

Recommendations to Expand Eligibility and Funding for the Alaska Infant Learning Program



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ALASKA EARLY INTERVENTION / INFANT LEARNING PROGRAM

Executive Summary

The purpose of this work is to ensure that every Alaskan infant and toddler has equitable access to Infant Learning Program (ILP) services, especially in smaller communities. We believe in the value of investing early, for long-term development and leveraging Alaska's existing infrastructure to support more families. Through the expansion of ILP eligibility, more Alaskans will have the opportunity for early intervention, reducing later need for more intensive interventions. Early intervention service provisions will set our infants and children up for long-term success, preventing compounding developmental challenges. Ultimately, our goal is to secure support for ILP services, recognizing their pivotal role in shaping the future of Alaskan children and families. This proactive, early investment in our children and families simultaneously supports improved intervention and outcomes, while decreasing long-term financial cost and burden to the state of Alaska.

Alaska's Early Intervention/Infant Learning Program is a multidisciplinary program designed to support Alaskan infants and toddlers with developmental delays and

disabilities, as well as their families, to access essential supports, resources, and interventions. Administered by the Alaska Department of Health, in accordance with the Individuals with Disabilities Education Act (IDEA), intervention services are provided to support optimal development of children from birth to three years old.

Dedicated to serving Alaskan families with children experiencing developmental delay, Alaska's programming is designed to empower families in advocating for the development of their children. Despite these efforts and essential mission, many of Alaska's most vulnerable and at-risk children are ineligible and precluded from accessing services due to the stringent eligibility criteria that has long been established by the state. Expanding eligibility access will ensure our state's most vulnerable children have access to essential developmental services.

Reviewing national best practices, outcome data, and evidence-based considerations, the following recommendations for eligibility and finance are identified.

Eligibility Recommendation

1. Expand eligibility for EI/ILP programming to parity with school-age special education (Part B)
 - 25% or greater delay in one area of development when compared with chronological age, or
 - 20% delay in two or more areas of development when compared with chronological age.
2. Implement eligibility changes incrementally to avoid overwhelming ILP service providers.
3. Determine eligibility in standard deviations to match percent delay (e.g., 1.5 standard deviations or more below the mean in one or more assessed areas as equivalent to 25% developmental delay).
4. Update and reorganize the List of Established Conditions. (See example in Appendix B.)
5. Develop a process and timeframe to update the list regularly.
6. Develop a process for providers in the field to contact the ILP office and get a response/determination for novel or ambiguous cases.
7. During implementation of eligibility expansion, revise the condition list with each increment to match the current level of developmental delay.

Financial Recommendation

1. Determine costs and reimbursement through conducting a cost modeling and rate setting study.
2. Expand Medicaid coverage for all ILP services (including developmental therapy) with billing guidelines and rates that include services in home and community settings.
3. Determine IFSP to be an authorizing document for Medicaid covered ILP services.
4. Accurately determine a child's month-to-month Medicaid enrollment and support retroactive claiming.
5. Reimburse for non-Medicaid eligible children under a fee-for-service for some ILP services, with formula grants for child find, professional development; extreme travel (flights); language access.
6. Create a mandate for private health insurance coverage for ILP services under 'essential health benefits.'
7. Explore potential funding through other state agencies and programs e.g., child welfare (Title IV–E public health [Title V], Mental Health, Department of Education & Early Development, etc.).
8. Enhance ILP data system to support billing, accountability and reporting.
9. Develop a Central Finance Office (CFO) where data entered into the ILP data system is developed into claims and submitted to third parties including Medicaid and private insurance (including Tricare).

A final recommendation is to seek a state budget increment for the Alaska Infant Learning Program in order to catch up to the effects of cumulative inflation, which has reduced the present-day value of flat funding by 20% since 2015.

ACKNOWLEDGMENTS

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Introduction

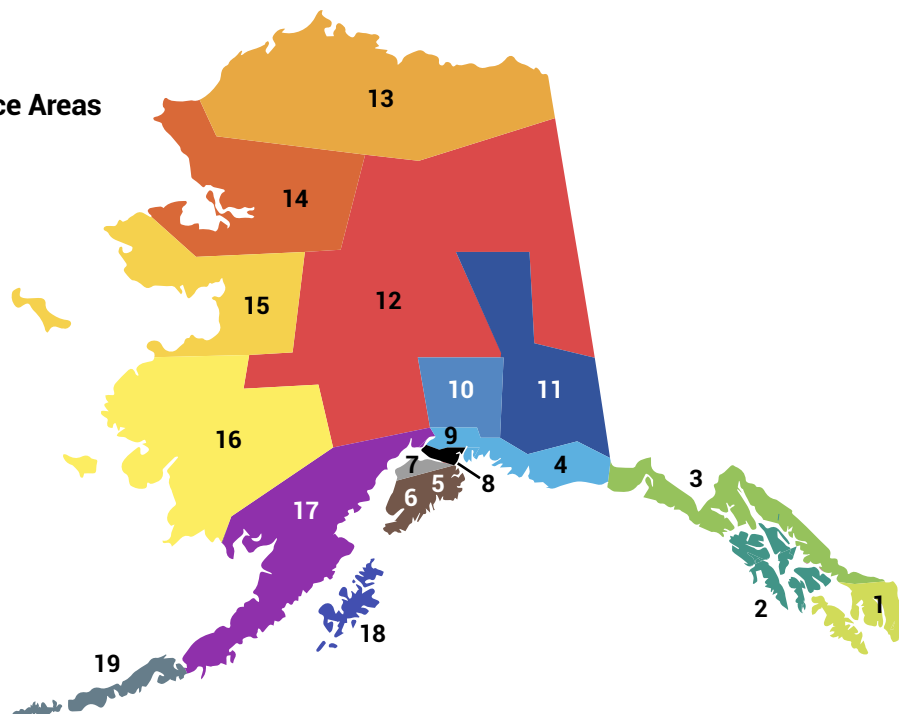
Early Intervention - Alaska Infant Learning Program

Part C of the Individuals with Disabilities Education Act (IDEA) provides funds for states to establish Early Intervention (EI) programs, which offer services for infants and toddlers (birth to age 3) with disabilities or developmental delays, regardless of family income. In Alaska, these funds and services are coordinated by the Alaska Infant Learning Program (ILP), a state office within the Alaska Department of Health. Eligibility for ILP services is based on developmental delay – in areas such as motor skills, communication skills or cognitive skills – or conditions that are known to be associated with developmental delays. Early Intervention can

improve the developmental trajectories of infants and toddlers, prevent further delays, and has been shown to be a good financial investment in terms of future cost avoidance, as less intensive supports may be required later in childhood and throughout life (PN-3 Policy Roadmap, 2021).

The Alaska ILP program currently funds fifteen (15) local ILP provider agencies through a competitive grant contract system, distributing state and federal grant funds. Three-to-five-year grants are issued subsequent to approved proposals and budgets submitted by community-based organizations serving a specific region.

EI / ILP Service Areas





The Case for Eligibility Expansion

Under the guiding principle that every infant and toddler should have equitable access to services, the state must consider that a 2-year-old, for example, should have equitable access to services as compared to a 7-year-old with similar concerns and developmental needs. The process of updating and revising access to early intervention services must include processes for both looking at definitions of developmental delay and established conditions leading to eligibility. It is widely understood that serving more children through cost effective, early intervention programs can reduce costs in later interventions and programming, while simultaneously improving outcomes and wellness for infants, children, and families. Children engaged in EI programs have been demonstrated to have enhanced life outcomes as compared to those children who did not receive care (i.e., Heckman Equation, n.d.).

Early intervention has consistently been demonstrated to have improved developmental outcomes and long-term improved functioning and well-being (Frank Porter Graham Child Development Institute, n.d.). "By providing services to young children with less severe disabilities or lower levels of developmental delay, we can set more children up for kindergarten readiness and life-long success, instead of delaying intervention until later ages with more expensive services." There is no evidence-based rationale for not serving children with 25% delay. Without receiving services, it is likely the impact of the developmental delay will result in further and ongoing impacts, academically, socially and emotionally.

The Case for Funding Review

In addition to considerations of eligibility expansion, there is significant value in reviewing financing considerations, independent of eligibility expansion, to optimize revenue and programmatic funding sustainability over the long-term. Through addressing funding sustainability and optimizing billing and reimbursement, Alaska would have the opportunity to support equitable funding distributions based on enrollment patterns. This optimization will help ensure that children have equitable access regardless of which of Alaska's 15 service areas they reside within. Enhanced funding and reimbursement operations will ensure services are maintained, and will need to be able to increase in order to match increased need as eligibility expands. Funding improvements will support program enrollment increases and simultaneously be able to address cost increase due to inflation or changes in service models.

Individuals with Disabilities Education Act

Each state is responsible for effective implementation of the Individuals with Disabilities Education Act (IDEA). IDEA specifically outlines states' obligations to have policies and procedures in place to support fair and equitable education for individuals with disabilities. Under IDEA, states are obligated to identify, locate, and evaluate the developmental needs of children, offering services to children and families who could benefit from specialized services. Additionally, states must assist and assign financial responsibility to the appropriate, supportive services. Obligations under IDEA Part B include protections for children ranging from ages 3 through 21. IDEA Part B protects access to Free Appropriate Public Education (FAPE) and ensures that children with disabilities are entitled to free education in the least restrictive environment, appropriate to their needs. Part C under IDEA supports infants and children with developmental delays or disabilities from birth to their third birthday.

The Infant Learning Program (ILP) supports children birth to three and their families through provision of a comprehensive array of early intervention services designed to meet the unique and varied developmental needs of eligible infants and toddlers with disabilities. These services are specifically designed to be family centered, emphasizing the importance of family involvement and collaboration as an integral component to the intervention process, and as members of the intervention team (US Dept of Education, Accessed May

2024). Additionally, IDEA outlines that services should be provided in the natural environment, resulting in service provision occurring where typically developing peers are similarly likely to be. To support this level of inclusion and access, service provision at this age generally occurs within the home or childcare setting.

The number of students receiving special education and related services under IDEA has significantly increased over time. During 2010-2011, 6.4 million students received services under IDEA. During 2021 - 2022, the number of engaged students increased to 7.3 million. This increase in identified students receiving services represents an increase from 13 to 15 percent of total public-school enrollment across the United States (National Center for Education Statistics, 2023). Unfortunately, the rates of engaged students are not equally distributed across states. Under IDEA, states are independently able to set state specific eligibility criteria and similarly can establish their own processes and procedures for identifying and evaluating children, presuming that minimum standards set forth by IDEA are adhered to. Similarly, Part C allows but does not require states to provide services to at-risk infants and toddlers (US Government Accountability Office, 2019). These differing processes results in discrepancies across states regarding the number and types of children accessing services, and ultimately may result in a child qualifying for and receiving EI/ILP programming in one state, while they simultaneously may be ineligible for those same services in another state.



