Medicaid Physician & Managed Care Liaison Committee Meeting (MPMCLC)

Tuesday, 1/10/17 from 10:00 AM – Noon
Conference Room 7A/B
600 East Broad St. Richmond, VA 23219

Dial In # 1-866-842-5779
Conference Code #: 7439901269, followed by the #

Meeting #8

AGENDA

| I. Welcome & Introductions           | Cindi B. Jones, Director  
Dr. Kate Neuhausen  
Chief Medical Officer (CMO),  
Chair of MPMCLC  
Department of Medical Assistance  
Services (DMAS) | 10:00 am |
|--------------------------------------|--------------------------------------------------|
| II. Overview of Medallion 4.0        | Cheryl Roberts, Deputy Director of  
Operations  
Dan Plain, Director of Division of  
Health Care Services  
Department of Medical Assistance  
Services (DMAS) | 10:05 am |
| III. Common Core Formulary and ED Care Coordination Innovations in Medallion 4.0 | Dr. Kate Neuhausen  
Chief Medical Officer (CMO),  
Chair of MPMCLC | 10:25 am |
| IV. Public Testimony by Stakeholders| MPMCLC Members and  
Stakeholders | 10:30 am |
| We invite stakeholders to provide 2-3 minutes of public testimony on your specific recommendations for the Medallion 4.0 program that will improve outcomes for pregnant women, parents, and children. Sign in available at the meeting. Bring a hard copy of remarks. If you have comments, but do not wish to speak, please send to M4.0Inquiry@dmas.virginia.gov | |
| V. Next Steps & Adjourn              | Dr. Kate Neuhausen &  
Cheryl Roberts | 11:55am |
Cheryl J. Roberts, J.D.
Deputy of Program & Operations
MEDALLION 4.0
will cover 761,000 Medicaid and FAMIS members
effective August 1, 2018
MEDALLION 4.0 PROGRAM DESIGN

- Medallion 4.0 will be a 1915 (b) waiver program that will cover the basic Medallion 3.0 and FAMIS populations
  - New carved in populations and services:
    - Early Intervention Services
    - Third Party Liability (TPL)
    - Community Mental Health and Rehabilitation Services (CMHRS)
- Members will have a choice of 3 or more plans in each of six regions
- Our focus is on each covered population
MATERNITY

- Early Prenatal Care
- Increase Case Management
- Increase Post Partum Care including depression screenings
- Less Early Elective Deliveries
- Lower C-Section Rate
- Breast Feeding
- Increase Family Planning Utilization
- Increase HEDIS scores
- Implement Addiction and Recovery Treatment Services (ARTS)
- More Outreach and Education
- Use of Social Media
- Possible Value-Based Purchasing
- Possible Kick Payment
INFANTS 0-3

- Increase Immunizations
- Increase Well Visits
- Early Assessments
- Safe Sleep
- Neonatal Abstinence Syndrome (NAS) Babies
- Reduction in Infant Death (Three Branch Workgroup)
- Early Detection, Screening and Intervention
- Zero to Three Workgroup
CHILDREN 3-18

- Increase
  - ✓ Oral Health
  - ✓ Vision
  - ✓ Well Visits
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Obesity
- Asthma
- Blood Lead Screening
- Adolescent Focus
CHILDREN 3-18

- Special Needs Children
- Trauma Informed Care
- Community Mental Health and Rehabilitation Services (CMHRS)
- Improve Coordination
  - Department of Education (DOE)
  - Department of Social Services (DSS)
  - Virginia Department of Health (VDH)
  - Department of Behavioral Health and Developmental Services (DBHDS)
FOSTER CARE & ADOPTION ASSISTANCE

- Continue health plans agreement to work with DMAS
- Plans work with State DSS as well as local DSS Social Worker and Eligibility Worker
- Support foster care parents
- Regional case management
- Increase reporting
- Seamless transitioning of children to new status
ADULTS

