COMMONWEALTH of VIRGINIA

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November 15, 2017

The Honorable Thomas K. Norment, Jr., Co-chair
The Honorable Emmett W. Hanger, Jr., Co-chair
Senate Finance Committee
14th Floor, Pocahontas Building,
900 East Main Street,
Richmond, VA 23219

Dear Senator Norment and Senator Hanger:

Item 315.H.2. of the *2017 Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to report on the Part C Early Intervention System in Virginia.

Please find enclosed the report in accordance with Item 315.H.2. 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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The Honorable S. Chris Jones, Chair
House Appropriations Committee
900 East Main Street
Pocahontas Building, 13th Floor
Richmond, Virginia 23219

Dear Delegate Jones:

Item 315.H.2. of the *2017 Appropriation Act*, required the Department of Behavioral Health and Developmental Services (DBHDS) to report on the Part C Early Intervention System in Virginia.

Please find enclosed the report in accordance with Item 315.H.2. 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

July 1, 2016 – June 30, 2017

(Item 315 H.2)

November 15, 2017

DBHDS Vision: A Life of Possibilities for All Virginians

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Virginia’s Part C Early Intervention System

Preface

Item 315.H.2. of the 2017 Appropriation Act requires the Department of Behavioral Health and Developmental Services (DBHDS) to submit an annual report to the Governor and the General Assembly.

> *H.2. 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, toddlers and families served using all Part C revenues, and (d) services provided to those infants, toddlers, and families.*

Virginia's Part C Early Intervention System

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Introduction

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 to 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.

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 Virginia.

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. In order to address a $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 $2.3 million in state general fund dollars in FY 2013 and another $6 million for FY 2014. A total of $13.2 million was allocated for early intervention in FY 2015, $14.8 million in FY 2016, and $15.5 million in FY 2017.

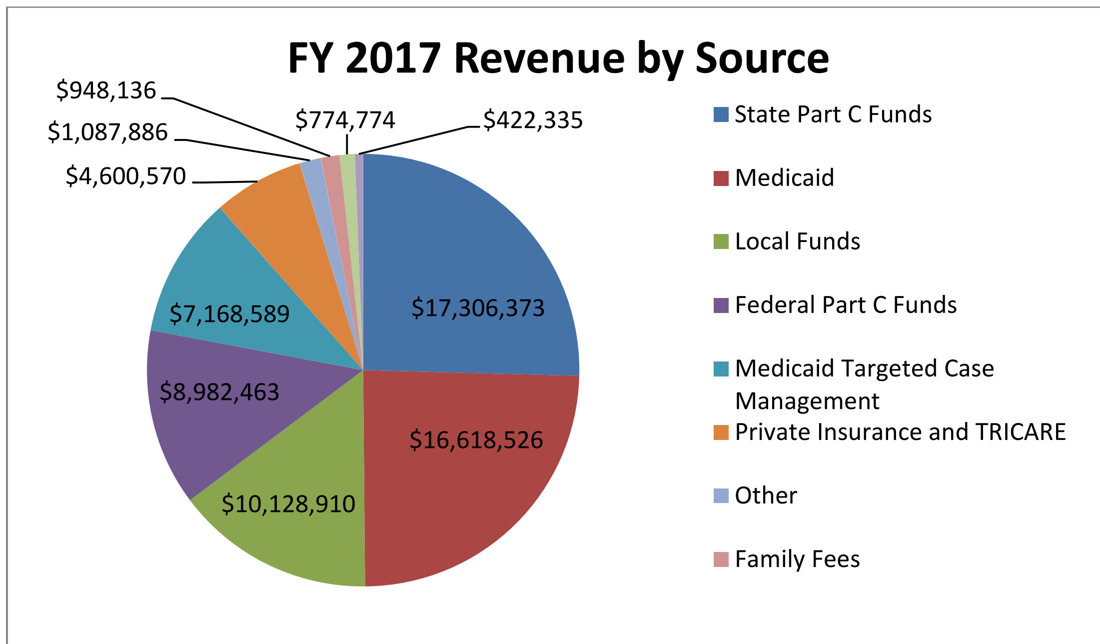
In FY2017, reported revenue kept pace with reported expenses in the Part C early intervention system. However, the completeness and accuracy of expense and revenue data is of concern since local lead agencies and private providers collect their data separately and there is no central mechanism to ensure reporting by all private providers or to ensure non-duplication. The following factors underscore the importance of continued revenue growth to support the system:

