Private Health Insurance Feasibility Study Final Report

Utah Baby Watch Early Intervention Program (BWEIP)

Utah Department of Health and Human Services (DHHS)

Public Consulting Group LLC

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PUBLIC CONSULTING GROUP

CONTENTS

EXECUTIVE SUMMARY

Background: History and Report Purpose

The following Executive Summary provides a high-level overview and highlights key findings of the feasibility study conducted by the Public Consulting Group (PCG) into the potential implementation of private health insurance billing to finance Early Intervention (EI) services within Utah's (UT) Baby Watch Early Intervention Program (BWEIP). This study was prompted by specific financing recommendations outlined in a 2017 Utah Legislative audit as well as PCG's broader cost analysis and rate study of the BWEIP in 2021. This Executive Summary offers stakeholders, policymakers, agency leadership, and other interested parties a clear understanding of the methodology utilized in PCG's feasibility study as well as the resulting analysis and findings.

Key Research Questions

From October 2022 through July 2023, the PCG Team and BWEIP leadership team collaborated to address the following key research questions:

- What are the anticipated costs and potential revenue associated with BWEIP billing private health insurance plans in Utah for EI services?
- What are the requirements in order for the BWEIP team to submit claims to private health insurance plans?
- What are the necessary business process steps BWEIP would need to implement fee-for-service (FFS) claiming?
- How would BWEIP be impacted if the program were also to bill the federal Medicaid program on an FSS basis?
- What would be the return on investment (ROI) for BWEIP to implement the two financing approaches noted above, namely the potential utilizing private health insurance billing and Medicaid FFS?

In the following report, PCG has provided a comprehensive analysis regarding the impacts these changes would have on the BWEIP to better inform decision-making by the Utah Department of Health and Human Services (DHHS) administration and other state leadership.

Feasibility Study Methodology

In the report's methodology section, PCG provides a summary of IDEA Part C Early Intervention claiming nationally. Notably, approximately half of the states across the United States currently bill private health insurance for EI services. Based directly on our firm's experience as the billing and claiming contractor for other states' IDEA Part C Lead Agencies, the PCG Team was able to make specific assumptions in our financial analysis. For example, due to our nationwide long-term and in-depth billing and claiming operations for IDEA Part C programs, the PCG team provides highly informed estimates for both costs and revenue regarding each of our detailed implementation options. Lastly, the PCG Team engaged with major private health insurance plans based in Utah as well as with representatives of the Utah Medicaid program to further refine our assumed cost and revenue projections.

Implementation Analysis: Initial Comparison Between Bundled Claiming and FFS Billing and Drill-Down Comparison of FFS Structure Options

In the Implementation Considerations section of this report, the PCG Team outlines the various options that BWEIP could pursue moving forward, additionally providing details regarding both the risks and the benefits of EI services claiming within BWEIP's current model. Furthermore, PCG provides a drill-down comparison between (1) bundled claiming and (2) FFS billing. Finally, PCG reviews how FFS billing could be structured, including: (2a) cost avoidance; (2b) pay-and-chase; and (2c) pooled funding.

Critical Path Forward: Necessary Operational Changes to UT's Current BWEIP to Implement New FFS Billing Model

If DHHS and BWEIP executives and other state leaders choose to move forward with an FFS billing model within BWEIP, PCG details the necessary operational changes required for this financing approach. The necessary business process changes primarily revolve around centralizing BWEIP's billing and claiming functions. These functions are currently performed by Local EI programs across the state of Utah, which use a bundled rate for billing. Centralization is an effective way that IDEA Part C Lead Agencies nationally use to manage FFS billing and, ultimately, to realize maximum revenues from third party payors. There are three options for BWEIP to consider in a centralized billing model:

Option #1: Centralize all functions in-house to BWEIP and hire additional staff to manage billing and claiming at the state level;

Option #2: Outsource revenue cycle management to electronic health record (EHR) vendors readily available in the marketplace; and,

Option #3: Procure the services of a contractor that specializes in managing billing and claiming for IDEA Part C claiming.

In the following report, The PCG Team also reviews what an FFS model would look like if claiming were to remain the responsibility of local EI programs. However, PCG does not recommend that DHHS leadership and other state leaders pursue this option as it would not result in maximizing potential revenues for private health insurance billing.

Overview of Necessary Statutory and Administrative Policy Changes

In considering what statutory and administrative policy changes must be undertaken by BWEIP and DHHS to implement FFS billing, the PCG Team provides an analysis of the statutory changes that should be proposed to the Utah Legislature and/or made through the administrative rule-making process. These proposed changes primarily involve new or expanded mandates on private health insurance plans in the state of Utah. PCG also notes important protections that need to be codified for families and custodial caretakers who consent for their health insurance plans to be billed for early intervention services.

Required System Changes to UT's Baby and Toddler Online Tracking System (BTOTS)

In addition to the changes and stipulations for BWEIP that are detailed within the report, BWEIP leadership will also need to make changes to its current case management/child record system, known as the Baby & Toddler Online Tracking System (BTOTS). The PCG Team details the specific new data points the system would need to collect to facilitate the billing and claiming process to private health insurance plans on an FFS basis.

Potential Revenue Projections by Billing Private Health Insurance Plans and Medicaid

With all of these considerations around implementation, the PCG Team provides projections regarding the potential revenue that BWEIP could realize from billing both private health insurance plans and the federal Medicaid program. Overall, PCG concludes that, if all conditions and assumptions detailed in this report are correct, BWEIP could potentially realize approximately the same revenue from billing Medicaid through FFS as they would today (approximately $9.5M annually) in addition to new net revenue from private health insurance plans.

FFS Implementation Costs for BWEIP

Finally, the PCG Team examined the FFS implementation costs for BWEIP. We examined the models detailed earlier, which include: 1) in-house billing, 2) EHR vendor's revenue cycle management 3) EI billing specialist contractor (also referred to as a central finance office, or EI CFO); in addition to local EI

programs remaining responsible for claiming. We do not recommend local EI programs retaining the responsibility for billing and claiming if BWEIP were to move to an FFS model. We further used the three centralized billing options in our ROI calculations. From most expensive to least costly, we found that utilizing an EHR vendor as an option would be the most expensive for BWEIP, followed by in-house billing, further followed by an EI billing specialist contractor. Because of this, utilizing a billing contractor who specializes in early intervention claiming would realize the quickest return on investment for BWEIP in implementing FFS billing (potentially by the second year after implementation). The ROI scenarios are listed below:

TABLE 1. FFS RETURN ON INVESTMENT, BY MODEL

	EHR Vendor		In-House Billing		EI CFO	
Year	ROI $	ROI %	ROI $	ROI %	ROI $	ROI %
0	-$289,085.00	-100%	-$296,085.00	-100%	-$214,685.00	-100%
1	-$833,544.40	-64%	-$544,033.21	-54%	-$426,843.21	-48%
2	-$525,557.65	-23%	$69,360.05	4%	$243,561.60	16%
3	$1,107,550.86	33%	$2,017,037.28	81%	$2,270,108.57	102%
4	$3,074,652.62	68%	$4,308,144.82	132%	$4,662,599.80	161%
5	**$5,385,767.44**	**96%**	**$6,952,985.59**	**172%**	**$7,432,013.62**	**208%**

Conclusion

In summary, if DHHS and BWEIP leadership were to pursue private health insurance billing, the most cost-effective of all available options would be centralizing the billing processes at the state level, and procuring a contractor with specialized tools and expertise in EI billing. However, PCG notes that pursuing this approach will require a significant upfront investment by BWEIP and DHHS as well as important legislative and administrative policy changes to support a fundamental shift in BWEIP's programmatic financing and operations. Additionally, implementation of FFS itself will be a large undertaking for BWEIP with a wide range of notable challenges. The PCG Team details these barriers throughout this report, and further notes other that there are unforeseen challenges that may not have been identified at this time.

PCG appreciates the opportunity to partner with BWEIP to undertake this study, in addition to all the others that helped to contribute to the final outcome of this project, including Medicaid, local EI programs, and to the private health insurance plans that engaged with us during our data collection phase. It is our hope that BWEIP, DHHS, and other stakeholders use the information we have collected and interpreted to make the most informed decision possible no matter which path BWEIP chooses, and in addition to making the decision that is best for the children and families eligible for early intervention in Utah.

GLOSSARY AND DEFINITIONS

270/271 Transactions: 270/271 transactions refer to the electronic exchange of eligibility inquiries (270) and eligibility responses (271) between healthcare providers or billing entities and health insurance companies or payers. These transactions are part of the HIPAA (Health Insurance Portability and Accountability Act) standard for electronic data interchange (EDI) in the healthcare industry.

Assessment: Procedures used, in accordance with IDEA Part C, to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility.

Baby Watch Early Intervention Program (BWEIP): Lead Agency for the administration of IDEA Part C with the Utah Department of Health and Human Services.

BTOTS: The Baby & Toddler Online Tracking System (BTOTS) is the statewide data system for the BWEIP. BTOTS provides secure access to child records for local early intervention providers and parents, as well as data for state monitoring and compliance.

Central Finance Office (CFO): A centralized administrative department within a healthcare organization that is responsible for managing the financial operations and financial planning related to medical services. The primary focus of a CFO is to oversee the financial aspects of patient care and ensure the financial viability of the healthcare organization. In early intervention, there are contractors who provide CFO operations on behalf of state IDEA Part C Lead Agencies. A CFO may be referred to interchangeably as a Central Reimbursement Office (CRO) or Central Management Office (CMO).

CPT/HCPCS Codes: Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes are standardized sets of medical codes used to describe and report healthcare procedures, services, and supplies. CPT codes are primarily used by physicians and healthcare professionals, while HCPCS codes are used for a broader range of services and supplies, including those covered by government healthcare programs. Both coding systems play a crucial role in billing, insurance claims, and accurate documentation of medical services.

Early Intervention (EI) Services: IDEA Part C requires that state early intervention programs make available 17 services, including speech, occupational and physical therapy, special instruction, nursing, social work, psychological services, service coordination (case management) etc., to meet the developmental outcomes of eligible infant and toddlers (birth to age three) with developmental delays and disabilities.

Electronic Data Interchange (EDI): Refers to the computerized exchange of business documents and information between different organizations using a standardized electronic format. It allows for the automated and seamless transmission of data between trading partners, eliminating the need for manual data entry and paper-based processes. EDI enables the exchange of various types of business documents, such as purchase orders, invoices, shipping notices, and payment information, in a structured and machine-readable format.

Electronic Health Record (EHR) System: A digital repository that stores and manages patients' health-related information electronically. It is a comprehensive and longitudinal record of a patient's health history, including medical history, diagnoses, treatments, medications, laboratory results, immunization records, and other relevant healthcare data.

Electronic Remittance Advice (ERA): Also known as an 835 transaction, an ERA is an electronic transaction that provides detailed information about the adjudication and payment of healthcare claims. It is an electronic version of the traditional paper remittance advice or explanation of benefits.

Explanation of Benefits (EOB): A document or statement provided by a health insurance company or payer to an individual or a healthcare provider. It explains the details of how a healthcare claim was

processed and the benefits provided by the insurance plan for the services rendered. The EOB serves as a summary of the financial aspects of a claim and provides information about the coverage, payment, and any patient responsibility.

Evaluation: Procedures used, in accordance with IDEA Part C, for a multidisciplinary team to determine the child's eligibility for early intervention services based on the state's eligibility criteria for developmental delay and the diagnosed medical conditions.

Fee-for-Service (FFS): A method of healthcare reimbursement where healthcare providers receive payment for each individual service or procedure they perform or provide to a patient. Under fee-for-service billing, healthcare providers bill and receive payment based on the specific services rendered, rather than receiving a fixed payment or capitated amount for the overall care of a patient.

Fiscal Year (FY): Data utilized in this report are from Fiscal Year 2022 (July 2021 – June 2022)

ICD-10 Diagnosis Codes: Also known as International Classification of Diseases, Tenth Revision, ICD-10 codes are a standardized set of alphanumeric codes used to classify and categorize medical diagnoses, symptoms, procedures, and other relevant health information. They are maintained by the World Health Organization (WHO) and widely used internationally for medical coding, billing, and statistical reporting purposes.

Individualized Family Service Plan (IFSP): A written plan that includes the developmental needs and outcomes for eligible infants or toddlers (birth to age three) and the early intervention services to be provided within the daily routines, activities and places for each child and their family.

Individuals with Disabilities Education Act (IDEA) Part C: Is the federal law and regulation that govern state's implementation of a statewide system of early intervention for infants and toddler (birth to age 3) with developmental delays and disabilities and their families.

Local EI Programs: Programs employing direct early intervention service providers. These programs either contract with BWEIP or are directly operated by the Utah Department of Health and Human Services, BWEIP.

