Date: February 24 , 2021

Source of Report: LD 135 (Resolve 2021, Chapter 109) Resolve, Directing the Department of Education and the Department of Health and Human Services To Study a Centralized Billing Process for Developmental and School-based Services Covered by the MaineCare Program and Other Insurers and Report on Updates to the Child Find Process

Topic: LD 135

Context

Sec. 1. "Department of Education and Department of Health and Human Services to study a centralized billing process for developmental and school- based services covered by the MaineCare program and other insurers. Resolved: That the Department of Education shall collaborate with the Department of Health and Human Services to study the development of a centralized billing system to process claims to the MaineCare program and other insurers, including private insurance, for children with disabilities from birth to 22 years of age. The study must address:"

Findings Regarding MaineCare Billing

How to maximize revenue through automation and efficiencies:
Only 45% of Maine school districts participated in reimbursement for eligible services provided in the public school setting, based on information obtained by Maine Education Policy Research Institute (MEPRI) in conducting an analysis of MaineCare at the state level. This supports the argument that Maine is leaving a significant amount of federal funding behind, which could be used to support children with disabilities in an educational setting (MEPRI Report 2021, pg. ii).

Maine has an opportunity to expand resources to support students with special education needs through increased utilization of federal Medicaid funds for medically-necessary services in the educational setting. This could reduce the costs borne by state and local governments, and/or provide increased levels of services to students. An increase in MaineCare reimbursements can be facilitated by changing Maine's system for school-based services to one that is simpler for districts to use, covers more of the services allowed by the federal Centers for Medicare and Medicaid, and reimburses the districts for more of the costs of providing medical services to eligible students (MEPRI Report 2021, pg iii)

The reasons school administrative units (SAUs) do not bill MaineCare were provided in the MEPRI Report conducted over the last year and released in the Spring of 2021. 60 SAUs

responded to the survey and the information obtained is consistent with discussions and information gathering with the field. SAUs are resistant to bill MaineCare based on the complexity of the system, fear of an audit resulting in penalties, and the time and energy that must be invested to recoup a portion of costs. Additionally, because SAUs only receive approximately 63 % to 70% (this rate is calculated annually) reimbursements for rates that many times are well below the cost of a service, SAUs expressed that net reimbursements were not worth the time and effort required.

Table 3. Reasons why district does not bill MaineCare for IEP services

	All Districts n=60	District 1000 students n=29	District 501-999 students n=7	District 101-500 students n=15	District 100 or fewer students n=6
The net reimbursement amount is not worth the amount of time and effort required for billing	47%	52%	57%	33%	50%
District fears an audit	30%	41%	29%	7%	33%
Service provided by therapist is needed for FAPE, but is not medical	18%	17%	14%	13%	33%
Providers are contracted to bill MaineCare directly	17%	14%	29%	27%	0%
Therapist coaching and preparation time is not billable	13%	14%	0%	7%	33%
District does not want to pay individual/ company for billing of services to MaineCare	12%	14%	0%	13%	0%
Parent refusing to allow billing of MaineCare	12%	14%	29%	0%	17%
Children losing eligibility for MaineCare	10%	7%	0%	13%	17%
When two or more children receive therapy at the same time, it is not billable	8%	7%	0%	13%	0%
District is unsure which services are billable	5%	7%	14%	0%	0%
Service is provided by an individual who is not eligible for MaineCare reimbursement (ex. EdTech I)	5%	7%	14%	0%	0%
Service provided is needed for FAPE, but is medical	5%	7%	0%	7%	0%
District is not able to find a knowledgeable individual/company to handle billing	3%	0%	0%	7%	0%
MaineCare rejects claims	2%	3%	0%	0%	0%
Services are provided by an individual who is not enrolled with MaineCare (ex. out-of-state provider)	0%	0%	0%	0%	0%
Other	28%	38%	43%	20%	0%
I do not know	13%	7%	0%	20%	17%

Total	100%	100%	100%	100%	100%

Additional barriers to billing MaineCare MEPRI discussed in their report include:

- Most of Maine's numerous small, rural districts lack the information systems and dedicated staff that are needed to make billing feasible.
- The overall complexity is a barrier for school districts that lack the knowledge, expertise, information systems, or time to manage the billing process.
- The time and energy necessary to bill MaineCare is not worth the costs recouped, especially considering the inconsistency between actual costs and reimbursement rates allowed under MaineCare policy.
- MaineCare continues to be an underutilized source of support for mental health services.
- It uses the same regulations for both healthcare entities and schools, unlike some other states that have streamlined system with separate rule chapters for public schools.
- In MaineCare policy, services must "Be included in the member's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP); and Be medical in nature (rather than educational). " This language does not fit with IDEA and has been a challenge for licensed providers billing MaineCare. This may also be a reason why some districts do not bill MaineCare." (MEPRI Report 2021, pg 10)
- Maine has a manual for schools with each page linking to the Medicaid manual rather than providing explanations or clarifications tailored to theschool-based audience.

Recently OMS, in partnership with the DOE, released their proposed update to Section 106. The recommendations support separating school based billing procedures from medical services. The new rule if enacted would simplify billing for medically necessary services offered in schools.

MaineCare is also currently engaged in a reform of its Rate System to ensure the development and maintenance of MaineCare payment models and rates that are consistent with efficiency, economy and quality of care in order to support MaineCare member access to services, in compliance with the United States Social Security Act, Section 1902(a)(30)(A).

This reform applies to all MaineCare services, including services delivered in schools. MaineCare will be conducting rate studies to establish rates where no appropriate benchmark rates exist.

A rate study consists of the following steps:
•Public notice
•Review of data, including provider costs and national best practices
•Development of proposed rates
•Public presentation of draft rates for public comment
•Response to comments and incorporation of feedback, as appropriate

Included here is the timeline for rulemaking and rate study activities:

Rulemaking and Rate Study Activities		
2022	Winter	Engage with stakeholders
	Spring	Finalize rule development Kick off rate studies
	Fall	Finalize rates/rate models
2022/ 2023	Winter	Propose Major Substantive Rule/ Public Hearing
2023	Spring	Submit Provisionally Adopted Rule for Legislative Review
	Spring	Legislative Review Completion
	Summer	File Final Adopted Rule with Secretary of State; rule becomes Effective 30 days after filing

What services are currently billed, what services are not currently billed but are covered by the MaineCare program or private insurance and could be billed, what servicesare coverable by Medicaid programs but are not currently covered by the MaineCare program and how to align service definitions;

Provided by the Office of Maine Care Services for This Report

Federal Medicaid Law:

In designating covered services, OMS is obliged to fully comply with the Centers for Medicare and Medicaid Services' (CMS) requirements applicable to MaineCare provider reimbursement for the provision of School Health-Related Services. MaineCare reimbursement for services provided in schools falls at the intersection of two complex federal law systems—those governing education, including the Individuals with Disabilities Education Act (IDEA), and the federal Medicaid laws. Medicaid is a joint federal-state program governed by Title XIX of the Social Security Act (Act). In 1988, Congress amended section 1903(c) of the Act to allow Medicaid payment for medical services provided to children under IDEA through a child's Individualized Education Program (IEP).