- The number of children served in the Part C early intervention system increased by 7 percent from FY 2016 to FY 2017. At the same time, revenue from private insurance and TRICARE decreased by 12 percent, and federal Part C funding remained stagnant.
- Increases in the number of substance exposed infants, earlier identification of autism spectrum disorders and improved statewide collaboration with Neonatal Intensive Care Units (NICUs) is expected to result in even higher annual increases in the number of children referred to and served in Virginia's early intervention system.
- Nine local systems requested additional funds in FY 2017. The funds were needed to support the expenses of the local system, including the cost of providing services. DBHDS was able to provide the local systems with 84 percent of their requests. The additional funds were from savings at the state level and from retained funds from four local systems who volunteered to return funds to assist local systems with a fiscal need.

To the maximum extent possible, the following narrative, charts and other graphics respond to the legislative requirements as delineated in Item 315.H2. The following data is based on revenue and expenditure reports received from the 40 local lead agencies and includes data from the private providers with which the local lead agencies contract.

Total Revenue Used to Support Part C Services

The chart and table below describe the total revenue to support Part C Early Intervention Services in FY 2017.



Revenue Source	FY 2017 Revenue Amount
Federal Part C Funds	$8,982,463*
State Part C Funds	$17,306,373*
Other State General Funds	$422,335
Local Funds	$10,128,910
Family Fees	$948,136
Medicaid	$16,618,526
Medicaid Targeted Case Management	$7,168,589
Private Insurance and TRICARE	$4,600,570
Grants/Gifts/Donations	$11,352
In-Kind	$763,422
Other	$1,087,886
Total	$68,038,562

