly continue to help Virginia's Part C early intervention system identify and serve increasing numbers of eligible infants, toddlers and their families. Looking ahead, the system is still growing and remains stressed. While revenue realized through the Medicaid Early Intervention Services Program continues to provide funding for services to children with Medicaid, the amount of funding (i.e., federal, state, local, private insurance, and family fees) available for services to children without Medicaid and the reimbursement rate for service coordination (e.g., case management) for children with Medicaid are inadequate to cover the costs for these services Approximately 59% of children enrolled in early intervention in FY 2015 were covered by Medicaid. Private insurance companies pay lower rates for early intervention services than Medicaid does and do not reimburse at all for service coordination, which must be provided for all children, or developmental services. Federal and state Part C funds must be used to make up the difference between the insurance rate and the Medicaid rate and to pay for services that are not covered. In addition to these general challenges, local systems report difficulty in being accepted as in-network providers with a number of insurance companies, and report declining reimbursement rates. Also, local systems report difficulty obtaining reimbursement for speech-language pathology services for infants and toddlers since this is generally a habilitative service (helping the child keep, learn or improve skills) for this population rather than a rehabilitative service (helping the child regain lost skills).

Unless funding keeps pace with growth, Virginia runs the risk of falling into noncompliance, which puts federal funding at risk and may result in children and families not getting the supports and services they need in a timely and effective manner. DBHDS, in collaboration with other state agencies and local stakeholders, is continuing to identify and evaluate possible sources of additional revenue, to develop strategies to address private insurance challenges, to closely monitor the local fiscal situation and to ensure local system personnel have the skills to provide effective oversight of local budgets and spending. DBHDS is providing ongoing guidance and management support to the local lead agencies to address locality-specific fiscal issues.

Total Number of Infants, Toddlers and Families Served

A total of 17,022 infants, toddlers and families received Part C early intervention services in the one-year period from July 1, 2014 – June 30, 2015. The 17,022 children and families served in FY 2015 represent a 4.6% increase from FY 2014. This maintains a similar level of growth as the previous year (4.8%).

The following table shows the services that were provided to Part C eligible infants and toddlers by the type of early intervention service determined to be needed in order to achieve the child's outcomes as listed on the child's Individualized Family Service Plan (IFSP).

Services Provided to Infants, Toddlers and Families

Type of Early Intervention Service	Estimated # of Children With Initial IFSP Listing That Service in FY 2015
Assistive Technology	9
Audiology	68
Counseling	2
Developmental Services	2,519
Health Services	0
Nursing Services	7
Nutrition Services	2
Occupational Therapy	2,349
Physical Therapy	4,409
Psychological Services	5
Service Coordination	17,022*
Sign Language and Cued Language Services	10
Social Work Services	34
Speech-Language Pathology	5,515
Transportation	2
Vision Services	51
Other Entitled EI Services	136

* All eligible children receive service coordination.

In addition to the services listed on IFSPs, a total of 10,522 children received an evaluation to determine eligibility and/or an assessment for service planning in FY 2015.

Revenue and Expense Data

The table below shows revenue from all sources as reported by the 40 local early intervention systems for FY 2015.

Total Revenue to Support Part C Early Intervention Services

Revenue Source	FY15 Revenue Amount
Federal Part C Funds	$ 9,215,082
State Part C Funds	$ 15,045,226
Other State General Funds	$ 437,267
Local Funds	$ 9,536,372
Family Fees	$ 1,257,692
Medicaid (State and Federal shares)	$ 14,081,813
Targeted Case Management	$ 6,150,990
Private Insurance and TRICARE	$ 6,871,031
Grants/Gifts/Donations	$ 13,069
In-Kind	$ 505,489
Other	$ 5,019,063
Total	**$ 68,133,094**

In accordance with Item 308.H.2, the chart below provides detail about the total amount of federal and state Part C funds expended in FY 2015 for Part C early intervention services as reported by the 40 local lead agencies and the private providers with whom those local lead agencies contract.