As School Administrative Units (SAUs) and Child Development Service (CDS) staff are aware, under IDEA, the IEP specifies all special education and "related services" that the child needs. The Medicaid program can pay for the "health related services" in an IEP if they are covered by

the state's Medicaid plan or available through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which provides screening and treatment for childhood health conditions. The "health related services" which are covered services as listed in the MaineCare Benefits Manual (MBM) may include, but are not limited to the following: Children's Behavioral Health Day Treatment, Occupational Therapy, Physical Therapy, Private Duty Nursing Services, Rehabilitative and Community Support Services for Children with Cognitive Impairments, and Speech and Hearing Services.

MaineCare reimbursement is only available for services and assessments that are medically necessary and provided by qualified and enrolled MaineCare providers. Reimbursement is not available for non-medical services such as Specially Designed or other Academic Instruction.

I. MaineCare-Covered Services Provided in Maine Schools, Reimbursement Being Sought

IDEA Services

The following services are currently being reimbursed when listed in a member's IEP:

- Children's Behavioral Health Day Treatment (Section 65, MBM)
- Non-Emergency Transportation (Section 113, MBM)
- Occupational Therapy Services (Section 68, MBM)
- Physical Therapy Services (Section 85, MBM)
- Private Duty Nursing Services (Section 96, MBM)
- Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations (Section 28, MBM)
- Speech and Hearing Services (Section 109, MBM)

A detailed list of covered services within the above referenced sections can be accessed in the MBM sections linked above. Supplemental information is also available in the MaineCare in Education 2021 Billing Guide, located on MaineCare's School Health-Related Services web page.

IDEA services at this time are being provided by enrolled schools and contracted through other providers. Providers may include mental health agencies, hospitals, and other enrolled providers.

School Health Clinic Services

Schools may enroll as School Health Clinic locations as defined in Section 3 of the MBM. Enrollment as a School Health Clinic with MaineCare enables schools to receive reimbursement for any student enrolled in a MaineCare program, not just those who qualify for IEPs. School Health Clinics may provide a range of covered services outlined below.

Covered services for School Health Clinics (see MBM 3.04-1) include:

- preventive, diagnostic and/or therapeutic services for acute, episodic and chronic conditions furnished by the clinic's professional staff;
- supplies commonly furnished for the provision of these services; and
- basic laboratory services essential for immediate diagnosis and treatment.

The following professionals may provide services through a School Health Clinic under Section 3 of the MBM: Physician, Nurse Practitioner, Licensed Clinical Social Worker (LCPC), Alcohol and Drug Counselor, Registered Nurse, Licensed Clinical Professional Counselor (LCPC), Psychologist, Respiratory Therapist, Nurse-Midwife, and other Qualified Staff.

MaineCare-enrolled School Health Clinics are not required to contract with the Maine Center for Disease Control (CDC) unless they intend to provide immunization clinics. In that case, the provider would need to follow all CDC requirements in addition to promulgated policy requirements in the MaineCare Benefits Manual. However, in addition to enrolling with MaineCare under Section 3 of the MBM, some currently enrolled School Health Clinics also contract with the CDC to operate as School Health Centers. The CDC's School Health Center program has additional requirements for participation beyond the MaineCare enrollment requirements. School Health Centers are required to provide care to all students regardless of insurance status and offer confidential services as appropriate. Centers must also make available a base set of services. The CDC does provide funding to offset some costs associated with these requirements.

In addition to enrolling as School Health Clinics, School Administrative Units (SAUs) also have an opportunity to contract with existing Federally Qualified Health Centers (FQHC) to provide services. There are several SAUs and FQHCs who partner in this manner. FQHCs who are providing services in this way are not considered under MaineCare policy to be School Health Clinics; rather they fall under MaineCare's FQHC general requirements and reimbursement schedule (See Ch. II, Section 31 and Ch. III, Section 31 of the MBM) .

SAUs may also contract with hospitals or other providers to deliver services. In that case, hospital services would be billed through Chapter II, Section 90 of the MBM. Other providers would bill through the contracts applicable to their provider type as well pursuant to the MBM.

Provider Discretion

The Department is aware that some providers travel to schools and either rent, lease, acquire, or otherwise arrange to utilize space on school property to provide services to eligible MaineCare members. This is allowable when services are provided pursuant to the MBM. Providers utilizing space in this way are not considered part of School Health Clinics under MaineCare policy and must be separately enrolled as MaineCare providers.

II. MaineCare Covered Services Not Being Billed, or Minimal Reimbursement Being Sought

Targeted Case Management

Targeted Case Management (TCM) services may be provided by MaineCare-enrolled schools under current MaineCare policy (MBM Section 13). TCM services consist of assessment, planning, referral and related activities, and monitoring and follow-up activities for youth with developmental disabilities, behavioral health disorders, or with chronic medical conditions. It does not appear there are any SAU or CDS locations billing MaineCare for the provision of TCM services.

Under MaineCare policy and federal law, it is the TCM provider's responsibility to provide TCM services for MaineCare members across all settings (with few exceptions like within institutes for mental disease or incarceration). Some SAUs and CDS regional offices may be challenged by this requirement as the TCM provider would be responsible to support a youth with their needs beyond the school and outside the school calendar.

Although SAUs and CDS providers do not currently provide this service, OMS staff conducted a brief survey of other state programs and confirmed SAUs in other states do provide TCM services.

BCBA, Occupational Therapy, Physical Therapy and Speech Therapy Consultation Services

The MBM describes evaluation and re-evaluation services which may align with what Maine Unified Special Education Regulations (MUSER) describe as consultation services. If there is a direct evaluation or re-evaluation, as described in the MBM (85.06-1, 68.06-1, 109.07-1, 28.04-3), that takes place as part of the consultation service, the consultation service is billable to MaineCare.

IEP documents regularly include consultation services but SAUs and CDS do not typically pursue MaineCare reimbursement for those services. The enrolled provider would have to ensure that consultation services are conducted by a MaineCare qualified provider, as there are individuals approved by MUSER who may not be qualified according to the MBM. For example, MUSER allows for consultation services to be provided by special education teachers; however, MaineCare does not recognize teaching credentials as eligible qualifications to provide health-related services. MUSER states "Consultation may be provided to special educators by related service personnel or education consultants," so it appears that related service providers who are considered by MaineCare to be qualified professionals would be able to seek reimbursement for these services. Reimbursement of consultation services would only apply to the time during which there is a direct encounter with the MaineCare member as described in the MBM. It would not cover time spent relaying information to a teacher, parent/guardian or other professional.