Medicaid: Medicaid is a joint federal and state government healthcare program in the United States that provides medical assistance to individuals and families with limited income and resources. It is one of the largest public health insurance programs in the country, primarily serving low-income adults, children, pregnant women, elderly adults, and people with disabilities**.** Utah Medicaid is housed within the Utah Department of Health and Human Services.

Part C of IDEA: The section of the Individuals with Disabilities in Education Act (IDEA) that establishes a federal grant program that lays out the requirements for states in operating a comprehensive statewide program of early intervention services for infants and toddlers with developmental delays and disabilities, ages birth to three years, and their families.

Practice Management System (PMS): Also known as a Medical Practice Management System, a PMS is a software solution designed to streamline and automate administrative and operational tasks within a healthcare practice or medical facility. It is specifically developed to support the management of clinical, financial, and administrative processes involved in delivering patient care and running a healthcare practice efficiently.

Prior Authorization (PA): Prior authorization, also known as preauthorization or preapproval, is a process by which healthcare providers or patients obtain approval from an insurance company or payer before certain medical services, procedures, medications, or treatments can be covered or reimbursed. It serves as a mechanism for payers to assess the medical necessity, appropriateness, and cost-effectiveness of healthcare services before providing coverage.

Private Insurance: Private health insurance refers to health insurance coverage that is purchased by individuals or families from private insurance companies, as opposed to government-funded programs like Medicare or Medicaid. Private health insurance provides coverage for various healthcare services and medical expenses, offering financial protection and access to medical care beyond what is typically covered by government programs.

Public Consulting Group LLC (PCG): The contractor hired by BWEIP to conduct this feasibility study. Founded in 1986 and headquartered in Boston, Massachusetts, PCG helps primarily public sector health, education, and human services organizations make measurable improvements to their performance and processes. More about PCG can be found at www.publicconsultinggroup.com.

Revenue Cycle Management (RCM): The process of managing and optimizing the financial aspects of a healthcare organization's revenue cycle, from the initial patient encounter to the final reimbursement. It involves various administrative and financial activities aimed at maximizing revenue, ensuring accurate and timely billing, and minimizing payment delays or denials. The primary goal of revenue cycle management is to enhance the financial performance and sustainability of a healthcare organization.

Utah Health Information Network (UHIN): UHIN is a nonprofit organization based in Utah. It is a health information exchange (HIE) that facilitates the secure exchange of health information between healthcare providers, payers, and other authorized entities in the state of Utah. UHIN serves as a centralized platform for sharing electronic health records (EHRs), lab results, imaging reports, medication histories, and other health-related data.

DISCLOSURES

Public Consulting Group LLC (PCG) is the vendor contracted by BWEIP to conduct this study to determine the feasibility of billing early intervention claims to private health insurance payors along with evaluating the impact of fee-for-service billing to private health insurance and Medicaid. PCG was contracted due to our in-depth knowledge and previous experience with the BWEIP and national experience and operations of managing billing and claiming operations for other IDEA Part C Lead Agencies. Specifically, we disclose that:

- PCG previously conducted a cost study for the BWEIP, which began in March 2020 and concluded in June 2021. One of the recommendations of that study was for BWEIP to consider implementing fee-for-service billing and expanding the program to bill private health care insurers for families enrolled in private insurance.
- PCG currently serves as the billing and claiming vendor for the IDEA Part C Lead Agencies in New York, Indiana, Connecticut, and New Jersey, in addition to a number of other governmental programs in human services, health, and education. In early intervention, PCG is also referred to as a "Central Finance Office" or "Central Reimbursement Office" in its current contracts.

INTRODUCTION AND PURPOSE

The Baby Watch Early Intervention Program (BWEIP) released a Request for Proposals (RFP) in March of 2022 seeking an independent contractor to conduct a feasibility study to explore billing private health insurance for Utah early intervention services. PCG is a national public-sector management consulting firm with expertise in IDEA Part C and was selected to work on the project which commenced in October 2022 under DHHS contract number 9989.

This is the final report based on the data gathered by PCG over the course of the project and it details the results of our analysis and our additional fiscal considerations for BWEIP.

OVERVIEW OF THE BWEIP PROGRAM

The BWEIP is Utah's designated Lead Agency for Early Intervention (EI) under Part C of the Individuals with Disabilities Education Act (IDEA). BWEIP is housed within the Utah Department of Health and Human Services (DHHS), Division of Family Health, Office of Early Childhood. The mission of BWEIP is *"to enhance early growth and development in infants and toddlers, who have developmental delays or disabilities, by providing individualized support and services to the child and their family[1]."*

Early intervention services are provided in accordance with the federal regulations for IDEA Part C and are designed to meet identified developmental outcomes of infants and toddlers (birth to age three) with developmental delays or disabilities, as well as support the family to assist in their child's development. States are required to make available 17 early intervention services including: speech and language pathology; physical and occupational therapies; social work; special instruction; nursing; nutrition, service coordination, and other similar services to support positive developmental outcomes for eligible infants and toddlers with developmental delays and disabilities.

The delivery of early intervention services to eligible children and families in Utah is set up through contracts that BWEIP has with 14 Local EI programs to ensure that services are provided regardless of where a family resides in the state. BWEIP also directly operates, and funds one program housed within DHHS. These programs are recognized as subrecipients of federal grant funding, wherein contracts with BWEIP are currently set up on a cost reimbursement basis.

Current Funding Structure

BWEIP has a number of revenue sources that fund early intervention services in the state, including Federal Part C grant funds, state general funds, Medicaid, Children's Health Insurance Program (CHIP), and Parent Fee collections. Below is a table showing the actual expenditure information for the BWEIP by revenue source for Fiscal Year 2022.

TABLE 2. BWEIP FY 2022 EXPENDITURES

Revenue Source	SFY22 Actual Expenditures	
	Amount	% of Total
Federal IDEA Part C Funds	$7,825,705.00	22.5%
State General Fund	$16,739,000.00	48.1%
Medicaid	$9,379,220.00	26.9%
CHIP	$124,400.00	0.4%
Parent Fee Collections	$752,570.00	2.2%
TOTAL REVENUES:	**$34,820,895.00**	**100%**

OFFICE OF THE LEGISLATIVE AUDITOR GENERAL - AUDIT FINDINGS

In 2017, BWEIP was one of the programs that underwent a performance audit[1] of the former Division of Family Health and Preparedness (FHP), conducted by the Office of the Legislative Auditor General. One of the recommendations identified in the audit was:

> #5. We recommend that the Division of Family Health and Preparedness develop and implement a plan to improve funding for the Baby Watch Early Intervention Program and report annually their progress to the Social Services Appropriations Committee. This plan should include:
>
> a. A cost benefit analysis to determine if a fee schedule would be an improvement over the current bundled Medicaid payments,
> b. A cost benefit analysis of private insurance utilization, and;
> c. If private insurance is deemed cost effective, development of statutory language supporting private insurance billing."

The findings from the audit that led to this recommendation were listed as:

- BWEIP could benefit from additional revenue streams to expand resources/services.
- States elsewhere have established a fee schedule model for Medicaid billing to capture service type and duration.
- Connecticut was specifically cited as a state that had recently shifted from a bundled rate to a fee schedule system (as disclosed previously, PCG is currently the contracted vendor that manages EI billing for the Connecticut Birth to Three system, beginning in 2017).
- Approximately half of states in the U.S. currently bill private insurance plans for reimbursement for IDEA Part C early intervention services.
- Some states have consolidated all billing for early intervention services at a state-wide level, and some, such as Kentucky, Indiana, and Missouri have outsourced this billing function to a contracted vendor. PCG serves as the contracted vendor in Indiana.

One of the major components of the rationale for this project and subsequent report is to address these specific recommendations from the Legislature.

[1] Office of the Utah Legislative Auditor General, November 2017. "A Performance Audit of the Division of Family Health and Preparedness." Number 2017-13. https://le.utah.gov/interim/2017/pdf/00004974.pdf

2020-21 BWEIP RATE STUDY

The former Utah Department of Health and BWEIP previously contracted with PCG to conduct a cost and rate study. The report was finalized in July 2021 and included both fiscal recommendations regarding rate structure and potential revenue enhancements, as well as rate recommendations to cover the cost of providing evidence-based early intervention services to infants and toddlers with developmental delays and disabilities and their families in accordance with IDEA Part C.

PCG worked with the BWEIP team, the one in-house local early intervention program, and 13 local early intervention programs to collect the following data:

- *Cost data* – including the personnel (salaries and benefits) and administrative cost data related to providing early intervention services.
- *Personnel data* – including the current hourly rate paid for early intervention staff and contractors.
- *Time study* – including the direct early intervention time with eligible children and their families, as well as the indirect time (e.g., travel, preparation, report writing, and all paid time off for employees, etc.)
- *Market analysis* – a review of data from the Bureau of Labor and Statistics (BLS) for early intervention disciplines within similar fields (e.g., education, health care)

Rate recommendations were made utilizing PCG's rate build up methodology that starts with the blended market hourly salary and builds on the administrative costs and non-billable indirect time (e.g., travel, preparation, report writing, paid time off, etc.) that is required to provide early intervention services. The recommended rates were built on 15-minute units and, in the case of Service Coordination, a per child per month rate.

The rate study report recommended that BWEIP transition to a fee-for-service system in order to:

1) Have a standard reimbursement methodology between BWEIP, Medicaid, and private health insurance.
2) Have a fee-for-service payment methodology with Medicaid and CHIP to enable BWEIP to propose that private health plans also be required to fund early intervention services.
3) Include Fee-for service rates for:
    - Early intervention 15-minute rate
    - Include modifiers for:
        - Tele-intervention
        - Local rate group (urban, rural, frontier)
    - Service Coordination – monthly rate, per child, accommodating all Service Coordination activities done for a child in addition to direct services.

PURPOSE OF THIS PROJECT

The purpose of the current study is to assess the various factors involved in implementing private health insurance billing for early intervention services in the State of Utah. The study aims to analyze the costs, benefits, challenges, financial feasibility, and operational considerations associated with BWEIP billing private health insurance plans. Below are some of key aspects that were studied in this analysis:

- billing private health insurance companies,
- evaluating the impact of billing fee-for-service to private health insurance and Medicaid,
- establishing an in-house billing department,
- unbundling the current Medicaid and CHIP rates; and,
- modifying the existing funding formula to align with a fee-for-service model and private insurance billing.

METHODS AND DATA GATHERING

NATIONAL PICTURE OF BILLING PRIVATE HEALTH INSURANCE CLAIMING FOR EARLY INTERVENTION

According to the national IDEA Infant & Toddler Coordinators Association (ITCA) Funding Structure State Profiles 2023, 31 states and territories reported billing private health insurance.

Based on the information gathered as part of the ITCA Finance Survey in 2021

- 12 states reported they have insurance legislation and one state said they are considering adding statutory language.
- Seven states indicated that early intervention services are included in their state's definition of essential benefits under the Affordable Care Act.
- 15 states indicated there was no cap on the amount the insurance company will pay on an annual basis. One state's cap was $5,000 and the other state's cap was $7,838.

The reported amount of revenue generated for early intervention from private health insurance nationally is $81.5 million. However, this is likely a significant undercount, as only nine states and territories are able to report on the health insurance revenue amount collected by local early intervention programs.

In addition, no information currently exists on the number and percent of states and territories where private health insurance claims are conducted by the local early intervention programs versus through a central finance office (either state staff or through a contracted vendor).

Finally, the Colorado and New York State IDEA Part C Lead Agencies have a "private insurance fund," whereby private health plans pay into the fund based on the covered children under their health plan who are eligible for IDEA Part C. The state then draws from the insurance pool based on the utilization of Individualized Family Service Plan (IFSP) services for enrolled children (see subsection "Single Private Insurance Fund for Early Intervention" of this report for more information). Note: NY's private insurance fund is currently being developed and has not gone live.

The national Early Childhood Technical Assistance (ECTA) center has provided resources for Building the Case to Expand Medicaid and Private Insurance for Early Intervention. This includes state video stories and a planning tool.

OTHER STATE DATA USED IN MODELING

In the later sections of this report, data was utilized from PCG's early intervention billing operations in Indiana, Connecticut, New Jersey, and New York to help make estimates around private insurance and Medicaid billing on a fee-for-service basis. To make these estimations, these data went into calculations related to recoupment rates for private insurers and Medicaid, proportions of common CPT/HCPCS codes used for early intervention for different therapy types, common ICD-10 diagnosis codes for early intervention, and other areas in which data do not currently exist in Utah.

IN-STATE INSURANCE COMPANY ENGAGEMENT

At the start of the feasibility study PCG planned to connect with the nine largest private insurance companies in the state: SelectHealth, Regence Blue Cross Blue Shield of Utah, United Healthcare Insurance Company, Molina Healthcare, BridgeSpan Health, University of Utah Health Plans, Cigna Health and Life Insurance, Aetna Life Insurance Company, and PEHP Health and Benefits.