Total Expenditures for all Part C Early Intervention Services

Assessment for Service Planning	$ 3,159,395
Assistive Technology	$ 33,223
Audiology	$ 9,816
Counseling	$ 1,507
Developmental Services	$ 3,472,341
Evaluation for Eligibility Determination	$ 911,992
Health	$ 63,196
Nursing	$ 4,327
Nutrition	$ 27,930
Occupational Therapy	$ 2,231,656
Physical Therapy	$ 3,083,003
Service Coordination	$ 18,910,255
Social Work	$ 149,265
Speech language pathology	$ 9,557,189
Transportation	$ 105,125
Vision	$ 124,124
Other Entitled Part C Services	$ 686,376
EI Services by private providers	$ 21,463,571
Total-Direct Services	**$ 63,994,291***

*The local lead agencies reported an additional $7,905,752 of expenses related to the system components (administration, system management, data collection and training) that are critical to implementation of direct services. **Therefore, total expenses are $71,900,043**.

In FY 2015, reported expenses exceeded reported revenue in the Part C early intervention system. This discrepancy is primarily related to an increase in the number of children served, the insufficient reimbursement rate for Early Intervention Targeted Case Management and decreases in private insurance/TRICARE reimbursement and in other state funds used to support Part C early intervention.

Data System Update

The existing early intervention data system, the Infant and Toddler Online Tracking System (ITOTS), was developed and implemented in 2001 primarily to meet annual federal reporting requirements related to child data. The system provides data on who is getting services and includes the number of children by local system, race/ethnicity, gender, age, and the reason for eligibility. Reports can be pulled for point-in-time data on who is being served, annual review, and limited trend data. ITOTS presents a number of challenges to DBHDS in meeting federal and state reporting requirements, including the following:

- Child data is collected in ITOTS only at entry into the early intervention system and is not collected as child status or service needs change.
- No financial data for Part C services is collected through ITOTS, resulting in a burdensome paper process for collection and reporting of comprehensive and reliable data related to the cost of providing services and the revenue sources that are accessed in providing services.
- Local systems incur additional costs as ITOTS cannot accept data from local information systems. Additional time is spent preparing manual or Excel reports.
- ITOTS data reports are limited in scope and, therefore, the analysis of the available data does not allow analysis of outcomes.

ITOTS allows for the collection of data on the services planned on each child's initial IFSP but does not provide for the collection of data on how those services change over time, on delivered services, or on payment for services. Because of the significant limitations of this system, there is no mechanism available for local systems or for DBHDS to get the kind of real-time, ongoing data necessary to effectively and efficiently monitor service delivery for individual children, to study trends and patterns, to determine the impact of demographic and service delivery factors on outcomes for children and families, or to monitor funding sources and service costs by child or by local system.

Between 2006 and 2010, a number of initiatives were implemented to analyze and improve ITOTS. Although incremental data system improvements have been implemented to address data integrity and better reporting, fiscal constraints and competing data priorities within DBHDS led to delays in developing or purchasing a data system with the complete functionality necessary to enter and report on delivered services and to have more complete and accurate revenue and expense data.

Since many local agencies and service providers have or are in the process of developing and implementing electronic health record systems, DBHDS's focus on data collection for all programs has shifted to identifying and implementing the most effective and efficient mechanism for importing the data already collected by local systems into a state database through which that data can be aggregated, analyzed and reported. DBHDS designated $250,000 for FY 2015 to develop such an interface for Part C early intervention data. That new functionality is in the testing phase now, with its release for external use expected in 2016. The interface itself will not expand the type of data collected in ITOTS but will provide a foundation upon which service delivery and financial data can be added and collected directly from local systems in the future. Until a significantly more robust system that includes delivered service and financial data is fully developed and implemented, DBHDS's challenges in meeting federal and state reporting requirements will continue.

I. *Background*

Congress enacted early intervention legislation in 1986 as an amendment to the Education of Handicapped Children's Act (1975) to ensure that all children with disabilities from birth through the age of three would receive appropriate early intervention services. This amendment formed Part H of the Act, which was re-authorized in 1991 and renamed the Individuals with Disabilities Education Act (IDEA). When the IDEA was re-authorized in 1998, Part H became Part C of the Act. IDEA was reauthorized most recently in December 2004. Virginia has participated in the federal early intervention program, under IDEA, since its inception.

