



Department
of Health

Early Intervention Coordinating Council Rate Setting Methodology Task Force

Council Meeting, September 12, 2024

Steve Held, Chair

Task Force Members

- Task Force Chair: Steve Held
- Parents: Amy De Vito and Leah Esther Lax
- Provider: Brigitte Desport
- Discretionary: Lidiya Lednyak
- Municipal Representatives: Marina Yoegel, Heidi Bond
- State Agency: Bonnie Caitlin (Office of Mental Health)
- Local Early Intervention Official Designee: Jordan Kase
- DOH Staff: Raymond Pierce, Peter Baran, Mike Iorio, Rhorianne Foster, Diane Ginsburg, Jennifer Sandshaw, and Ashley Tomlin

Council Rate Setting Taskforce Update

We have been given a 5% rate increase effective April 1, 2024.

This rate increase is retroactive:

- Will this be implemented with the launch of the EI HUB?
- When will the retroactive rate increase be paid?
- What will be the differentiator between in-person and telehealth?

Task Force Proposed Rate Set Process

- **Rates**

- We will need to know what the total modifier budget for April 2025 will be.
- We can estimate some of the totals we have now to obtain an estimate, and what the cost will be.
- We will need to separate from total evaluations vs general services.
- An average service rate will need to be calculated. We have estimated about thirty-one (\$31) dollars per service. This would put us in the ballpark of a solid proxy.
- We will need to know more about the budget and what it entails before implementing the modifier.

Preliminary Topics for Consideration

- In the future data, does the data become more complicated for the overall efficacy of an IFSP when only tele-health as a hybrid and in-person only.
- If a parent approves tele-health does that mean they are no longer able to toggle to telehealth.
- Can we use historic data or the results of the tele-health survey to see what the percentage of services were in person compared to tele-health.
- What is the ratio from the survey of tele-health to in-person.

Preliminary Topics for Consideration

- The poverty and rural percentage is very sufficient to catch the data we need, and the average number of days it takes to get services, if any.
- If there are no children in certain areas, there will not be any historical data. We can only estimate on those areas right now.
- We do not know what the modifier dollar amount would be, therefore, we can use some of the totals to do an estimate as to what the cost will be.

Council Rate Setting Taskforce Update

- If we use data from each year as tele-health becomes more of a reality, how pure will the data be in the future?
- If we use a divisor of half a million and look at four thousand children, that modifier should incentivize getting providers out in the field. This proxy looks like it will work for us.
- Looking at this data, there are multiple conditions that influence our decision to have an incentive.
- Poverty level is one, time to receive services is another, as well as the density of providers in the area.
- If we look at it by individual child, and they exceed the thirty days to receive services, then that individual child would be eligible to receive the incentive rider.

Council Rate Setting Taskforce Update

- We need to start with a set criteria, and zip codes will be part of that criteria.
- We do not want to make it a state policy that we are not providing services on time. We need to focus on getting the services as quickly as possible within the thirty-day timeline.
- Right now, 45 days is the compliance timeline, but the average is ninety.
- We are pleased with the proxy and where we may end up.
- The sooner we come to a conclusion on the Bureau's recommendations, we can hit the ground running, and in-person capacity will increase based on that quick divisor.
- We hope to make a recommendation by the December 2024 task force meeting.

Discussion and Questions?