Initial contact was made with seven of the nine providers by December 21, 2022 and the remaining two were contacted in January 2023. Of the nine private insurers, PCG received responses from five.

Between December 2022 and March 2023, a minimum of 3 contact attempts were made to insurers who had not responded.

Of the five responses, the following four private insurers agreed to meet with PCG: SelectHealth, Molina Healthcare, University of Utah Health Plans, and PEHP Health and Benefits. During these meetings, PCG explained the nature of IDEA Part C both in Utah and nationally, the mission of this project, and discussed the willingness of the insurers to cover services provided by BWEIP without a legislative mandate.

SelectHealth, University of Utah Health Plans, and PEHP were the only insurance companies that shared their rate schedules by CPT code, allowing PCG to make the most accurate revenue estimations as possible.

TABLE 3. PRIVATE HEALTH INSURANCE OUTREACH

Insurance Plan	Initial Contact	Final Follow Up	Method	Reply	Initial Meeting Date
SelectHealth	12/21/2022	–	Email	Yes	1/17/2023
Regence BCBS of UT	12/21/2022	3/27/2023	Email & Phone	No	–
UnitedHealthcare Ins Co	12/21/2023	1/11/2023	Email	Yes	–
Molina Healthcare (DBA AmFam)	12/21/2022	–	Email	Yes	1/9/2023
BridgeSpan Health	12/21/2022	3/27/2023	Email	No	
University of Utah Health Plans	12/21/2022	–	Email	Yes	1/4/2023
Cigna Health and Life Insurance	12/21/2022	1/12/2023	Email & Phone	No	–
Aetna Life Ins Co	1/12/2023	3/27/2023	Phone	No	–
PEHP	1/24/2023		Email	Yes	5/2/2023

UTAH MEDICAID ENGAGEMENT

From the onset of this project, BWEIP and the PCG teams have engaged with representatives from Utah Medicaid to research and identify how and what would need to change in BWEIP to implement fee-for-service (FFS) billing with Medicaid. Utah Medicaid has provided detailed reviews of PCG's Medicaid-specific work products, taken on additional research activities on the project's behalf, and advised how our recommendations would affect Medicaid billing.

Medicaid confirmed that FFS would have to be adopted in BWEIP's Medicaid billing if the BWEIP were to begin FFS billing with private insurance. Once this determination was made, a Medicaid policy official provided an initial review of PCG's recommended CPT/HCPCS code schedule to determine the most appropriate codes to bill for the early intervention services under IDEA Part C that BWEIP provides.

IMPLEMENTATION CONSIDERATIONS

STRUCTURAL MODELS

In this section, we describe various billing and payment models that are employed by IDEA Part C Lead Agencies nationwide, as well as their inherent risks and benefits. An important note to consider for this and proceeding sections is that some of the descriptions, definitions, risks, and benefits detailed are not specific to early intervention, but rather provided in a more general context of health care billing and claiming. We have inferred as best as possible where health care industry themes and analysis would apply to early intervention and have listed them as appropriate.

Currently, BWEIP employs “bundled rate” billing for the Medicaid claims that are submitted by Local EI programs directly to Medicaid for reimbursement. Local EI programs seek reimbursement from BWEIP for non-Medicaid covered services on an “at-cost” basis, based on meeting a minimum threshold of visits per month. As noted previously, the major research questions of this report are to determine the feasibility of BWEIP moving to a different billing model, specifically fee-for-service (FFS) billing, and also explore whether management of claiming/payment should move to a centralized or statewide level or remain the responsibility of individual Local EI programs.

Bundled Rate Billing

A bundled rate model, also known as bundled payment or episode-of-care payment, is a payment method in which multiple healthcare services related to a specific episode of care or treatment are combined into a single bundled payment. Instead of reimbursing each service separately, all services are included in the bundled payment. Again, this is the current Utah model of billing Medicaid for IDEA Part C early intervention services.

Below illustrates how a bundled rate billing model functions in IDEA Part C:

- Episode Identification: A specific episode of care would be defined based on the needs and goals of the child receiving early intervention services. For example, it could be focused on a specific developmental area like communication, motor skills, or social-emotional development, and is typically identified in the assessment and eligibility phase of a child’s time with an early intervention program. Outcomes / goals in these areas are documented in the child’s IFSP.
- Service Inclusion: All the necessary services and interventions provided within the defined episode of care are included in the bundle. This may include assessments, evaluations, intervention and coaching with the family and other caregivers in the home or other community settings.
- Bundled Payment Determination: The payment amount for the bundled episode would be determined based on an average cost of providing services to children with a wide variety of developmental needs.
- Collaboration Among Providers: Early intervention typically involves multiple early intervention professionals such as early intervention specialists, speech therapists, occupational therapists, and physical therapists, nurses, vision and hearing specialist. Early intervention providers collaborate to coordinate the intervention for the child and family, share information, and deliver the necessary services within the bundled episode. BWEIP currently defines all providers in the program as EI Specialists, albeit with different (state-licensed and certified) specialties.
- Coordination and Efficiency: Providers work together to ensure the coordination and delivery of services in a cohesive and efficient manner. This involves creating an individualized intervention plan, setting goals, monitoring progress, and adjusting interventions as needed.

- Financial Incentives: If the actual cost of providing the bundled services falls below the bundled payment, the early intervention program or service providers may retain a portion of the savings as an incentive. On the other hand, if the costs exceed the bundled payment, providers may bear some financial risk.

The bundled rate model aims to promote cost containment, care coordination, and value-based delivery. By aligning incentives and encouraging collaboration among providers, it aims to improve the quality and efficiency of care while controlling healthcare costs.

Bundled Rate Billing Risks and Benefits

Benefits

Coordinated services: A bundled model encourages coordinated care among different providers involved in an episode of intervention. It promotes collaboration, communication, and integration of services, leading to a more holistic and comprehensive approach to the child's development. Service coordination (case management), as a required service in IDEA Part C, may be included or outside of the bundled rate. Note: the service coordination (case management) role and the development of an IFSP by the multidisciplinary team promotes coordination in each of the reimbursement models.

- Improved Outcomes: By promoting coordination and collaboration, a bundled model can contribute to improved outcomes for children receiving early intervention services. Providers can work together to ensure that interventions and therapies are delivered in a coordinated manner, thereby focusing providers' time and energy into supporting families. Additionally, bundled rate billing can help in promoting parental coaching, which further lead to positive outcomes. Note: In early intervention the IFSP includes the identified outcomes and strategies that the multidisciplinary team works towards collaboratively across reimbursement methods.

- Cost Containment: Bundled payments can help control costs by providing a fixed payment for an entire episode of intervention (typically defined by BWEIP as one hour of service). Providers have an incentive to manage resources efficiently and avoid unnecessary or duplicative services and keep within the bundled monthly amount, thus potentially reducing overall expenditures.

- Simplified Administration: Implementing a bundled model can simplify administrative processes. Instead of tracking and reimbursing multiple individual services, a single bundled payment reduces the administrative burden for both providers and payers, streamlining billing and reimbursement processes.

Risks/Challenges

- Risk of Inadequate Payment: Bundled payments must be carefully determined to ensure they adequately cover the range of services provided. If the bundled payment is too low, it may create financial strain for providers, impacting the quality and availability of services.

- Service Limitations: The bundled model may create limitations on the types or number of services included in the bundle. If certain services or interventions are excluded from the bundled payment, it may limit access to necessary care or hinder the ability to address specific needs of individual children. Local early intervention programs may also be reluctant to provide the services that children with significant developmental delays and disabilities need because the bundled rate is seen as not adequately reimbursing them for children who need multiple EI services on a frequent basis and whose costs are higher than the average costs on which the bundled rate is based.

- Variable Complexity of Episodes: early intervention episodes can vary significantly in complexity and resource requirements. Young children and families receive a range of service types (such as physical therapy or special instruction) and service frequencies (such as four one-hour services per month) to meet the child's developmental needs. A bundled model may not fully account for these variations, potentially resulting in underpayment for more complex cases or overpayment for less complex cases.

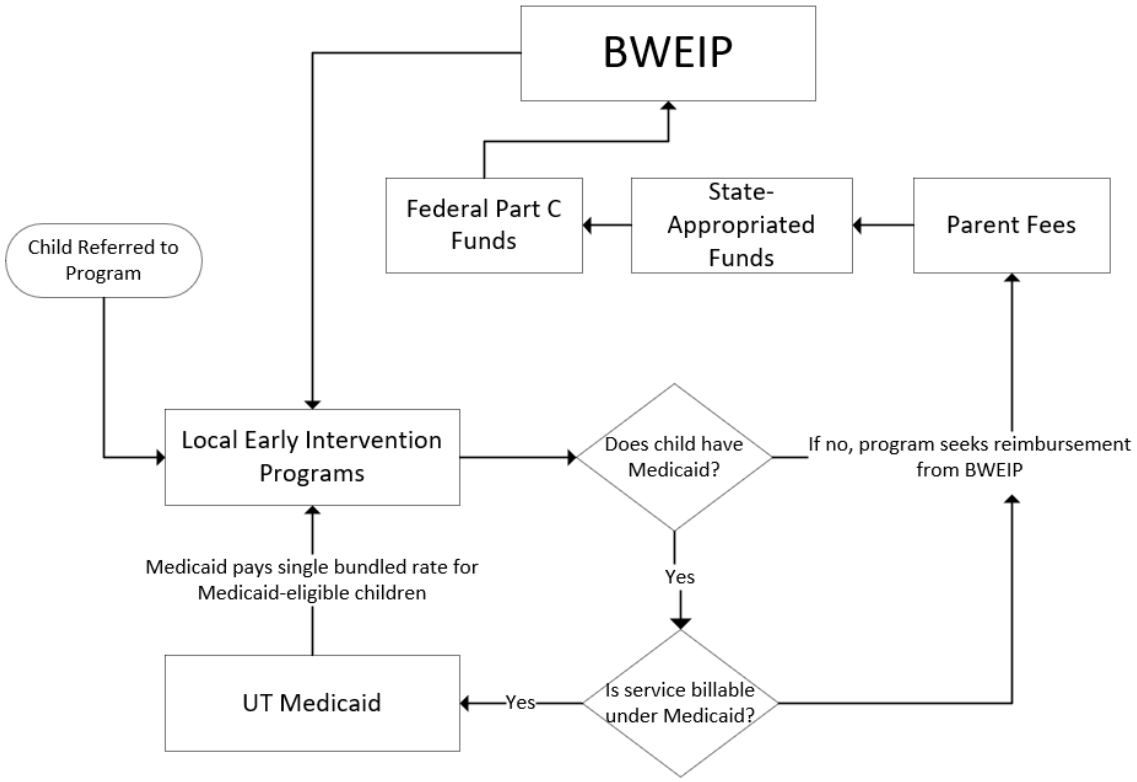
- Inequity in Payment: because a bundled rate may compensate for services at a state-wide level, it does not accommodate for the differences or challenges local EI programs may have depending on geography, provider type, or similar factors. For instance, with one single rate state-wide, urban areas that have higher population density may benefit more than rural areas due to travel or difficulties in provider recruitment.

- Care Fragmentation: While the bundled model aims to promote care coordination, there is a risk of care fragmentation if the coordination among providers is not adequately established. Lack of communication and coordination can hinder the delivery of seamless and integrated care.

- Incentive to provide less services: If local EI programs are reimbursed the same bundled payment regardless of the amount of service provided – where the program would receive the entire payment whether they provided one or five services for a child in a given month – the EI Program is incentivized to provide less service.

Below is the current BWEIP bundled rate billing system process for Medicaid payments:

FIGURE 1. CURRENT BUNDLED RATE BILLING MODEL



Fee-For-Service Billing (FFS)

Fee-for-service billing in private health insurance and/or Medicaid refers to a payment method where healthcare providers bill and receive reimbursement for each specific service or procedure they provide to a patient. In the case of BWEIP, Local EI programs and direct service providers (i.e., rendering providers) would be the billing entities for the services to eligible children and families they serve under a FFS model.

In an FFS model, each early intervention service is assigned a specific code, typically using a coding system like the Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, which helps determine the appropriate reimbursement amount. PCG developed a detailed crosswalk of the most commonly used CPT/HCPCS codes used in IDEA Part C in states where PCG currently manages their billing systems, which is in a separate Excel workbook due to its complexity and would be difficult to add to a Word document. This workbook is available for review upon request from BWEIP.

According to the national Infant Toddler Coordinators Association (ITCA)[2] FFS is the most common methodology for billing for early intervention services with 25 states and territories reporting using an FFS reimbursement structure.

