

EASTER SEALS SOUTHERN NEVADA
RESPONSE TO RFI 3/25/09

A. **Description of Nevada's Early Intervention System**

Questions:

1. Describe your ideas on what and how Nevada's model for early intervention services should be delivered, using evidenced-based practices. Your model must ensure services are available and accessible statewide.

As far as service provision, ideally, the State of Nevada would maintain service coordination and in-depth intake as the single point of entry for all children entering the EI system. The State would also maintain the billing of all Medicaid for NEIS and community providers. Since Medicaid HMOs have already accepted NEIS as a Medicaid provider and granted them the leeway to back bill prior to becoming a provider this would eliminate the time lost when a new community provider applies. Also, if service coordination was performed by NEIS, then Medicaid could be billed for targeted case management, maximizing Medicaid reimbursements. NEIS would also maintain those children with special healthcare needs. Community Providers would be required to submit an RFQ, meeting strict criteria, before being added to the provider list. An RFQ process should be done annually to solicit new providers for maximum parent choice and to ensure there would be enough providers for all of the eligible children, although ongoing acceptance of provider applications would be optimum. State service coordinators would facilitate IFSP meetings but community providers would then develop the IFSP with the family, provide special instruction, therapies and playgroups. Each child will be billed monthly.

1. Parents are referred to the program through physicians, child find activities, parent support groups. Families call the State Intake phone number (by region). Once a family calls the number, they would speak with a knowledgeable staff member who would conduct a thorough intake questionnaire to determine the family's concerns, health issues, insurance, past experience with an EI program or other interventions/therapies, to ensure the child may be eligible. If referral is other than parent or guardian, then only demographic information would be obtained and SPOE representative would then follow up with the family.
2. During the in-depth intake, details provided by families would determine if they should remain with the state for special healthcare needs. Once those initial medical needs have been met, the child would then be referred into the Part C, EI system and a provider chosen by the family for developmental services.
3. Community provider would be notified that a family has chosen them and the family would be assigned to a state service coordinator who would then contact the community provider, family and other needed team members and schedule the initial meeting for the

development of the IFSP. The community provider would assign a developmental specialist who would then attend the initial meeting.

4. Community provider would begin services after IFSP is developed and would provide monthly documentation on IFSP, child's progress and there would be consistent communication between developmental specialist and service coordinator for accountability.
5. It is understood and supported by evidence that the benefits of receiving interventions in the natural environment is very beneficial to the child and family and Easter Seals agrees. However, some parents may not choose a clinic based therapy setting and prefer home care and those wishes should be respected. Clinic therapies should be considered upon the families' request with approval of IFSP team. The developmental specialist will be required to co-treat with the community therapist. Strategies from the clinic will be implemented in to the home during home visits. This would also ensure that the majority of services are provided in the natural environment.
6. Community developmental specialists would work with children and become coaches for the family to help the parent become proficient at helping their child to succeed and to become advocates for their child.

2. Describe your ideas regarding the balance of services provided in the natural environment and/or clinic model. How would you most efficiently and effectively provide services to as many children as possible while demonstrating compliance with the Part C requirement for natural environment recognizing the limited pool of licensed therapists?

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3. Describe your model including all components such as: intake process for each region of the state (rural, northern and southern), the evaluation process, the development of the Individualized Family Service Plan (IFSP), the delivery of services for IFSP's, and transitioning process when the child reaches his/her third birthday or attains age appropriate developmental skills.