**These figures are 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:

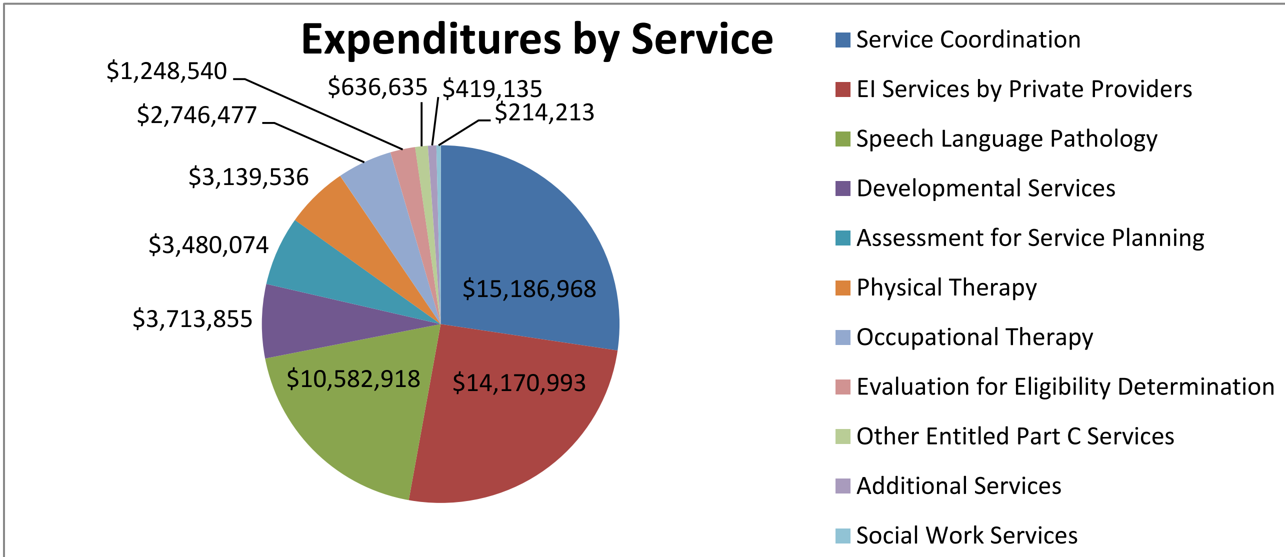
Funds Allocated by Local Lead Agency*

Infant & Toddler Connection of:	State	Federal
Alexandria	$ 421,460	$ 238,161
Alleghany-Highlands	$ 72,503	$ 48,404
Arlington	$ 655,849	$ 349,378
Augusta-Highland	$ 126,058	$ 75,728
Blue Ridge	$ 554,859	$ 304,926
Central Virginia	$ 388,442	$ 204,419
Chesapeake	$ 480,932	$ 257,494
Chesterfield	$ 493,358	$ 285,571
Crater District	$ 130,050	$ 89,226
Cumberland Mountain	$ 77,922	$ 48,623
Danville-Pittsylvania	$ 139,039	$ 95,990
DILENOWISCO	$ 79,214	$ 48,307
Eastern Shore	$ 111,243	$ 67,765
Fairfax-Falls Church	$ 3,028,589	$1,651,705
Goochland-Powhatan	$ 118,368	$ 72,716
Hampton-Newport News	$ 434,468	$ 232,296
Hanover	$ 206,645	$ 118,201
Harrisonburg-Rockingham	$ 192,145	$ 114,735
Heartland	$ 139,531	$ 79,774
Henrico-Charles City-New Kent	$ 693,922	$ 480,654
Highlands	$ 101,864	$ 61,435
Loudoun	$ 639,742	$ 341,730
Middle Peninsula-Northern Neck	$ 334,959	$ 247,584
Mount Rogers	$ 121,643	$ 70,888
New River Valley	$ 133,266	$ 115,876
Norfolk	$ 452,702	$ 240,583
Piedmont	$ 124,859	$ 73,963
Portsmouth	$ 176,778	$ 102,204
Prince William, Manassas and Manassas Park	$ 834,590	$ 436,084
Rappahannock Area	$ 663,260	$ 442,202
Rappahannock-Rapidan	$ 281,508	$ 154,738
Richmond	$ 342,813	$ 180,174
Roanoke Valley	$ 373,753	$ 197,196
Rockbridge Area	$ 95,119	$ 58,706
Shenandoah Valley	$ 375,547	$ 222,880
Southside	$ 70,831	$ 46,493
Staunton-Waynesboro	$ 81,846	$ 59,588
Virginia Beach	$ 1,045,555	$ 548,632
Western Tidewater	$ 276,869	$ 167,771
Williamsburg-James City-York-Poquoson	$ 453,226	$ 244,958
Total	**$15,525,327**	**$8,877,758**

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

Total Expenses for All Part C Services

The chart and table below describe the total expenditures for Part C Early Intervention (EI) services in FY 2017.



Service	Amount
Assessment for Service Planning	$ 3,480,074
Assistive Technology Devices	$ 54,341
Audiology	$ 14,600
Counseling	$ 27,563
Developmental Services	$ 3,713,855
Evaluation for Eligibility Determination	$ 1,248,540
Health	$ 84,175
Nursing	$ 29,971
Nutrition	$ 20,192
Occupational Therapy	$ 2,746,477
Physical Therapy	$ 3,139,536
Psychology	$ 0
Service Coordination	$ 15,186,968
Social Work	$ 214,213
Speech Language Pathology	$ 10,582,918
Transportation	$ 139,302
Vision	$ 48,991
Other Entitled Part C Services	$ 636,635
EI Services by Private Providers**	$ 14,170,993
Total-Direct Services	**$55,539,344***