FFS is also the most common way healthcare is paid for in the United States, however it is not without its critics. According to a Harvard Business Review[3] article it is sometimes considered *"the single biggest obstacle to improving health care delivery, [because it] rewards the quantity but not the quality or efficiency of medical care."*

Fee-for-Service billing in IDEA Part C follows a general process as described below, though every state utilizing FFS operates somewhat differently:

1. Eligibility Determination: A child's eligibility for IDEA Part C services is evaluated and determined based on criteria such as age, developmental delay, or disability. If the child meets the eligibility requirements, they are enrolled in the early intervention program.
2. Individualized Family Service Plan (IFSP): An Individualized Family Service Plan is developed in collaboration with the child's family and a team of early intervention professionals. The IFSP outlines the child's specific needs, outcomes (goals), and the frequency, method, and duration that early intervention services are to be provided. Ideally, in a fee-for-service model, the IFSP would also receive approval from, typically, the child's primary care physician (PCP) as an ICD-10 diagnosis code(s) would need to be assigned to the child in order to generate an appropriate claim that can be processed by private insurance and Medicaid.
3. Service Delivery: IDEA Part C services are provided based on the child's individual needs and the goals identified in the IFSP. Services may include assessments, evaluations, intervention / therapy sessions in home and community settings aimed at coaching the parents and other caregivers and promoting the child's healthy development.
4. Documentation and Coding: Providers document the services provided, including the type of service, duration, and any relevant information about the session or intervention. They assign appropriate codes, such as CPT codes or other relevant coding systems, to each service delivered.
5. Claims Submission: Local early intervention programs or a state-level Central Finance Office (CFO) submit claims for reimbursement to the appropriate payer, including private health

[2] Infant Toddler Coordinators Association (ITCA) State Profiles – Funding Structure (2023)
[3] Porter, Michael E. and Robert S. Kaplan (2016). "How to Pay for Health Care." *Harvard Business Review Magazine* https://hbr.org/2016/07/how-to-pay-for-health-care

insurance plans or Medicaid based on the child's enrollment. The claims include the coded information, along with any supporting documentation required by the payer.

6. Adjudication: The payer reviews the claims, verifies the child's eligibility, and assesses the medical necessity and appropriateness of the services rendered. They apply the reimbursement rates or fee schedules for the specific services provided.
7. Reimbursement: Once the claims are approved, the payer reimburses the IDEA Part C provider for the services delivered based on the predetermined reimbursement rates or fee schedules. In normal medical billing operations, the reimbursement amount may be subject to any deductibles, copayments, or coinsurance as outlined by the child's insurance plan or the Medicaid program. In the case of IDEA Part C, per federal regulation, copayments, deductibles, and other factors cannot be applied for these services unless specified in the state early intervention program's "System of Payments." State early intervention programs can waive copays and deductibles and insurance legislation can clarify that the family will not be subject to any out-of-pocket expenses.
    - There are a number of instances where the private health insurer or Medicaid will deny or reject a claim for various reasons. That claim can either be corrected and resubmitted to the payor, or if the claim is denied for a valid reason, it is then submitted to the secondary health insurer for the child or Medicaid depending the child's enrollment status, and then finally to the state Lead Agency to pay for the remainder cost of the claim.

In Medicaid, fee-for-service billing follows a similar principle to private health insurance. However, the reimbursement rates for Medicaid fee-for-service are typically established by state Medicaid agencies and may differ from private insurance fee schedules. State early intervention programs often align reimbursement rates across Medicaid and state payments for non-Medicaid eligible children for equity and to avoid any perceived incentives or disincentives of serving one group over another.

Fee-for-service risks and benefits

Benefits

- Adaptability: In a fee-for-service model, Local EI programs can bill for each individual service or procedure rendered to child and family. Fees can also be established based on the service location and method e.g. a higher reimbursement can be established for services provided in the home or community involving travel time and expenses for the EI provider and a lower rate when services when no travel is involved, including if provided in the center or through tele-heath. This allows for greater adaptability in determining the scope of services provided and reimbursed.
- Reimbursement Potential: Since each service is billed separately, there is a potential for higher reimbursement if multiple services are provided, knowing that due to the child's developmental needs they may receive varying levels of services based on their IFSP, e.g. a child with mild developmental delays may receive 1-2 service session per month, whereas a child with more significant delays or disability may receive several services per week.
- Transparent Reimbursement: The fee-for-service model provides transparency in reimbursement. Providers receive payment for each service rendered, which can help ensure fair compensation for the services they provide. This can encourage providers to deliver high-quality, evidence-based interventions and ensure that they meet the needs of each child. Geographic locations of the provider should also be taken into consideration, where local EI programs in rural areas would require additional compensation due to higher costs of recruitment, retention, and other challenges that are not seen in more urban areas. Private health insurance plans do typically have a fee schedule that differs based on a provider's locale.

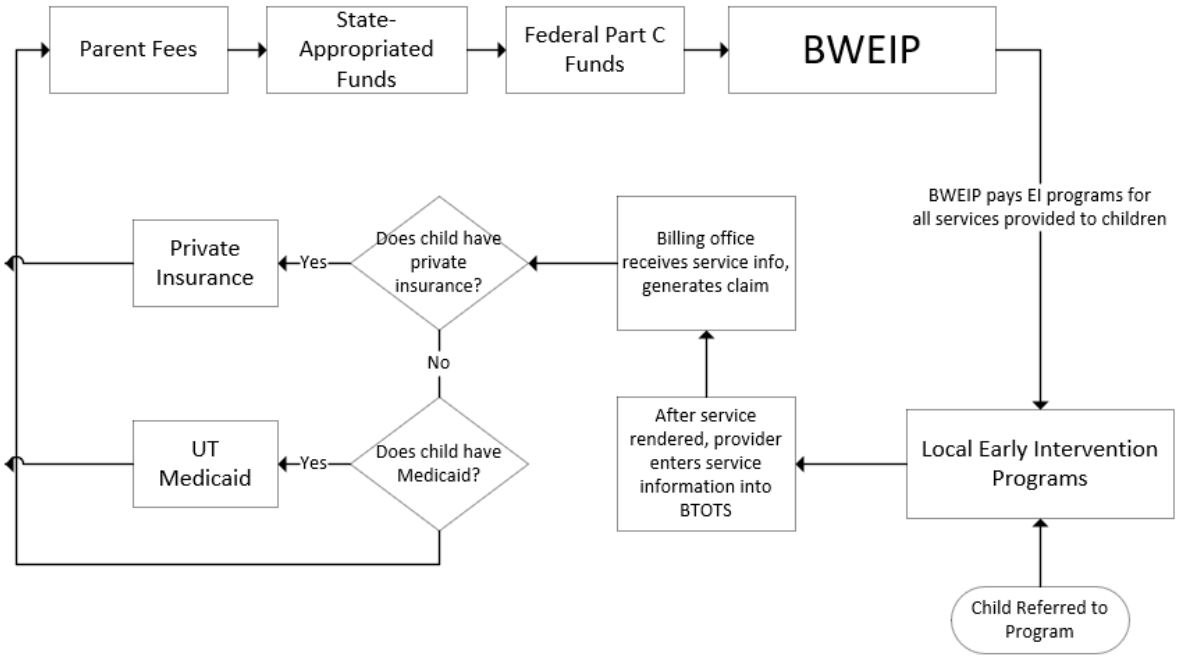
- Accountability: Fee-for-service billing promotes accountability as providers are reimbursed based on the specific services delivered. State early intervention programs can clearly monitor the EI services provided, including whether the services were provided timely and in accordance with the IFSP.

Risks/Challenges

- Overutilization: Fee-for-service models may incentivize providers to provide and bill for more services, potentially leading to overutilization or unnecessary procedures. This can increase healthcare costs and may not always align with the child's best interests. Additionally, this could lead to less parent coaching of strategies to occur between visits in the child's daily routines as it incentivizes more direct service visits. Note: in IDEA Part C this is mitigated in that EI providers can only provide and bill for service in accordance with the IFSP.
- Fragmented Services: The fee-for-service model in healthcare is sometimes seen as inadvertently leading to fragmented care, where providers may focus on individual services or sessions rather than taking a comprehensive and coordinated approach to a child's development. However, in IDEA Part C the IFSP and the service coordination (i.e., case management) role promotes a coordinated multidisciplinary approach where the team works together to meet the child's and family's needs.
- Administrative Burden: Fee-for-service billing requires coding, claims submission, and documentation. This administrative burden can be time-consuming and resource-intensive for both local EI programs and the IDEA Part C Lead Agency. Note: Inadequacies in this area can be addressed through a data and billing system and central billing office (CFO), where the data can be used centrally to generate claims either by state staff or outsourced to the CFO vendor, rather than having administrative staff at each of the Local EI programs generating and submitting claims.
- Lack of Financial Stability: With a fee-for-service reimbursement system Local EI programs will likely experience month-to-month fluctuations in reimbursements due to the variability in the number of services i.e. less EI services provided during holiday periods.

Below is a visualization of the process if BWEIP were to implement an FFS system of payment for private insurance and Medicaid. This is with the assumption that the state takes on a centralized billing role.

FIGURE 2. FFS BILLING MODEL



Centralized Cost Avoidance Payment Model

A centralized cost avoidance payment model is a method used in IDEA Part C to determine the payment rates for each service. In this model, the state Lead Agency establishes a reimbursement rate for each service based on estimated or actual cost of providing that service. Local EI service providers submit claims for the services they deliver, and based on the fee schedule that the Lead Agency establishes, are paid for the service that is provided.

This model ensures that Local EI programs and service providers receive fair and adequate reimbursement for the services they provide, while also promoting consistent and standardized payment rates. This helps support the availability and accessibility of early intervention services, as well as control costs and allocate resources effectively.

In this model, the state Lead Agency may require Local EI providers to seek reimbursement from private insurance and Medicaid prior to the state agency paying the remaining balance of the rate. For example, the payment rate for physical therapy may be $100 for 1 hour of service and the service provider receives a $50 payment from the child's private insurance company and a $25 payment from the state Medicaid program. The state early intervention program would then pay the service provider the remaining $25. States may require Local EI providers to demonstrate that they have sought and been denied 3rd party payments, including denials from health insurance plans before receiving state funding reimbursement.

This model puts the burden of billing and claiming on the Local EI programs, which are facilitated by an adjudication matrix established by the Lead Agency. The Lead Agency notifies the Local EI programs which claims must be submitted and/or triaged prior to the state paying the service provider. Local EI providers could face additional financial challenges waiting for third party payments and / or denials before receiving state reimbursement for services rendered (typically around three months). This may cause a cash flow challenge for Local EI programs that need to pay staff and contracts before they receive reimbursement from payors and the Lead Agency.

Centralized Pay-and-Chase Model

The pay-and-chase model means that the state EI program reimburses the Local EI provider for the total amount under the established payment schedule for the services early intervention provided on a fee-for-service basis. The payment schedule can be weekly, bi-weekly, or monthly for the services provided. The state EI program then seeks reimbursement from another liable third party (Medicaid and private health insurance plans).

The payments to the Lead Agency from private insurance companies through electronic remittance payments deposited into the state agency's fund are considered revenue that can be used to continuously reimburse Local EI providers.

Similarly, Medicaid reimbursement can be made through interagency transfer. State EI programs may choose to do pay-and-chase for private insurance, but still have the state Medicaid agency reimburse the Local EI providers directly after claims are submitted through the established central finance office.

State EI programs must pay attention to the Maintenance of Effort (MoE) requirements 34 CFR §303.225(b) of Part C of IDEA that requires that states budget for the current year at least the same aggregate amount of State and local public funds spent in the most recent preceding fiscal year. States using a pay and chase model will need to fiscally account for the funds expended at the end of the year along with the third-party reimbursement received. States must also be certain an equal amount of funds are budgeted for the following year.

A challenge could also be the recruitment and retention of billing staff in the current job markets both in Utah and nationally, DHHS financial staff have reported difficulties in recruitment.

Single Private Insurance Fund for Early Intervention

Several states utilize a system that is more commonly known in the broader healthcare field as "risk-based assessments" or "risk-based payments." This term refers to the practice of health insurance plans contributing to a designated fund to support the provision of healthcare services for a specific population or a specific purpose.

The concept of risk-based assessments or payments recognizes that certain populations may require specialized or targeted services that go beyond standard coverage. By pooling resources through these assessments or payments, health insurers can ensure adequate funding for the specific healthcare needs of the identified population.

It is worth noting that the specific terminology used may vary across regions or contexts. Other related terms that might be used include "risk-sharing arrangements," "special population funds," or "dedicated funding pools." The precise terminology used can depend on the specific program, initiative, or regulatory framework in place within a particular healthcare system or jurisdiction.