The Current State

IDEA Part C was implemented nationwide in the United States in 1986, and since its inception, Alaska has utilized an eligibility criteria that includes a 50% developmental delay cutoff for ILP eligibility. To be determined eligible, an infant or child, birth through age three, must demonstrate one of the following:

1. A 50% developmental delay in one or more area of development, and/or
2. Must have one of a selected list of identified medical diagnoses or established conditions known to likely result in a developmental delay, and/or
3. Have eligibility determined through the informed clinical opinion of a multidisciplinary team (Alaska Dept of Health, Accessed May, 2024).

Federal policy does not limit a state at the 50% threshold for developmental delay. This standard for Part C eligibility is outlined through state regulations and implemented through policy. Only three states have – like Alaska – restricted eligibility to 50% delay (IDEA Infant & Toddler Coordinators Assn, 2022). All other states have determined much less restrictive definitions and criteria for service eligibility. The ILP (Part C) 50% eligibility is in contrast with Alaska's less restrictive special education (Part B) program, which supports children and youth aged three through 21. For Part B, children or youth may be eligible for intervention services with a 25% delay in one area of development or a 20% delay in two or more areas of development. The disparity in eligibility criteria results in a likely significant difference in the rate of children and youth who are eligible for services. Children with a 25%-49% developmental delay, who were not eligible for services under Part C, become eligible for Part B services as they reach age 3.

Early intervention is crucial for supporting the long-term health and wellness of our state's most vulnerable youth. Children with disabilities are at increased risk for adversity, adverse childhood experiences (ACEs) and/or adverse life events, and are more likely to be expelled or suspended from early childhood education, due to behavior related considerations. Those children who experience exclusionary practices early on are at risk for further expulsions, risking eventual disengagement from the education system or dropping out (Meek &

Gilliam, 2016). At the same time, disadvantaged children benefit the most from early childhood education (Elango, Garcia, Heckman & Hojman, 2015). Early intervention is known to be associated with improved health outcomes, academic outcomes and social outcomes, reducing the need for services throughout the lifespan. The long-term cost to the state is higher than the cost of early, proactive intervention (Allen, 2017). These risks of ACEs and exclusionary practices are further amplified for Black, Indigenous, People of Color (BIPOC) and minority identified infants, children and families.



Role and Authority of Interagency Coordinating Council

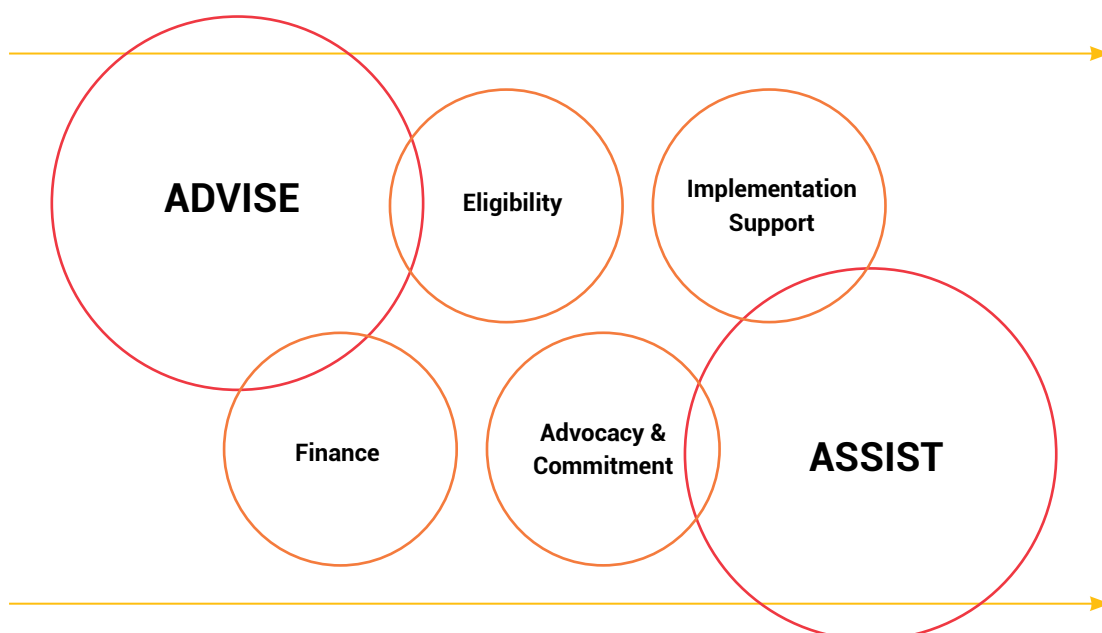
IDEA law requires that each state establish and maintain an Interagency Coordinating Council (ICC), supporting the lead agency in overseeing early intervention. In Alaska, the Governor's Council on Disabilities and Special Education (GCDSE) houses the ICC. The ICC plays a crucial role as the primary advisory group with responsibilities that are outlined in state and federal statutes. ICC designated responsibilities (Alaska state statute 303.64) include:

1. Advising and assisting the lead agency in identification of fiscal and other support services for early intervention programs as outlined by Part C.
2. Assigning appropriate financial responsibility to the associated and coordinating agency.
3. Supporting coordination and collaboration through both intra- and inter-agency collaboration for child find.
4. Support provision of transition services for toddlers entering preschool or other similar supportive services.
5. Prepare and submit an annual report to the Governor's office and OSEP reviewing the status of the state's early intervention programming.

In addition to the core identified functions of the ICC, an ICC may be authorized to support and assist the

Part C lead agency in provision of appropriate services for children with disabilities between birth and age three. The ICC may provide consultative support and advisement to appropriate agencies throughout Alaska on the appropriate integration of services for children and families with disabilities, and those who may be at risk for disabilities. Additionally, an ICC may be tasked with coordination and collaboration with the State Advisory Council Early Childhood Education and Care for children and families with disabilities (Governor's Council on Disabilities and Special Education, 2021).

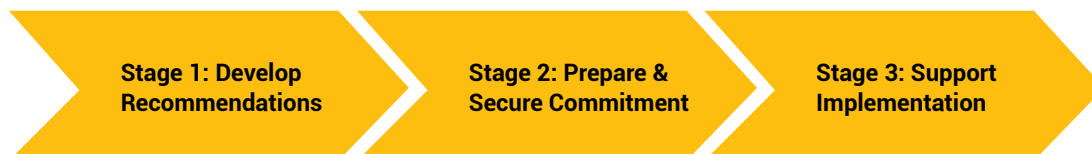
A sub-committee of the ICC was developed to review current policies and support enhancement and expansion of services. This subcommittee remains under the direction of the ICC and was tasked with developing recommendations to the full ICC. Subcommittee members included family members, providers, representatives of other state agencies such as Medicaid, with whom ILP is required to coordinate financing for early intervention services. This elevates the unique factors and considerations for Alaska and Alaskan residents specifically. The intent of the subcommittee was initially to strengthen ICC knowledge of ILP fiscal systems, and identify and formulate recommendations, but soon expanded to include review and consideration of eligibility expansion.



Process and Methods

The process of reviewing, outlining and adopting evidence-based best practices is delineated into three distinct stages. Each stage represents an essential body of work that is foundational for the long-term success of implementation of strategic, evidence-based practices for early intervention eligibility and service provision.

This subcommittee of the ICC was solely focused on Stage 1 and the processes of reviewing national best practices, standards, and processes with the goal of developing both process and financial recommendations for the larger ICC to review and consider. Preliminary recommendations for Stages 2 and 3 will be reviewed briefly in the section covering recommendations for next steps.



Stage 1: Develop Recommendations

Throughout the course of monthly meetings, subject matter experts reviewed current practices and policies, outcome data, and completed reviews of other similar states policies and procedures. The taskforce initiated a review of national trends in data and early intervention eligibility. The review of national trends supported the opportunity for comparison with peer states and exemplars. Specifically, the ICC subcommittee identified benchmark states used for inter-state comparisons including New Mexico, North Dakota, and Oregon. Once the subcommittee had a firm understanding of local and national trends, focus groups and interviews with key stakeholders such as Alaska Infant Learning Program Association (ALPA), Tribal providers, and staff members employed with the Medicaid/ Insurance office for the state of Alaska. The subcommittee additionally reviewed Alaska ILP data.

Part C of IDEA specifically requires that all recommendations be scientifically informed as an underpinning of regulation language. The workgroup identified and followed guiding principles of evidence-based considerations within the context of relationships, connections and community, flexibility and collaboration, equity and accessibility, in the development of new guidance to support Part C implementation. In addition to review of eligibility criteria, this subcommittee attended to long-term fiscal viability for programmatic sustainability.

Eligibility

Definition and Explanation of Developmental Delay

The term 'Developmental Delay' is outlined under IDEA describing children experiencing significant delays in one or more developmental areas including: physical development, cognitive development, communication development, social or emotional development, and/or adaptive development. Specific criteria may vary state by state, and states retain the ability to define what constitutes a significant delay, though this determination is usually made through standardized testing and professional assessments (Individuals with Disabilities Education Act, Accessed, 2024; Federal Law: 34 C.F.R., Accessed, 2024). Alaska generally shares this definition of eligibility, recognizing significant delay for children demonstrating significant delay at least 1.5 standard deviations below the mean on standardized tests in one of the noted five areas of development (Alaska Administrative Code, 2024). Currently Alaska requires a 50% eligibility in developmental delay, meaning a 24-month-old must function at a 12-month-old level in order to be eligible for services. Only three other states have established this level of restriction for service eligibility. In addition to percent delay, there are a number of established conditions and genetic disorders qualifying infants and toddlers for service eligibility.

Established Conditions

In addition to assessed developmental delay, Alaska maintains a list of established conditions and medical diagnoses that may determine an infant or child to be eligible for early intervention services. The Alaska ILP list of established conditions is a longstanding compilation of health conditions known to impact child development and long-term developmental outcomes. This list has been in place for an extended period with limited changes or updates. The current identified conditions constitute a list of 46 identified conditions, that fall under the identified categories of: A) Diagnosed Physical or Mental Conditions, B) Low Incidence Disability Expanded Definitions: B1 – Deaf or Hard of Hearing and B2 – Blind or Visually Impaired (Alaska EI-ILP Part C Policies, 2024). For a full list of current approved conditions, please see Appendix A.