The state would be the single point of entry with a regional phone number for EI referrals. Once a family calls the number, they would speak with a knowledgeable staff member who would conduct a thorough intake questionnaire to determine the family's concerns, health issues, insurance, past experience with an EI program or other interventions/therapies, to ensure the child may be eligible. If referral call is received from a professional like a physician, then demographics would be obtained and more detailed information would be obtained during the intake completed when the family is called. If the SPOE contacts the family after an outside referral is made it can be determined if the family is interested in the program thus potentially saving time and money for all programs. After the phone intake, the State EI intake staff would list the available providers and ask the parents if they had a preference. Once a provider is chosen, the family would receive information about the provider, the referral would be sent to the community provider for follow up and to schedule a meeting within one week. The community provider would meet with family and other team members to develop IFSP and begin services. Community provider coordinates transition process when the child reaches his/her third birthday, in conjunction with state service coordinator, by including all relevant team members and providing parents with resources for the transition to school. As for a child transitioning out of the program because they have attained age appropriate developmental skills, the child would be exited and the parents would be given resources to continue monitoring the child's developmental progress along with instructions on how to re-enter the program if needed again in the future. Children re-entering the system should be able to automatically re-enter the system without being placed on the waiting list.

4. In your description, if the activity of a single point of entry (SPOE) is included, please add detail on the functions of a SPOE.

There should be a single point of entry for families. This would make the process smoother, however, the current system of an outside SPOE would not be needed if the State was doing the initial, in-depth intake process over the phone, they would become the single point of entry – in each region.

5. Who should deliver the services and specify the level of responsibility? A few examples include but are not limited to: state-operated programs only, combination of public and private agencies/providers, private agencies only, regional consortiums or networks, a hybrid, etc.

As mentioned above, the state could provide initial in-depth intake, service coordination and Medicaid billing as well as serving children with special health care needs with current contracts established with audiologists, nutritionists and other specialties. Community providers could provide special instruction and therapies. Having a choice of community providers is important for the families. In the event one agency is no longer able to provide services, other agencies will acquire the children without laps in service. Allowing multiple providers will also promote healthy competition and ensure a high level of care.

6. If the state were to transition to your envisioned model, describe your recommendations for how this transition could occur.

This transition would take some time, over the next two bienniums. Experienced and educated state developmental specialists could be transitioned into the service coordination role and vacancies for developmental specialists would not be filled, leading to attrition. With an annual RFQ for EI providers and an ongoing process to accept new provider applications, a more diversified group of providers could be formed to accept the growth to the community that would result when state DS positions were vacated.

7. What are key questions that the state should consider before choosing a particular approach to a service delivery system?

How efficient and effective is the service model? What is the long term sustainability of the service model? Is there parent choice in the delivery model? How pliable is the service model to make changes as the community needs change? Does the current model work now and provide all families in need with an adequate service? Is the current model cost effective? With long waiting lists and having to return unused funds, the answer must be no. Adding community providers will give more parent choice, promote healthy competition to be the best service provider and will increase capacity to serve more children.

8. Describe how you would sustain this change and make it statewide.

Qualified providers would enter the system at least annually or preferably ongoing in order to meet the needs of the community. The state would provide ongoing and consistent training and support to these entities and also any other training topics as requested by the community providers. The model as described above would remain the same in the North, South and rural areas and if there are no community providers available in some areas (i.e. rural) then Northern and Southern community providers may expand services into the rural areas and the desire to serve multiple areas should be a question in the RFQ. This service model is sustainable because the more providers available, the more choice for families, more children can be served and with many providers the services can continue even if some providers pull out of delivering services.

B. Description of Determining Program Service Capacity

Questions:

1. With approximately 3,650 children statewide served each year, how should the state procure services? Examples include but are not limited to: awarding a sole source

contract, designating the state responsibility for only specific services, or enrolling annually a pool of providers for early intervention services, etc.

The responsibilities would be distributed between the State and community providers as noted above. The state would provide intake, service coordination, Medicaid billing and services to children with special health care needs. Community providers would provide special instruction and therapies. There should be an ongoing or, at minimum, annual process for community providers to apply to be added to the provider list.