The local lead agencies reported an additional $10,289,367 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 $65,828,711**.**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.*

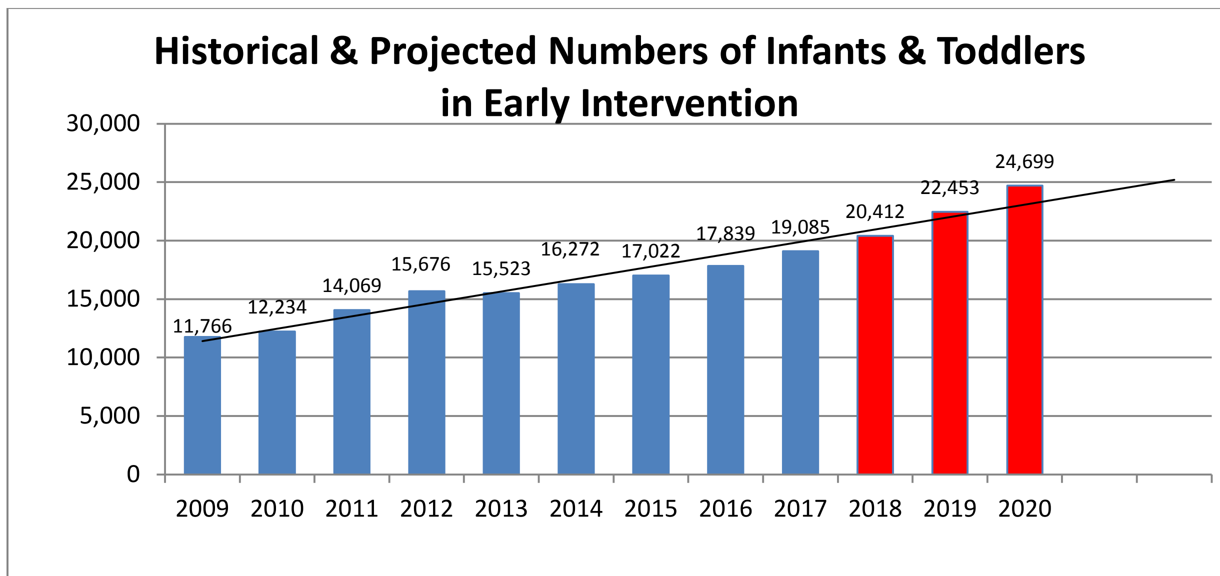
Total Number of Infants and Toddlers in Early Intervention

The table below shows the total number of infants and toddlers evaluated by those who were eligible and entered services and by those who did not enter services since 2004.

Year	Total Count – 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
July 1, 2015 – June 30, 2016	17,839	1,976
July 1, 2016 – June 30, 2017	19,085	2,078

