Ohio Early Intervention System of Payments Frequently Asked Questions

Question	Answer
A. Purpose	
How does this rule impact EI service delivery using a primary service provider approach?	This rule only addresses the system of payment for EI services and functions. EI providers are expected to continue to provide EI services using evidence based practices (including a PSP approach).
B. Definitions	
For determining EME, who is considered in the family unit? And do we need to get income for everyone in the home?	The family determines who is in the family unit. However, those identified must be living in the family home. Income is needed for every working adult identified in the family unit.
Do canceled appointments count as units?	No.
In terms of using units, what is the breakdown of partial units used? Can a provider use .5, .25, .75 at a time? Are units truly an accumulation of 60 minutes? For example, if a provider does a visit that is 40 minutes long, how is this recorded?	Early Intervention Units are measured in real time, so 40 minutes is 40 minutes. The determination of how many minutes will be provided, is determined through the IFSP process (intensity), and providers are expected to provide the service as specified in the IFSP.
How are the differences between the EI definition of "unit" and the definition(s) of "unit" in the insurance world reconciled?	EI units are defined for simplicity in tracking planned and delivered EI (IFSP) services. Insurance defined units vary by service type and even insurers. The SC is only required to track EI units provided.
Can 55 units be split between different payors? What if they are for the same service?	The IFSP process remains the same. For each service that the team determines is needed to meet an outcome, the frequency, intensity, and *funding source* is determined. Therefore, yes, different funding sources may be used for different services. However, given the evidence of effective interventions practices, only one provider of a service should be working with parents or the primary provider at any time.
Is 55 units per child or per family?	*Each eligible child* and their family during *each* IFSP year (B)(10).
Do the 55 units include consult visits that are not on the IFSP?	Any *service* that is needed to meet an outcome needs to be included in an IFSP. This includes joint visits. All of these services are factored into the unit calculation. "Team meetings" are not included in the unit calculation.
How many units is a copay? How many units is a deductible?	EI units are determined by frequency of service provision specified on an IFSP. Units are not related specifically to co-pays or deductibles.

Is there a list of items covered as assistive technology devices?	Assistive Technology (AT) in early intervention is any service or item that supports an eligible infant or toddler's ability to participate actively in his or her home, community settings, or other natural environments, and is necessary to meet an IFSP outcome. It is a broad term that includes a service or items ranging from "low tech" (such as a foam wedge for positioning or an adapted spoon) to something as "high tech" as an electronic communication device. A full definition may be found in the state and federal EI rule/regs -- http://ohioearlyintervention.org/federal-and-state-regulations
C. Provision of and payment for EI services	
If CBDD is providing services currently without a cost to parents, can the parent choose to use all 55 hours for additional services outside of the CBDD?	No. This rule establishes payment for EI services. CBDDs are part of the EI system. Services provided through other providers on the IFSP (defined in this rule) are EI services that count towards the 55 units.
C(2)(a) seems to suggest that CBDDs may choose to provide EI services in excess of 55 units, at public expense, based on its policies and strategic plan. Is this accurate?	Yes. The level of support from CBDDs for EI will continue to be a local decision and defined in board policy.
Units	
Who is paying for the 55 units that are at no cost to family?	Any of the funding sources listed in C(2)(a, b, c, and e) may be used for the first 55 units.
Funding sources	
Will the services provided by Early Head Start (EHS) through the IFSP be counted towards the 55 units?	No. While any provider may agree to provide an IFSP service and be included in the IFSP, and Early Head Start funds are federal (public), only those services funded through the funding sources listed in "C" of this rule are part of the "EI system of payments" and count toward the 55 units.
Are the EI vision and hearing state provider services included in the 55 units?	Yes; these providers are funded by the department to provide EI services.
How do Family Engagement or Family Support funds play into figuring units?	CBDD Family Support funds are NOT one of the early intervention funding sources listed in C(2). The parent/CBDD may choose to use these funds for an EI service, but there is no obligation to do so.
If there are no POLR providers in your county for your family to access does EI have an obligation to transportation - not speaking of Medicaid families but those with no car and/or gas money.	Transportation can be an EI service as defined under both state and federal regulations. See OAC 3701-8-01(CCCC). If you have questions about how this might apply in a particular situation, please contact your EI program consultant.