In Colorado, private health insurance plans are required to contribute to the "Early Intervention Services Trust Fund"[4] if a child enrolled in their healthcare plan is found eligible to receive IDEA Part C services. As of 2023, Colorado health insurance plans are required to pay approximately $7,500 annually into the trust fund for each child on their roll who is found eligible. The state IDEA Part C program then bills the trust fund on a fee-for-service basis for the EI services provided to eligible children. Similarly, New York State recently passed legislation for health insurance plans to pay into a pooled fund for early intervention services based on a regional Covered Lives Assessment (CLA).[5]

[4] Code of Colorado Regulations (state.co.us) (see Section F. on Page 13)
[5] GME Regional Covered Lives Assessment Rates (ny.gov)

SYSTEM MANAGEMENT

If BWEIP decides to move to a new system of billing and payment for early intervention services, particularly FFS, the next step would be to determine how to operationalize the new model. This section provides details around the tools and resources BWEIP would need to procure and implement FFS billing.

Outsource to Generic EHR Systems

In addition to the basic requirement of enhancing BWEIP's Baby and Toddler Online Tracking System (BTOTS), see BTOTS Enhancements section for more detail, BWEIP should procure an Electronic Health Record (EHR) system. There are many vendors that provide general practice EHRs with several examples provided in **Appendix A**.

Regardless of which EHR is in place, it will be necessary to convert the current case management data captured in BTOTS and adapt data into a format that can feed into a traditional health insurance claim. EHR is a comprehensive electronic database that would include children's early intervention services, medical history, diagnoses, and other relevant information for billing purposes.

Importantly, the EHR would take specific service log, progress notes, and other developmental and clinical information entered into BTOTS, and store it in a standardized and structured model to support accurate and comprehensive recording of a child's service data.

Data cannot be actioned upon without someone conducting revenue cycle management (RCM) for BWEIP. Many EHR system companies also offer RCM services that would be crucial to the health claims lifecycle for the program. BWEIP could outsource these services to an EHR vendor, or they could keep functions in-house, the latter of which is described in the subsection "State-Managed Billing Management." The revenue cycle management process is the human factor in utilizing the procured EHR to manage the billing and claiming process on behalf of BWEIP. RCM staff use the EHR for the following activities:

1. Child Registration and Eligibility Verification: The revenue cycle begins with child registration, where the EHR system collects and validates child demographic information, insurance details, and other necessary data. The vendor may also integrate with eligibility verification services to check child insurance or Medicaid coverage (known as 270/271 electronic data interchange (EDI) transactions).
2. Charge Capture: Charge capture involves accurately capturing and documenting all billable services and procedures performed during child encounters. The EHR system should have functionalities to capture charges automatically or manually, ensuring that all relevant services are recorded for proper billing.
3. Coding and Documentation: Coding is a critical step in revenue cycle management. EHR systems often incorporate tools to facilitate accurate coding of diagnoses, procedures, and services. These tools may include features such as code suggestions, code search functionality, and links to coding references and guidelines. The system should also support proper clinical documentation to substantiate the services provided.
4. Claims Generation and Submission: Once the coding and documentation are complete, the EHR system generates claims based on the captured charges and relevant coding information. The system should have the capability to create standard claim formats, such as electronic claims (EDI) or paper claims, based on the requirements of different payers. It should also perform validations and edits to ensure the claims are accurate and comply with payer guidelines. A claim submission file via EDI is known as an 837 Professional Health Care Claim.

5. Claims Scrubbing and Editing: The EHR system may incorporate claims scrubbing functionality to check claims for errors, inconsistencies, or missing information before submission. This helps identify and resolve issues that could result in claim denials or delays. The system may also include features for manual claim editing and correction, if necessary.
6. Claims Submission and Tracking: After claims are generated and scrubbed, the EHR system facilitates the electronic submission of claims to insurance payers. It should have the ability to transmit claims electronically through clearinghouses or directly to payers. The system should also provide mechanisms for tracking the status of submitted claims, including the receipt, acceptance, or rejection of claims by payers.
7. Payment Posting and Reconciliation: As payments and remittance advice are received from payers, the EHR system supports the posting of payments and reconciliation with the corresponding claims. The system should automate the matching of payments to claims, identify discrepancies or denials, and facilitate the resolution of payment-related issues. Similar to the 837 files, insurers provide electronic remittance advice (ERA) via an 835 EDI file, which provides claim payment information and/or Explanations of Benefits (EOBs).
8. Denial Management and Appeals: When claims are denied or rejected, the EHR system should assist in the management of denials and the appeals process. It should provide tools to identify and analyze denial trends, track appeals, and generate necessary documentation to support the appeal process. These would also be detailed in the received 835 file.
9. Reporting and Analytics: The EHR system should offer reporting and analytics capabilities to monitor and analyze key revenue cycle metrics. This includes tracking accounts receivable, payment trends, claim submission and acceptance rates, denial rates, and other financial indicators. These reports help identify areas for improvement, measure performance, and support decision-making in optimizing the revenue cycle.

Outsource to Customized EI System Vendor

BWEIP could consider hiring a vendor that specializes in IDEA Part C billing and claiming. This would be an alternative to procuring a “generic” EHR and using their revenue cycle management offerings or managing billing in-house, discussed in the next subsection.

Such vendors typically have a system that is optimized to effectively support IDEA Part C programs and/or other government-run programs, in billing and claiming to maximize third party claims. Hiring a vendor with a billing system tailored to IDEA Part C would likely achieve higher insurance reimbursement rates than a more generic billing system vendor. The implementation process is frequently easier and smoother, as these systems are purpose-built for early intervention.

PCG offers this specific function, and currently is the billing and claiming vendor for IDEA Part C Lead Agencies in New York, Connecticut, Indiana, and New Jersey. There are other vendors such as Therap and Gainwell Technologies, and BWEIP could release a competitive RFP to obtain proposals to conduct these services.

State-Managed Billing Management

If BWEIP decides to centralize its IDEA Part C billing process, taking over claiming for services for all Local EI programs, it would require procurement and implementation of some components required to outsource the billing to a generic EHR system.

In addition to procurement of an EHR, BWEIP would need to procure an additional Practice Management System (PMS). A PMS is a software application used by healthcare practices, clinics, and medical offices to manage various administrative and financial aspects of the practice. It is designed to streamline day-to-day operations and improve efficiency in managing child appointments, billing, scheduling, and other

administrative tasks. The main components that the PMS would add to and augment the functions of the state's EHR specifically would be:

- Billing and claims management: PMS enables the generation and management of insurance claims and reimbursement processes. It may include features such as automated coding, claims submission, and tracking of payment status. Most importantly, the PMS would take the data from the EHR regarding the service rendered and convert that data into a health insurance claim which can then be transmitted to a payor directly or a claims clearinghouse.
- Revenue cycle management: PMS would support the management of BWEIP's revenue cycle, including tasks such as charge capture, coding, claim submission, payment posting, and accounts receivable management.

In addition to procuring an EHR with an accompanying PMS, which typically would be provided by the same vendor, BWEIP would need to contract with a health insurance claims clearinghouse, such as TriZetto[6] or Change Healthcare[7] (formerly known as Emdeon). A claims clearinghouse, also known as a healthcare clearinghouse or electronic data interchange (EDI) clearinghouse, is an intermediary entity that facilitates the electronic submission and processing of healthcare claims between healthcare providers (i.e., BWEIP programs) and insurance payers. It acts as a central hub for transmitting and translating claim data between different parties involved in the healthcare revenue cycle. The key functions that the clearinghouse would provide BWEIP, which would be critical in efficient billing and claiming to private health insurance plans, are:

1. Data Exchange: A claims clearinghouse receives electronic claim files from healthcare providers and exchanges them with the appropriate payer. This ensures that the claim data is accurately represented and formatted according to industry standards and specific payer requirements.

2. Claims Validation and Editing: The clearinghouse performs various checks and edits on the claims data to ensure it meets the required standards and completeness. This includes verifying the accuracy of patient demographic information, checking for coding errors or inconsistencies, and validating claim information against payer-specific rules and guidelines. The clearinghouse may identify and flag any issues or missing information that could result in claim rejections or denials.

3. Transmission to Payers: Once the claim data is validated and edited, the clearinghouse electronically transmits the claims to the appropriate insurance payers on behalf of the healthcare providers. It utilizes secure EDI protocols to securely transmit the claims to the respective payer systems.

4. Receipt and Acknowledgment: The clearinghouse receives acknowledgment or receipt notifications from the payers indicating the successful receipt of the claims. These notifications confirm that the claims have been received by the payer and are being processed for adjudication.

5. Claim Status and Reconciliation: The clearinghouse provides visibility into the status of submitted claims, including updates on claim acceptance, rejections, and adjudication outcomes. It allows healthcare providers to track the progress of their claims and reconcile them with the payments received from the payers.

6. Electronic Remittance Advice: In addition to claim submission, some clearinghouses also handle electronic remittance advice (ERA) transactions. ERAs provide detailed information about the payment and adjustment codes associated with each claim, facilitating automated payment posting and streamlining the reconciliation process. In addition to electronic remittance, where an

[6] https://www.trizettoprovider.com/
[7] https://www.changehealthcare.com/

ERA is not received, a paper explanation of benefits (EOB) must be received and entered manually.

These functions would be of enormous value to BWEIP in maximizing revenue from private insurers in Utah, including both in-state and out-of-state plans. Some claims clearinghouse companies may also offer full-service revenue cycle management (RCM) for programs.

Billing and Claiming Staff Needs

If Utah decides to keep the revenue cycle management and billing in-house, and not contract out either to an EHR or EI-specific billing and claiming vendor, there are five recommended roles BWEIP administrative and finance staff would have to play to manage these processes. These roles may be filled by multiple staff each, depending on the needs of the Lead Agency. Note: An assessment would need to be conducted to determine how many FTE (Full-time Equivalents) would be needed to effectively carry out these roles, with some roles possibly requiring require multiple FTEs to efficiently handle the volume of a statewide program:

- **A health insurance coder**, also known as a medical coder or coding specialist, is a professional who assigns specific codes to medical diagnoses, procedures, and services provided to patients. These codes are used for various purposes, including billing, reimbursement, statistical analysis, research, and compliance with healthcare regulations.
- **A health insurance biller**, also known as a medical biller or billing specialist, is a professional responsible for preparing and submitting medical claims to insurance companies or government programs for reimbursement. They play a crucial role in the healthcare revenue cycle by ensuring accurate and timely billing processes.
- **A payment poster** is responsible for accurately recording and posting payments received from insurance companies or patients onto the healthcare provider's financial system. The payment poster reviews the remittance advice and matches it to the corresponding claims in the healthcare provider's billing system. They accurately record the payments, adjustments, and write-offs associated with each claim. This includes posting the amounts received, applying contractual adjustments, or allowed amounts, and adjusting patient balances accordingly.
- **A Health Insurance Claim Collections and A/R (Accounts Receivable) Clerk** is a professional who specializes in managing the collection of outstanding payments for healthcare services rendered. They play a crucial role in the revenue cycle management process, focusing on resolving unpaid or overdue claims and optimizing cash flow for healthcare providers.
- **An RCM Manager or Supervisor**, who is responsible for managing the billing and collections team and is familiar with all functions of the roles that are involved with the team.

Billing Remains with Individual Local EI Programs

The fourth, and our least recommended billing model for the BWEIP, would be for the state to mandate Local EI programs process and submit their own private insurance claims.

In this scenario, the state would still need to make significant changes to its BTOTS system to accommodate the additional data needed, Local EI programs would shoulder the responsibility of procuring an EHR/PMS and hiring staff to conduct billing and claiming activities. This would be a complex undertaking and would see each program adopting their own practices for billing private insurance, in addition to FFS billing of Medicaid, rather than the simpler bundled Medicaid billing that they do today. This would be a significant cost to Local EI programs, and though the state could reimburse programs (through additional appropriations or other mechanisms that would need to be identified) for the systems and staff required, it would still leave room for significant additional administrative burden for both the EI programs and the state.

Local EI programs will likely exhibit significant differences in their ability to bill private insurance and Medicaid efficiently and effectively on a fee-for-service basis, leaving it unlikely that the state would be maximizing revenues from revenue sources. To comply with federal payor of last resort requirements BWEIP would be required to track and monitor all revenue received from private insurance and Medicaid billing by Local EI programs.

LEGISLATIVE AND OTHER CONSIDERATIONS

State Statute Considerations

Twelve states reported that they have insurance legislation regarding mandated coverage of early intervention services, and one state is considering adding statutory language.

State legislative health insurance mandates are sometimes passed to ensure that health plans operating in the state cover certain benefits. Accountability for coverage comes from a state's health insurance regulatory agency, which for Utah is the Utah Insurance Department. A statute requiring a benefit for early intervention services would mean that private health insurance plans doing business in Utah would be required to include early intervention as a covered benefit.

