



Department  
of Health

# EICC Rate Setting Methodology Task Force

EICC Meeting December 15, 2022

**Steve Held, Chair**

# Principals Worth Considering

Discussed changing geographic regions from 16 to 2 and adding NYC as an additional region (for 3 regions).

Achieved consensus on 3 regions for rates based on Ken's presentation.

Maria noted that Westchester should be considered with NYC and LI.

NYC needs to feel engaged with this new approach.

Add the consideration for travel issues in hard-to-reach areas in upstate NY and NYC (costs of parking & gas) as well as areas not traditionally served.

# General Discussion

Capacity is an issue. When you have county lines touching, certain counties have a harder time with capacity.

Revisit the concept in Medicaid billing that if the rate could be billed in 15-minute units, would this be a more appropriate alignment and reimbursement program? Is this another approach for the current debate over the basic being 30-or 45 minutes?

There are 15-minute billable units for Medicaid. You need to have 2 units of 30 minutes to start billing.

# Discussion Continued

- We may consider tying future increases to Medicaid, then increases are consistent with CMS.
- We need to build in greater flexibility. Building flexibility allows for more individualized services.
- The challenge to engage providers in some counties is often exasperated by the difference in the basic service that is written as a 30 minute vs. 45-minute time mandate. When a neighboring county writes the service for 30 minutes, the ability to keep providers in the other county adds to the tension created by capacity. Providers working in a municipal region where basic is 30 minutes receive a reimbursement that is one third higher.
- Possibly change the basic rate to 30 minutes.

# Continued Discussion

- Consider the IEP plan for 3-5, which is generally 30 minutes. This is for the IEP related services.
- Consider regional consistency in future guidelines.
- Steve voiced that an incremental increase in rates should preserve the individuality of IFSP, so establishing a 15-minute unit add-on might work.
- Ken suggested that the ideal would be 15-minute units, but we are not there yet.

# Discussion

- The point was made regarding no difference between OT/PT, Speech and Special Instruction through an equalization process for all EI professionals. There is consensus on this idea.
- The department also agrees on this idea.
- Further, all evaluations will be the same/supplementals within the region. Do we have an add-on for bilingual? If so, there needs to be a process to show the evaluation is in the child's native language.

# Discussion on Hard-To-Serve Areas

- Discussion on hard-to-reach areas. We need a specific definition on how to identify these areas. Ken is working on a definition for hard-to-reach areas. The definition will be presented to the EICC. Should this be an add-on? Would \$100 solve the problem?
- Lidiya mentioned the underserved population and the data supporting this population. Is the definition operationalized? Does Medicaid address this population? This is important to continue to analyze. How do other states address this group? Existing examples include poverty level, language, zip codes, and federal definition of rural, etc.
- Ken asked, "What triggers an add-on rate?" An analysis could be completed by service type, for example, using a zip code, and then possibly create a measure. Any service taking more than 20% longer to staff would get add-on within this zip code.

# Continuation on Hard-to-Reach Areas

- It was noted that EIOs and EIODs know the hard-to-reach areas that providers are willing to serve or not serve. Concerns were expressed about teletherapy as the only service for these areas.
- Other concerns are urgency for services, driving time, number of providers, and difficulty of the area and home. This is similar to the concerns in NYC.
- Suggestion on how to recommend to EICC and the Department what proxy could be recommended for a modifier. Heidi mentioned that a speech provider in the northern end of the county driving to the southern area takes 45 minutes, which is not worth her time and effort to see one child. This is when teletherapy benefits the rural communities. Research in this area needs to continue and possibly develop a survey to send out to EIOs for feedback.



# Teletherapy Rates

Should teletherapy rates be different than face-to-face? This may be a Medicaid issue. If they were the same, there needs to be strong guidance and regulation when teletherapy can be used. Ken noted there may be no choice for a differential rate because of Medicaid. Medicaid has parity and stronger requirements. We may be able to fix some issues through guidance.



Hard-to-reach areas in urban settings are also a problem. Look at OPWDD county planning process which may be helpful. Technology access is another serious issue. What does OPWDD do? More information would be helpful.

# Continued Discussion

- It seems like there should be an incentive for an in-person service delivery model. Some issues can be addressed through guidance, but a real impact would be to see an incentive in rate and/or separate rate for teletherapy and in-person. One rate does not acknowledge travel. All agreed teletherapy is not the best way to provide services and some families are rejecting teletherapy. "Give me face-to-face or nothing." This statement has been made throughout the state.
- It is important to preserve that the provision of any service via teletherapy should be driven by family choice and not preference of clinicians.
- Marina brought the discussion back to teletherapy and in-person with many families saying no to teletherapy. She noted an adequate job cannot be done with a telehealth evaluation. She sees differences in the determination of eligibility; this type of evaluation is not adequate. There are merits to telehealth, but in-person is critical.
- Family engagement is compromised. We need more specificity in the guidance.

# Discussion: Continue to get Issues in a Parking Lot Que

Lidiya has reviewed the literature on services. There is zero literature regarding evaluations. COVID forced the model. What is Medicaid's position between diagnosis and follow-up care? Are distinctions being made?



Ken noted that in terms of clinical service delivery, every service has an evaluation rate and we separate them out, either by evaluation or service. The evaluation rate is greater.

Look at other states.



Providers benefit from the separation of evaluations and services. Evaluations determine the level of services unless there is a valid reason not to have in-person MDE, all should be in-person unless the family has an issue. Ken emphasized how we can work together to develop guidance. There are concerns expressed by parents choosing to wait for in-person services. Ken will speak with other states on how they are doing a hybrid model now and bring back the information for discussion.