What happens if a claim is denied by the insurance companies?	For the first 55 units of services (for each eligible child regardless of parent's ability to pay) and for units beyond 55 (for an eligible child of a parent determined unable to pay), when an insurance plan denies a claim and there is no other publically-funded option, the state will pay the contracted provider. If a funding source changes due to a parent granting or withdrawing consent to use insurance or denial by the insurance plan, the IFSP will be reviewed and revised accordingly.
Providers: CBDD/Private providers/contractual EI providers	
Assuming a parent has been determined unable to pay and they have used their 55 units, and the CBDD is going to pay for units over 55- is there additional paperwork/documentation that the SC needs to complete?	Parents determined unable to pay will never have to pay for any services, no matter how may are needed. The SC will continue to track needed and accessed services. The only time the additional forms will need to be completed is for a POLR application.
Does this rule affect county boards of developmental disabilities billing Title XX?	No.
Will private therapy providers be considered EI providers?	As stated in (C)(5), only providers (other than county boards of developmental disabilities) who enter into an EI SOP contract with the department will be EI providers.
How are the costs of developmental specialists covered?	This interventionist is typically employed by CBDDs, and funded with CBDD public funds.
Are "developmental specialists" covered by private or public insurance?	Not to our knowledge.
If a parent has a relationship with a private provider and then the child is referred to EI, may the team continue to use the current private provider (instead of accepting the same service through a CBDD)? And if so, will the services from the private provider count as part of the 55 units?	Parents may always choose to access private therapeutic services. However only those services from providers that meet the requirements of this (and other EI) rule are "EI providers" and part of the EI system of payments. If the child is receiving private therapy and that provider is interested in becoming an EI contractual provider, she or he may enter into a contract with the department and become part of the EI system of payments. Otherwise, the EI team is required to locate EI services needed, while the parent continues to seek and receive non-EI services. Non-EI services are not calculated in the EI units.

What if the parent wants a POLR provider instead of the CBDD?	The IFSP team will continue to determine the needed service to meet IFSP outcomes and the SC will continue to identify possible providers to meet those outcomes. Any qualified personnel [(B)(2)] may be used to provide an EI service.
Let's say a family is getting 60 minutes with CBDD SLP twice a month. They also choose to get private speech twice a month using private insurance for 60 minutes. Does the private speech count toward 55 units and do we do a POLR application for the copay? Then what does the grid and outcomes look like?	The IFSP team is responsible for determining the Early Intervention service needs necessary to meet the IFSP outcomes. Any service that the parent seeks outside of the IFSP process, is not an EI service. The EI provider is certainly encouraged to engage in communication with the non-EI provider if that is helpful to the parents, but there is no action required of the SC for the non-EI service.
How do non-CBDD providers enter into a contractual relationship with DODD (C)(5)?	Information may be found at the Ohio Early Intervention website. The EI Resource Coordinator may also be contacted.
Assistive Technology	
Who pays for assistive technology devices?	Assistive technology services and devices are "EI Services," and the funding sources in (C) apply to AT services/devices.
Can CBDDs be reimbursed for AT device cost?	No. CBDDs may choose to cover the cost of an AT device or service, but are not required to do so.
May all 55 units be used to fund an assistive technology device?	Technically, yes. However, all the federal and state requirements for determining the need for an AT device or service must be met, including the requirements for assessing the need for AT device/service, and the team determination of what is needed to meet the IFSP outcome (related to better function and participation in typical routines and environments).
At No Cost	
How do we describe the services that are provided at "no cost" to the parent? "Free?" or "at no cost?"	These services are provided at "public expense." They are also "at no cost *to the parent*."
Parents and community members (including medical providers) believe that EI is "free" to families. How will this new information be communicated statewide?	Under past ODH SOP rules, there was a parent cost share. The new SOP rule guarantees 55 units of services at *no cost* to every parent of an EI child in Ohio, creating greater equity. The rule was developed with extensive stakeholder feedback and the EI Advisory Council will continue to provide recommendations to the state on statewide communication opportunities.
D. Determination of a parent's ability to pay for EI services	