2. What are your recommendations to serve the maximum number of children with the current available dollars?

If the responsibilities are distributed between state and community providers, there would be more efficiencies in delivering service and meeting Part C requirements. If the state only paid for those staff who remained in a service coordination capacity, there would be state salary savings and with the State having more capacity to bill Medicaid for targeted case management and other services and has an established relationship with Medicaid and Medicaid HMO providers, they could maximize the Medicaid funding to the State. The State also has established relationships with special healthcare providers and can get children those services in a more efficient manner than sending them to the community and then the community has to procure those services or refer them back to the state to receive those services. The community providers can recruit and train developmental specialists quickly and efficiently so they can maximize hours on each IFSP and community providers also have the latitude to make personnel changes as needed. There should be a change in DS requirements that allows for a bachelor's degree or higher in a related field and one year experience working with children with special needs (paid or unpaid), to take the place of the early childhood endorsement. This would make it easier to recruit developmental specialists and maintain them in the program. Many states do not require anything more than this and Florida does not have any requirements other than the DS is required to attend a 4 hour training provided by the state. While this is not nearly a high enough standard in our opinion, we do feel that the requirements stated above and also requiring the DS to have mandatory new employee training from the state and ongoing training and credits throughout the year is enough to deem them a qualified provider and the ECE is not necessary. As this is not a federal requirement, the State could make this change and still ensure quality providers.

More children could also be served by allowing clinical therapies to occur if chosen by the family. The bundled monthly rate for services is much more conducive for doing business for both the community provider and the state if the bundled rate is at least \$750 per month, rather than billing per service. In cases where a child has severe needs (i.e. autism) and must require more services, then community providers should bill for every hour over 12 hours of therapy per month. This model is used in many other states and ensures the goals on the IFSP are met, eliminating potential issues in the future if the child does not receive the proper amount of intervention because the program cannot afford to provide as much as the child might need if those needs are extensive.

3. Describe the role of state government in interfacing with public and private providers.

The health division would remain the fiscal agent for EI services and the State NEIS program would provide service coordination, intake and special healthcare. The State would also develop the RFQ, review the applicants and annually review the programs to ensure they are maintaining those qualifications. The community providers would still receive ongoing training from the state but the training should be more consistent and structured with specific topics outlined and dates for those trainings established for the entire year. Providers could also request additional training throughout the year on specific topics as needed. Community providers would work closely with the state service coordinators on documentation and transition processes.

4. Describe how the state should determine a program's service capacity.

If a community provider has met or exceeded the requirements in the RFQ, then they are well equipped to determine their own caseload capacity and would update the intake team at NEIS when they have vacancies, much like the current SPOE system.

C. Description of Nevada's Reimbursement System for Early Intervention Services

Questions:

1. Based on your responses to the two above sections, describe how early intervention programs should be reimbursed for services rendered. Examples may include but are not limited to: fee for discrete services, incentives and penalties, a monthly rate for each child served, billing third party payers (Medicaid, private insurance), etc.

State would handle all Medicaid billing and reimburse community providers a monthly rate for each child with an IFSP.

2. How should reimbursement rates be calculated and allocated?

Reimbursement rates per child should be calculated at the mean cost of all expenses, including all administrative costs (accounting, postage, supplies, equipment, benefits, tax and fringe, audit costs, facilities, staff, etc.) and audiology, nutrition, vision, vision teacher, dual sensory teacher, and nursing. The current rate calculation has subtracted some costs that were believed to be exclusive to the State program but, in fact, are costs that the community providers also incur.

3. How should funding be distributed by state government among public and private providers?

Funding would be distributed for the cost of all of the above, per child monthly, for the most efficient use of funds per child.

4. What should be the consequences if a program does not meet or exceeds the contractual obligations?

Programs that do not meet the contractual obligations would receive a review and listing of those areas for correction and would be given time to correct those areas. If a program consistently does not meet the qualifications or loses some of their qualifications, then they would no longer be a service provider.

5. Should there be a maximum number of children served and also dollars awarded to community providers?

No, it should be based on the capacity of the community programs and parent choice.