Alaska Enrollment Compared to Other States

Enrollment in Early Intervention services is determined annually through a single day point in time count. This point in time count considers both the number of children birth to age one and the number of children birth to age three engaged in Early Intervention. These point in time counts are divided by the population of children in those age ranges in the state, providing the percentage of young children engaged in early intervention services.

The Infant Toddler Coordinators Association (ITCA) delineates states into three categories based on eligibility criteria. States are categorized with designations A through C. Those states with an 'A' designation demonstrate the least restrictive eligibility while states with a 'C' designation demonstrate the most restrictive eligibility.

Category A: At Risk, Any Delay, Atypical Development, one standard deviation in one domain, 20% delay in two or more domains, 22% in two or more domains, 25% delay in one or more domains.

Category B: 25% in two or more domains, 30% delay in one or more domains, 1.3 standard deviations in two domains, 1.5 standard deviations in any domain, 33% delay in one domain.

Category C: 33% delay in two or more domains, 40% delay in one domain, 50% delay in one domain, 1.5 standard deviations in 2 or more domains, 1.75 standard deviations in one domain, 2 standard deviations in one domain, 2 standard deviations in two or more domains.

IDEA Infant & Toddler Coordinators Association, 2022

Alaska currently holds a Category C eligibility given its criteria consisting of a 50% delay in one domain (ITCA, 2022). Eligibility criteria are not the sole factors responsible for infant and child enrollment as evidenced by those states with an 'A' designation simultaneously serving limited percentages of infants and children. Additional considerations impacting enrollment and utilization include Child Find practices, how well-resourced systems are, including funding, and overall implementation of programming. These limited numbers identify the essential roles of Child Find requirements and public awareness factors around availability of services that may impact both the number and percentages of infants and toddlers enrolled in Early Intervention services.

Table 1: Percentage of Children Served, Birth to Age One

Category A Eligibility (17)

New Mexico	5.88
Washington	2.78
Pennsylvania	2.46
Vermont	2.26
Kansas	2.02
District of Columbia	1.80
Virginia	1.47
Maryland	1.44
Delaware	1.43
Michigan	1.29
Iowa	1.17
Colorado	1.16
Texas	1.15
Hawaii	1.03
Wisconsin	1.01
Alabama	0.71
Arkansas	0.68

Category B Eligibility (19)

Massachusetts	4.23
West Virginia	3.69
North Dakota	2.73
Wyoming	2.72
New Hampshire	2.34
Indiana	1.55
Rhode Island	1.35
South Dakota	1.30
Tennessee	1.30
Illinois	1.27
Nebraska	1.22
Utah	1.21
California	1.10
Ohio	1.04
North Carolina	.091
New York	0.87
Minnesota	0.85
Mississippi	0.62
Puerto Rico	0.40

Category C Eligibility (16)

Alaska	2.03
Idaho	1.67
Missouri	1.63
South Carolina	1.42
Louisiana	1.28
Nevada	1.20
Oregon	1.02
Maine	0.98
New Jersey	0.86
Arizona	0.85
Montana	0.77
Oklahoma	0.77
Connecticut	0.64
Georgia	0.64
Florida	0.63
Kentucky	0.46

— **Average: 1.26**

For children under the age of one, eligibility is predominately determined by the presence of an established qualifying medical condition, given the difficulty identifying developmental delay at this early age. In the most recent numbers, from 2022, Alaska's percent of children birth to age one served, 2.03 percent, is above the national average of 1.26 percent (ITCA, 2022).

Table 2: Percentage of Children Served, Birth Through Age Three

Category A Eligibility (17)		Category B Eligibility (19)		Category C Eligibility (16)	
New Mexico	11.20	Massachusetts	10.40	New Jersey	5.61
Vermont	6.79	West Virginia	8.51	Connecticut	4.94
Pennsylvania	6.11	Wyoming	6.28	South Carolina	4.91
Kansas	5.41	Rhode Island	6.14	Missouri	3.94
District of Columbia	5.12	New Hampshire	6.04	Louisiana	3.49
Delaware	4.90	Indiana	5.93	Idaho	3.48
Maryland	4.63	North Dakota	5.71	Maine	4.48
Washington	4.49	New York	5.05	Oregon	3.38
Virginia	4.12	California	4.44	Nevada	3.20
Michigan	3.92	Illinois	4.11	Alaska	3.12
Colorado	3.88	Tennessee	3.93	Kentucky	3.12
Wisconsin	3.46	Puerto Rico	3.79	Florida	2.69
Hawaii	3.28	Utah	3.69	Arizona	2.35
Texas	2.85	Ohio	3.46	Georgia	2.33
Iowa	2.76	South Dakota	3.37	Montana	2.00
Alabama	2.53	Nebraska	3.24	Oklahoma	1.78
Arkansas	1.18	Minnesota	3.14		
		North Carolina	2.92		
		Mississippi	0.40		

— **Average: 4.01**

For children under the age of three, Alaska has the same Category C eligibility with the requirement of a 50% delay in a single domain. At the time of the last count, Alaska's percentage of eligible infants and toddlers, based on developmental delay, is 3.12% of the population, below the national average of 4.01% (ITCA, 2022).



Alaska's current identification policies and processes for ILP result in a significant diminished number of infants and children accessing services. At the time of the 2022 point in time count, Alaska demonstrated a rate of 3.12% of children under the age of three receiving services by eligibility. When compared to the national average (4.01%) Alaska is missing and failing to identify one out of every four children needing services. When this rate is compared to the top 3 performers in Category C (New Jersey, Connecticut, and South Carolina; Table 2 above) collectively averaging 5.15%, Alaska is failing to identify and serve two of every five children in need of services (ITCA, 2022).

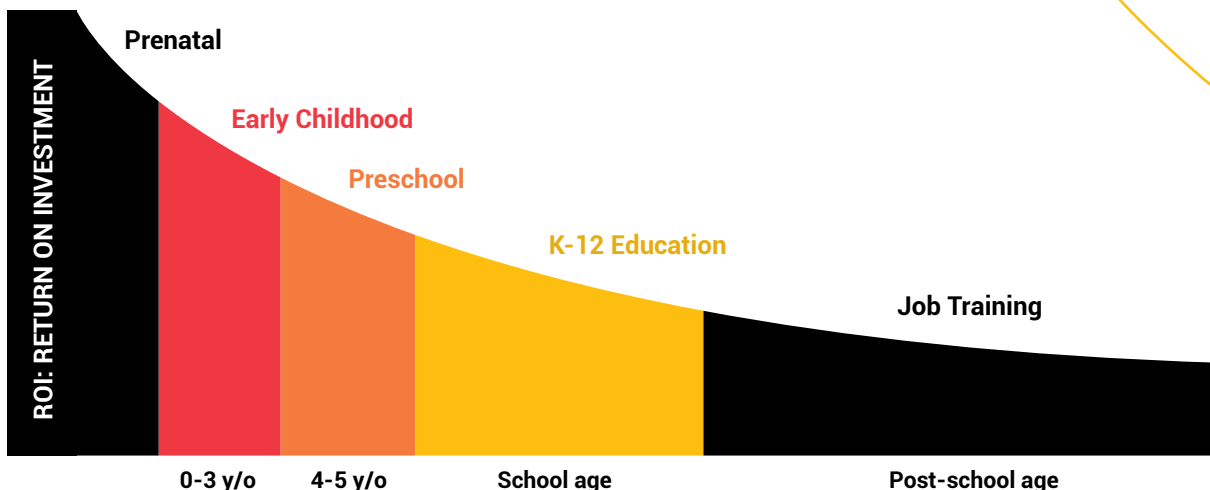
In conjunction with stringent eligibility for services, Alaska has unique characteristics impacting the state's child find and engagement processes. Medical providers come into Alaska from all over the country, and as each state has their own processes for determining eligibility, providers will have varying understanding of what constitutes a developmental delay. This variety in understanding and application of criteria for disability directly undermines the Child Find system which is specifically designed to identify, locate, and evaluate infants and children who may have developmental delays or disabilities.

Currently 20% of infants and children are eligible for ILP through clinical opinion, 20% through established conditions, and the remaining 60% enroll through developmental delay (Governor's Council on Disabilities and Special Education, 2022). By increasing eligibility through known conditions, enrollments will grow through increased provider referral rates. Currently providers are hesitant to refer children as they are unsure whether will meet developmental delay requirements. Through expansion of services in conjunction with the lower percentage delays, providers will be able to quickly and easily refer families for services without the concern that a referral may be declined for lack of sufficient developmental delay or not being included on the list of established conditions.

Percent Delay

Changing the required percentage of developmentally disabled eligibility requirements is supported by scientifically and fiscally based considerations. The very nature of early intervention is to identify children with special needs and to provide services early, to avoid developmental delay to potentially accumulate. There is significant benefit in providing early intervention for infants and toddlers in the 25-49% delay range, as many other states choose to do. By providing intervention to infants and children with lower percentage delay, they will have increased opportunities for skill development and require less specialized education services, thus decreasing the total number of children needing intensive services at older ages. In addition to the child and family outcomes of intervening early, research on economic outcomes has shown that earlier investment – through service delivery – results in great economic returns. EI programs have been demonstrated to have a substantial return on investment. Studies demonstrate a \$2.05-\$17.07 for every dollar spent. The Heckman equation specifically identifies that the long-term effects of EI and result in a 13% return on investment (Heckman Equation, n.d.). The graph demonstrates the significant increased rate of return for those early intervention programs administered in the earliest points of a child's life, including pre-natal and early interventions services (Heckman Equation. (n.d.).

Economic Impact of investing in early childhood learning.