Services provided by a Board-Certified Behavior Analyst (BCBA) are also reimbursable when the member is receiving Section 28 services. BCBAs may be reimbursed for the following activities: conducting Functional Behavioral Assessment, Individual Treatment Plan (ITP) development; conducting summary and analysis of data on member progress; coordinating member care with other providers; conducting parent training on behavioral principles and interventions specific to the member; and conducting other evidence-based practices in accordance with the member's ITP.

Non-Emergency Transportation (NET) Services

Non-Emergency Transportation services are available for MaineCare reimbursement under a CMS-approved waiver authorized under Section 1915(b) of the Social Security Act. The waiver requires MaineCare to contract with regional brokers who are responsible for the provision of all NET services in their region, including establishing a transportation network to supply rides to members, processing transportation requests, arranging for transportation, and tracking and reporting on all NET services delivered. Any changes to the waiver require a public notice process and CMS review and approval.

In order for an SAU or CDS to receive reimbursement for transporting a child to a school setting for the whole day, services would need to be billed by an enrolled MaineCare provider for more than 50% of the documented time the member is in the school setting for that day.

Currently, it is most common for SAUs to request standing transportation orders in order to provide NET to students enrolled in MaineCare. There are also two other options available to SAUs wishing to provide NET transportation services to their student population:

The first option is for districts to contract directly with the NET brokers as transportation providers, which would allow each SAU (or CDS) to negotiate a mileage rate for reimbursement for students accessing MaineCare services in school who need transportation, and directly provide that transportation. This option would require a formal contract between the SAU or CDS and one or all three designated brokers, depending on the NET regions(s) in which the school would pick up children to provide rides. The SAU or CDS site would first obtain a Prior Authorization from the broker, then utilize their own vehicles, drivers, and escorts to transport the member. SAUs or CDS sites would receive a negotiated reimbursement rate for any transportation of members when a member is traveling primarily to receive a MaineCare-covered service.

The second option is for districts/schools to seek prior approval from the broker for mileage reimbursement on a case by case basis. In this case, after seeking Prior Authorization from a broker, an individual overseen by the district/school would provide transportation, then after the transport, seek mileage reimbursement from the broker(s) at the broker's standard reimbursement rate. This is the process used by all brokers through the "friends/family/neighbor program." This

option does not require a formal contract with brokers and the rate is set by the broker (not subject to negotiation).

A SAU or CDS administrator may set up either option simply by contacting the NET broker directly prior to transporting a member or members(s). Becoming a contracted transportation provider will take more time than the second option of seeking mileage reimbursement. The SAU or CDS should contact the broker to determine an anticipated time frame—some SAUs have completed the work to execute a contract within a week or two, while others may take longer. MaineCare staff do not facilitate provider agreements or reimbursement rates between schools and the transportation brokers.

Other Medicaid Services Not Currently Available through MaineCare

Contemplated Section 106 Rulemaking

In January of 2020, OMS proposed a new section of policy for the MBM, Section 106, School Based Services. Included in the proposed rule were new reimbursement opportunities and reimbursement for some services already being provided in schools. New covered services outlined in the proposed rule included Adaptive Behavior Assessments, Behavior Supports, Comprehensive Applied Behavior Analysis, Crisis Support, Developmental Preschool and Services, and Social Work.

The Department received a significant volume of comments, including concerns from a number of enrolled providers, immediately after the filing of the proposed rule. The Department withdrew the rule prior to the public hearing due to these concerns. The timing meant the Department was not able to provide written public responses to expressed provider concerns.

OMS expects to move forward with the adoption of a new rule in 2022/2023 following stakeholder engagement. In the updated rule, OMS anticipates outlining new services included in the first filing, in addition to allowing schools to provide some covered services to all students enrolled in MaineCare, regardless of their eligibility for Special Education services. This will include many services currently reimbursed as IDEA services. Services may include Behavioral Health Therapy, Occupational Therapy, Physical Therapy, Social Work, and Speech Therapy.

OMS will also propose to move the School Health Clinic policy, currently in Section 3 of the MBM, into the new rule to provide one comprehensive policy inclusive of most school health-related covered services. The exception to this will be that FQHC policy will remain in Section 31 of the MBM. Hospitals providing contracted services would continue to follow Section 90 policy in the MBM.

Developmental Therapy Services

Special Services staff from the Maine DOE have requested that MaineCare consider creating a service specifically to meet the needs of members ages 3-5. Other states reimburse for a service called "developmental therapy" and have identified developmental therapist credentials with clear education, training, and certification requirements, which Maine currently lacks.

MaineCare previously covered Developmental Therapy for reimbursement, but this service was discontinued in 2010 due to widespread challenges with the appropriate delivery of the service. MaineCare feels that if and once a developmental therapist credential is established, including scope of service, policy work can commence to design the benefit as a MaineCare-covered service. We would like to have a discussion with DOE about a potential licensure or certification process for developmental therapy services. (End of Office of MaineCare submission for the report).

Maine DOE is exploring parameters for developmental therapy around adaptive behavior, self-help, communication and social emotional learning and appropriate certification requirements to comply with federal and state regulations for children identified under developmental.

Examples of other states with centralized billing systems, including but not limited to New Hampshire and New York, using data and information provided by a statewide education policy research institute and other 3rd-party entities, as available:

Because there is state discretion on how they administer their Medicaid programs, there is substantial variation from state to state, according to the MEPRI Report on MaineCare. One thing that sets Maine apart from other states is that Maine uses the same regulations for both healthcare entities and schools, unlike some other states that have streamlined system with separate rule chapters for public schools (MEPRI Report 2021, pg. ii).

The Maine, Massachusetts, and New Hampshire state websites for Medicaid in schools were reviewed in the MEPRI report conducted earlier this year. Maine's Medicaid for school's website stood out for its complexity. This same finding was seen by Baller and Barry in a 2016 review of all 50 state school Medicaid systems Baller and Barry found more than half of the states had ten or fewer unique billing codes for school-based speech-language services and occupational and physical therapy codes. Maine stood out among states as having the most unique billing codes for speech-language services (42) and occupational and physical therapy codes (40). Some states use a bundled code for these therapies. (Baller and Barry, 2016) (MEPRI Report 2021, pg. 11)

It appears that Maine asks school districts to bill as a healthcare entity, which is different from other states. Since some educational institutions in Maine bill both for school-based and medical necessity, there is no way to differentiate the two types of reimbursement. This is particularly

problematic for Child Development Services (CDS) who frequently get charged for seed on non-special education expenses. Significant administrative time goes into verifying seed reports for CDS. This could be easily adjusted if there were a modifier added to billing which would distinguish school based from medically necessary services.