It should be noted that state mandates do not apply to self-insured group health plans in the state since self-insured plans are regulated under federal law (ERISA) rather than state law. In a rather unintuitive description, non-ERISA plans **can** be regulated by state law, while ERISA plans **cannot.**

IDEA Part C services are considered "medically necessary" by Medicaid, as the public health insurance plan for a significant percentage of young children that receive early intervention services through BWEIP. Therefore, a strong argument can be made that IDEA Part C services are medically necessary under private health insurance plans.

Statutory language can also address co-pays, deductibles and yearly and lifetime caps. Out-of-pocket expenses for families enrolled in early intervention have to be addressed in the state's early intervention 'System of Payments' policy, in accordance with the federal IDEA Part C regulation Sec. 303.521 System of payments and fees

- The statute can stipulate that families receiving early intervention through BWEIP will not be charged a ***co-payment*.** For example, if the usual and customary fee for the early intervention service is say $100.00 and the co-pay on the family's health plan is $15.00 the BWEIP would receive $85.00 reimbursement from the health plan – but would not collect the $15.00 from the family. In effect IDEA Part C funds and/or state funds are used to pay the co-payment on behalf of the family to the local early intervention program.
- The state can also include that families receiving early intervention through BWEIP will not be charged if they have not met the ***deductible*** on their health plan. For example, if the family has a $1,500 deductible, BWEIP would submit claims to the health insurance plan, but would not receive any reimbursement from them until the deductible was met. and BWEIP would not collect payments from the family for the early intervention service they receive.
- State statutes also can require insurers to exempt early intervention claims from **prior authorization** requirements or streamline them. IDEA Part C systems typically apply a TL modifier to an individual claim's CPT/HCPCS code to indicate to the insurance plan that this is an early intervention claim and for it to be handled accordingly, whether bypassing prior-authorization requirements as stated by law, or through different means of verification. As an example, some IDEA Part C programs require Primary Care Physician approval of a child's IFSP with the inclusion of an ICD-10 diagnosis. In this case, the IFSP can be submitted to the insurer as evidence of a "prescription" from a qualified medical professional and should suffice as evidence to obtain prior authorization from the insurer.
- While the Affordable Care Act (ACA) prohibits health insurance plans from imposing yearly or lifetime caps on essential health benefits, a statute mandating coverage of early intervention

services by private health plans can ensure that no yearly or lifetime caps are applied to IDEA Part C early intervention services. Seven states have stated that IDEA Part C early intervention services are included in their state's definition of essential benefits under the ACA.

Several states include an annual cap on the amount of funding for IDEA Part C early intervention services that a health insurance company would have to pay for a child and family. These annual caps range from $5,000 to $7,838 and were often included by states in order to increase the chance that the legislation would pass. Some states have subsequently eliminated the yearly cap. Fifteen states have indicated there was no cap on the amount the insurance company will pay on an annual basis.

Medicaid FFS Requirements

Utah Medicaid has confirmed that if BWEIP decides to bill private insurance on an fee-for-service (FFS) basis, then Medicaid early intervention claims must also be *required* to bill on an FFS basis. This means BWEIP would no longer be able bill Medicaid for early intervention services under the current bundled rate. Additional considerations on billing Medicaid on a FFS basis are discussed below.

Medicaid utilizes the Utah Health Information Network (UHIN), an internet-based system that can be used to interface between a medical billing system and UHINet, UHIN's internal portal. It can also be used to directly type in claims, eligibility inquiries, exchange administrative messages (i.e., claims, remits, claim attachments). UHIN is the receiving point for Medicaid health care transactions, and transactions sent to Medicaid via UHIN are immediately placed in the MMIS for processing during the next claim cycle.

If providers use software other than UHIN, it must be compatible with UHIN and conform to ANSI standards. Software vendors can advise the systems which use the ANSI standards in compliance with HIPAA and UHIN requirements.

Prior Authorization

BWEIP should collaborate with Utah Medicaid to develop service definitions/standards that define the scope of EI services, including that the IFSP shall count in lieu of obtaining prior authorization. This document can also define the services to be included under EI and those that would remain under their regular Medicaid card as well as the codes and modifiers to be used.

In the case that Medicaid could still require prior authorization, the provider must complete a current copy of the appropriate prior authorization request form and submit it, with all required documentation, to the Prior Authorization Unit at the Division of Integrated Healthcare. The appropriate forms are found at https://medicaid.utah.gov/prior-authorization, "General PA Forms or Pharmacy Criteria Forms."

Requirement to Enroll with Medicaid

All early intervention specialists will need to apply for a National Provider Identifier (NPI) number by following these instructions from CMS: How_to_apply_for_an_NPI_online (hhs.gov)

Once an NPI is assigned to a provider, they can begin the process to enroll with Medicaid online at: https://idhelp.utah.gov/ or by filling out paper forms at https://medicaid.utah.gov/provider-enrollment-forms/ and faxing them to the appropriate number.

Other Health Insurance Billing Models

Capitation Model (utilized in Nevada's early intervention program):

- In a capitation model, healthcare providers receive a fixed payment per patient, per period (typically monthly or annually), regardless of the services rendered. The payment covers a defined set of services for a specific population. Providers assume the financial risk for delivering necessary care within the fixed payment amount.

Pay-for-Performance Model (P4P):

- Pay-for-performance models tie reimbursement to specific quality metrics or outcomes. Healthcare providers receive financial incentives or penalties based on predefined performance measures, such as patient satisfaction, adherence to clinical guidelines, or health outcomes. It is unknown if any state early intervention utilizes this model.

Episode-of-Care Model:

- In an episode-of-care model, a single payment is made to cover all services related to a specific episode of care. An episode of care refers to a specific period during which a patient receives continuous medical treatment, services, and attention for a particular health condition or set of related conditions within a defined time frame. This model aims to incentivize coordination and efficiency among providers involved in the episode. This can be used to fund all the services and activities involved in the initial multidisciplinary developmental evaluation to determine a child's eligibility for IDEA Part C.

Shared Savings Model:

- Shared savings models promote cost savings by rewarding healthcare providers for achieving reductions in healthcare spending while maintaining or improving the quality of care. Providers receive a portion of the savings achieved when they deliver care below a predetermined spending target.

Global Payment Model

- In a global payment model (also known as a global budget or global cap), healthcare providers receive a fixed, predetermined budget to cover the healthcare needs of a defined population over a specific period. Providers are responsible for managing the budget and delivering care within that financial constraint.

BTOTS SYSTEM CHANGES

In addition to procuring an EHR and practice management system or outsourcing the billing functions to an EI-tailored vendor, BWEIP would need to make additional investments into the Baby and Toddler Online Tracking System (BTOTS) case management database.

PCG used rough estimations of what the costs may be in terms of developer hours and rates for implementing these changes. BWEIP would need to obtain a cost estimate from their BTOTS vendor for these changes.

PCG recommends the following new fields, processes, and/or APIs (Application Programming Interface) i.e. for the transfer of data, to be developed in the BTOTS database:

- Insurance Information Screen, including fields for:
  - Insurance company name
  - Member ID
  - Group Number
  - Eligibility beginning and end dates
  - An indicator to whether the insurance is active or inactive
  - Indicator whether the insurance is the primary, secondary, or tertiary insurer
  - Confirmation of authorization to bill insurance
  - Pre-authorization information
- Additional fields relating to the service provided, including:
  - ICD-10 codes / diagnosis codes for eligible children
  - Rendering provider
  - CPT codes
  - Program NPI
  - A mechanism for voiding/correcting a service already entered
- Lastly, an API would need to be developed for BTOTS that can engage with the EHR/PMS that BWEIP would ultimately need to procure.

REVENUE MODEL

MEDICAID

If BWEIP decides to move to a fee-for-service model in billing for early intervention claims to private health insurance plans, the program has been informed by the state Medicaid agency that claims to Medicaid would also then be required to adopt FFS billing for Medicaid claims. The current bundled rate for early intervention services under Medicaid utilizing CPT code T1024, would no longer be used for claims. Therefore, to justify any programmatic change in billing, Medicaid revenues *must* be equal or greater than what is currently recouped by Local EI programs using the bundled rate.

PCG worked with Utah's Medicaid program throughout this project and identified a list of appropriate CPT codes that could be billed for the range of EI services. The most critical of these would be related to delivery of special instruction, case management, and evaluations, which would be the largest value service types for BWEIP, so securing Medicaid's complete assurances that they would reimburse on the recommended CPT codes is required in any change to the current billing model. In developing the following revenue estimates for claiming to Medicaid on a FFS billing schedule, PCG used CPT/HCPCS codes that were tentatively found to be appropriate for billing by Medicaid; however, further discussions and planning with Medicaid policy officials will be needed to ensure that Medicaid will reimburse for early intervention service utilizing the codes that they recommended.

To build the model, PCG started with the total number of service instances that were logged in BTOTS* - inclusive of both Medicaid and state-paid children - and multiplied them by four to get an estimated number of 15-minute increments that were logged, using the logic that one service instance is approximately one hour. The 15-minute increments are used since the majority of CPT codes are established as 15-minute units. In the case where a code is timed at 30 minutes or per occurrence, the number of units were adjusted accordingly in the calculations. Below is the list of EI service volumes logged in BTOTS for state fiscal year 2022.

*Currently BTOTs does not collect data of the length of time for the EI visit, only that the visit (instance) took place.

TABLE 4. SFY 2022 EI SERVICE VOLUMES

EI Service	Instances	Est. 15 Min Units
Psychological	3	12
Nutrition	319	1,276
Social Work	645	2,580
Nursing	1,767	7,068
Family Training	2,142	8,568
Service Coordination	13,713	54,852
Occupational Therapy	17,372	69,488

EI Service	Instances	Est. 15 Min Units
Physical Therapy	17,777	71,108
Speech-Language Pathology	26,210	104,840
Non-IFSP Service Visit	64,332	257,328
Special Instruction	66,152	264,608

Once we determined the total estimated units for each of the early intervention service, we applied them to the following estimation model, which provides suggested CPT codes for each EI service, and the rate for which Medicaid reimburses for claims utilizing those codes. Using data PCG has from managing EI billing operations in other states, PCG applied an estimated percentage of how many claims each CPT code would be billed under each EI service. In order to calculate the number of claims that would be billed to Medicaid we used the percentage of BWEIP eligible children that are enrolled in Medicaid, which is 38.8% (note that this does assume Medicaid and privately insured children receive the same quantity of services, which is not always the case). The calculation also assumes an estimated a 95% payment rate (this is a *highly* conservative estimate) to the units paid and multiplied them by the published Medicaid rate (as of June 2023).

TABLE 5. ESTIMATED MEDICAID RECOUPMENTS BY CPT CODE

Service Type	CPT Codes	% of CPT Codes Paid	# 15 Min Units (or Instances)	Medicaid Units	Estimated Paid Units	UT Medicaid Rate	Unit	UT Medicaid Total Recoup
Occupational Therapy	97530	93.7%	65,140	25,274	24,011	33.18	15 Min	**$796,671.01**
Occupational Therapy	97535	4.3%	1,482	575	546	90.73	30 Min	**$49,561.76**
Occupational Therapy	97165	0.9%	604	235	223	24.88	15 Min	**$5,542.91**
Occupational Therapy	Others*	1.0%	695	270	256	N/A	N/A	**$8,517.76**
Speech Therapy	92507	98.2%	25,742	9,988	9,489	58.52	Instance	**$555,275.34**
Speech Therapy	92526	1.0%	266	103	98	64.78	Instance	**$6,356.57**
Speech Therapy	92523	0.5%	143	55	53	173.3	Instance	**$9,104.60**
Speech Therapy	Others*	0.2%	58	22	21	N/A	N/A	**$1,255.62**
Physical Therapy	97530	84.1%	59,832	23,215	22,054	33.18	15 Min	**$731,757.64**
Physical Therapy	97112	6.2%	4,414	1,713	1,627	30.71	15 Min	**$49,966.62**
Physical Therapy	97110	6.2%	4,379	1,699	1,614	26.49	15 Min	**$42,757.31**
Physical Therapy	Others*	3.5%	2,489	966	917	N/A	N/A	**$28,856.85**

Service Type	CPT Codes	% of CPT Codes Paid	# 15 Min Units (or Instances)	Medicaid Units	Estimated Paid Units	UT Medicaid Rate	Unit	UT Medicaid Total Recoup
Special Instruction	H2014	100.0%	264,608	102,668	97,535	18.28	15 Mins	**$1,782,930.82**
Social Work	96156	0.0%	-	-		73.97	Instance	**$0.00**
Nutrition	97802	14.3%	46	18	17	27.78	Instance	**$468.55**
Nutrition	97803	85.7%	273	106	101	24.14	Instance	**$2,431.30**
Psychological	90837	57.7%	2	1	1	145.07	Instance	**$92.60**
Psychological	90791	41.8%	5	2	2	39.89	15 Min	**$73.83**
							Total	**$ 4,071,621.10**

*There are numerous other CPT codes used under each of the service types, in the cases where we listed “others” under the CPT code column, we have consolidated the additional, but less commonly used, CPT codes from PCG’s billing data.