- Wellness
- Chronic Diseases
  - Diabetes
  - Hypertension
  - Heart Disease
- Obesity
- Specialty Programs

ARTS
Addiction and Recovery Treatment Services
ADULTS

- Behavioral Health and CMHRS
- Family Planning/ Long Acting Reversible Contraceptive (LARC)
- Social Determinants of Health
- Emergency Department Use
GROWING STRONG
Medallion 4.0
Program Themes & Focus

- Big quality, data, and outcome focus
- Maternal child health partnerships
- Behavioral health models
- Strong compliance and reporting
- Provider and member engagement
- Innovation
Medallion 3.0
KEEPING THE BEST OF MEDALLION 3.0

Program
- Statewide
- High program acceptance
- Quality programs
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - National Committee for Quality Assurance (NCQA) Accredited
- Expansive Networks
- Adequate Rates

Innovation
- Behavioral Health Homes
- Managed Care System Partnerships
- ARTS (April 2017)
- Foster Care
- Performance Incentive Award (PIA)
- Telehealth
- Compliance and Technical Manual
- Program Integrity
- CMS managed care regulations
ALIGNMENT

- Common Core Formulary
- Data Integrity Language
- Quality (in part)
- Alternate Payment Models
### Features of APM Framework Categories

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
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<tr>
<td>• Payment tied to units of service</td>
<td>• Maintains unit based payment (i.e. FFS)</td>
<td>• Bonus payments for savings compared to spending target</td>
<td>• Single payment covering broad array of services, including preventive health, health maintenance, and health improvement services in addition to standard health services</td>
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<td>• Minimal to no financial incentives for quality, efficiency, or patient satisfaction</td>
<td>• Can include infrastructure support</td>
<td>• Can include shared risk w/ provider penalty for spending above target</td>
<td>• Entities establish teams of health professionals to provide enhanced access and care coordination</td>
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<td>• No funding for care coordination or care management infrastructure</td>
<td>• Incentives/ penalties for data reporting</td>
<td>• Payments under FFS over a period of time used to define spending targets</td>
<td>• Potential rewards/penalties for quality performance</td>
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<tr>
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<td>• Potential rewards/penalties for quality performance</td>
<td>• Targets can be set around an episode of care, procedure, or defined population</td>
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<td></td>
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<td>• Incentives account for quality</td>
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Each APM category includes features meant to move providers towards more advanced health care delivery systems. Categories 3&4 introduce the strongest incentives for high-quality, efficient patient care. Goal to move from Category 1 onward.
STRONGER MEMBER ENGAGEMENT

DMAS
- Enrollment broker
- Expedited enrollment
- Open enrollment
- Member meetings
- Social media

Health Plans
- Member focused
- Service centers
- Case managers
- Outreach teams
- Smartphone Apps
- Social media
- Social determents of health
- Incentives
- Tracking and engagement
PROVIDER ENGAGEMENT

DMAS

- Network adequacy
- Access
- Provider enrollment
- Program integrity
- Stakeholder meetings

Health Plans

- Provider contracting & credentialing
- Network management
- Case managers
- Provider training and service support teams
- Ease of access
- Provider visits
- Developing partnerships and supporting innovation
- Reporting and data submission
# Medallion 4.0 Provider & Stakeholder Regional Webinar Series

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<th>Date</th>
<th>Time</th>
<th>Registration Links</th>
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MEDALLION 4.0
Six Regions
LOOKING FORWARD

- RFP drafting ongoing
- Stakeholder engagement begins
- Release spring 2017
- Award winter 2017
- Regional Implementations 2018
  - August, September, October, November, December 2018
  - Concurrent operation of Medallion 3.0 and Medallion 4.0
MEDALLION 4.0 REGIONAL EFFECTIVE DATES

- **Tidewater Region**: 08/01/2018
- **Central Region**: 09/01/2018
- **Northern/Winchester Region**: 10/01/2018
- **Charlottesville/Western Region**: 11/01/2018
- **Southwest Region**: 12/01/2018