Ohio Early Intervention System of Payments Frequently Asked Questions

If a child has WIC or Medicaid (due to waiver or other circumstance) but over the FPL, do they still have an "inability to pay?"	Yes. Either of these automatically make a parent "unable to pay" (D)(2). There is no need to ask about income.
Which categories of determining inability to pay are the responsibility of the SC and have to be completed in the first 45 days?	In (D)(2), (a-c) are the categories which the SC uses to determine "inability to pay" with in the first 45 days. Category (d)--Extraordinary medical expenses-- is determined by the department, and can only be determined *during* the IFSP year after medical expenses have been incurred.
When will the category of "Extraordinary Medical Expenses" for "inability to pay" even apply?	EME category of "unable to pay" will apply to parents who are able to pay when the IFSP is developed and the team anticipates more than 55 units being needed in the IFSP year. Parents may collect EME data DURING THE IFSP YEAR in order to potentially be determined "unable to pay" at some point in the IFSP year.
What if the factors that determine "inability to pay" change after determination and the IFSP?	The parent's inability to pay for EI services may be re-determined at any time during the IFSP year. (D)(4) notes that parents may request a redetermination.
Are parents required to notify service coordinators if their income changes?	No. The only requirement is that determination of inability to pay is completed annually, but may be done at any time. It benefits parents to request redetermination when income is decreased, and more than 55 units of EI service is expected to be needed in an IFSP year *and* the parent is able to pay.
When a parent chooses *not* to share financial info with SC then the parent is "able to pay." If getting all services (1st 55) from CB, this could work. But how would POLR pay for 1st 55 if don't share finance info?	Application is made to DODD without any financial information; financial information is not required for first 55 units.
If a child is eligible for a Medicaid waiver, does this meet the criteria of having Medicaid and thus meet the criteria of being determined not able to pay?	Yes.
Does ability to pay have to be determined for all parents?	Yes, per (D) (1) (unless a parent chooses not to disclose financial information (D)(3)). However, the explanation of the EI SOP and all the safeguards must be reviewed with all parents prior to the initial or annual IFSP or before any funding changes are made to the IFSP (particularly use of insurance).

If a family meets their EME after paying for some services, will they be reimbursed?	Parent (with SC support and provided forms) will need to track expenses and apply to DODD for determination of inability to pay. Parents will not receive reimbursements.
May the EME be met without including any of the child's services (e.g. another family member's medical costs)?	Yes.
Does this impact un-documented families?	No
There are several places in rule that require the SC to explain the SOP rule to parents. Will there be a script or guidance document to explain this to families?	In addition to the SOP rule trainings for SCs, an SOP parent brochure will be available and given to all parents. SCs will need to be able to explain both rule and brochure to parents (as was previously required in the ODH rule). In the coming months, DODD will continue to provide additional materials to support service coordinators in explaining the SOP rule to parents. If you have questions or suggestions, please contact the EI Resource Coordinator.
E. Parent cost participation	
How do we keep families from jumping ship when they hear anything about the possibility of paying?	This rule does not change the process or the fact that there are potential parent costs for early intervention, although it does change the specifics. The majority of EI children and their families will receive most, if not all, of their EI services at no cost, and all are assured the 55 units at no cost, which was not previously guaranteed.
If a parent has been determined able to pay and goes over 55 units, whom do they pay--the service provider?	Yes, parents that have an ability to pay will pay the service provider for those services beyond 55 units.
If we know the county board covers services, do we have to ask about private insurance and/or Medicaid still?	CBDDs do not cover all mandated EI services. Additionally, both in the past ODH SOP rule as well as this new SOP rule, the SC is required to explain the SOP rule to the parent. That explanation will include the funding sources for EI (C)(2), which include public and private insurance.
F. Using the private insurance….	
Is it true that private insurance *must* be accessed for the first 55 units?	*Absolutely not*. In fact, private insurance may *only* be used to fund EI services after all of the required activities in (F) of this rule have been completed, including informed parent consent for the use of the insurance.