An important note regarding special instruction claims is that our recommended CPT/HCPCS code H2014 reimburses for $18.28 for every 15 minutes, which is very close to the rate PCG recommended in its 2021 cost study for special instruction which is $18.71 / 15 mins.

Medicaid will also reimburse for other early intervention services such as service coordination (case management), participation in IFSP development and evaluation and assessment to determine the child’s eligibility for early intervention and their ongoing developmental needs. The following calculations were made using the estimated number of Medicaid-enrolled children BWEIP serves in a year, or in the case of case management, the estimated number of children at any point in time being served by the program.

TABLE 6. NON-THERAPY MEDICAID REVENUE AND TOTAL MEDICAID RECOUPMENT

Non-Therapy Services	#	Rate	$ Totals
Total Number of Initial Evals	2849.47	$251.98	$718,009.95
Total Number of Ongoing Evals	712.37	$251.98	$179,502.49
IFSP Annuals	631.28	$18.37	$11,596.54
IFSP 6 months	1267.98	$18.37	$23,292.87
Case Management	1790.23	$207.96	$4,467,559.76
Case Management, IFSP development, Evaluation & Assessment Revenue			$5,399,961.61
EI Services Revenue			$4,071,621.10

Non-Therapy Services	#	Rate	$ Totals
Potential Total FFS Medicaid Revenue			**$9,471,582.71**

When estimates from the case management, IFSP development and evaluation and assessments are added to the other EI services, it is estimated that BWEIP could *potentially* recoup approximately $9.5 million from Medicaid based on the assumptions that have been laid out above utilizing an FFS billing model. It is important to keep in mind that this total FFS Medicaid Revenue is based on children only having Medicaid and no private insurance. If the child has both private insurance and Medicaid, the private insurance should always be billed first. We should also note that there was an extension of Medicaid eligibility that was in place during the FY22 period, has also ended, and BWEIP may see a decrease in Medicaid-enrolled children going forward.

PRIVATE INSURANCE

To estimate the total revenue that BWEIP could realize from claims to private health insurance, PCG received rate schedules from a number of private insurance plans that operate in Utah and calculated an average rate by CPT code from the schedules we received. Similarly, to the calculations for Medicaid, the total service volume logged in BTOTS were used as the base volume of units by CPT codes in this model, in addition to the application of CPT code proportions under each service type. Total units were then multiplied by the estimated proportion of children who are not enrolled with Medicaid (66.3%). PCG then applied an estimated payment rate using data from other states' billing for private insurance, which ranged from 30%-34% by EI service (this is a highly conservative estimate*). The final total of units/instances were then multiplied by the average reimbursement rates by CPT code that private insurance plans provided to PCG in addition to confirming that they would be covered under their plans.

*This payment rate would increase if Utah decides to enact insurance legislation that requires that private health insurance plans reimburse for EI services provided to their members

TABLE 7. ESTIMATED PRIVATE INSURANCE REVENUES

Service Type	CPT Codes	% of CPT Codes Paid	# 15 Min Units (or Instances)	Units Excluding Gov't Plans	Paid Units Est.	Unit	Est. Insurance Rate	Est. Private Insurance Totals
Occupational Therapy	97530	93.7%	65,140	43,188	13,820	15 Min	$36.66	**$506,604.94**
Occupational Therapy	97535	4.3%	1,482	983	314	30 Min	$32.49	**$10,214.46**
Occupational Therapy	97165	0.9%	604	401	128	15 Min	$100.22	**$12,851.58**
Occupational Therapy	Others	1.0%	695	461	147	N/A		**$5,296.71**
Speech Therapy	92507	98.2%	25,742	17,067	5,803	Instance	$94.95	**$550,988.69**
Speech Therapy	92526	1.0%	266	176	60	Instance	$105.12	**$6,308.10**

Service Type	CPT Codes	% of CPT Codes Paid	# 15 Min Units (or Instances)	Units Excluding Gov't Plans	Paid Units Est.	Unit	Est. Insurance Rate	Est. Private Insurance Totals
Speech Therapy	92523	0.5%	143	94	32	Instance	$281.19	**$9,034.31**
Speech Therapy	Others	0.2%	58	38	13	N/A		**$1,245.93**
Physical Therapy	97530	84.1%	59,832	39,669	13,487	15 Min	$36.66	**$494,409.28**
Physical Therapy	97112	6.2%	4,414	2,927	995	15 Min	$33.92	**$33,750.08**
Physical Therapy	97110	6.2%	4,379	2,903	987	15 Min	$29.26	**$28,885.66**
Physical Therapy	Others	3.5%	2,489	1,650	561	N/A		**$19,496.58**
Development Therapy (Special Instruction)	97130	75.0%	198,456	131,576	34,210	15 Min	$22.25	**$761,315.67**
Development Therapy (Special Instruction)	97129	25.0%	66,152	43,859	11,403	15 Min	$22.95	**$261,737.90**
Social Work	96156	100.0%	645	428	128	Instance	$132.46	**$16,992.99**
Nutrition	97802	14.3%	46	30	9	Instance	$36.26	**$330.05**
Nutrition	97803	85.7%	1,093	725	217	15 Min	$31.52	**$6,852.47**
Psychological	90837	57.7%	2	1	0	Instance	$139.02	**$47.88**
Psychological	90791	41.8%	5	3	1	15 Min	$196.22	**$195.98**
							Total	**$2,726,559.26**

As with Medicaid, identifying the most appropriate CPT code for billing special instruction services to private insurance will be critical to the success of an FFS model for BWEIP. Although the insurers PCG was able to engage with indicated the CPT codes 97130 and 97129 are covered under their plans, claims for these services will require additional documentation and information on what is conducted during these services than is being collected today. Based on these and previously stated assumptions, it is estimated that BWEIP could realize $2.7 million in additional revenue per year by billing private health insurance.

It should be noted that in order to bill private health insurance plans, BWEIP will need to facilitate individual local programs to get credentialed and in-network with each major private insurer in the state.

COSTS TO ESTABLISH BILLING OFFICE(S)

STATEWIDE CENTRALIZED BILLING

In the System Management section of this report, PCG detailed the four most viable programmatic changes to the BWEIP that could accommodate a fee-for-service billing structure in Utah. An important early decision is whether to centralize billing activities within BWEIP or to mandate local programs to implement their own systems and conduct billing activities on their own, which as stated earlier would likely impose a significant administrative burden on Local EI programs (see next section). This section of the report looks at the costs to implement the three models that fall under the centralized billing/finance office structure:

1) Revenue Cycle - EHR Vendor
2) In-House Billing Office
3) EI Central Finance Contractor

Estimated Initial Set-Up Costs

Regardless of which of the "centralized billing/finance office" models is chosen, BTOTS will require enhancements to accommodate the data elements and processes to capture the information needed to build and submit FFS claims. These estimates are based on $100 per hour of contracted developer time for each of the cost categories that are listed below, generally taking about 40 or 80 hours of work per category. As noted earlier, BWEIP will need to determine a more accurate estimation for these enhancements with the BTOTS vendor.

The following are assumptions for the costs below for the set up in order to do fee-for-service billing and claiming:

1) In an outsourced revenue cycle management model with a generic EHR vendor, BWEIP would only need to purchase the licenses necessary and any associated start up fees for implementation, while also hiring a billing manager to coordinate with the vendor on an ongoing basis.
2) If BWEIP manages the billing and claiming entirely within the program with state staff, it would still require these expenditures in addition to the procurement of a practice management system for claim generation and contracting with a claims clearinghouse.
3) With a specialized EI Central Finance Office (CFO) contractor there would likely be a set up fee, but all other costs would be assumed by the vendor.

In all of these models, training and banking setup will take similar amounts of effort and cost.

Lastly, it should be noted that in the shift to FFS, receivables for claims submitted take approximately three months to be processed by private insurance plans, which would create a delay in cash flow to local programs if a pay-and-chase model is not adopted (see earlier section of this report). This issue has been accounted for as a "special payment" to programs, providing them three months of their average revenue in advance to cover the time until claims are fully adjudicated. These payments would be recouped over a period of approximately three months by the state or EI CFO, so they would not be an additional expense for BWEIP.

TABLE 8. ESTIMATED COSTS TO ESTABLISH CENTRALIZED BILLING FOR BWEIP

	Cost Category	Outsourced Rev Cycle (EHR Vendor)	In-House Billing	EI Central Finance Office
BTOTS System	BTOTS Private Insurance Info Page	$4,000	$4,000	$4,000
	BTOTS Service Provision Enhancements	$4,000	$4,000	$4,000
	BTOTS Primary Care Physician Approval	$4,000	$4,000	$4,000
	BTOTS ICD-10 and CPT Code Business Rules	$8,000	$8,000	$8,000
	BTOTS API/CSV Export to Medical Claims System	$8,000	$8,000	$8,000
Generic EHR	Per Entity Per Month (Annual, 14 Programs)	$134,400	$134,400	
	Set Up Fees	$30,000	$30,000	
	Practice Management System (Claim Generator)		$2,000	
EI Central Finance Office	Early Intervention Billing System Set Up			$150,000
Clearing House	Claims Clearinghouse Services (Set Up)		$5,000	$5,000
Staff	UT Employed Billers	$65,000	$65,000	
Misc.	Escrow Account Setup and Management	$1,685	$1,685	$1,685
Training	Provider and State Training (3 Months, 0.5 FTE)	$18,000	$18,000	$18,000
	User Manuals/Billing Rule Documentation (1 Month, 1 FTE)	$12,000	$12,000	$12,000
	Total	**$289,085**	**$296,085**	**$214,685**
	Post Go-Live Payments to Cover Transition Costs (Special Payments)	**$3,525,000**	**$3,525,000**	**$3,525,000**

Estimated Ongoing Costs

Ongoing costs for both model 1) Revenue Cycle - EHR Vendor and model 2) In-House Billing Office the annual licenses/fees for the EHR system would be required. Based upon previous experience and consultation with other subject matter experts within PCG's Health Practice Area, which uses a number of generic EHR systems, outsourcing revenue cycle management typically comes at a cost of around 5%-6% of total recoupments the vendor is able to make. EHR costs do not apply to model 3) EI Central Finance Vendor.

The ongoing costs and operational activities provided here for an EI CFO vendor are based on how PCG or other contractors charge for these services at a fixed fee rate; however, in some contracts pricing can be set up as a percentage of recoupments similar to an EHR vendor. An EI CFO vendor may also have a helpdesk/support center to work with Local EI programs in managing the claim data that are submitted.

In the outsourced revenue cycle management model, PCG has estimated BWEIP would still need to employ two staff to provide oversight of the EHR vendor and support for the local programs (coding, claims correction, etc.).

In the fully in-house model within BWEIP, PCG estimates they would need to employ five FTE (full time equivalents) to perform the billing and claiming operations with Medicaid and private health plans for the state. The roles for those staff are detailed in the System Management subsection of this report.

TABLE 9. ANNUAL ONGOING COSTS FOR BWEIP CENTRALIZED BILLING

	Cost Category	Outsourced Rev Cycle (EHR Vendor)	In-House Billing	EI Central Finance Office
EHR	Per Entity Per Month (Annual, 14 Programs)	$134,400	$134,400	
	EHR Rev Cycle Mgmt. (6%)	$649,811		
	Practice Management System (Claim Generator)		$15,000	
EI Central Finance Office	Early Intervention Billing System Annual			$175,000
	Manage EDI for inbound/outbound service auth/claims			$30,940
	Monthly data transaction for eligibility			$30,940
	Payments to providers, loading files for ACH payment			$2,080
	Payments to families for travel costs, loading files for ACH payment			$2,080
	Banking - Payment to providers, lockbox			$17,550
	Claims Fund Source Reconciliation			$8,775
	Family EOB Submission			$8,775
	General Support Activities			$15,470
	1099 Processing		$300	$300
Clearing House UT Staff	Enhancement Hours Bucket	$10,000		$20,000
	Claims Clearinghouse Services		$36,000	$36,000
	UT Employed Billers	$208,000	$520,000	
Training	Training / Provider Support / Call Center			$322,000
Misc.	Escrow Account Management	$1,685	$1,685	$1,685
	Total Annual Ongoing Costs	**$1,003,896**	**$707,385**	**$671,595**

BILLING MANAGED BY LOCAL PROGRAMS

In the path alternative to centralizing billing and claiming in Utah, local programs could shoulder the burden of billing and claiming EI claims to Medicaid and private insurance plans. In this instance, stand up costs to the Lead Agency would still be related to BTOTS enhancements and covering the first three months of local program revenue in advance. Stand up costs to local programs in this case would be related to the procurement of an EHR, hiring their own billing staff, and covering training needs. Ongoing costs would generally affect local programs rather than the Lead Agency. As noted in the System Management subsection, PCG does not recommend moving forward with this model.