**MEDALLION 4.0 Begins**: 08/01/2018
Medallion 4.0 Focus:

- Evolving from the Medallion 3.0 foundation
- Serving over 700,000 healthy connected Medicaid & FAMIS members & their communities
- Engaging Health Systems & Stakeholders
- Providing holistic & integrated care
- Adding new services & populations
- Flexible delivery systems & payment models
- Growing stronger through improved quality, data & reporting

Important Medallion 4.0 Managed Care Timeline Dates:

Milestones | Proposed Dates*
--- | ---
Post Request for Proposals (RFP) | Spring 2017
Announce Awards | Fall 2017

Medallion 4.0 Managed Care Regional Effective Dates:

Regions | Proposed Effective Dates*
--- | ---
Tidewater Region Effective Date | August 1, 2018
Central Region Effective Date | September 1, 2018
Northern/Winchester Region Effective Date | October 1, 2018
Charlottesville/Western Region Effective Date | November 1, 2018
Roanoke/Alleghany Region Effective Date | December 1, 2018
Southwest Region Effective Date | December 1, 2018

SEND COMMENTS & QUESTIONS
M4.0Inquiry@dmas.virginia.gov
QUESTIONS

M4.oInquiry@dmas.virginia.gov
MEDALLION 3.0
2017-2018

Daniel Plain
Director, Health Care Services
PREPARING FOR CHANGE
KEEPING THE BEST OF MEDALLION 3.0

- Program
  - Statewide
  - High acceptance
  - Stable and mature
  - Strong compliance and reporting
  - Quality programs
    - Healthcare Effectiveness Data and Information Set (HEDIS) &
    - National Committee for Quality Assurance (NCQA) Accredited
  - Networks
  - Rate setting
  - Good outcomes

- Innovation
  - Behavioral Health Homes
  - Managed Care System Partnerships
  - ARTS (April 2017)
  - Foster Care
  - Enrollment Broker
  - Social Media
  - Expedited Enrollment
  - Technical Manual (JLARC Best Practice)
  - Value-Based purchasing
    - Language
    - Performance Incentive Award (PIA)
DRIVING CHANGE: WHAT IS DIFFERENT NOW?

- A Healthy Virginia
- General Assembly Scrutiny
- Populations
  - Low-Income Families and Children (LIFC) Focus
  - Community Mental Health
  - Aged Blind and Disabled (ABD) population moving to CCC Plus
- Procurement
- Delivery System Models are Changing
- Value-Based Purchasing & Innovation
- Managed Care Regulations
MEDALLION 3.0 AMENDMENT
APRIL 1, 2017

Hepatitis C
Medallion 3.0 Medicaid Managed Care

Important Dates for 2017

DMAS unbundled payment of post-partum insertion of LARC device from the delivery DRG; MCOs to cover for members who consent

01/01/2017

Hepatitis C criteria

02/01/2017

Implement ARTS

04/01/2017

2016

July  Aug  Sept  Oct  Nov  Dec  Jan  Feb  Mar  Apr  May  June

2017
MANAGED CARE REGULATIONS JULY 2017/2018

Medallion 3.0 Changes

- 40+ New Contract Mods
- Compliance and Reporting
- Mega Annual Report
- Medical Loss Ratio (MLR) vs Capitation Payment
- Provider Enrollment
- Provider Adequacy
- Grievances and Appeals
- Medicaid Enterprise System (MES) – Transformed Medicaid Statistical Information System (T-MSIS)
- Increased Enrollee Protections
- Encounter Data
- Program Integrity
- Public Reporting
- Enrollment Broker’s Duties Increase
- Subcontractor Work
- Care Coordination
- Increased Quality Provisions
- Increased Use of External Quality Review Organization (EQRO) for Oversight
- Institution for Mental Disease (IMD)
MEDALLION 3.0
Alignment with CCC Plus

- Common Core Formulary
- Data Integrity Language
ARE YOU READY ?
Medallion 3.0 Medicaid Managed Care