General Assembly Guidance and Support

In 1992, the Virginia General Assembly passed state legislation that codified an infrastructure for the early intervention system that supports shared responsibility for the development and implementation of the system among various agencies at the state and local levels. The Department of Behavioral Health and Developmental Services (DBHDS), was designated and continues to serve as the State Lead Agency. The broad parameters for the Part C system are established at the state level to ensure implementation of federal Part C regulations. Within the context of these broad parameters, 40 local lead agencies manage services across the Commonwealth.

Subsequent to 1992, the General Assembly passed legislation establishing mandates for state employees' health plan and private insurance coverage for early intervention services, maximizing Medicaid coverage for Part C eligible children. In 2001, the General Assembly adopted legislation requiring a statewide family fee system.

In 2004, DBHDS commissioned a cost study of Virginia's Part C Early Intervention System. Based on the projected number of eligible children and the average annual per child cost for early intervention services identified in the cost study, the General Assembly significantly increased the allocation of state general funds for use in the provision of early intervention services from $125,000 per year during 1992 – 2003 to $975,000 in 2004, and $3,125,000 in 2005. For FY 2007, a total of $7,203,366 was appropriated.

In 2012, the General Assembly appropriated the state funds necessary to increase the Medicaid reimbursement rate for early intervention targeted case management from $120 per month to $132 per month for FY 2013, beginning July 1, 2012. In order to address a looming $8.5 million deficit in funding for early intervention due to significant increases in the number of children served and static federal funding, the General Assembly provided critical support for Virginia's early intervention system in 2013 by allocating an additional $2,250,000 in state general funds for early intervention in FY 2013 and another $6 million for FY 2014. A total of $13,203,366 in state general funds were allocated for early intervention in FY 2015. The 2015 *Appropriation Act*, under Item 308.H.2., states:

> *"By November 15 of each year, the Department shall report to the Chairmen of the House Appropriations and Senate Finance Committees on the (a) total revenues used to support Part C services, (b) total expenses for all Part C services, (c) total number of infants and toddlers and families served using all Part C revenues, and (d) services provided to those infants and toddlers and families."*

Report of Required Data

To the maximum extent possible, the following narrative, charts and other graphics respond to the legislative requirements as delineated in Item 308.H.2. The information provided for each reporting requirement includes identifying limitations in the data reported and future steps for addressing the limitations. The following data is based on reports received from the 40 local lead agencies and includes data from the private providers with whom the local lead agencies contract.

II. *Total Revenue Used to Support Part C Services*

As noted previously, the ITOTS data system does not collect financial data for Part C early intervention services. However, in its contracts with local lead agencies, DBHDS requires reporting of revenues from local lead agencies. In addition, revenue reporting is required from private providers.

Total Revenue to Support Part C Early Intervention Services

Revenue Source	FY 2015 Revenue Amount
Federal Part C Funds	$ 9,215,082*
State Part C Funds	$ 15,045,226*
Other State General Funds	$ 437,267
Local Funds	$ 9,536,372
Family Fees	$ 1,257,692
Medicaid	$ 14,081,813
Targeted Case Management	$ 6,150,990
Private Insurance and TRICARE	$ 6,871,031
Grants/Gifts/Donations	$ 13,069
In-Kind	$ 505,489
Other	$ 5,019,063
Total	**$ 68,133,094**

**These figures are the amount of Part C funding actually received by local systems. In some cases, local systems had more funds than indicated in the allocation table below because they had retained earnings from the previous fiscal year.*

The following table represents the federal and state revenue allocated by DBHDS to the 40 local lead agencies. Federal and State Part C funds are allocated based on a formula that provides a base amount to support required systems operations and a direct service amount. The base amount includes a fixed allocation of $50,000 plus a proportional share based on the local system's December 1 count of all children enrolled in the local early intervention system. The direct service amount is a proportional share of funds based on the local system's December 1 count of children not covered by Medicaid (since services for children with Medicaid are covered by Medicaid):