In discussions with third party Medicaid Billing agencies and other state SEA special education leads, it was reported that states who had lower Medicaid billing averages provided the following reasons for ineffective billing practices:

- Listed administrative costs on the local education agency (LEA)
- Bureaucratic complexity with paper systems
- Tracking services by various providers
- Difficulty understanding LEA claiming
- Maintaining documentation such as parental consent to ensure claims were submitted meeting compliance expectations
- Comprehensive compliance support
- Providing transparent data and visibility for claiming and cost settlements
- Many schools had a poor understanding of the Medicaid reimbursement
- Providers were submitting paper-based service logs, and Administrative staff had the burden of labor-intensive manual submission.
- Limited resources of staff to oversee the program.
- Documentation was lacking there was no easy-to-understand state training plan, and districts were searching through guides trying to understand school-related services

The application of an integrated statewide billing system in states leads to a reduction in administrative costs to local education agencies and significant increase in the amount of money provided to support Medicaid reimbursable school-based services. In states that have adopted a third party entity to support Medicaid billing, their intake of federal funding increased dramatically.

As reported by MEPRI, Maine's system of Medicaid reimbursement is more complex in many ways from other states. While there are efforts under way to support simplified billing practice, these changes will not mitigate the need for a unified system and administrative needs associated with billing. One way to navigate the complexity is to have a state-wide system in supporting SAUs to navigate these challenges.

How a centralized billing system could best be designed to be accessible and user-friendly for school administrative units:

Data suggests that without a statewide initiative to bill MaineCare which includes administrative support, the likelihood that SAUs will elect to bill MaineCare will remain unchanged. A centralized billing system would support a unified system of support to SAUs, address administrative challenges that prevent smaller SAUs from billing, and remove many of the barriers associated with the current system such as the complexity of billing procedures. A

centralized system would also minimize audit risk, which is the 2nd highest reason SAUs currently don't bill MaineCare (MEPRI Report 2021, pg. 9). Additionally, administrative staff would be required to support SAUs in obtaining and completing necessary documentation to effectively bill for reimbursement.

Options for the development of a billing system through a 3rd party or through stateagencies, such as the Department of Health and Human Services, the Department of Education or the Department of Administrative and Financial Services:

In an effort to understand billing practices the Department explored through various entities how Maine could support a unified system. It was discovered that there are several options to support a centralized system for MaineCare reimbursement. There are three ways to approach billing from a 3rd party billing institution: 1) flat funding by state agencies, 2) flat funding by state agencies working toward shifting all or a portion of a cost to SAUs, 3) 3rd party institution takes a percentage of the profit of SAUs based on number of Medicaid clients and amount of reimbursement.

To flat fund a 3rd party billing agency would be the most appealing to SAUs given that it would allow them the benefit of accessing the highest possible portion of MaineCare funding. Because the 3rd party institution is taking on administrative tasks and creating systems to mitigate risk in the event of an audit, SAUs may feel more comfortable engaging in billing. Additionally, it is appealing for SAUs to have a 3rd party institution navigate the complexity of MaineCare reimbursement rather than attempting to do that independently. The support of the Department of Education may also increase SAUs in feeling there is less risk to bill MaineCare. The estimated cost of a flat fee is between 1-3 million dollars.

Another option would be for the state to pay for the cost of a 3rd party institution initially and then shift all or part of the fiscal burden to the SAUs over a several year period. This will potentially have the result of providing initial buy in as the cost will be minimal to SAUs (strictly in time to engage in staff training of a new software program), and ease the SAU into understanding the full breadth of how much money they may be able to attract if billing practices were maximized.

The 3rd option on the surface may seem like the most intuitive path forward given the lack of expense to any party. However, the impact of accessing a percentage is that smaller SAUs with less billable clients will pay a higher percentage, thus making the effort of billing minimal. Additionally, the way the SAU pays seed currently in the state (30% of the total payment) when combined with a percentage paid to a 3rd party billing institution will make billing seem prohibitive and not worth the effort given the small amount of money the SAU would receive.

How seed money is currently used to fund MaineCare-covered school-based services:

Each year, a formula determines the federal share of a state's Medicaid costs based on its per capita income relative to the national average.1 In recent years, the federal government has been paying 63% to 70% of Maine's Medicaid costs. The remaining share of 37% to 30% is passed along to the local school districts for services provided under an IEP. The Maine Department of Education manages this process by calculating the amount not covered federally – known as the MaineCare Seed – and withholding that amount from the state subsidy that is paid to the district.2 This practice is different from medical services provided outside of the public educational system; when MaineCare is used to cover health care costs for eligible low-income Mainers, the leftover share after federal reimbursement is paid by the Maine Department of Health and Human Services out of state funds. (MEPRI Report 2021, i)

Many SAUs report the net reimbursement after seed is not worth the time and effort required to bill MaineCare for school-based services.

How special purpose preschools could maintain their own separate billing system ifa centralized system is implemented:

The public data that was used to analyze public school billing patterns also contains information on services that are provided at special purpose private schools and billed to MaineCare. By federal and state policy, the resident school district is fiscally responsible for special education services. When a student needs more intensive services than can be provided by the local district and is placed in a private school program (typically for day treatment services), the private school can bill MaineCare for eligible services. However, the MaineCare seed payment is covered by the sending (resident) district. By analyzing the amount of seed payments send from public school districts on behalf of private school billing we were able to explore the fiscal impact on local school districts.

In FY2020, local school districts paid a total of $9.3M in seed payments on behalf of students served at private schools. Because the seed amount was 30% of the total, this means that the private schools were reimbursed a total of $30.9 M for MaineCare eligible services. This is more than double the $13.1M that was billed for services provided by public schools. (MEPRI Report 2021, pages 6-7)

Findings Regarding Child Find

Sec. 3 Department of Education to report on updates to child find

Meetings and recommendations from the state interagency coordinating council described under 20 United States Code, Section 1441:

In October of 2020, CDS transitioned to new leadership for both Part C and Section 619 Services. Dr. Roberta Lucas became the Director of CDS and the Section 619 Coordinator. Jamie Michaud

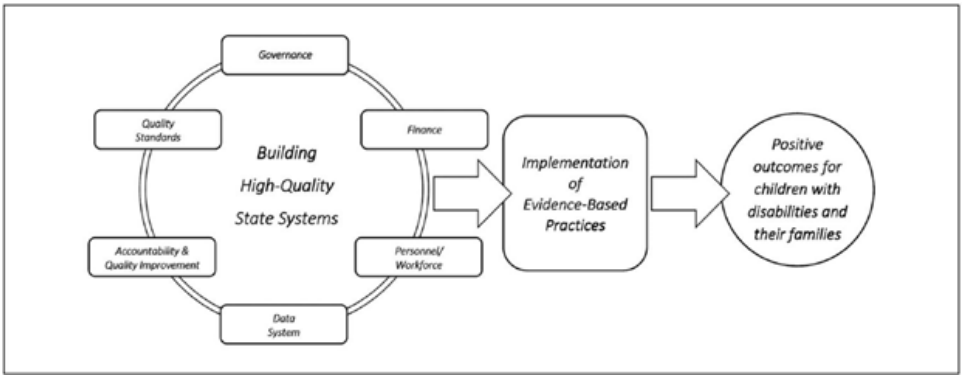
became the Part C Coordinator for the state. Although the Interagency Coordinating Council was established, its operations were stagnant under the previous administration. The Part C Coordinator quickly reestablished regular meetings with the ICC and sought new members for the council to insure it met federal guidelines for membership. Additionally, CDS administration continued monthly meetings with OSEP and the national technical assistance center, to provide guidance and statewide professional development. The agreement is awaiting Commissioner signature.