Important Dates for 2018

Medicaid Managed Care Regulations 07/01/2017

CCC + Begins 07/01/2017

HAP begin regional transition to CCC +

01/01/2018

CCC transitions into CCC+

All ABD transition to CCC +

08/01/2018

Medallion 4.0 Begins

01/01/2018

Medallion 3.0 Ends 12/31/2018

07/01/2017

01/01/2018

08/01/2018
Final Medallion 3.0 is 18 months

Six month overlap with CCC Plus
  (July 1, 2017 – December 31, 2017)

Medallion 4.0
  (August 1, 2018-December 31, 2018)

Medicaid Enterprise System (MES) impact

Waiver and Regulation changes
DMAS Medallion 4.0

• Virginia’s Plan for Well-Being (The Plan) is a call to action for Virginians to create and sustain conditions that support health and well-being. One of The Plan’s key aims is to ensure a strong start for children. The well-being of children determines the health of families and communities and can help predict future public health challenges. To give children a strong start, The Plan recommends a focus on helping Virginians plan their pregnancies and eliminating the racial disparity in infant mortality as foundational to achieving the aim.

• Ensure Quality of Care for All Women and Infants
  o Assure comprehensive approach to tobacco prevention and cessation, including referring patients to Virginia tobacco quitline for counseling; providing coverage of tobacco cessation medications.

• Improve Maternal Risk Screening for All Women of Reproductive Age
  o About half of pregnancies are unintended. Screening all women of reproductive age (18-44) for chronic conditions and other psychosocial risk factors for poor birth outcomes can have a positive effect on improving women’s health and birth outcomes.

• Enhance Service Integration for women and infants
  o Provide access to a quality, comprehensive and coordinated community-based system of services. For women of reproductive age, this may mean providing and coordinating maternity, reproductive health, primary care and child health services.
  o The medical home is a model for such service integration. The pregnancy centered medical home model embraces the team concept of comprehensive care for pregnant women and provides a high level of care management with built-in quality control measures.
  o Beyond the medical home, other models for effective service integration include engaging high-risk pregnant women and families in evidence-based home visiting programs that have demonstrated positive impact on subsequent pregnancy spacing and economic self-sufficiency.

• Improve Access to Health Care for Women Before, During and After Pregnancy
  o Assure access to preconception care, including appropriate screening and interventions for medical and social risk factors; reproductive life planning (whether and when to have children); and counseling to support the use of appropriate contraceptive methods. Preconception care can be built into annual preventive visits.
  o Similar risk assessment occurs during interconception, especially for women with a prior history of adverse pregnancy outcomes.

• Prevent teen pregnancy
  o Ensure access to quality family planning
  o Educate about all contraceptive methods and their level of effectiveness and screen for and address factors that increase the risk for and multiply the effects of teen pregnancy/parenting, such as depression, poor education and adverse childhood experiences
    ▪ Reduce barriers to accessing highly effective forms of contraception, such as long acting reversible contraceptives, which are considered first-line in teens
    ▪ This includes barriers to placement and removal of such contraception
• Improve provider and patient awareness of the influence of Social Determinants on Health outcomes
  o Incentivize patient education about the link between socio-economic and environmental factors and disease
  o Support access to healthy food and transportation through referrals and/or screenings
  o Assess and address health literacy during medical encounter.
• Increase and sustain outreach to vulnerable and disadvantaged populations
Medicaid Physician & Managed Care Liaison Committee (MPMCLC) Meeting—January 10, 2017

Bergen Nelson, MD, MS; Assistant Professor of Pediatrics, Children’s Hospital of Richmond at VCU