The list of established conditions is maintained by the Infant Learning Program in each state and lists conditions that are known to have a great likelihood of developmental delay or need for special education supports. The Alaska list was most recently updated in 2015. States vary in their approach to their list, with varying degrees of detail, and with differences in the conditions that are listed. Some lists have been in place for 20 years, while others have been updated in the last year or two. There is no documented process that describes how, or expectation of how often, the Alaska list of established conditions is updated, which puts it at risk of being slow to respond to changes, in the research and in the Alaska population. Alaska's current eligibility requirements create a system of limited referrals by medical providers and expert caregivers due to concerns that an infant or child may not fully meet criteria, whether developmental delay may

not yet be at 50%, or because conditions are difficult to diagnose, which could be due to the child's presenting symptoms or behaviors, or because of a shortage of providers with the ability to diagnose the child's condition. It also results in the situation where 20% of children in ILP are enrolled through informed medical opinion, where a child presents developmental patterns that are difficult to evaluate with available tools and an individualized justification for services has to be developed, reviewed and adjudicated. The current system can therefore result in delayed intervention that may ultimately result in a more costly long-term intervention requirement as children age. Decreasing the required developmental delay will increase access for infants, children, and families and ultimately result in decreased-long-term systemic impact as a whole as more children will be able to enroll with safeguards, supports, and interventions already in place.

Recommendations for Eligibility Change

Recommendations include changes for developmental delay threshold and the established condition list. With the reduced developmental delay threshold, in conjunction with the updated conditions list, barriers for enrollment will be removed and informed clinical opinion can be used for children with difficult to measure developmental differences, as intended. In the interim, the Clinical Opinion policy was recently updated and disseminated, clarifying the current guidance to increase supervisory oversight and compliance monitoring and encourage program managers to oversee their use within their programs.

Reduce the Developmental Delay Threshold

It is specifically recommended that the State of Alaska align the eligibility for the two adjacent parts of IDEA, ILP (Part C) and school-age special education (Part B) [12]. Doing so will improve the state's ability to identify children eligible for school-aged special education, and in some cases even meet and prevent that need before they get to school age. Specifically, this is a recommendation to adopt a 25% delay in one or more areas, or 20% delay in one area domain of development, e.g., social-emotional, speech and language, or motor development. Adopting this new requirement will better align Early Intervention and Special Education, allowing for a seamless transition from ILP to special education services, as well as addressing an age-based equity issue in terms of service access. This expansion will increase access for children birth to age three.

It is further recommended that this expansion from 50% to 25% developmental delay is done incrementally, to allow the development of the necessary provider workforce and supporting infrastructure over time, monitoring anticipated and actual increases in children needing and receiving services. Under-compensation, burnout and high turnover are already a significant concern for this workforce. It will serve the workforce, children, families, and the state of Alaska to ensure these changes in expansion are made incrementally over time to support sustainability.

In addition to changing the level of developmental delay required for eligibility, it is also recommended that the way that delay is established is expanded from the current method of age-based percent delay to include a method based on average development by age and standard deviation from that average. Utilizing an equivalence of 1.5 standard deviations or more below the mean in one or more assessed areas will increase ease in identifying delay utilizing many standardized assessment tools. This would allow early intervention and other professionals (i.e., SLP, OT, PT, Psychology) who are trained on and frequently utilize standardized assessments in their work to more easily identify children based on their assessment scores.

To stay in alignment, a standard deviation should be determined for each step of the incremental expansion of percent delay.



Update the Established Condition List and Establish Supporting Procedures

Based on review of comparison states and the current Alaska list, an update to the list of established qualifying conditions is recommended. In conjunction with updating the list, a more comprehensive support system is warranted to keep the list up to date and easy to use. The list should be reorganized to match the categories outlined in ILP policy to support effective communication of the types of conditions that can qualify a child.

Additional instruction is also warranted to clarify that the list is not intended to be comprehensive, but rather a list of examples and common conditions that fall under each category.

To provide support when conditions are identified that may not be included on the list, clearly fall within one of the categories, or otherwise cast doubt on whether a condition would qualify, it is recommended that the ILP state office develop a decision-making process by which they can receive and adjudicate questions and requests for eligibility in a standard process with clearly defined criteria or guiding principles.

In order to make changes more sustainable without unnecessary future efforts, it is also recommended that the state ILP office develop a standard process for updating the list and establish a timetable for a regular review and update, e.g., every 5 years. In the course of this work,

example conditions were named for consideration in the next update, such as low/very low birth weight/small for gestational age; complicated prematurity with established criteria, and unilateral hearing loss with criteria.

Specific recommendations for the list of established conditions include:

- Reorganize the list of established conditions using the categories established in ILP policy for ease of use and improved functionality (see attached example in Appendix B).
- Develop a process for the state ILP office to regularly review and update the list, considering input from both the ICC and a medical expert panel. A first test of the process would include considerations of the changes recommended in this report. During the change process to expand eligibility, the ILP state office should consider working with a medical expert panel to review and align the condition list with each incremental level of developmental delay.
- Develop a system and a decision-making process where providers can contact the ILP office for consultation and receive a determination regarding novel or ambiguous cases.
- Identify conditions that can potentially resolve and indicate those clearly on the list. Considerations of such conditions might include examples such as low birth weight, prematurity or cleft palate.



Funding for Infant Learning Programs

Current fiscal system for Alaska's Infant Learning Program (ILP)

The following is a high-level summary of the current Alaska Infant Learning Program (ILP) fiscal system by funding source.

ILP funding

ILP is resourced by state general funds and federal funding, with no established funding formula, or method of regular increases. Funds are distributed to regional EI Programs through a competitive grant process every 3-5 years, considering factors such as population and enrollment data, cost of living, travel, and historical patterns. The current ILP grant funding for ILP provider agency (state funds and IDEA Part C grant funds) is an average of \$5,100 per child (the range is \$3,600 to \$19,400 per child) but does not factor in the variance in the level of services provided across ILP programs. While the population of children served in the region is considered when making the grant allocation, there is currently not a mechanism to increase or decrease the grant amount based on the number of children served or the volume of early intervention services provided, for example if the ILP provider agency experiences an increase in referrals and eligible children and families.

ILP Provider agencies receive a quarterly advance payment and must submit a quarterly revenue report through an electronic portal on the amount of third party (Medicaid, private insurance, Tricare) and other revenue (in-kind, fund raising, etc.) received. A total of \$7.4 Million in state general funds and \$1.8 Million in IDEA Part C funds were included in ILP provider agency grants in Fiscal Year (FY) 2023.

Medicaid Funding

Medicaid Therapy Services

ILP provider agencies bill Medicaid fee-for-service (a rate per service provided) for occupational therapy, physical therapy and speech and language therapy. ILP providers bill the established Medicaid rates for OT, PT and SLT services.

There are no specific ILP early intervention rates and codes for these services. Current Medicaid rates assume a center/clinic-based service delivery model that does not consider the travel costs associated with providing ILP services in home and community-based settings. Because there is also no specific code and/or modifier for therapy services provided to ILP children and families, reports cannot be generated regarding utilization of services or expenditures. The ILP office is therefore reliant on the ILP provider agencies reporting the Medicaid revenue they receive.

There is variability regarding the amount and percentage of Medicaid therapy revenue collected across ILP provider agencies that may be related to billing procedures and operations within the organizations, as well as availability of therapy staff or contractors in regions across the state. There may also be Medicaid revenue collected but not credited to the ILP program as the organization may not be able to track the payment received as being for ILP eligible children. Additionally, ILP provider agencies may have agreements with therapy providers in their region that process their own claims, resulting in the Medicaid expenditures for ILP services not being accounted for by the local ILP provider agency and therefore not included in the overall ILP program expenditures.

There is currently no Medicaid reimbursement for special instruction (developmental therapy), a reimbursable service in a majority of states.

\$789,000 in Medicaid therapy services revenue was collected in FY2023.

Medicaid Targeted Case Management (TCM)

Alaska ILP was successful in adding billing for Targeted Case Management (TCM) in 2006 to fund family service coordination (case management) services for children enrolled in ILP related to intake, coordinating the assessment, IFSP and services, as well as finding solutions to challenges identified by the parent or member of the team working with the child and family. There is a specific billing manual for TCM services with a service code and a current monthly rate of \$346 that is periodically adjusted for inflation.

\$2.5 Million in TCM revenue was reported in FY2024, with all ILP provider agencies receiving TCM funding.

Medicaid Administrative Claiming (MAC)

Alaska ILP was successful in adding billing under Medicaid Administrative Claiming (MAC) in 2018 that allows ILP provider agencies to be reimbursed for activities that support the Medicaid program in accordance with section 1903(a) of Title XIX of the Social Security Act. Activities that can be documented for MAC include 1) outreach 2) provider travel for Medicaid related outreach 3) facilitating applications and 4) arranging transportation. Medicaid Administrative Claiming can be billed for pre-enrollment activities related to assisting families in learning about, applying for, and/or utilizing Medicaid benefits.

ILP provider agencies are reimbursed based on a flat monthly encounter rate, per eligible child, for a maximum of 12 in a calendar year. The current encounter rate being \$303.08.

\$241,000 in MAC revenue was reported in FY2023 by 8 of the 15 ILP provider agencies. At the current time, Tribal Organizations which have Tribal MAC billing programs have not been authorized to bill ILP.

Private Insurance

ILP provider agencies are required to bill private health plans and TRICARE (the uniformed services health care program) for early intervention services provided. Currently, ILP provider agencies submit claims to health plans through their finance office with some using a clearing house/billing agent. There is currently no mandate under the Alaska Division of Insurance for health insurance plans to cover early intervention services under a statute or the state's 'Essential Health Benefits (EHB)'.

\$291,000 in private insurance revenue was reported in FY2023 with 7 of the 15 ILP provider agencies reporting. A total of \$267,000 in TRICARE revenue was reported in FY2023 with 7 of the 15 ILP provider agencies reporting. ILP provider agencies are working on how these data can be accurately reported with their agency.

Other Revenue

ILP provider agencies are required to report revenue from other funding sources including donations, in-kind, fund raising. A total of \$262,000 in 'other' revenue was reported in FY2023 by 8 of the total 15 ILP provider agencies.