Data regarding the correlation, if any, between the provision of early intervention services and the need for services later in life:

The ten-year National Early Intervention Longitudinal Study (NEILS) first documented both short-term and longer-term positive effects of early intervention for children under 3 years of age. (NEILS Report, Jan 2007) At 36 months (the exit date for Part C early intervention services) parents overwhelmingly reported positive effects in the areas of general health, functioning, behavior, and developmental skills for their children who had received services. The study also noted a reduced need for special education services after age 3; after receiving early intervention services only 63% of three-year-olds enrolled in the study required special education in Part B of IDEA. Kindergarten teachers also reported positive outcomes in typical areas of kindergarten screening for their students in special education who had previously received early intervention services; sensory/motor, communication, academics, and social skills and behavior. The Public Consulting Group (PCG) report offered additional information that supports early intervention for children with disabilities.

In their report, Public Consulting Group note two sources that provide both correlation and positive effect of good quality early intervention services and their impact on future services for children. While no confirming data is included, both sources note the effect of early intervention in reducing the number of students placed in special education in later years and reducing the amount and intensity of special education services required for children who continue to qualify for special education later in life. (Educational Evaluation and Policy Analysis Spring 2003, Vol. 25, No. 1, pp. 75-95). The Early Childhood Special Education Technical Assistance Center also provided a state program system design to underscore the importance of integration of high quality fully funded systems coupled with evidence-based early intervention practices to produce positive outcomes for young children with disabilities and their families. (fig 6 from PCG report, Oct 2020)

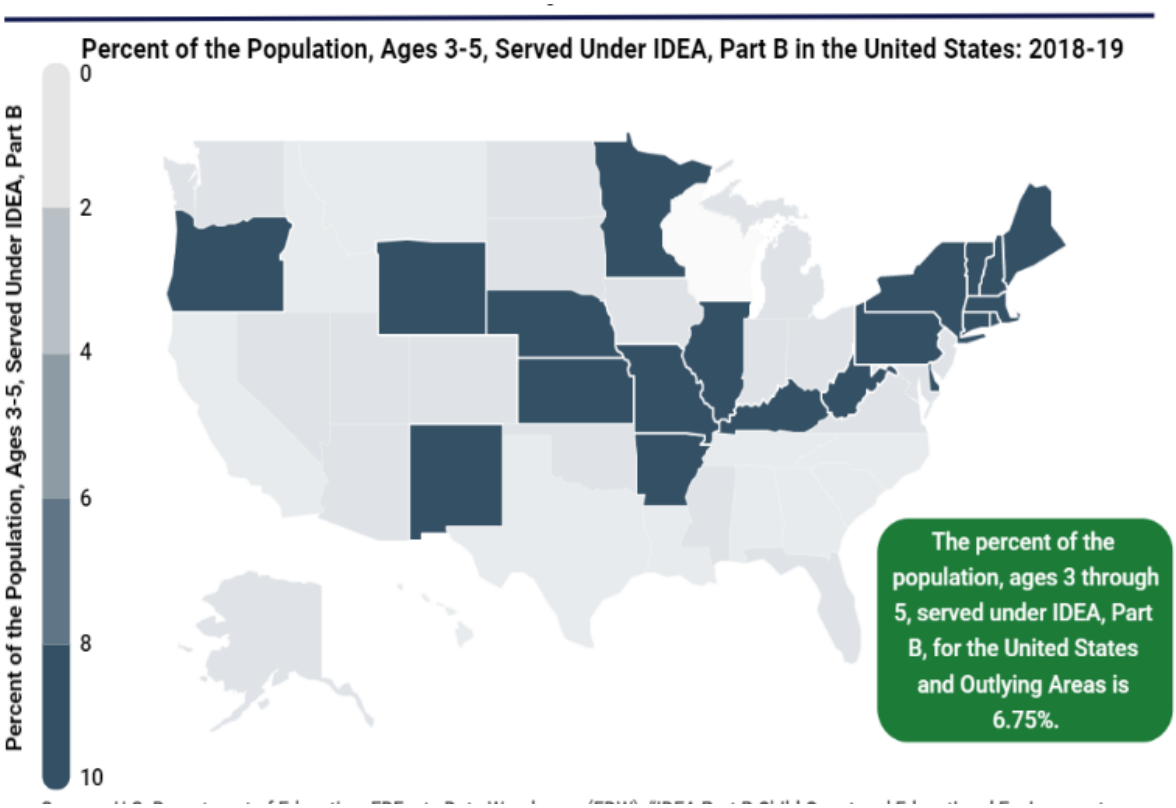
FIGURE 6. ECTA SYSTEMS FRAMEWORK



<u>Updates on current child find initiatives; Understanding variability between Part C and Part B Section 619 child find data</u>

There has been a historic misunderstanding of child find data in Part C and B. Part of the confusion is that CDS Part C and Part B services are frequently grouped together in the perception of stakeholders. It is important to clarify the differences between child find in Part C and Part B.