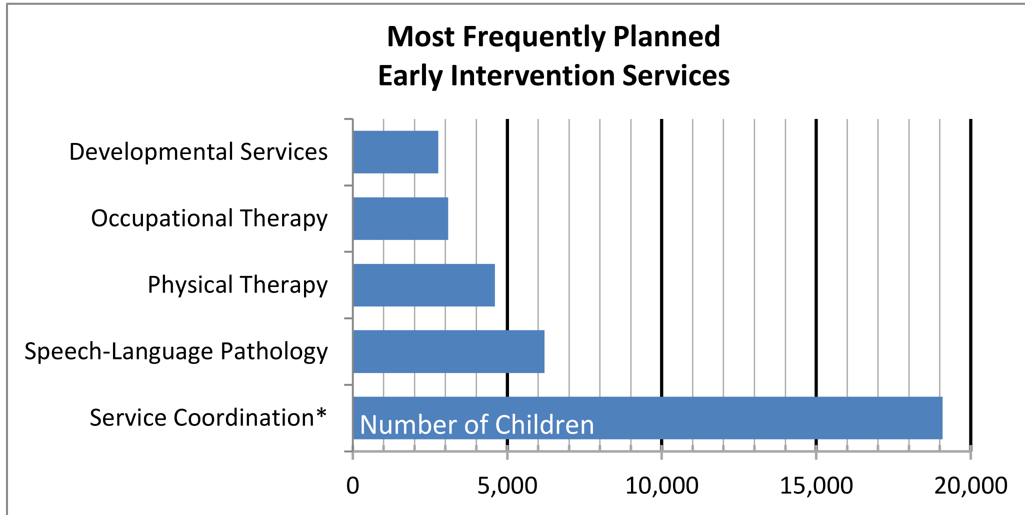
* These children received a multidisciplinary team evaluation to determine eligibility and, in some cases, an assessment for service planning, but did not enter services because they were either found ineligible for Part C, declined Part C early intervention services, or were lost to contact. Since evaluation and assessment must be provided at no cost to families by federal law, 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 shows actual numbers (blue columns) served through SFY 17 and trends (red) the projected number of eligible infants and toddlers served through 2020.



Services Provided to Eligible Infants and Toddlers

The chart and table below describe the types of services provided to eligible infants and toddlers and the total number of children receiving each service in FY 2017.



*All eligible infants & toddlers receive service coordination.

FY 2017 Estimates of Total Number of Children Receiving Each Service

Type of Early Intervention Service	% of Children with an Initial IFSP* Listing that Service on 12/1/16	Estimated # of Children with an Initial IFSP Listing that Service in FY 2017 (% multiplied by Total Served)
Service Coordination	100*	19,085
Speech-Language Pathology	32.5%	6,203
Physical Therapy	24.1%	4,599
Occupational Therapy	16.2%	3,092
Developmental Services	14.5%	2,767
Audiology	0.60%	115
Vision Services	0.50%	95
Social Work Services	0.40%	76
Other Entitled EI Services	0.20%	38
Assistive Technology	0.04%	8
Sign Language and Cued Language Services	0.04%	8
Nutrition Services	0.03%	6
Medical Services	0.02%	4
Counseling	0.01%	2
Psychological Services	0.01%	2
Health Services	0%	0
Nursing Services	0%	0
Transportation	0%	0

*All eligible infants & toddlers receive service coordination.

** IFSP = Individualized Family Service Plan.

In addition to the services listed on Individualized Family Service Plans (IFSP), a total of 12,814 children received an evaluation to determine eligibility and/or an initial assessment for service planning in FY 2017.

Data Limitations

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. 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. As a result, 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, to plan for future needs, or to monitor funding sources and service costs by child or by local system. A robust data system will allow Virginia's Early Intervention program to become a data driven system. For example, a data driven system will provide the data needed to determine the types of services that have the best outcome for a specific child.

Since no financial data for Part C services is collected through ITOTS, DBHDS must rely on a burdensome paper process for collecting and reporting data on the cost of providing services and the revenue sources that are accessed in providing services. Local lead agencies and private providers each maintain separate billing and accounting systems, so there is no method to reliably ensure non-duplication of reporting of expenses and revenues, 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.

Non-duplication of revenue and expense reporting can only be fully ensured once a reliable statewide mechanism is implemented to collect or import data from local systems on expenditures and on the source and amount of revenue for every service delivered. DBHDS has begun developing a data system solution to accomplish this task. Development is expected to take one to two years.

Overall Fiscal Climate for Part C for FY 2017 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 2017 to fully support the cost of providing service coordination to Medicaid eligible children and there were continued challenges in supporting the costs of providing all appropriate services to children who do not have Medicaid. Specifically, the funding challenges in FY 2017 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 DMAS. During the 2012 session, the General Assembly 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.