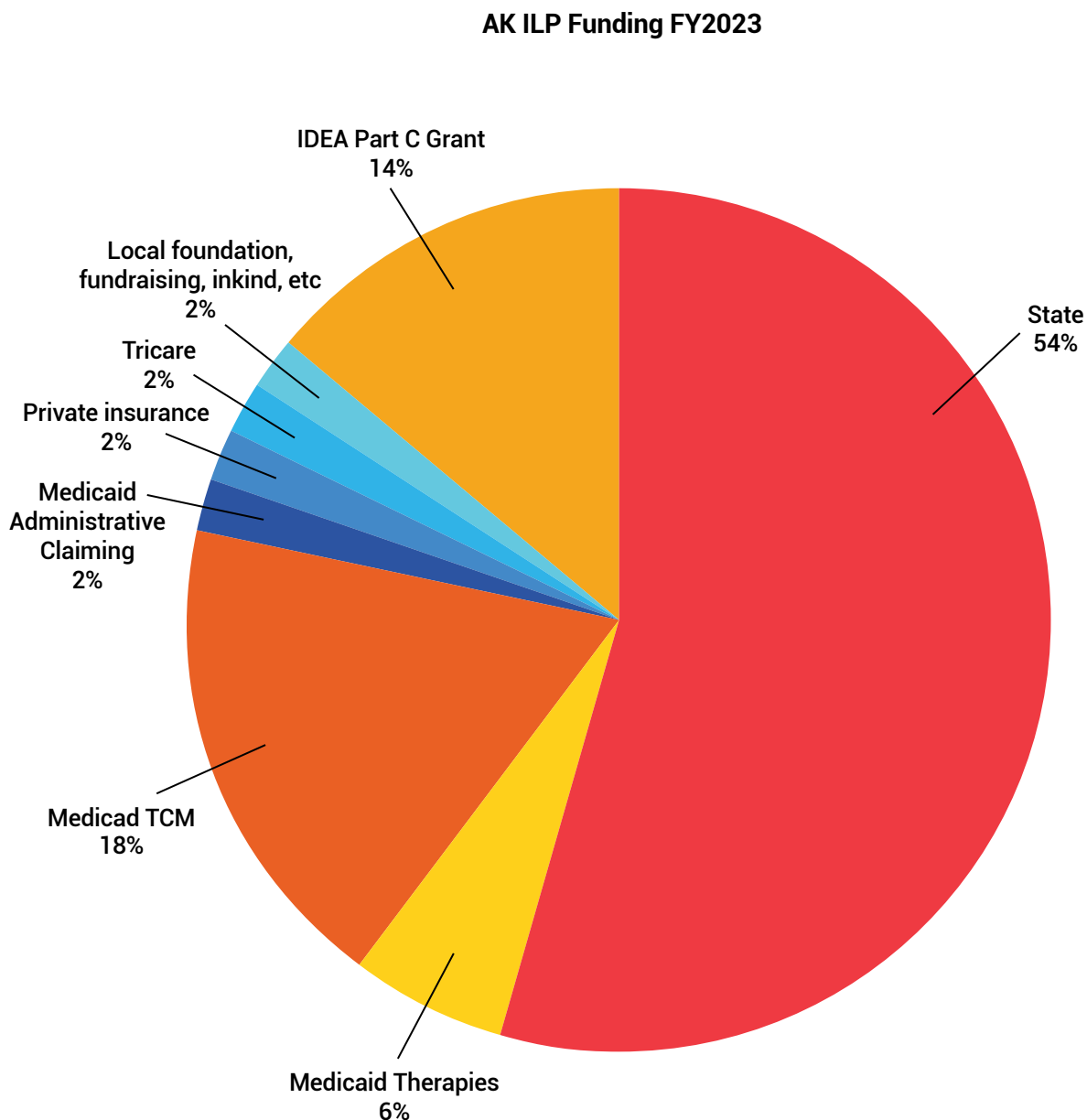


Total Funding Picture for ILP

The following chart shows the total funding for the ILP in FY2023 as reported by the ILP provider agencies. The 'IDEA Part C Grant' and 'state' funding are included in the grants to the ILP provider agencies. All other funding sources are revenue collected and reported by the ILP provider agencies.

As previously mentioned, some organizations are not able to accurately report on all revenue received from third party payers for services provided to children and families in the ILP program due to their accounting and billing operations. Additionally, some services are provided by community therapy providers under agreements with ILP provider agencies, but because they submit claims outside of the ILP, it is not captured as revenue by the ILP.

The largest funding source is state funds, but between therapy services, Targeted Case Management (TCM), and Medicaid Administrative Claiming, Medicaid is at 26%.





National Fiscal Picture for Early Intervention (Part C)

State and local funding

State general fund appropriations for early intervention account for 49% of the overall funds expended nationally. State ILP funds are either line itemed in the state budget for early intervention or appropriated to the lead state agency. States may also include other state appropriated funds in other state agencies or divisions that are used to support early intervention, including: state special education funds; small amounts of TANF, children with special health care needs; state mental health; deaf and blind school funds; and developmental disability funding. Local funds account for 10.1% of the overall funding with some states requiring county contributions and tax levies, generally if early intervention is administered through a county-based system.

Medicaid funding

All states access Medicaid funding for at least some early intervention services. Medicaid funds are 17.3% of total early intervention funding nationally, which is likely an undercount, as some states can report the Medicaid expenditures, whereas other states have established billing codes or modifiers identifying the service as an early intervention service for reporting and accountability purposes.

The state match (based on the Federal Medical Assistance Percentage (FMAP)) ranges from 76.9% – 50% and may be paid from a state's early intervention program's budget or with the Medicaid agency paying the state match in other states.

The early intervention services covered by Medicaid vary across states. Here is a summary based on a 2023 survey of states by the Infant Toddler Coordinators Association of the percentage of states where Medicaid covers a particular service:

- 69% Special instruction (developmental therapy)
- 72% Service coordination (case management)
- 72% Family counseling
- 69% Social work
- 85% Psychological services
- 74% Nutrition
- 82% Nursing

A number of states have included early intervention in their state plan and/or have developed specific billing guidelines for early intervention services, including service codes and modifiers and rates (including specific rates for home and community-based services). Additionally, in 53.7% of states Medicaid accepts the IFSP for authorization purposes.

Private Insurance Funding

Private insurance accounts for just 3% of total revenue for early intervention nationally, although, like Medicaid, this is likely an undercount due to some states inability to accurately collect private insurance revenue data.

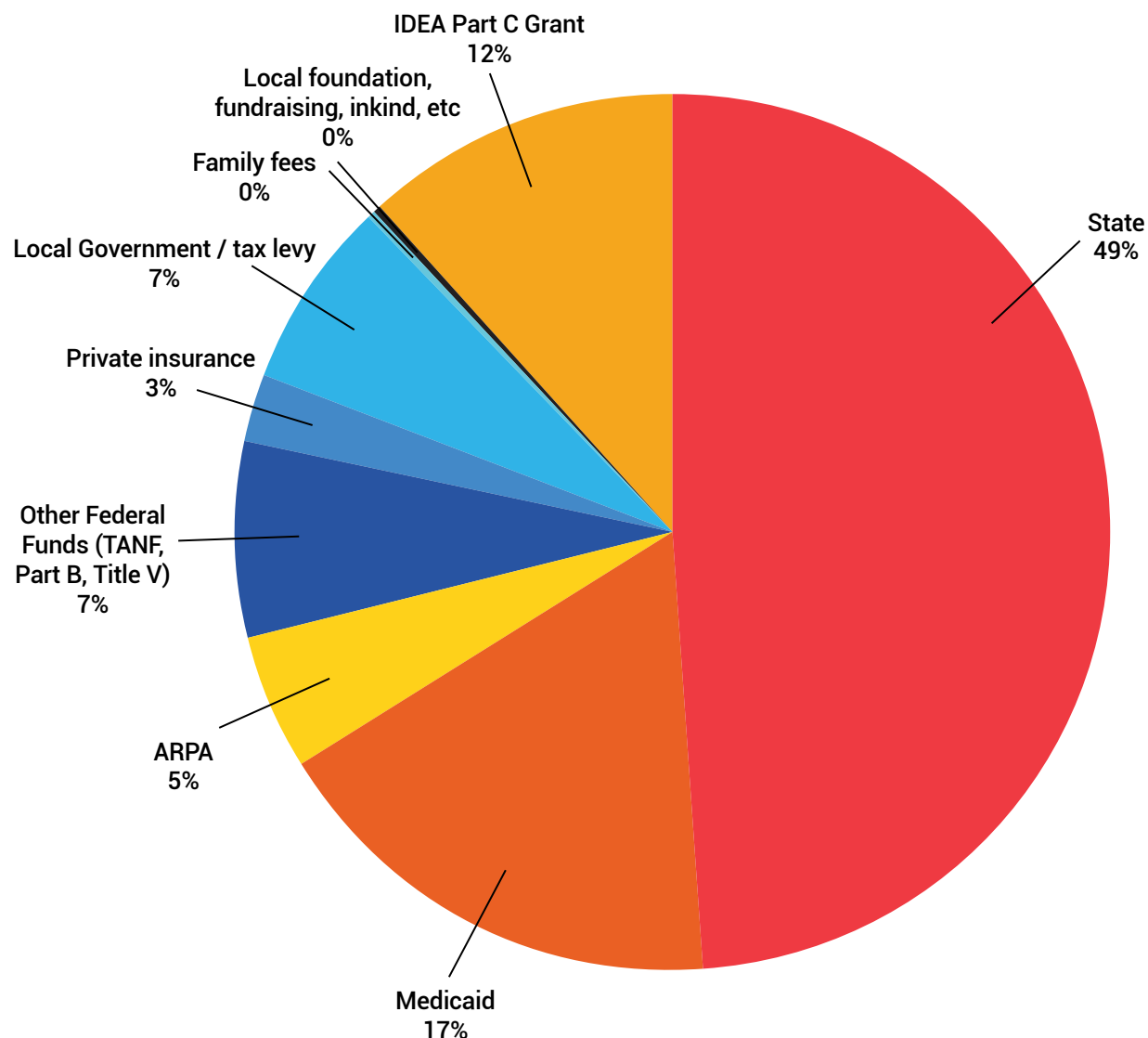
31% of states have private insurance legislation that mandates coverage of early intervention by health insurance plans within in the state. Another 12% of states have included early intervention services in their state's definition of 'Essential Health Benefits' that mandates the services health plans must cover. State mandates for private insurance can reduce denial of claims and therefore reduce administrative costs related to chasing up denials.

National Funding for Early Intervention in Summary

The following chart shows the total national funding for the early intervention as reported in the fiscal survey of states by the Infant Toddler Coordinators Association (2023), with 46 states responding to the survey.

As previously mentioned, some states are not able to accurately report on revenue received from all funding sources, including third party payers for early intervention services provided.

National Funding of IDEA Part C





Peer State Examples

Three peer states were interviewed to see if there are lessons to be learned about their finance and payment structure that would be potential strategies for Alaska's ILP program to consider. States were chosen in consultation with the ILP state team, to include large diverse western states with significant Native American populations, as well as states that use a fee-for-service and grant structure. The states chosen were Arizona, New Mexico and West Virginia. The following is a summary of the financing and payment systems in these states:

Arizona

The Arizona Early Intervention Program (AzEIP) is within the Arizona Department of Economic Security. Early intervention services are provided by ten (10) service provider agencies statewide, with other services providers through the Division of Developmental Disabilities (DDD), and the Arizona Schools for the Deaf and Blind (ASDB). AzEIP uses a routines and team-based approach.