Funds Allocated by Local Lead Agency*

	State	Federal
Alexandria	$367,104	$219,548
Alleghany-Highlands	$69,313	$61,781
Arlington	$605,134	$358,554
Augusta-Highland	$137,629	$88,633
Blue Ridge	$399,189	$236,947
Central Virginia	$341,019	$199,639
Chesapeake	$374,539	$222,765
Chesterfield	$541,331	$317,876
Crater District	$105,369	$68,925
Cumberland Mountain	$100,698	$65,874
Danville-Pittsylvania	$116,705	$157,912
DILENOWISCO	$84,953	$74,819
Eastern Shore	$68,998	$48,603
Fairfax-Falls Church	$2,455,681	$1,746,975
Goochland-Powhatan	$96,710	$66,051
Hampton-Newport News	$307,185	$237,210
Hanover	$201,519	$126,339
Harrisonburg/Rockingham	$152,307	$95,004
Heartland	$85,270	$57,004
Henrico-Charles City-New Kent	$552,545	$323,097
Highlands	$70,345	$49,050
Loudoun	$491,682	$293,148
Middle Peninsula-North Neck	$182,344	$281,317
Mount Rogers	$97,759	$85,058
New River Valley	$210,580	$127,095
Norfolk	$366,928	$217,239
Piedmont	$105,701	$67,535
Portsmouth	$160,879	$100,849
Prince William, Manassas and Manassas Park	$776,877	$453,806
Rappahannock Area	$721,489	$422,673
Rappahannock-Rapidan	$218,576	$132,749
Richmond	$270,656	$159,034
Roanoke Valley	$354,594	$207,145
Rockbridge Area	$103,252	$68,223
Shenandoah Valley	$275,957	$163,794
Southside	$76,171	$53,009
Staunton-Waynesboro	$91,409	$61,291
Virginia Beach	$835,448	$488,997
Western Tidewater	$304,176	$182,161
Williamsburg-James City-York Poquoson	$325,345	$266,369
Total	**$13,203,366**	**$8,654,098**

**Please see Appendix A for a listing of the localities included in each system.*

Limitations: Because the local lead agencies and private providers each maintain separate billing and accounting systems, there is no method to reliably ensure non-duplication of reporting in revenue categories, with the exception of Medicaid and Medicaid Targeted Case Management

revenue. Through a data exchange agreement between DBHDS and the Department of Medical Assistance Services (DMAS) for implementation of the Medicaid Early Intervention Services Program, DBHDS is able to report the exact amount of Medicaid funds used to support Part C early intervention services for FY 2015.

Future Actions to Address Limitations: Non-duplication of revenue reporting for other revenue sources can only be fully ensured once a reliable statewide mechanism is implemented to collect or import data from local systems on the source and amount of revenue for every service delivered. DBHDS is working to identify the most effective and efficient mechanism to accomplish this task.

III. *Total Expenses for all Part C Services*

The figures below show the amount of funds spent on each Part C early intervention service in FY 2015, as reported by the 40 local lead agencies and including data from private providers with whom the local lead agencies contract.

Expenditures for Part C Early Intervention Services

Assessment for Service Planning	$ 3,159,395
Assistive Technology	$ 33,223
Audiology	$ 9,816
Counseling	$ 1,507
Developmental Services	$ 3,472,341
Evaluation for Eligibility Determination	$ 911,992
Health	$ 63,196
Nursing	$ 4,327
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Transportation	$ 105,125
Vision	$ 124,124
Other Entitled Part C Services	$ 686,376
EI Services by private providers**	$21,463,571
Total-Direct Services	**$63,994,291***

*The local lead agencies reported an additional $7,905,752 of expenses related to the system components (administration, system management, data collection and training) that are critical to implementation of direct services. **Therefore, total expenses are $71,900,043**.

**The local expenditure reporting forms were revised in FY 2013 to eliminate duplicate reporting of expenses paid with Part C funds. It was not possible to eliminate the duplication by service category, so private provider expenses for all early intervention services are reported as a lump sum.

In FY 2015, reported expenses exceeded reported revenue in the Part C early intervention system. This discrepancy is due to the following factors:

- The number of children served in the Part C early intervention system increased by 4.6% from FY 2014 to FY 2015. At the same time, the total amount of federal and state Part C funds allocated to local systems in FY 2015 increased by only 1.5%, Medicaid revenue increased by 3.7%, revenue from private insurance and TRICARE decreased by 35%, and other state general funds used by local systems to support Part C early intervention decreased by 35%. There are three possible reasons for the decrease in private insurance revenue: possible inaccurate data reporting or collection, reduced reimbursement rates and increased denials, or inadequate follow-up on denied claims. Our current data system does not have the ability to identify the cause of the decrease.
- The current Early Intervention Targeted Case Management reimbursement rate of $132 per month does not cover the expenses of providing this service.
- Concerns about the completeness and accuracy of expense and revenue data and possible duplication of reporting remain since local lead agencies and private providers collect their data separately and there is no central mechanism to ensure reporting by all private providers or to ensure non-duplication. Duplication or inaccuracies in data collection and reporting may account for all or some of the discrepancy in reported expenses and revenue as well as the decrease in private insurance/TRICARE reimbursement and state general fund dollars.