- Revenue from private insurance and TRICARE decreased by 12 percent from FY 2016 to FY 2017 following a 16.3 percent decrease from FY 2015 to FY 2016 and a 35 percent decrease the previous year. While these decreases 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 in 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 general, insurance companies pay the same rate as services provided in the clinic setting and do not include reimbursement for the additional cost of providing services in the family's natural environment, which is typically their home. Providing services in the natural environment is a federal requirement. Additionally, insurance companies do not reimburse at all for service coordination or developmental services. Because there is a uniform Early Intervention rate, regardless of reimbursement source, 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.
- While federal Part C funds remained stagnant and private insurance and TRICARE revenue declined, the number of children served in the Part C early intervention system increased by 7 percent from FY 2016 to FY 2017. This is an even higher rate of increase than the approximately 5 percent annual increases seen in other recent years.

While reported revenue kept pace with (and even slightly exceeded) reported expenses for FY 2017, that data provides an incomplete and misleading picture of the actual financial situation for the early intervention system for several reasons:

- The completeness and accuracy of reported expense and revenue data is of concern 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.

- Nine local systems requested additional funds in FY 2017. The funds were needed to support the expenses of the local system, including the cost of providing services. DBHDS was able to provide the local systems with 84 percent of their requests. The additional funds

were from savings at the state level and from retained funds from four local systems who volunteered to return funds to assist local systems with a fiscal need.

- Reported expenditures reflect the early intervention rate paid for each service, which may be lower than the full cost of providing that service.

- Local systems with anticipated budget shortfalls used a variety of strategies, including reducing funding for system operations, like training; requiring the local system manager to also provide direct services to children and families; or increased caseloads, especially for service coordination, in order to ensure services for all eligible children and families. While these strategies assist local systems to operate within available funding and maintain compliance with federal and state requirements, long-term use of these strategies may negatively impact the quality of services delivered and eventually the outcomes for eligible children and families.

- Some of the local systems' need for additional funds in FY 2017 was met using unspent Part C funds returned to DBHDS from a few other local systems. In many instances these funds were returned because of isolated circumstances, like an inability to fill a vacant position. Since these circumstances are not likely to recur, this is not a reliable source of additional funds in future years.

Looking ahead, the system is still growing each year and the following factors underscore the importance of continued revenue growth in order to support the system:

- An increase in the number of substance exposed infants;

- Earlier identification of autism spectrum disorders with a need for more intensive and frequent services;

- Expected increases in referrals from Neonatal Intensive Care Units as a positive result of a *Virginia Board for People with Disabilities (*VBPD) funded grant to the VA Hospital and Healthcare Association;

- Expected increases in referrals from Medicaid Managed Care Organizations as a positive result of including Early Intervention Part C services in managed care; and

- Federal early intervention requirements that necessitate aggressive outreach for public awareness and other efforts to identify all eligible children, meeting rigorous standards for timely and effective services, and ensuring there are no waiting lists. All states are also required by the U.S. Department of Education to implement strategies to improve outcomes for infants and toddlers. This worthwhile effort requires both human and fiscal resources. Unless funding stays apace with growth and the service needs of infants and toddlers in Early Intervention, Virginia runs the risk of falling into noncompliance with federal requirements for the program.

Only three months into FY2018, five local systems have already identified the need for additional funds totaling about $350,000 in order to maintain services for all eligible children through June 30, 2018.

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. To 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;
- Work with local systems to maximize private insurance and TRICARE reimbursement for early intervention services; and
- Work to fund and develop a comprehensive early intervention data system that will collect delivered service and non-duplicated revenue and expenditure data.

Consultation with national fiscal experts confirms that DBHDS is taking all reasonable fiscal management actions given the current data available and that a more comprehensive data system is essential to truly effective state and local fiscal management and oversight.

Conclusion

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. 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 19,085 eligible infants, toddlers and their families during FY 2017. These funds also touched the lives of almost 2,100 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 and that Virginia continually improves outcomes for infants, toddlers, and their families.

Appendices

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