May a parent provide consent to use private insurance and then later decide to withdraw that consent?	Yes; parents may always choose *not* to provide consent for access to private insurance.
What are the advantages and disadvantages to using private insurance?	The generic possible costs to using private insurance are specified in (F)(1)(c). There may be an advantage in using private insurance when the department pays the co-pays and deductibles for the EI services; the family deductible may then be met sooner for other family members.
If parent chooses to not use private insurance, how will the services be funded?	The funding sources in (C)(2) always apply. CBDD or public insurance may be accessed when available and given parent consent. When these sources are not available, the services will be paid by the department using state and federal funds.
What if the private insurance has limits on covered services -- for example 20 visits by SLP in a year -- and the insurance is used for EI SLP services. Won't that limit parent access to future SLP services that might be sought at a hospital or clinic?	EI services are evidence based and insurance is a potential funding source. The potential costs of using the private insurance must be reviewed with the parent. Parent must provide consent prior to the use of the insurance.
If a parent is utilizing their private or public insurance to access services that are not EI services, would also billing EI services to private or public insurance be duplicative billing?	The rule applies only to EI services provided through the IFSP. It is possible that in insurer would deny a service coverage if it were perceived to be duplicative of a service already being provided.
Will parents receive statements showing what has been billed to private insurance, including deductibles and co-payments that have been paid?	The Explanation of Benefits (EOB) from the parent's insurance plan will continue to serve as the document that communicates information regarding coverage and cost of services. DODD will work directly with the providers to make these payments.
Are the county boards going to bill insurance?	As a general rule, CBDDs do not have the ability to bill insurance. This SOP rule primarily clarifies and articulates the process that is currently in place in Ohio for funding EI services.
Can families split their first (free) 55 units between county board EI services and private therapy? If yes- and a family has private insurance and deemed eligible to pay, will DODD cover a family's deductible and/or co-pays for first 55 units?	The IFSP team determines service needs and identifies available EI providers. CBDD and EI contracted providers may be used to provide EI services, and all are part of the unit calculation. If a family consents to the use of their private insurance, regardless of their income, the department will pay for their deductible and their co-pay (this applies only to contractual providers).
G. Using the public insurance	

If a family has public insurance and then they get private insurance, will they be required to share that?	It is Ohio law that private insurance be billed prior to billing public insurance (Medicaid). Parents shall provide that information with the Medicaid agency at the very least, and hopefully with the SC.
Related to sections G(1) and (2) -- may the EI system bill public insurance if the parent enrolled in public insurance after receiving information about the program?	Yes.
H. Procedural safeguards	
(NONE)	
PROCESS:	
Tracking Units	
How are units calculated when two EI providers are in the home (e.g., joint visit) at the same time?	The units are determined through the IFSP process; if each service is specified as 1 hour (each) per visit, 2 units would be used.
Are we tracking actual or visits on IFSP promised?	Actual
Will there be a specific form that can be used to track units used?	At this time there is no required form for tracking.
Will there be guidance from DODD about how service coordinators can track service provider units?	The units provided are determined by the IFSP. Both CBDD and contractual providers (through contract language) are expected to provide service delivery documentation. There is no required DODD form to track units and how SCs track units will likely depend on the family's circumstances (e.g., the 55 units are irrelevant for parents that have an inability to pay).
What if parent cancels appointments or for any reason doesn't use all units on their IFSP?	The IFSP and provider process is the same. This rule clarifies funding sources. The 55 publically funded units are available for the IFSP year, and do not "roll over" into the next IFSP year.
If a family exceeds 55 units and the SC mistakenly tracks units and the family goes over, who holds responsibility to pay the provider?	In these rare situations, please contact the EI Resource Coordinator.
Is there a timeframe after service delivery that the units used are expected to be tracked or recorded?	The 55 units need to be tracked in a way that the SC will know when or if they are exhausted. The IFSP team, including the parent, should have a fairly good idea of how many units will be anticipated to be needed for the next six months based on the IFSP. Depending on the frequency of services, the SC may need to check with the provider(s) more or less frequently prior to six month review.