Limitations: Although DBHDS continues to refine the instructions and technical assistance related to the reporting forms used by local lead agencies and private providers to report expenditures, there remain limitations with this process for collection of expense data. Because the local lead agencies and private providers each maintain separate billing and accounting systems, there is no method to reliably ensure non-duplication of reporting of expenses associated with each service. The local expenditure reporting forms were revised in FY 2013 to eliminate duplicate reporting of expenses paid with Part C funds. It was not possible to eliminate the duplication by service category, so private provider expenses for all early intervention services can only be reported as a lump sum.

Future Actions to Address Limitations: Non-duplication of expense reporting can only be fully ensured once a reliable statewide mechanism is implemented to collect or import expenditure data from local systems. DBHDS is working to identify the most effective and efficient mechanism to accomplish this task.

IV. *Total Number of Infants and Toddlers and Families Served*

Local lead agencies are required to enter into the early intervention data system, ITOTS, every child who enters the local Part C early intervention system. Local lead agencies must use quarterly ITOTS verification reports to confirm the accuracy of the data entered. The following table provides the total number of children served for each year, as reported from ITOTS.
Not all children who were served during that one-year period were served for the full year.

There was an increase of 4.6% from FY 2014 to FY 2015 in the number of children served. As a result of statewide efforts to identify and enroll all eligible children per federal child find

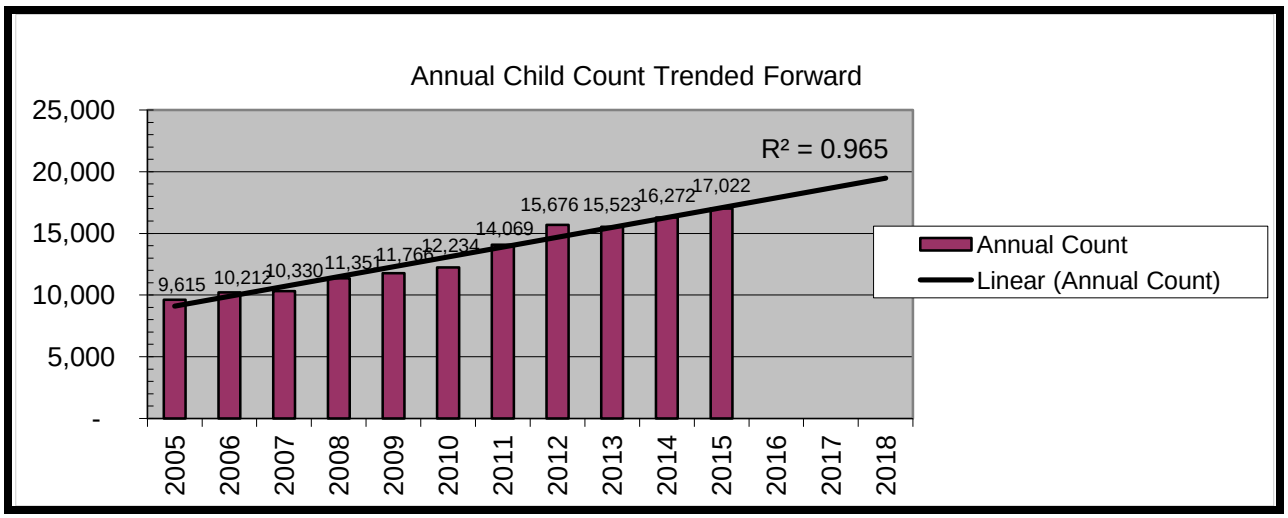
(outreach) requirements, Virginia had experienced significant growth from FY 2007 to FY 2012, with an almost 52% increase over that period in the number of children served. Virginia had also added prematurity as an automatic eligibility criterion for service in December 2010, which may have contributed to the especially sharp increases in children enrolled in FY 2011 and FY 2012. Virginia's Part C early intervention system experienced significant budget shortfalls in FY 2013 that resulted in several local systems establishing waiting lists for services and a decrease of just under 1% in the number of children served in FY 2013. With the increase in state funds allocated by the General Assembly for Part C early intervention for the last quarter of FY 2013 and for FY 2014, local systems were able to begin serving children who had been waiting for services and to resume child find efforts to identify all eligible children in FY 2014. Successful child find efforts continued in FY 2015.