- **Medicaid:** AZ has a developmental disabilities waiver that covers many young children eligible for early intervention, along with fee-for-service under Managed Care Organizations (MCOs). Medicaid funds 'special instruction' along with a range of other early intervention services required under IDEA. The rates are 15 minutes and are the same amount across the Medicaid waiver and AzEIP, and include funding for teaming and IFSP development.
- **Private insurance:** Claiming is done by the AzEIP provider agencies, and there is no state mandate for insurance coverage of early intervention. If the claim is denied the provider agency can bill AzEIP and they can also bill AzEIP for the difference between what the insurance plan pays and the established AzEIP rate for that service.
- **State / IDEA Funds:** AzEIP utilizes a fee for service system with rates subject to a 'rebase' process every few years which requires a rate study.
- **Billing and claiming:** AzEIP has a data system that is used to enter service delivery and for billing purposes.

New Mexico

The New Mexico Family Infant Toddler (FIT) Program is within the newly established Early Childhood Education and Care Department (ECECD), having formerly been within the Department of Health. Early intervention services, including service coordination, is provided through 29 FIT Program provider agencies statewide.

- **Medicaid:** In NM early intervention through the FIT Program continues to be carved out managed care. Early intervention services, including special instruction and service coordination (case management) and a range of other services are billed to Medicaid on a fee-for-service basis. Claiming for Medicaid is done through the central finance vendor utilizing the FIT-KIDS (Key Information Data System). FIT-KIDS receives a Medicaid electronic enrollment file monthly to maximize claims, including retroactive claiming for children who did not show as enrolled the previous month. Payment rates for services under Medicaid are the same as those paid by the FIT Program for non-Medicaid enrolled children. Funding for team consultation and IFSP development is included and there are billing guidelines for early intervention under Medicaid, including that the IFSP is the authorizing document for services, and no prescriptions are required.

- **Private insurance:** Like Medicaid, private insurance claiming is done through the central finance vendor. NM uses a 'pay-and-chase' model, where the FIT provider agencies are paid in full for the service provided and the central finance vendor 'chases' the third-party reimbursement from the health plan. NM has private insurance legislation that was passed in 2005 that includes a \$5,000 per year cap.
- **State / IDEA Funds:** The FIT Program utilizes a fee for service system, with 15-minute units for EI services, a monthly unit for service coordination and a bundled unit for the initial evaluation. The FIT program conducted cost studies in 2017 and 2023 to determine rates and was able to get an increased legislative appropriation as a result of the studies. The FIT Program funds 'professional development', 'child find', and 'language access' (translation and interpretation) through grants with each FIT provider agency.
- **Billing and claiming:** Services are entered into the FIT-KIDS data system and the central finance vendor processes the delivered services data into HIPAA compliant electronic claims to Medicaid and private health insurance plans, and generates an invoice for non-Medicaid enrolled children to the FIT Program.



West Virginia

The West Virginia Birth To Three (BTT) program is within the WV Department of Health and has grants with System Point of Entry (SPOE) providers in each of the eight regions that includes child find, interim service coordination, evaluation and eligibility determination and initial IFSP completion. Service coordination is provided by designated contract agencies and the early intervention providers include both organizations and individual practitioners.

- **Medicaid:** Early intervention services are defined in the state plan, including special instruction and the IFSP is designated as the authorizing document, with no prescriptions for services required. There are early intervention specific codes and modifiers and rates for each service. Teaming is reimbursable, as well as virtual (tele-health) services. WV BTT utilizes a central finance vendor that processes claims to Medicaid. A Medicaid eligibility file is accessed weekly to maximize claims for Medicaid enrolled children, including retroactive claiming when a child who is retroactively enrolled in Medicaid.
- **Private insurance:** Early intervention services are not billed to private health insurance plans.
- **State / IDEA Funds:** WV BTT utilizes a fee for service system with 15-minute units for early intervention services and claims and payments are processed through the central finance office vendor.
- **Billing and claiming:** Services are entered into the WV BTT data system and the central finance office vendor processes the delivered services data into HIPAA compliant electronic claims to Medicaid and to the state office weekly. BTT providers receive payments from the state account, through the state auditor's office, and receive an Explanation of Payments (EOP).



Financial Recommendations

Financial recommendations have been delineated into four specific areas of opportunity that are fiscally responsible and sustainable and support the provision and expansion of EI services including address the recommended expansion of eligibility.

1.

Cost Study: Recommendations include considerations for completion of a cost study to support determinations of costs of providing early intervention and reimbursements through a cost modeling and rate study.

2.

Medicaid Changes: Medicaid changes can be implemented to support expanding the ILP services covered by Medicaid, with the IFSP as the authorizing document. Efficiencies can also include data sharing with Medicaid to maximize the claims submitted for Medicaid enrolled children monthly, and supporting the submission of retroactive claims.

3.

Non-Medicaid Coverage and Funding: Non-Medicaid coverage includes expanding private health insurance coverage for ILP services through the creation of a mandate. Another recommendation regarding funding and reimbursement for non-Medicaid eligible children is through fee-for-service payments for the provision of ILP services. Additionally, potential funding considerations through other state agencies may simultaneously be explored to support ILP services and functions.

4.

ILP Data System Efficiency Changes: To further support and enhance provision of ILP services, enhancements to the data system could be made to support ILP effective and efficient billing and reporting. Additionally, a central finance office would maximize third party claiming to private health insurance plans and Medicaid.

The following tables further expand on and delineate recommendations for the Alaska ILP program to consider implementing, to maximize revenues and establish efficient and effective systems for billing and claiming. Several of the recommendations for efficiencies can also lead to savings in administrative costs.

Recommendation 1

Determine costs and reimbursement through conducting a cost modeling and rate setting study

Pros / Advantages

- Can determine the cost (direct, indirect, and administrative costs) of providing evidence-based EI services.
- Results can be used to determine grant amounts and/or rate recommendations for EI services including 1) center, 2) home & community; and 3) via telehealth.
- Can analyze the cost of child find, professional development, language access, travel.
- Can be used to make rate recommendations to Medicaid.

Cons / Challenges

- Cost of conducting cost modeling and rate setting study is between \$150K - \$250K.
- Cost and rate study generally takes 9-12 months.

Effort / Change:

☐ Statute ☐ Regulation ☐ Policy ☐ Guidance ☒ Other: Funding

State level implications:

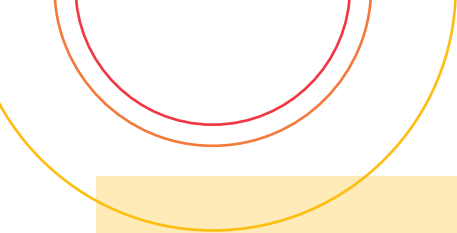
- Secure funding
- Develop a procurement (Request for Proposal)
- Work with Medicaid and Office of Rate Review to understand their requirements

ILP Program implications:

- Participation in the study can take time – cost reports, personnel rosters, time study

Evidence / Justification:

- A number of states conduct periodic cost and rate studies
- AZ statute requires rate rebase every few years
- NM did a rate study in 2017 and 2022



Recommendation 2

Expand Medicaid coverage for all ILP services (including developmental therapy) with billing guidelines and rates that include services in home and community settings

Pros / Advantages

- Developmental therapy (special instruction) services can be covered.
- Other IDEA services (family therapy, nursing, social work, psychological services, etc.) could be covered.
- Unique ILP rates for home & community and teleintervention can be established.
- Medicaid utilization and expenditures can be tracked and reported by ILP.
- May include reimbursement for 'teaming'.

Cons / Challenges

- Will likely need to strengthen the credentialing of developmental therapists.
- May need a statute to define ILP early intervention services.
- May require a state plan amendment.

Effort / change:

☒ Statute ☐ Regulation ☒ Policy ☐ Guidance ☐ Other: Funding

State level implications:

- ILP with the Division of Public Assistance to develop language for the statute to define the coverage for ILP EI services (similar to TCM and Medicaid in the schools)
- Division of Public Assistance to submit a state plan amendment if necessary
- Develop ILP services Billing Manual with codes reimbursement methodology (rates)

ILP Program implications:

- Increase funds from Medicaid and with rates that cover the costs of providing services in home and community-based setting

Evidence / Justification:

- Medicaid in a majority of states cover developmental therapy and other EI services
- In comparison states (NM, AZ, WV) Medicaid cover these services

Recommendation 3

Determine the IFSP to be an authorizing document for Medicaid covered ILP services.

Pros / Advantages

- Reduced time developing a separate plan of care and obtaining prescriptions* by parents and ILP provider admin staff.
- Reduced delays in providing services while obtaining prescriptions.
- Increase the revenue from Medicaid.

**Prescriptions for some services may be required by licensing.*

Cons / Challenges

- May have to be achieved through legislation and a Medicaid state plan amendment (see also #2).
- May result different requirements for approval for Medicaid and private health insurance claims.

Effort / change:

☒ Statute ☐ Regulation ☒ Policy ☐ Guidance ☐ Other: Funding

State level implications:

- ILP with the Division of Public Assistance to develop language for the statute to define the coverage for ILP EI services (similar to TCM and Medicaid in the schools)
- Division of Public Assistance to submit a state plan amendment if necessary

ILP Program implications:

- Reduced administrative cost

Evidence / Justification:

The Infant Toddler Coordinators Association Finance Survey Report (2023) found:

- 54% of states report that Medicaid accepts the IFSP for authorization purposes i.e., no additional plan of care
- 44% of states reported that no physician signature is required
- 31% of states reported that no prescription is required

Recommendation 4

Accurately determine a child's month-to-month Medicaid enrollment and support retroactive claiming

Pros / Advantages

- Ensure that all claims for Medicaid enrolled children are processed to Medicaid.
- Enable billing for children who are made retroactively eligible for Medicaid.

Cons / Challenges

- Cost of developing data transfer protocol of Medicaid enrollment file from Medicaid.