Background:
Universal developmental surveillance, and periodic developmental screening using structured, validated tools, are recommended by the American Academy of Pediatrics (AAP) as the primary ways to detect developmental delays and disabilities in young children. Developmental screening is a required service under the Medicaid EPSDT benefit, is included in the CHIPRA core set of quality measures, and is associated with CPT code 96110 in 45 states. Despite these guidelines and incentives, only an estimated 30.8% of parents with children aged 10 months to 5 years report receiving a developmental screening by their child’s PCP on average across the U.S., and that varies widely by state. Examples of successful state models are described below. Studies also show that even when developmental screening rates can be improved, various barriers to referral, follow-up, and care coordination remain at the family-, practice-, and system levels. Therefore, in thinking through an optimal approach to early childhood development, it is important to consider not just screening but also care coordination and access to high-quality intervention services. Finally, almost 25% of children under age 5 do not have overt developmental delays but are at high risk for poor school readiness and may benefit from developmental supports before kindergarten. State Medicaid programs and Medicaid Managed Care Organizations have the potential to play important roles in a system that supports early childhood development.

In 2007 VA engaged in a state-wide Assuring Better Child Development (ABCD) project, facilitated by the National Academy for State Health Policy, in partnership with the state AAP Chapter, Department of Education and Part C Early Intervention (EI) program. This effort resulted in development of a standardized EI referral form, screening and referral guidelines, training providers in use of the Ages and Stages Questionnaire (ASQ), and support of an ABCS Stakeholders Group to promote guidelines, with an increase in claims for screening.

Other Selected State Models:
- Massachusetts: Screening required by court order for all well-child visits under age 21 years, with list of approved tools, reimbursement for screening and additional reimbursement for counseling after +screen
- North Carolina: System to promote screening and care coordination through Community Care of NC and ABCD → state Medicaid system requires screening and also supports community care coordination
- Connecticut (and expansion to 25 affiliate states): Help Me Grow (HMG) framework → 1) Healthcare provider outreach to support early detection and intervention; 2) Community outreach to promote use of HMG and networking opportunities; 3) Centralized telephone access point; and 4) Data collection. Structural requirements include an organizing entity, statewide expansion, and continuous QI.
- California: County-based public/private partnerships used to implement HMG, i.e. in Los Angeles with First 5 LA (foundation) and LA Care (a large Medicaid MCO). Also testing pilot of telephone-based screening and care coordination through 2-1-1 Los Angeles County

Strategies to Improve Developmental Screening and Services:
- Require MCOs to report developmental screening rates, specifically with standardized, validated tools
- Provide financial incentives for quality (i.e. auto-assignment of beneficiaries to MCOs with high quality measures, including developmental screening; or including developmental screening in value-based purchasing and contract decisions)
- Support/ participate in collaboration among state agencies and across service sectors, to share data and improve practices across systems (i.e. Interagency Developmental Screening Task Force, or state Early Childhood Longitudinal Data System), potentially using a HMG framework/ focus on creating linkages among Medicaid program, primary care providers, and intervention service providers from 0-5 years
- Care Coordination (i.e. NC local Health Check EPSDT Coordinators provide outreach and follow-up for families of children with positive screens; also possible through a HMG framework or 2-1-1)
References and Resources:


Karen Ransone Statement/Medallion 4.0 Common Formulary

Hello, my name is Karen Ransone and I am a practicing pediatrician in Deltaville, Virginia. I am pleased to be able to serve on this Committee on behalf of the Medical Society of Virginia. Thank you for the opportunity to comment on the new Medicaid Medallion 4.0 and the important changes DMAS is proposing to the Medicaid program.

In the past Medicaid has been challenging for physicians for several reasons, most notably lower than average reimbursements and excessive administrative hurdles. The changes DMAS has made recently and those DMAS are proposing will significantly improve the program for our patients and for Medicaid providers.

When implementing any change to prescription coverage, there must be a balance between cost savings and providing quality and timely medical care. Requirements for repeated authorization for chronic or acute medications create significant administrative barriers to access; Medicaid members should have access to the prescriptions their physician prescribes.