Total Number of Infants and Toddlers Served in Each Year

Year	Total Number Served – Eligible and Entered Services	Total Number Evaluated Who Did Not Enter Services*
Dec. 2, 2003 – Dec.1, 2004	8,540	
Dec. 2, 2004 – Dec. 1, 2005	9,209	
July 1, 2006 – June 30, 2007	10,330	
July 1, 2007 – June 30, 2008	11,351	1,760
July 1, 2008 –June 30, 2009	11,766	1,671
July 1, 2009 – June 30, 2010	12,234	1,494
July 1, 2010 – June 30, 2011	14,069	1,829
July 1, 2011 – June 30, 2012	15,676	1,797
July 1, 2012 – June 30, 2013	15,523	1,745
July 1, 2013 – June 30, 2104	16,272	1,720
July 1, 2014 – June 30, 2015	17,022	1,815

** These children received a multidisciplinary team evaluation to determine eligibility and, in some cases, an assessment for service planning, but did not enter services because they were either found ineligible for Part C, declined Part C early intervention services, or were lost to contact. Since evaluation and assessment, by federal law, must be provided at no cost to families, neither private insurance nor families can be billed for these services. Unless the child has Medicaid or Tricare, federal and state Part C funds are generally used to pay for evaluation and assessment.*

The chart below projects number of eligible children served through 2018.



V. *Services Provided to Eligible Infants and Toddlers*

Previous efforts to include delivered service data on the expenditure reports from local lead agencies and private providers resulted in inconsistent and duplicative counts. Until there is an electronic mechanism to collect reliable delivered service data from local systems, DBHDS will report estimates based on planned services data. The ITOTS data system provides a report of the number of children active on December 1 of a given year for whom the initial IFSP listed each type of early intervention service. The table below estimates the total number of children served between July 1, 2014 and June 30, 2015 who have each service listed on their initial IFSP. This is based on the percentage of children with initial IFSPs having those services listed on December 1, 2014.

Estimates of Total Number of Children Receiving Each Service: July 1, 2014 – June 30, 2015

Type of Early Intervention Service	% of Children with an Initial IFSP Listing that Service on 12/1/14	Estimated # of Children with an Initial IFSP Listing that Service in FY 2015 (% multiplied by Total Served)
Assistive Technology	0.05%	9
Audiology	0.40%	68
Counseling	0.01%	2
Developmental Services	14.8%	2,519
Health Services	0%	0
Nursing Services	0.04%	7
Nutrition Services	0.01%	2
Occupational Therapy	13.8%	2,349
Physical Therapy	25.9%	4,409
Psychological Services	0.03%	5
Service Coordination	N/A*	17,022
Sign Language and Cued Language Services	0.06%	10
Social Work Services	0.20%	34
Speech-Language Pathology	32.4%	5,515
Transportation	0.01%	2
Vision Services	0.30%	51
Other Entitled EI Services	0.08%	136

*All eligible children receive service coordination.

In addition to the services listed on IFSPs, a total of 10,522 children received an evaluation to determine eligibility and/or an initial assessment for service planning in FY 2015.

Limitations: The numbers provided above are only estimates and almost certainly underestimate the number of children receiving each service, since some children whose initial IFSP does not list a service (e.g., physical therapy) may have that service added at a subsequent IFSP review during the 1-year period. The ITOTS data system captures only those planned services identified on a child's initial IFSP, with no updates of services added on subsequent IFSPs and no data on services actually delivered.

Future Actions to Address Limitations: Accurate reporting of the number of children actually receiving each early intervention service can only be fully ensured once a reliable statewide mechanism is implemented to collect or import delivered service data from local systems.