Effort / change:

☐ Statute ☐ Regulation ☐ Policy ☒ Guidance ☒ Other: Cross agency funding

State level implications:

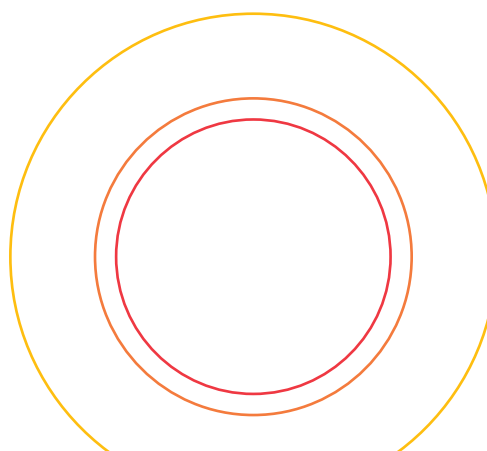
- ILP to work with Division of Public Assistance to explore data sharing / data transfer to support automatic display and utilization for Medicaid enrollment status for the month.

ILP Program implications:

- Integration with current electronic medical records.

Evidence / Justification:

- A number of states (including NM and WV) have been able to integrate their data systems to establish accurate Medicaid enrollment through a data files transfer or other data matching
- States report increasing revenue from maximizing Medicaid claims, including retroactive eligibility claiming



Recommendation 5

Reimburse for non-Medicaid eligible children under a fee-for-service for some ILP services with formula grants for child find, professional development; extreme travel (flights); language access

Pros / Advantages

- Equity of funding across ILP programs and regions.
- Reimbursement of ILP programs will be based on utilization of services and children served i.e., reimbursement grows based on services provided.
- Reimbursement rates established based on cost study and can include methodology to increase based on inflation.
- Equity of reimbursement across ILP (state, Medicaid and private insurance) – no incentive/dis-incentive to serve one group or another.
- Supports state and IDEA funds as 'Payer of last resort'.

Cons / Challenges

- ILP provider may fear the change of predictable grant revenue for fluctuating revenue based on utilization.
- ILP contracts may change to provider agreements i.e., ILP provider approved to bill for EI services based on a billing table.

Effort / change:

☐ Statute ☐ Regulation ☒ Policy ☒ Guidance ☐ Other

State level implications:

- Revise contracts to provider agreements
- Develop billing policy and guidance
- Develop procedures to process monthly invoices from ILP programs

ILP Program implications:

- Revenue will vary from month-to-month based on utilization but will also increase as more children are served

Evidence / Justification:

- Significant number of state conduct period rate studies
- AZ statute requires rate rebase every few years
- NM did a rate study in 2017 and 2022

Recommendation 6

Create a mandate for private health insurance coverage for ILP services under 'essential health benefits.'

Pros / Advantages

- Increased revenue for OT, PT, SLP.
- May include developmental therapy and other IDEA services.
- Could be processed through central finance office.

Cons / Challenges

- May need legislative bill to require the addition to Alaska's 'essential health benefits'.
- Changes to 'essential health benefit' are only done periodically.
- Would not apply to self-insured / ERISA plans.

Effort / change:

☒ Statute ☐ Regulation ☒ Policy ☐ Guidance ☐ Other

State level implications:

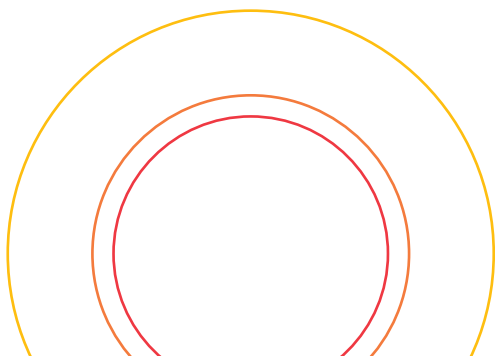
- ILP with the AK Division of Insurance to do projects of revenue projection i.e. estimated number of child covered x cost per child
- ILP with the AK Division of Insurance to draft language for the statute

ILP Program implications:

- Reduced administrative burden due to less denials

Evidence / Justification:

- Medicaid = public health insurance for EI services, therefore the justification can be made for equity that private insurance should cover EI services
- Some states have generated significant revenue for the EI program
- Even if health plans do not fund the full costs – it is additional revenue for the ILP program



Recommendation 7

Explore potential funding through other state agencies and programs e.g., child welfare (Title IV-E public health (Title V)), Mental Health, Department of Education & Early Development, etc.

Pros / Advantages

- IDEA Part C encourages a multi-agency approach to funding and provision of early Intervention services.
- Some providers may be accessing these funds.
- May fund activities like child find screening, mental health consultation.

Cons / Challenges

- May be more successful in collaboration with those programs/agencies to provide supports e.g., child find, infant and early childhood mental health, rather than actually funding existing ILP services.

Effort / change:

☐ Statute ☐ Regulation ☒ Policy ☒ Guidance ☒ Other: Cross agency planning

State level implications:

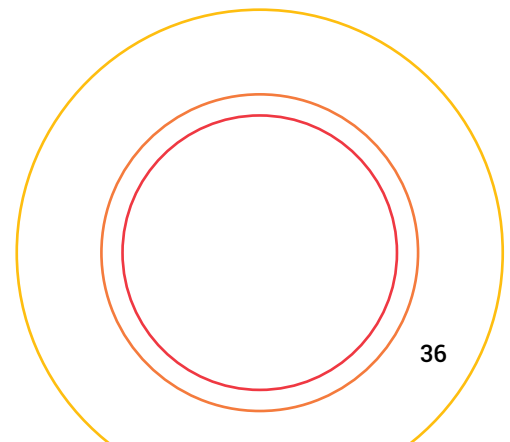
- Invite presentations at the ICC to explore opportunities
- ILP to meet with state agencies and programs

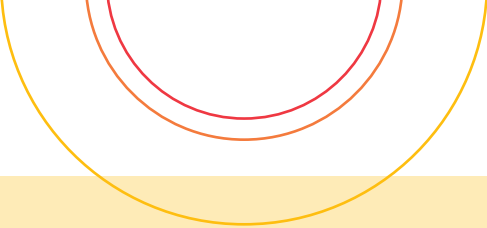
ILP Program implications:

- May support collaborative opportunities

Evidence / Justification:

- There is not a lot of evidence nationally that this can generate a lot of funds but may support collaboration





Recommendation 8

Enhance ILP data system to support billing, accountability and reporting

Pros / Advantages

- Include service logging (potentially to include on mobile devices) to include all data fields needed for billing, including time in/out).
- Ensure inclusion of other data needed for claiming (diagnosis code; insurance coverage, etc.).
- Include service notes option.
- Develop reports, extracts for billing/claiming at the provider level.
- Include ability for ILP provider to mark paid claims to enable reporting on all revenue expended for ILP services.
- Consider developing a parent portal – where parents they can access documents (IFSP, evaluation) and service notes.

Cons / Challenges

- Cost of upgrades to the current ILP data system.
- Training and support needed for ILP programs.
- Provide technical assistance around integration with current electronic medical records.

Effort / change:

☐ Statute ☐ Regulation ☒ Policy ☒ Guidance ☒ Other: Funding

State level implications:

- ILP to work with current database developer to develop system requirements, development and testing. Consider outsourcing for modules as necessary (e.g., mobile friendly service logging; parent portal, etc.) .

ILP Program implications:

- Integration with current electronic medical records.

Evidence / Justification:

- This enhancement would generate claims level data for ILP/state billing
- A number of states have a data system that captures services delivered for billing and accountability purposes

Recommendation 9

Develop a Central Finance Office (CFO) where data entered into the ILP data system is developed into claims and submitted to third parties including Medicaid and private insurance (incl. Tricare)

Pros / Advantages

- Data system upgrades to capture all delivered services time to be used for claiming.
- Data can be used to analyze utilization of EI services and expenditures across funding sources.
- Reduce the administrative time and costs for providers in billing private insurance.
- Maximize revenue for Medicaid and private insurance.
- Enable clear system of payments/ payer of last resort where private insurance, Medicaid then state funds are billed.
- Medicaid reimburses ILP provider directly.
- Private Insurance claims can either include payments directly to ILP providers or can be made to the state ILP program (i.e. pay and chase).

Cons / Challenges

- Cost of database enhancements.
- Determine if state billing staff or vendor will provide the CFO functions.
- State personnel expansion or funding for vendor.

Effort / change:

☐ Statute ☐ Regulation ☐ Policy ☒ Guidance ☒ Other: Funding

State level implications:

- ILP to work with the current database developer to develop system requirements, development and testing
- Costs analysis regarding establishing CFO functions at the state or contracting with a vendor

ILP Program implications:

- Integration with current electronic medical records

Evidence / Justification:

- A number of states have shown that establishing a CFO maximizes revenue from third parties – Medicaid and private insurance, while minimizes admin support by local EI programs
- A CFO enables clear and accurate reporting and accountability on expenditures from all funding sources