Ohio Early Intervention System of Payments Frequently Asked Questions

Do units used need to be recorded within a certain timeframe in Early Track such as 30 days?	At this point Early Track will not track the units. There is no specific time frame in having to document the units used. It is very family specific based on the frequency of services on the IFSP.
If you complete an annual IFSP for example one month before annual due date, will units (55) start over then? Even though there may be a month left in the year?	Yes
Is there a plan for the future for tracking of units to be done in the EI data system?	DODD would like to make the IFSP pages in the data system better mirror the paper IFSP form. In addition, we have been asked many times over the years if service delivery could be tracked in the data system. This is something that we are continuing to explore.
SOP Forms	
ODH rule allowed the family cost share to include "during 12 month period *before* the date of written allegation of inability to pay." This rule seems to apply to "during plan span." How will this work?	Parents are able to start documenting EME with signature on IFSP during initial 55 units. Parent cost participation (E) applies until the EME qualifications for "unable to pay" (B)(8) are met.
Why are we getting insurance information if we're not billing them?	Insurance information (see form EI 17-01) is only asked for if and when parent consent for use of private insurance and/or sharing of PII for public insurance is obtained. Insurance is a funding source for EI.
When asking for paystubs we are asking for stubs for all adults in the home. Then we are told only for the "adults" the parent consider part of the family unit. Is it all adults in home or only adults in the home that parents consider part of their family unit?	The family determines who is in the family unit. However, those identified must be living in the family home. Income is needed for every working adult identified in the family unit.
Does the 17-01 need to be completed and on file for families that are determined *not eligible* for EI services? For example, if we decide that SCs will routinely be completing the 1701 form after the evaluation/assessment, in those cases where child is not eligible +/or in need, must we complete a 1701?	Form 17-01 must be completed within the first 45 days after the EI program referral and prior to the signing of the IFSP. In some cases, families will have exited due to being not eligible, loss of contact, etc. prior to completing the form.
Does the 17-01 need to be on file for children who are only receiving services through the local DD and the local DD is not seeking reimbursement from the family for those services?	17-01 needs to be completed for all eligible families.

Ohio Early Intervention System of Payments Frequently Asked Questions

What is the lifespan of form 17-01?	The 17-01 is good for the IFSP year, but can be revaluated at any time with changes in the family's circumstances.
Where do we send 1701, 1702, and IFSP? E-mail? Fax? Mail? Preference?	If you need to submit these forms to the department, a scanned e-mail or fax are preferred.
Income grids: pre or post taxes?	Gross income is before taxes.
Does SSI and SSD count toward family's income? Does child support and survivors benefits count toward income?	Family income is calculated using only paystubs.
Criteria for "family unit"?	The family determines who is in the family unit. However, those identified must be living in the family home.
What if a family has an HSA that their employer puts money into and they don't pay out of pocket medical expenses?	Only the non-reimbursed out of pocket expenses that a family pays can be put towards the EME
Can EMEs include transportation costs, parking, mileage, turnpike tolls, etc.?	Under the SOP rule (B)(8), these expenses would not count toward the EME.
When we complete the document to Determine Parents are unable to pay, do we email the form to someone in Columbus?	Only if the department will be paying for the EI services in whole or in part (e.g., paying the co-pay of a private insurance).
IFSP	
How are units documented on the IFSP grid?	In the same way they are now for intensity.
How will the payment source be identified on the IFSP for units that exceed 55 units when the parent is "able to pay?" What does 56th hour's amount look like for PSP or DS from County Board	"Parent out of pocket" or "private insurance" will generally be entered into the funding source in this example. However, if the CBDD has stated that their services will continue at no cost to the parent beyond 55 units, the CBDD will indicate the payment source for the IFSP.
The team can't control what frequency and intensity of services a POLR provider will offer, so how do they complete the IFSP and ensure that the provider matches the IFSP?	Decisions about the EI services needed to meet IFSP outcomes are determined by the IFSP team, not a single provider. POLR providers are only approved to provide services specified in the IFSP.
If a parent provides consent to use private insurance and then later decides to withdraw that consent, what is required in the IFSP process to change funding sources?	Because funding source is part of coordinating an EI service, an IFSP review must be held and the grid updated.
If a current provider is hesitant to recommend additional services, how does that impact the SOP application process? Some providers feel it puts them at risk of not providing enough services, and opens up chances for lawsuits…..	The need for services is determined by the IFSP team and is based on the child and family assessments. This has not changed.