VI. *Overall Fiscal Climate for Part C for FY 2014 and Beyond*

Revenue generated through the Medicaid Early Intervention Services Program continues to fully fund services (other than service coordination) for children with Medicaid. However, there was not sufficient funding available in FY 2015 to fully support the costs of providing service coordination to Medicaid eligible children or to support the costs of providing all appropriate services to children who do not have Medicaid. Specifically, the funding challenges in FY 2015 included the following:

- The Medicaid Early Intervention Targeted Case Management program that began in October 2011ensures eligible children and families receive service coordination that is appropriate to the needs of infants, toddlers and their families. However, the original Early Intervention Targeted Case Management reimbursement rate of $120 per month did not cover the expenses of providing this service, which are estimated at $175 per month, based on a cost study conducted by the Department of Medical Assistance Services. During the 2012 session, the General Assembly passed a budget amendment that appropriated the state funds necessary to increase the Medicaid reimbursement rate for early intervention targeted case management to $132 per month beginning July 1, 2012. These additional funds have helped to shrink, but not eliminate, the gap between revenue and the $175 per month expenses associated with service coordination for children with Medicaid.

- While the total amount of federal and state Part C funds allocated to local systems in FY 2015 increased by 1.5%, the number of children served increased by 4.6%. In order to serve all children, local systems used a variety of strategies, including reducing funding for systems operations, like training; requiring the local system manager to also provide direct services to children and families; or appealing to the local lead agency for additional one-time local funding for needed services.

- Revenue from private insurance and TRICARE decreased by 35% from FY 2014 to FY 2015. While this decrease may be due partly to inaccuracies or inconsistencies in reporting from year to year as a result of limitations in the state data system, local systems also report several challenges impacting actual insurance reimbursement. These include difficulty in being accepted as in-network providers with a number of insurance companies; declining reimbursement rates; and difficulty obtaining reimbursement for speech-language pathology services for infants and toddlers since this is generally a habilitative service (helping the child keep, learn or improve skills) with this population rather than a rehabilitative service (helping the child re-gain lost skills). In a recent survey, local system managers reported being reimbursed approximately 32% of the amount billed to private insurance companies for early intervention services and approximately 47% of the amount billed to TRICARE. In general, insurance companies pay lower rates for early intervention services than Medicaid does and do not reimburse at all for service coordination (which must be provided for all children) or developmental services. Federal and state Part C funds must be used to make up the difference between the insurance rate and the Medicaid rate and to pay for services that are not covered.

- Due to tight budgets in all local programs, the amount of other state general funds (beyond those designated by the General Assembly for Part C) used by local

systems to support Part C early intervention decreased by 35% from FY 2014 to FY 2015. Local lead agencies, especially Community Services Boards, may have state general funds other than those designated for Part C available to support their programs. They have discretion over how to use these other state general funds. Fewer are opting to use those other state funds toward Part C early intervention services.

Looking ahead, the system is still growing and remains stressed. Meeting federal early intervention requirements necessitates aggressive outreach for public awareness and child find to identify all eligible children, meeting rigorous standards for timely and effective services, and ensuring no waiting lists. Unless funding stays apace with growth, Virginia runs the risk of falling into noncompliance, which puts federal Part C funding at risk and may result in children and families not getting the supports and services they need in a timely and effective manner.

Only three months into FY 2016, nine (9) local systems have already identified the need for additional funds totaling at least $1,000,000 in order to maintain services for all eligible children through June 30, 2016.

Achieving a stable and sustainable fiscal structure for Virginia's early intervention system remains a top priority, as this is essential to ensuring an effective service system that leads to positive outcomes for infants and toddlers with disabilities and their families. Towards this end, DBHDS continues to:

- Closely monitor the fiscal situation across local systems;
- Provide additional support to local system managers and local fiscal staff to ensure effective oversight of local budgets and spending as well as accurate reporting of revenues and expenditures; and
- Work with local systems and the Virginia Interagency Coordinating Council on ways to maximize and possibly improve private insurance reimbursement for early intervention services.

In addition, Virginia applied and was selected to participate with three other states in a national fiscal initiative designed to build state capacity to support fiscal infrastructure development. This initiative offers the opportunity to address state-identified challenges by learning together with and benefitting from the experience of the other participating states and national experts.