Physicians dealing with the different Medicaid formularies face many challenges, including patients transitioning from one covered medication to another under a new formulary, the administrative burden in managing vastly different prior authorization criteria, and time spent keeping up with changes in each MCO's formulary. While these policies may be an effective cost-containment tool for payers, much of these costs are merely shifted to prescribers in the form of increased administrative burden and higher operational costs. A single formulary with only one list of preferred medications and one set of utilization management rules would eliminate a large percentage of the administrative burden currently experienced by providers. With a common formulary, a physician no longer has to tailor their recommended treatment based on which Medicaid plan the patient has at that time, but what they believe is the most appropriate medication for their condition. Consistent access to medications across Medicaid plans will also remove administrative hassle for physicians, encouraging physicians to see more Medicaid patients.

For many patients, the prescriptions they take are a lifeline. Multiple prescription formularies do more than inconvenience providers, however. Medicaid members — especially those with one or more chronic conditions — regularly experience inconvenience at the pharmacy, higher out-of-pocket expenses for non-covered medications, or disruption in drug therapy. We know that medication adherence may be central to keeping patients healthy and avoiding unnecessary hospitalizations or emergency room visits. Further, we know that prescription availability is one of the primary causes for plan change and turnover. If uniformly administered, a single common formulary reduces the needless changes and delays in treatment that can lead to poorer outcomes for patients.

I welcome any questions and appreciate the opportunity to share my thoughts on these important changes today.

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4 Ibid.
As a Representative of Virginia Early Intervention, I appreciate the opportunity to speak with the MPMCLC Committee today.

Brief History: In October 2009, the decision to carve out Part C (EI) services with DMAS led to greater billing efficiency at the local level which, in turn, allowed local systems to put more resources, including financial, toward service delivery. Currently, the EI benefit is assigned when a child’s data is entered into ITOTS, the DBHDS Part C database. Claims are paid based on this benefit. This process is imbedded in the Code of Virginia. The following are the most critical aspects of the current agreement that MCOs accept:

1. The IFSP (Infant family Service Plan) be accepted as the Plan of Care. This document contains the Family/Child Assessment; Goals with target dates, the Type and Frequency of Service recommended; and Physician Authorization.
2. MCO’s accept Local ITC (Infant Toddler Connection) Programs and Providers as In-network Participating Providers for EI services as they currently exist with DMAS. These programs are designated in S:ate Code as Providers of Early Intervention Part C services. Additionally, the Local Lead Agencies have policies and procedures in place mandated by and consistent with the Federal Part C Provision of IDEA. Providers are credentialed under their discipline specific licensure + carry the Virginia Early Intervention Professional certification. Credentialing as currently required by DMAS and DBHDS shall remain in effect.
3. Re-Authorization of services will occur annually when the plan is reviewed and updated based on the child’s progress and current level of function (Part C requirement). In the event that there is a change in services (type and/or frequency) prior to the Annual IFSP Review, the MCO will accept the IFSP Review Form as the Authorization for the new Plan of Care. The review form includes details on the child’s progress towards goals: the addition of new goals; and any changes in service type or frequency. Explanations are included to justify changes. A mandatory review is done at the 6 month interval (Part C requirement).
4. Rates of payment for Part C services, currently agreed upon between Part C and DMAS, are non-negotiable and agreed upon by all MCOs. This includes payment for EITCM based on the Part C service coordination requirements, which are extensive. Examples include the Initial EI Service Coordination Plan, the requirement of contact with the family at specific intervals, and the Health Status Indicator questions.
5. DBHDS Part C Staff act as the Agent for Quality Management Reviews, on behalf of DMAS, for children who have Medicaid. They have the in Part C requirements and can review, resolve, and mediate conflicts.

Requiring MCOs to adhere to the current agreement will insure a smooth transition to Medallion 4 for children who have Medicaid and receive early intervention services. It will allow Local lead Agencies to continue the provision of services without disruption and alleviate the burden of additional requirements that will complete already thin resources. Thank you for your time and attention!

Kelly Walsh-Hill, PT
Pediatric Physical Therapist
Early Intervention Professional, Certified
Chair, Virginia Interagency Coordinating Council