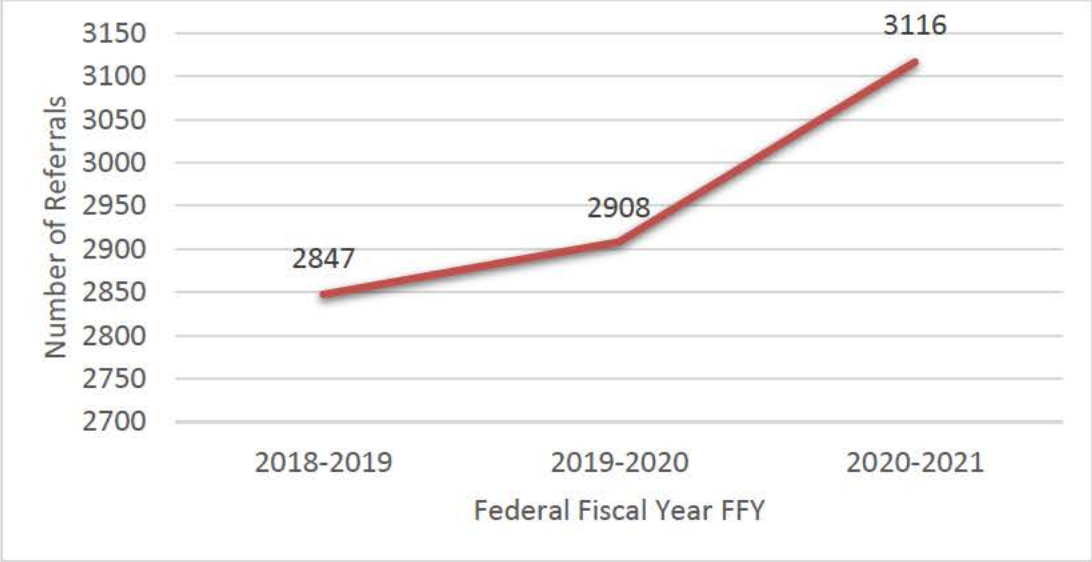
Part B Section 619 i



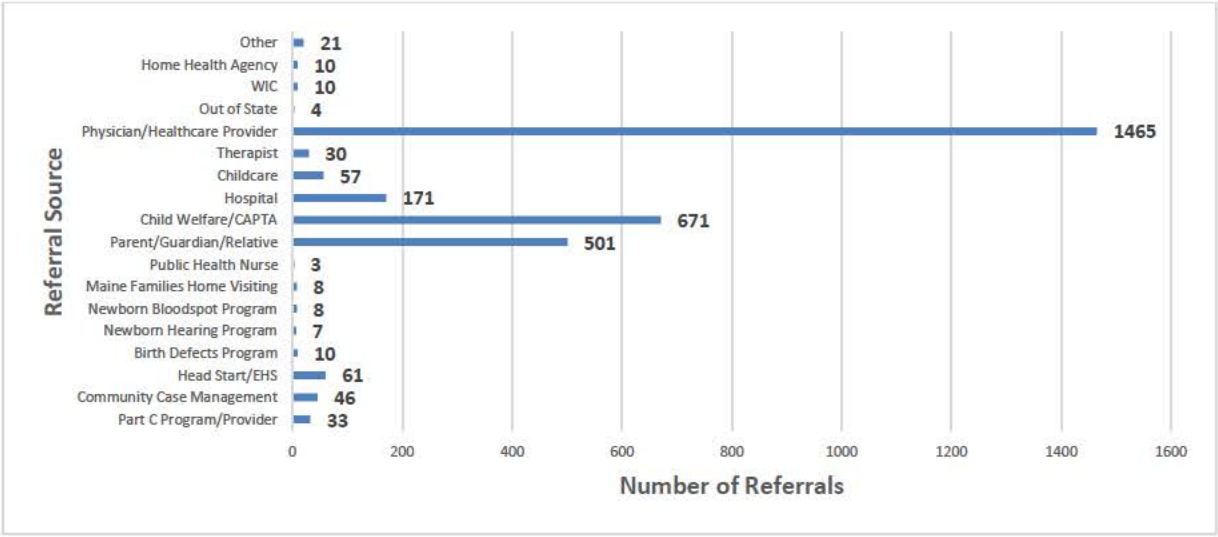
In 2018-19 data reported by OSEP, Maine had identified over 9% of children in the age ranges associated with Section 619. This rate shows consistency with northeast states and is amongst the highest rate nationally. Although referrals slowed during the beginning stages of the pandemic, at this time CDS rates have increased significantly and are up as high as 30% at some regional sites. This is consistent with referrals for special education in the SAUs in Maine and across the nation.

Part C Child Find

Annual referrals to Part C continued to demonstrate an increasing trend in Federal Fiscal Year (FFY) 2020, as shown on the graph below



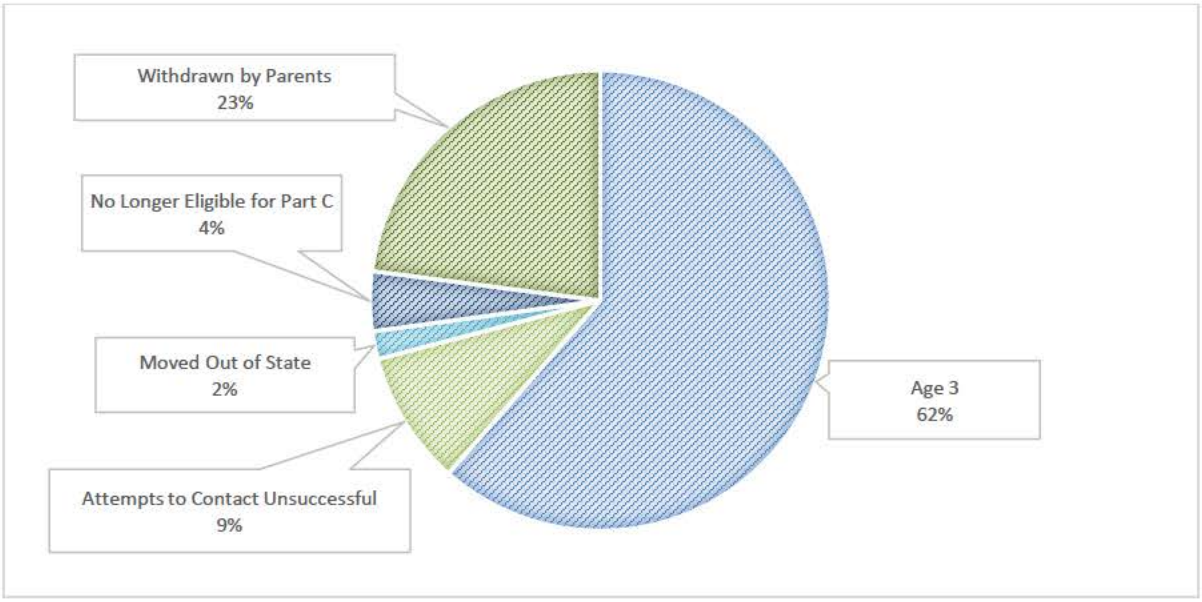
The top 3 referral sources for FFY 2020 remained as follows: (1) physicians, the Department of Health and Human Services (DHHS), and parents/guardians/relatives. The graph below illustrates the variety of Part C referral sources and how many referrals were made to Part C by each referral source in FFY 2020.



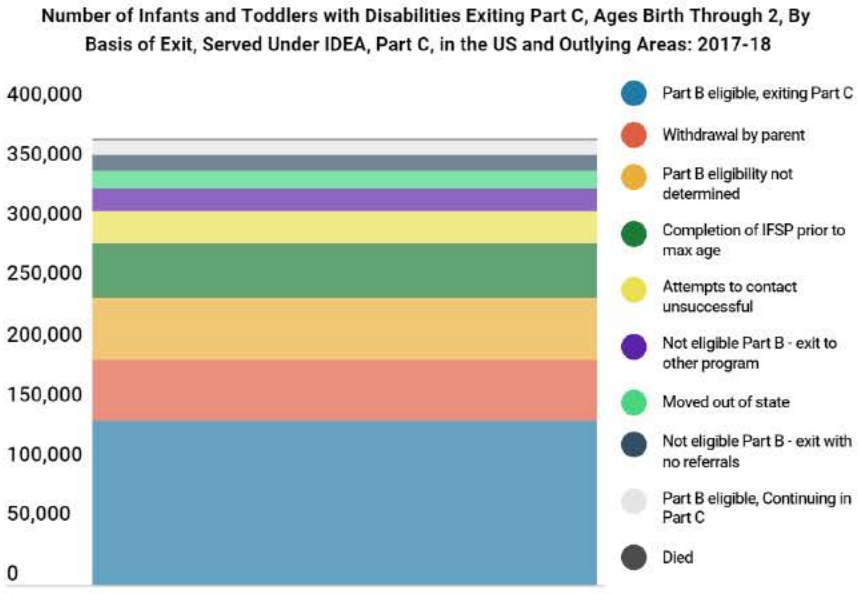
Child Development Services (CDS) evaluated a total of 1,455 infants and toddlers to determine their eligibility for Part C services in FFY 2020, with 79% being determined as eligible. Out of the 1,144 infants/toddlers that were determined eligible for Part C in FFY 2020, 716 were eligible by meeting Maine's criteria for Developmental Delay. An additional 257 infants/toddlers were determined to be eligible based on Informed Clinician Opinion, and 181 were automatically eligible with an established condition of risk.