VII. *Conclusion*

As demonstrated by the data reported above, the funding provided by the General Assembly permitted local Part C early intervention systems to provide a wide variety of needed supports and services to more than 17,000 eligible infants, toddlers and their families during fiscal year 2015. These funds also touched the lives of over 1,800 additional infants, toddlers and families who received evaluations for eligibility determination and assessments upon referral to the Part C early intervention system even though they did not proceed on to receiving other early intervention supports and services. As the number of eligible infants and toddlers identified continues to increase and federal Part C funding levels remain static or fall, state Part C funding is critical to ensure all eligible children and families receive timely and appropriate early intervention supports

and services Virginia and national data indicate that early intervention is leading to a number of positive outcomes for children and families. Research finds that early intervention reduces the need for special education and grade retention and reduces future costs in welfare and criminal justice programs. Estimates on the cost savings vary, but the long-term study associated with the Perry Preschool Project indicates at least a seven dollar return on every dollar invested in early intervention. DBHDS, local service providers and families are appreciative of the continued financial support for Part C early intervention provided by the General Assembly.

Appendix A
Local System Names and Included Localities

Local System	Localities Included
Alexandria	City of Alexandria
Alleghany-Highland	Alleghany County; Cities of Clifton Forge and Covington
Arlington County	Arlington County
Central Virginia	Counties of Amherst, Appomattox, Bedford and Campbell; Cities of Bedford and Lynchburg
Chesapeake	City of Chesapeake
Chesterfield	Chesterfield County
Williamsburg, James City, York	Counties of James City and York; Cities of Poquoson and Williamsburg
Heartland	Counties of Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, and Prince Edward
Cumberland Mountain	Counties of Buchanan, Russell, and Tazewell
Danville-Pittsylvania	Pittsylvania County; City of Danville
Eastern Shore	Counties of Accomack and Northampton
Fairfax-Falls Church	Fairfax County; Cities of Fairfax & Falls Church
Goochland-Powhatan	Counties of Goochland and Powhatan
Hampton-Newport News	Cities of Hampton and Newport News
Hanover County	Hanover County
Harrisonburg-Rockingham	Rockingham County; City of Harrisonburg
Henrico, Charles City, New Kent	Counties of Henrico, Charles City, and New Kent
Highlands	Washington County; City of Bristol, Abingdon
Loudoun County	Loudoun County
Middle Peninsula-Northern Neck	Counties of Essex, Gloucester, King & Queen, King William, Lancaster, Mathews, Middlesex, Northumberland, Richmond, and Westmoreland; Cities of Colonial Beach and West Point
Mount Rogers	Counties of Bland, Carroll, Grayson, Smyth, and Wythe; City of Galax and Marion
New River Valley	Counties of Floyd, Giles, Montgomery and Pulaski; City of Radford
Norfolk	City of Norfolk
Shenandoah Valley	Counties of Clark, Frederick, Page, Shenandoah, and Warren; City of Winchester
Piedmont	Counties of Henry, Franklin, and Patrick; City of Martinsville
DILENOWISCO	Counties of Dickenson, Lee, Scott and Wise; City of Norton
Crater District	Counties of Dinwiddie, Greensville, Prince George, Surry, and Sussex; Cities of Colonial Heights, Emporia, Hopewell, and Petersburg
Portsmouth	City of Portsmouth
Prince William, Manassas, Manassas Park	Prince William County; Cities of Manassas, Manassas Park and Quantico
Rappahannock Area	Counties of Caroline, King George, Spotsylvania, and Stafford; City of Fredericksburg
Rappahannock-Rapidan	Counties of Culpepper, Fauquier, Madison, Orange, and Rappahannock
Roanoke Valley	Counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson; City of Charlottesville
Richmond	City of Richmond
Blue Ridge	Counties of Botetourt, Roanoke and Craig; Cities of Roanoke and Salem
Rockbridge Area	Counties of Bath and Rockbridge; Cities of Buena Vista and Lexington
Southside	Counties of Brunswick, Mecklenburg, and Halifax; Cities of South Boston and South Hill
Augusta-Highland	Counties of Augusta and Highland
Virginia Beach	City of Virginia Beach
Western Tidewater	Counties of Isle of Wight and Southampton; Cities of Franklin and Suffolk
Staunton-Waynesboro	Cities of Staunton and Waynesboro