Ohio Early Intervention System of Payments Frequently Asked Questions

How is Assistive Technology (AT) included in the IFSP? What is the process for having it paid for with POLR funds if there are no other funds available?	For AT service or device to be considered "early intervention" it must meet the federal and state EI requirements, including being necessary to meet an IFSP outcome. It is included on the IFSP as are other services. EI consultants are available for IFSP technical assistance. As with any EI service, if there are no other available funds to pay for a necessary AT service or device, an application is made to the department.
Can a family choose where they want to use their 55 units? On their Special Instruction instead of ABA?	The service need is determined through the IFSP process. A parent may always decline a service.
If funding source isn't determined by initial IFSP this goes in services not yet coordinated. Do services wait until it is coordinated?	Yes - just as is required now.
How to list private insurance as payment on IFSP?	Use "private insurance" on IFSP. Will then choose "private insurance" from the dropdown in Early Track.
Contractual providers	
Is there any change in the way contractual providers are paid?	No.
How are providers paid when services provided exceed those that were stated on IFSP (e.g. 30 units were on IFSP, but provider bills for 32 units)?	Contracted providers are only paid for the pre-approved/IFSP specified services and units.
What happens when the provider is not a provider for the managed care plan or private health plan?	The service would be paid for by another source which, depending on the specific circumstances, could be at public expense (e.g., when the service is within the first 55 units provided at no cost to the family or when the service is beyond the first 55 units and the family has been determined unable to pay) or via private pay by the family.
Where can we find the list of billing codes and payment rates for providers?	The list of billing codes and payment rates for the fiscal year 2018 are posted at http://ohioearlyintervention.org/ in the SOP provider section.

What is the expectation for services in natural environments? May a parent choose a provider because the provider provides a service in a hospital or clinic instead of the home or other natural setting?	Both federal and state EI laws require EI services to be provided in natural environments, with certain caveats ("maximum extent appropriate" and inclusion of IFSP justification when not appropriate). Ohio has made significant progress in meeting this expectation. As we work with contractual providers, the department will look for ways to increase home and community service delivery *and* the process for monitoring. OSEP has provided legal guidance that "parent choice" is not a valid reason for not providing a service in a natural environment. This issue arose under the old SOP rule as well. Counties can contact their EI program consultant for support in working through any issues encountered in providing services in the natural environment.
Transitioning families from old SOP to new SOP	
When the SOP rule is implemented, do we review all current children mid IFSP, or wait until next annual IFSP?	Current families with a signed IFSP will generally wait to begin the new SOP process until their next Annual IFSP meeting. Service coordinators will need to meet all of the new SOP requirement process with parents in the 45 days *prior* to the Annual IFSP meeting. If a current family would have accessed POLR funding under the old rule, the SC should contact the EI Resource Coordinator to discuss how the new rule will apply to the family.
When do we start using the new SOP forms (17-01, 17-02, etc.)? Starting with every initial, annual, and periodic IFSP with a service added after August 1, 2017	The rule went into effect August 1. Any family that did not have a signed IFSP on the rule effective date will generally be rolled into this rule on August 1. All other families will be rolled in at their next annual IFSP. There may be rare situations where it was not practical in the days immediately following August 1 to apply the new rule (e.g., a family with a scheduled initial IFSP on August 2). These families will have the new forms completed at their annual review or if they need to access department funding to pay for EI services.
Other	
What happens if a family transfers in from out of state in regards to the 55 units?	The family would receive the full 55 units until their next annual IFSP is completed.