A total of 1,072 infants/toddlers exited Part C services in FFY 2020, with the majority of 62% exiting because of their 3rd birthday (see chart below). Other exit reasons included the following:

Withdrawn by Parents (23%); Attempts to Contact Unsuccessful (9%); No longer Eligible for Part C (4%); and Moved Out of State (2%). Of the 659 toddlers (62%) of toddlers that exited Part C due to their 3rd birthday, 398 were found eligible for and transitioned to Special Education and Related Services under Part B-619. A total of 55 of these toddlers did not meet the criteria for Special Education and were found not eligible under Part B-619. The remaining 206 toddlers were still waiting for their Part B-619 eligibility to be determined when they turned 3 and, therefore, aged out of Part C services.



These data are consistent with national averages, as illustrated below:



Source: U.S. Department of Education, EDFacts Metadata and Process System (EMAPS): "IDEA Part C Exiting Collection," 2017–18. Data extracted from: https://go.usa.gov/xd6jP.

Actions Undertaken for Child Find

The Part C Coordinator conducted many state-level Child Find activities in FFY 2020. These include:

- Collaborating with the Maine Center for Disease Control and Prevention (Maine CDC) to update and expand the list of established conditions that make infants/toddlers automatically eligible for Part C;
- Working with the Substance Exposed Infant (SEI) Internal Workgroup, DHHS-Office of Child and Family Services, Maine CDC, and the CradleME Networking Group to develop a referral pathway for all SEIs;
- Participating in ongoing collaborations with other state agencies and initiatives, such as:
    - Early Childhood Consultation Partnership;
    - Maine Early Hearing Detection & Intervention Stakeholder Group;
    - Substance Exposed Infants & Maternal Substance Use Task Force;
    - SEI & Maternal Substance Use State Steering Committee;
    - Early Intervention Working Group;
    - NEC Maine Deafblind Networking Group;
    - Cytomegalovirus (CMV) Workgroup; and
    - Help Me Grow;
- Meeting with stakeholders from a variety of state and private agencies that work with children with disabilities and developmental delays all around the state to gain input on increasing Maine's Child Find percentages;
- Providing an overview of Maine's Part C program to:
    - Maine CDC Lead Poisoning Unit;
    - Substance Exposed Infant (SEI) and Maternal Substance Use State Steering Committee;
    - Maternal & child health providers from the Center for Disease Control and Prevention (CDC), Department of Health and Human Services (DHHS), Maine American Academy of Pediatrics (MAAP), American College of Obstetricians and Gynecologists (ACOG) Maternal Fetal Medicine (MFM), Maine Medical Center (MMC), and Northern Light Pediatrics;
    - Special Education Directors across the state;
    - Bangor Public Health & Community Services/Public Health Nurses;
    - Northern Light Home Health and Hospice;
    - Regional DHHS staff across the state;
    - DHHS - PHN staff and contracted providers;
    - Perinatal Nurse Managers Group;
    - Maine Families Home Visiting Program Managers;
    - Statewide Early Childhood Education Conference;
    - Substance Exposed Infants & Maternal Substance Use Task Force; and

- Head Start Child Development Managers Group.

In addition to the state-level Child Find activities listed above, the Part C Coordinator developed an annual state-wide outreach plan that was implemented in January of 2021. This state-wide plan requires outreach to all primary referral sources by every regional CDS site annually. Primary referral sources include, but are not limited to, the following:

- Primary Care Physicians;
- ENTs;
- Audiologists;
- Birthing Hospitals/NICUs;
- Maine Families Home Visiting Program;
- Women, Infants, and Children (WIC);
- DHHS - Child Welfare;
- Case Management Agencies;
- Early Head Start;
- Maine Birth Defects Program;
- Public Health Nursing;
- Maine Newborn Hearing Program;
- Home Health Agencies; and
- Specialty Clinics/Medical Model Therapists.

As part of the state-wide outreach plan, presentations and/or written materials about Maine's Part C program were delivered to a total of 1,144 different referral sources across the state. These consisted of presentations by individual CDS regional sites to:

- Pediatricians/healthcare providers;
- Maine Roads to Quality - Family Childcare Community of Practice;
- Head Start/Early Head Start;
- Licensed childcares;
- Community case managers;
- Cleft Lip & Palate Program;
- Home health agencies;
- DHHS – Child Protective Services, and
- WIC State Directors, Breastfeeding Coordinators, and staff.

Written materials, such as the *Early Intervention Program* brochure, CDS referral form, and list of established condition that make children under age 3 automatically eligible for Part C, were sent to:

- Audiologists/ENTs;

- Pediatric clinicians/therapists (i.e., OT, PT, SLP);
- Physicians/healthcare providers;
- OB/GYNs;
- Hospitals/NICUs;
- Head Start/Early Head Start;
- Maine Families Home Visitors;
- Public libraries/community centers; and
- Licensed childcares.

Discussions/group meetings were held with local WIC offices, Community Action Programs (CAPs), Head Start/Early Head Start, physicians/healthcare providers, Maine Parent Federation, Maine Families Home Visitors, Edmund Ervin Pediatric Clinic, and home health and hospice agencies. Additionally, the regional Early Intervention Program Managers participated in many local stakeholder groups including:

- Maine Newborn Hearing Program Board;
- Waldo CAP Health Advisory Board;
- Child & Recovering Mothers (CHARM) Provider Group;
- Downeast Regional Community of Practice;
- Child Abuse and Neglect (CAN) Prevention Councils;
- Building Community for Children (BCC) Waldo County;
- Families First Prevention Services Act Stakeholders Implementation Workgroup;
- Penobscot Partners; and
- Penquis Family Enrichment Services Advisory Board.