TABLE 10. COSTS OF LOCAL PROGRAMS MANAGING BILLING AND CLAIMING

Cost Category	Stand Up Costs	Ongoing Costs
BTOTS Commercial Insurance Info Page	$4,000	
BTOTS Service Provision Enhancements	$4,000	
BTOTS Primary Care Physician Approval	$4,000	
BTOTS ICD-10 and CPT Code Business Rules	$8,000	
BTOTS API/CSV Export to Medical Claims System	$8,000	
Costs to Lead Agency	**$28,000**	
Post Go-Live Payments to Cover Transition Costs	**$3,525,000**	
EHR System Costs	$9,600	$9,600
Set Up Fees/Consultation	$2,500	$2,500
EHR Rev Cycle Mgmt. (6% Recoupments)		$3,741
Billing Staff Costs	$50,000	$50,000
Program Training and Billing Manuals	$5,000	
Costs to Local Program(s)	**$67,100**	**$65,841**

RETURN ON INVESTMENT TO ADOPT FEE-FOR-SERVICE MODEL

When comparing estimated revenues to costs, PCG reviewed the three models under a centralized billing system in Utah. In all cases, BWEIP would not realize a return on its investment until Year 2 after implementation and would not see more significant cumulative returns until Years 4 and 5. For each option PCG has added to the model an inflation factor, a factor for revenue increasing year-over-year, and a ramp up of Medicaid and private insurance revenues during the first two years of operation. Note that the latter-mentioned ramp-up is assuming that it will take two years for billing and claiming activities to be fully accurate and begin recouping the maximum expected revenue. These factors are noted in the table below.

TABLE 11. ROI COST AND REVENUE FACTORS

Cost and Revenue Factors	
Projected Inflation	3%
Revenue Increase Factor	3%
ME Revenue Start-Up Y1	85%
ME Revenue Start-Up Y2	90%
CI Revenue Start-Up Y1	70%
CI Revenue Start-Up Y2	85%

With the above factors applied, PCG calculated the point where BWEIP could recoup the total amount invested in implementation and surpassed total program revenues as of the implementation year, which would be the return on investment for this initiative. Based on the assumptions that have been noted to this point, PCG found that the model with the highest ROI five years after system implementation would be outsourcing the process to an EI CFO, with BWEIP taking on all billing and claiming activities as a close second.

TABLE 12. ROI FOR EHR WITH OUTSOURCED REVENUE CYCLE MANAGEMENT

Year	Costs	Medicaid Rev	Commercial Rev	Current Medicaid	New Revenue	Ongoing Revenue	Ongoing Costs	ROI	% Return
0	$289,085.00	$0.00	$0.00	$9,500,000.00	$0.00	$0.00	$289,085.00	-$289,085.00	-100%
1	$1,003,896.18	$8,050,845.31	$1,908,591.48	$9,500,000.00	$459,436.79	$459,436.79	$1,292,981.18	-$833,544.40	-64%
2	$1,034,013.07	$8,524,424.44	$2,317,575.37	$9,500,000.00	$1,341,999.81	$1,801,436.60	$2,326,994.25	-$525,557.65	-23%
3	$1,065,033.46	$9,471,582.71	$2,726,559.26	$9,500,000.00	$2,698,141.97	$4,499,578.57	$3,392,027.71	$1,107,550.86	33%
4	$1,096,984.47	$9,755,730.20	$2,808,356.04	$9,500,000.00	$3,064,086.23	$7,563,664.80	$4,489,012.18	$3,074,652.62	68%
5	$1,129,894.00	$10,048,402.10	$2,892,606.72	$9,500,000.00	$3,441,008.82	**$11,004,673.62**	**$5,618,906.18**	**$5,385,767.44**	**96%**

Table 13. ROI for BWEIP In-House Billing Team

Year	Costs	Medicaid Rev	Commercial Rev	Current Medicaid	New Revenue	Ongoing Revenue	Ongoing Costs	ROI	% Return
0	$296,085.00	$0.00	$0.00	$9,500,000.00	$0.00	$0.00	$296,085.00	-$296,085.00	-100%
1	$707,385.00	$8,050,845.31	$1,908,591.48	$9,500,000.00	$459,436.79	$459,436.79	$1,003,470.00	-$544,033.21	-54%
2	$728,606.55	$8,524,424.44	$2,317,575.37	$9,500,000.00	$1,341,999.81	$1,801,436.60	$1,732,076.55	$69,360.05	4%
3	$750,464.75	$9,471,582.71	$2,726,559.26	$9,500,000.00	$2,698,141.97	$4,499,578.57	$2,482,541.30	$2,017,037.28	81%
4	$772,978.69	$9,755,730.20	$2,808,356.04	$9,500,000.00	$3,064,086.23	$7,563,664.80	$3,255,519.99	$4,308,144.82	132%
5	$796,168.05	$10,048,402.10	$2,892,606.72	$9,500,000.00	$3,441,008.82	**$11,004,673.62**	**$4,051,688.03**	**$6,952,985.59**	**172%**

Table 14. ROI for EI Central Finance Office

Year	Costs	Medicaid Rev	Commercial Rev	Current Medicaid	New Revenue	Ongoing Revenue	Ongoing Costs	ROI	% Return
0	$214,685.00	$0.00	$0.00	$9,500,000.00	$0.00	$0.00	$214,685.00	-$214,685.00	-100%
1	$671,595.00	$8,050,845.31	$1,908,591.48	$9,500,000.00	$459,436.79	$459,436.79	$886,280.00	-$426,843.21	-48%
2	$671,595.00	$8,524,424.44	$2,317,575.37	$9,500,000.00	$1,341,999.81	$1,801,436.60	$1,557,875.00	$243,561.60	16%
3	$671,595.00	$9,471,582.71	$2,726,559.26	$9,500,000.00	$2,698,141.97	$4,499,578.57	$2,229,470.00	$2,270,108.57	102%
4	$671,595.00	$9,755,730.20	$2,808,356.04	$9,500,000.00	$3,064,086.23	$7,563,664.80	$2,901,065.00	$4,662,599.80	161%
5	$671,595.00	$10,048,402.10	$2,892,606.72	$9,500,000.00	$3,441,008.82	**$11,004,673.62**	**$3,572,660.00**	**$7,432,013.62**	**208%**

OTHER CONSIDERATIONS

Consider additional forms of 1915(i) State Plan Amendments or 1915(b) and Medicaid Waivers that could be used to target children and develop a coordinated set of services.

The Medicaid program is comprised of a State Plan and various Medicaid Waivers. A State Plan is a document that serves as an official agreement between the federal government and the State to administer the Medicaid program (Title XIX).

Section 6086 of the Deficit Reduction Act of 2005 (DRA) added section 1915(I) to the Social Security Act, which is similar to what is provided through 1915(c) HCBS waivers. The significant difference, however, is that a 1915(i) does not require an individual to meet an institutional level of care in order to qualify for HCBS (i.e., at risk of institutionalization is a requirement for the waivers). States can apply for this option to offer services and supports before individuals need institutional care, and also creating a mechanism to provide these supports and services for qualifying individuals.

An August 2010 State Medicaid Director Letter (SMDL#10-015; ACA#6) describes some changes made to the 1915(i) section made by the Affordable Care Act (ACA).

In addition to a State Plan, a state can ask the federal government for opportunities to test new or existing ways to deliver and pay for health care services that require some flexibility to waive certain Title XIX requirements – these are called Medicaid Waivers. There are four primary types of waivers and demonstration projects:

- **Section 1115 Research & Demonstration Projects:** States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- **Section 1915(b) Managed Care Waivers:** States can apply for waivers to provide services through managed care delivery systems or otherwise limit people's choice of providers.
- **Section 1915(c) Home and Community-Based Services Waivers:** States can apply for waivers to provide long-term care services in home and community settings.
- **Concurrent Section 1915(b) and 1915(c) Waivers:** States can apply to simultaneously implement two types of waivers to provide a continuum of services to the elderly.

The 1915(c) waivers allow the provision of long-term care services in home and community-based settings. CMS allows for states to "offer a variety of services under an HCBS Waiver program." Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e., supports and service coordination), homemaker, home health aide, personal care, and respite care. States can also propose 'other' types of services that may assist in diverting individuals from institutional settings.

- Utah should consider implementing a Medicaid waiver for young children. A number of states have implemented 1915(c) Medicaid Waivers that Utah can learn from. Many 1915(c) Medicaid Waivers are used to provide home and community-based services for the developmentally and physically disabled populations, but there is growing use of these waivers for children with early childhood mental health/behavioral health needs. Louisiana's Coordinated System of Care Waiver offers good model language for Utah's consideration.

1915(c) Medicaid waivers can provide Utah the flexibility to design a Medicaid program that meets the

specific needs of the child population.

Work tasks associated with this consideration include:

1. Identify a special population.
2. Identify related costs to BWEIP and other Medicaid programs.
3. Review other states with waivers for similar populations and review Utah's existing waivers.
4. Interview Utah DHHS staff, providers, and other community groups about service gaps for the specified special populations
5. Explore waiver development
    a. Identify the waivers that must be requested
        i. "State wideness"
        ii. "Comparability"
        iii. Income and resource requirements
    b. Define the waiver program
        i. Eligibility requirements
        ii. Services to be offered under the waiver
        iii. Types of providers under the waiver
        iv. Licensure and certification standards for each type of provider
        v. Level of care requirements
        vi. Geographic areas under the waiver
        vii. Recipient appeal rights if the desired service is not offered
    c. Determine methods that will be used to satisfy CMS procedural requirements
        i. Methods of informing recipients about waiver services
        ii. Evaluating recipients' needs
        iii. Documenting level of care
        iv. Developing plans of care
        v. Post-eligibility treatment of income and resources (applying excess income to the cost of waiver services)
        vi. Independent assessments (often waived)
        vii. Annual reports
        viii. Quality assurance and standards enforcement
        ix. Audits (i.e., may be covered through single state audit)
    d. Determine the cost and impact of the waiver program
        i. Projected caseloads
        ii. Utilization of waiver and non-waiver services
        iii. Average per capita costs
        iv. Room and board exclusion
6. Prepare a written report with findings and recommendations for implementation

As an additional note, parental refusal to participate in medical assistance programs should be addressed through targeted awareness and information activities, as parental refusal is often based on under-informed decision-making. A comprehensive training and communication effort aimed at parents of qualifying children related to increasing medical assistance participation can further alleviate burden on state funds

APPENDICES

APPENDIX A. LEADING ELECTRONIC HEALTH RECORD (EHR) AND BILLING SYSTEMS

TABLE 2. LIST OF GENERIC EHR AND BILLING SYSTEMS

Company Name	Website	Headquarters
AdvancedMD	https://www.advancedmd.com	South Jordan, Utah
Agilian	https://www.agilian.com/	Washington, DC
Allscripts Healthcare Solutions	https://www.allscripts.com/	Chicago, Illinois
Athena Health	https://www.athenahealth.com	Watertown, Massachusetts
Cerner Corporation	https://www.cerner.com/	Kansas City, Missouri
CureMD	https://www.curemd.com/	New York City, NY
DrChrono	https://www.drchrono.com/	Sunnyvale, California
eClinicalWorks	https://www.eclinicalworks.com/	Westborough, Massachusetts
Epic Systems	https://www.epic.com/software	Verona, Wisconsin
GE Healthcare	https://www.gehealthcare.com	Chicago, Illinois
Kareo Billing	https://www.kareo.com/	Irvine, California
McKesson Corporation	https://www.ontada.com/Providers-Solutions/iKnowMed/	Irving, Texas
MEDITECH	https://ehr.meditech.com/	Westwood, Massachusetts
NextGen Healthcare	https://www.nextgen.com/	Irvine, California

APPENDIX B. ICD-10 CODES UTILIZED IN EI

TABLE 3. COMMON ICD-10 CODES UTILIZED IN EARLY INTERVENTION

Medicaid-Only State	Private Insurance and Medicaid State
R62.50	F80.9
F840	Z13.42
Q90.9	R62.50
H902	F82
Q03.9	F80.1
Q90	R62.0
Q909	F80.89
Q05.9	R27.8
M436	M62.81
Q02	R27.9
P942	R62.5
G91	R53.1
G919	Z13.4
H903	Q90.9
G80.9	F80.2
Q99.2	F80
Q91.3	F80.4
Q040	F88
Q211	R63.3
Q210	M43.6