Plans for continuing to expand upon and improve Maine's current Child Find and referral system in FFY 2021 include the following activities:

- Collaborating with the Maine CDC and Public Health Nursing Program to have the Part C/Early Intervention Program added to the request form for CradleME, a referral system that helps connect birthing families with home-based services;

- Participating in the implementation of Help Me Grow, a model for improving access to existing resources and services for expectant parents and families with young children, in Maine;

- Ensuring that Maine's Early Intervention Program is included in the work being done through the Early Childhood Comprehensive System (ECCS): Health Integration Prenatal-to-Three Program, which is being implemented through a grant awarded from the U.S. DHHS and will allow Maine, with leadership from the Maine CDC Office of Maternal and Child Health, to use this funding opportunity to increase referrals to, and utilization of, prenatal-3 programs;

- Allocating over $500,00 of the $1.2 million that was awarded to Maine's Part C program from the American Rescue Plan Act (ARPA) fund for child find and public awareness activities including:
    - Renaming;
    - A robust marketing campaign;
    - A new website for Maine's Part C Program;
    - A series of promotional videos;
    - Table materials for conferences/workshops and community events; and
    - Translation of all Part C written materials into Maine's top 10 languages.

- Working in collaboration with Nancy Cronin, Maine's Act Early Ambassador, to promote early identification of delays and disabilities using materials from the CDC's campaign "Learn the Signs. Act Early."

Any applicable memoranda of agreement between the Department of Education andthe Department of Health and Human Services:

CDS drafted an updated MOU between DOE-CDS and DHHS in June of 2021. The draft was promptly sent to the AAG for review. Following the AAG's review and approval in August of 2021, minor edits were made to the proposed MOU. The final draft of the proposed MOU has been sent to DHHS for review by their AAG and is awaiting signatures from the Commissioner of Health and Human Services and the Commissioner of Education.

The purpose of this Cooperative Agreement is to develop a collaborative approach between CDS and DHHS to execute their respective authority and responsibilities with respect to the establishment and implementation of statewide policies, procedures, and practices to ensure that all children in Maine, ages birth to five, are identified, located, screened/evaluated, and, if eligible, receive timely and appropriate services in accordance with Individuals with Disabilities Education Improvement Act (IDEA) law and regulations and Maine statutes and regulations including 20-A M.R.S.A. §7001 et seq. and the Maine Unified Special Education Regulations (MUSER), Chapter 101.

Findings for Eligibility Criteria

Part B Section Eligibility Criteria:

Data shows that Part B Eligibility data is consistent with activity across the north east and high nationally. The identification rate for school aged children is high compared to national data, and averages at approximately 20% per SAU. This information predates the pandemic and may be higher currently due to increased referrals statewide.

Part C Eligibility Criteria:

Per Maine's Unified Special Education Regulations (MUSER), children must demonstrate a significant developmental delay (-2.0 standard deviations below the mean) in one domain or a moderate developmental delay (-1.5 standard deviations below the mean) in two or more domains to meet the criteria for Developmental Delay. This places Maine, along with 15 other states, in Category C for eligibility criteria (see table below).

Eligibility Category	**# of State**	**Level of Developmental Delay included in the state eligibility criteria**	**Standard Deviations (SD) Below Mean in state eligibility criteria**
A	15	-At risk, any delay, atypical development -25% delay in one domain -20% or 22% delay in two or more domains	-1.0 SD in one domain
B	20	-25% delay in two or more domains -30% or 33% delay in one or more domains	-1.3 SD in two or more domains -1.5 SD in one domain
C	16	-33% delay in two or more domains -40% delay in one domain -50% delay in one domain	-1.5 SD in two domains -1.75 or 2 SD in one domain -2.0 SD in two or more domains

Since Category C is the most restrictive eligibility category, Maine's Child Find percentages are highly likely to increase if the criteria for Developmental Delay was less restrictive. Moving to a lesser restrictive eligibility category would require changing the definition of Development Delay in MUSER, as well as significant budgeting and staffing considerations. Because more children are likely to be determined eligible for Part C given less restrictive criteria, it would be essential to plan accordingly for the increased costs and staffing needs to provide timely Early Intervention Services to all eligible infants/toddlers and their families and, therefore, remain in compliance with the Part C indicators under the Individuals with Disabilities Education Act (IDEA) that are reported to the Office of Special Education Programs (OSEP) annually in the State Performance Plan/Annual Performance Report (SPP/APR). A data analysis could be performed to determine how many more children would have been found eligible for Part C during a given time frame using lesser restrictive eligibility criteria, which would help inform future budgeting and staffing needs.

Additionally, federal proposed legislation should also be considered when determining whether Maine should move forward with lesser restrictive eligibility criteria at this time. Per Part C language included in a House Appropriations bill, the Education Department will work with the Department of Health and Human Services (HHS) and other partners, including experts in child development, researchers, families, disability rights advocates, and State Part C Coordinators, over the next year to develop model eligibility for Part C. These model criteria will be based on

the best available evidence about the benefits of Early Intervention Services for infants and toddlers, analyses of how States' current eligibility criteria contribute toward gaps in services for underserved populations, and a considered understanding about State capacity. If this bill is passed, there would be universal eligibility criteria for Part C nation-wide that States would be required to implement.

Current initiatives and future plans to improve support for children who are referred but not found eligible for services

Children determined to be ineligible for Part C services are routinely connected with any outside services and/or resources that are needed to meet the needs identified for the child and family. In addition, Service Coordinators offer a 3-month follow-up for all children who are referred but not found eligible for services. If concerns for the child's development remain at the 3-month follow-up, given parental consent, a re-evaluation to re-determine the child's eligibility for Part C is conducted.

Recommendations

Develop a Centralized Billing System, Including Administrative Support

To flat fund a 3rd party billing agency would be the most appealing to SAUs given that it would allow them the benefit of accessing the highest possible portion of MaineCare funding. Because the 3rd party institution is taking on administrative tasks and creating systems to mitigate risk in the event of an audit, SAUs may feel more comfortable engaging in billing. Additionally, it is appealing for SAUs to have a 3rd party institution navigate the complexity of MaineCare reimbursement rather than attempting to do that independently. The support of the Department of Education may also increase SAUs in feeling there is less risk to bill MaineCare. The estimated cost of a flat fee is between $1-3 million dollars.

CDS is currently supporting billing for private entities that service special education students in Part C and Part B, Section 619. This allows CDS to maximize access to maximize federal funding. As MEPRI reported, many SAUs lack administrative capacity to support effective billing practices. Administrative support is crucial to effectively increasing billing capacity statewide.

Continue Enhancements of Child Find and Referrals with Cross-Agency Personnel in Part C

To sustain the achievement of the long-term outcomes for referral sources to be well-informed of EI services, increasing the number of children and families receiving Part C services, and

increasing the number of referrals that lead to eligibility, Maine will continue its rigorous early intervention outreach efforts in FFY21. This will be done primarily through the continuation of the state-wide outreach plan that was developed and implemented in January of 2021, as well as a rebranding and robust marketing campaign that is planned to begin in July of 2022. Included with this marketing campaign will be a new website for Maine's early intervention program, promotional videos, and table materials for conferences and community events. In addition, Maine's list of established conditions that make infants/toddlers automatically eligible for Part C will be reviewed bi-annually with the updated document posted publicly on the CDS website and shared with primary referral sources annually as part of the state-wide outreach plan.

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