Moving Forward from Here

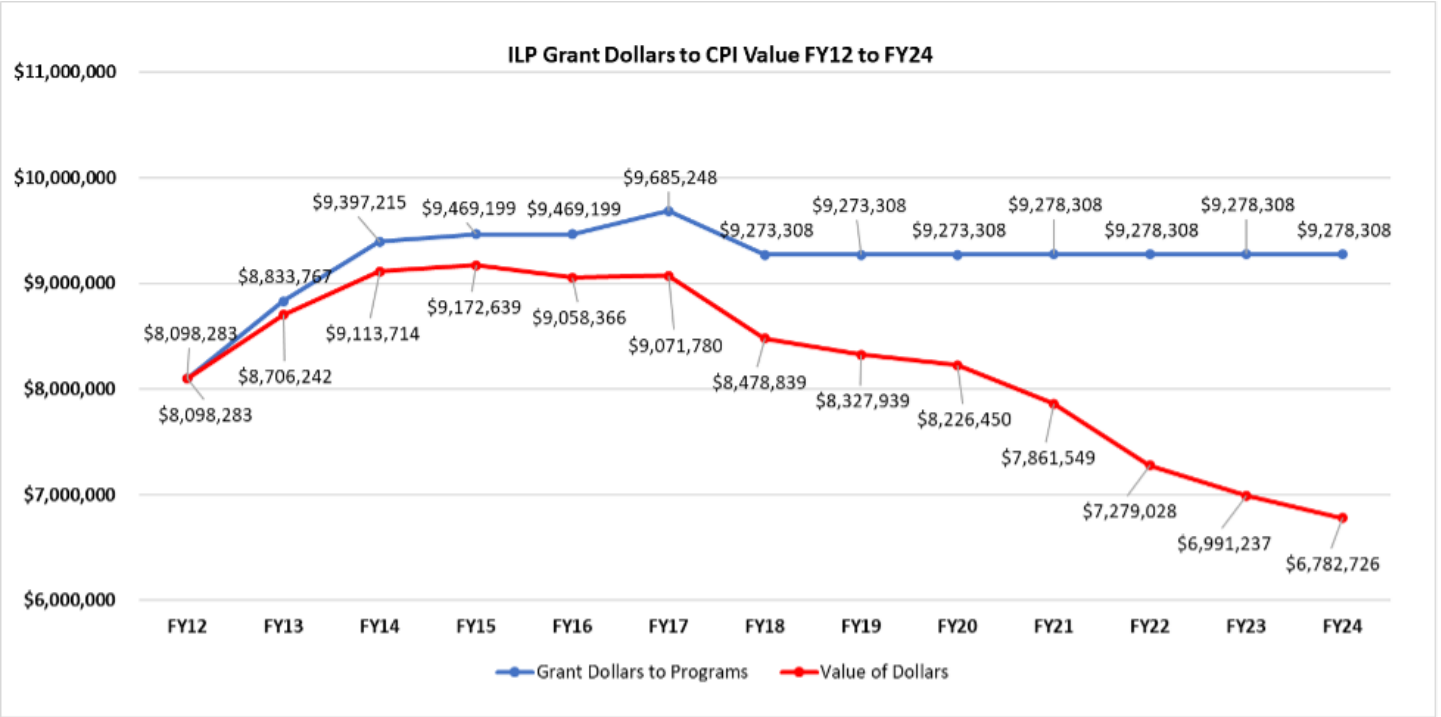
This project was solely focused on Stage 1, limiting our work to the development of recommendations for consideration by the GCDSE. Recommendations for future steps include continuation of Stages 2 and 3 of this three-step model of implementation.



Seek an Increment to Catch Up with Inflation

The expected effects of expanded eligibility include an increase in the number of children served and this is one of the main reasons that the scope of this work includes a review of funding sources and methods and financial recommendations. However, it is critical to understand that programs have already gone through years of having to stretch resources further and further. Over the time period of FY2015 to FY2023, service volumes have stayed the same, and at first glance, it might seem reasonable that funding would also stay relatively constant, around \$9.3M - \$9.5M annually. This view does not take into account the effects of inflation, which over the same period has increased costs by 20%, based on the consumer price index over the years 2015-2023 (based on Urban Alaska numbers; Alaska Department of

Labor and Workforce Development, n.d.). ILP providers have been forced to cover rising costs with the same amount of money. This results in decreasing ability to pay competitive wages, to provide professional development and other supports, and results in increased strain on the workforce, with greater risk of burnout and turnover. To preserve and improve the ability of the ILP system to deliver high quality, funding needs to catch up with inflation. Therefore, a foundational recommendation is to seek an increment reflecting inflation, in the vicinity of \$2 M based on the 20% CPI increase. It is also recommended that an inflationary increase is built into ILP funding at a regular interval, whether annually or every few years. These funds are needed to cover current service levels, and eligibility expansion will require further funding in addition.



Stage 2: Prepare and Secure Commitment

Step 2 involves advocacy and commitment. It is likely that the substantial changes required through the phased implementation of the recommendations outlined in this report will require significant and persistent advocacy with key stakeholders including the GCDSE, ILP Office, Tribal Leadership, local and state government, the Governor's office, content experts such as Alaska Infant Learning Program Association (AILPA) and many others to ensure expert consensus, backing, and unified implementation of this expansion work. Training opportunities must be considered to support effective advocacy at every level of state, local, and individual-based advocacy work. Additionally, work must be done to ensure effective alignment with other stakeholders such as the Early Childhood Advocacy Group.

Stage 3: Support Implementation

Effective implementation requires the utilization and employment of a change model fully grounded in implementation science. This evidence-based approach to implementation will ensure best practices including preparation and training, infrastructure development, fidelity in adaptation, pilot testing in communities, monitoring and support, and then scaling and spreading of programming and eligibility in a manner that will allow for long-term sustainability, capacity building, and outcome evaluation and monitoring.

As part of employing an implementation science-based approach, it is strongly recommended that implementation of the expansion of developmental delay be done incrementally in stages in order to allow provider organizations to adapt and build capacity for greater volumes. This paced expansion will additionally allow for workforce development, expansion of resources, and effective identification and problem solving for any unanticipated barriers that may present and need to be addressed. Starting and piloting the work with early adopters who have identified organizational readiness and capability to test expansion processes may be an optimal way to begin to capture data, monitor processes, and share learnings with other providers and communities. Subsequent work should be expected to surface additional changes and require further adaptation, as organizations other than early adopters become involved.



Summary and Conclusion

This work sets a strong framework to support every Alaskan infant and toddler experiencing developmental delay or a disabling complex health condition through ensuring equitable access to ILP services. There is incredible value in investing early, for long-term development and leveraging Alaska's existing infrastructure to support more families. Expanding ILP eligibility through addressing percent developmental delay and the established conditions list, in conjunction

with optimizing financial and insurance related practices will set infants and children up for long-term success, preventing compounding developmental challenges. ILP services play a pivotal role in shaping the future of Alaskan children and families. This proactive, early investment in our children and families will simultaneously support improved intervention and outcomes, while decreasing long-term financial cost and burden to the state of Alaska.



APPENDIX

Appendix A: Current List of Established Conditions in Alaska

Alaska EI/ILP Part C Qualifying Conditions

A. Diagnosed Physical or Mental Conditions

1. Adjustment Disorder
2. AIDS or HIV Positive
3. Anxiety Disorder of Infancy and Early Childhood
4. Arthritis
5. Autism Spectrum Disorder
6. Blind or Visually Impaired, Significant/Progressive
7. Central Nervous System deficit or degenerative disorder
8. Cerebral Palsy
9. Chronic Lung Disease
10. Chronic Otitis Media longer than 6 months
11. Cleft Palate with or without Cleft Lip
12. Complex Seizure Disorder
13. Cornelia de Lange syndrome
14. Cystic Fibrosis
15. Cytomegalovirus (CMV), congenital
16. Deaf or Hard of Hearing, Significant/Progressive
17. Deafblind
18. Disorders of Affect
19. Disorders of Relating or Communicating
20. Down Syndrome
21. Dwarfism
22. Epilepsy
23. Failure to Thrive
24. Fetal Alcohol Spectrum Disorder
25. Fragile X Syndrome
26. Hearing Impairment, Significant/Progressive
27. Heart Disease, Congenital
28. Hydrocephaly
29. Microcephaly
30. Muscular Dystrophy
31. Myelomeningocele
32. Neurological impairment
33. Orthopedic Impairment
34. Other (Diagnosis typically associated with substantial developmental delay)
35. Periventricular Leukomalacia, unresolved
36. Posttraumatic Stress Disorder
37. Prader-Willi Syndrome
38. Reactive Attachment Disorder

39. Renal agenesis with or without hypospadias
40. Rubella, congenital
41. Spina Bifida
42. Toxoplasmosis, congenital
43. Trisomy 13
44. Trisomy 18
45. Turner Syndrome
46. Uncontrolled maternal PKU

B. Low Incidence Disability Expanded Definitions:

1. Deaf or Hard of Hearing, Significant/Progressive:
 - a. 40 dB or greater in two or more frequencies, bilateral, pure tone, hearing loss diagnosed by an audiologist or
 - b. Chronic Otitis Media (six months or more months in duration) diagnosed by a medical provider, with fluctuating hearing loss;
 - c. Guidance for Use of Clinical Opinion to qualify children with Hearing Impairment, Significant/Progressive for Part C Services:
 - i. Less than 40 dB bilateral hearing loss (diagnosed by an audiologist) with additional risk factors which could lead to a 50% or greater delay in one or more areas of development or
 - ii. Unilateral hearing loss greater than 30 dB (diagnosed by an audiologist) with additional risk factors which could lead to a 50% or greater delay in one or more areas of development.
2. Blind or Visually Impaired, Significant/Progressive;
 - a. The following diagnoses indicate "Significant/Progressive Vision Impairment" for Part C eligibility:
 - i. Cerebral Vision Impairment
 - ii. Optic Nerve Glioma
 - iii. Optic Nerve Hypoplasia
 - iv. Bilateral Retinoblastoma
 - v. Retinopathy of Prematurity (Stage IV or V)
 - vi. Bilateral Peter's Anomaly
 - vii. Retinal Dystrophy/Leber's Congenital Amaurosis
 - viii. A designation of "Legal Blindness" as determined by an ophthalmologist

- b. There may be a qualification of "Significant/Progressive Vision Impairment" by Clinical Opinion when there is a high risk for a vision impairment diagnosis due to medical history (prematurity, birth injury, IVH, diagnosed syndrome, etc.) and visual skills less than expected for developmental age as assessed by a vision impairment educational specialist.
- c. The following diagnoses may qualify as "Significant/Progressive Vision Impairment" by Clinical Opinion and should be considered for Part C eligibility with additional evaluation and information:
 - i. Albinism
 - ii. Bilateral Congenital Cataracts
 - iii. Delayed Visual Maturation
 - iv. Glaucoma
 - v. Homonymous Field Defect
 - vi. Microphthalmia
 - vii. Nystagmus, Congenital
 - viii. Optic Atrophy
 - ix. Prader Willi Syndrome
 - x. Retinal Detachment
 - xi. Visual Field Defect
- d. Even within one diagnosis there can be a wide range of visual functioning between individuals. Therefore, final Part C eligibility is determined by:
 - i. An assessment of functional vision/developmental visual skills completed by a vision impairment educational specialist,
 - ii. Consideration of other medical/developmental concerns, and iii. Findings of an ophthalmological exam



Appendix B: Example of Reorganized List of Established Conditions

i. Chromosomal abnormalities

(Conditions associated with intellectual and developmental disabilities)

- 20. Down Syndrome
- 43. Trisomy 13
- 44. Trisomy 18

ii. Genetic or congenital disorders (Congenital or genetic central nervous system disorders; Birth defects or syndromes)

- 7. Central Nervous System deficit or degenerative disorder
- 21. Dwarfism
- 37. Prader-Willi Syndrome
- 27. Heart Disease, Congenital
- 39. Renal agenesis with or without hypospadias
- 13. Cornelia de Lange syndrome
- 25. Fragile X Syndrome
- 45. Turner Syndrome

iii. Sensory impairments

(Deaf or Hard of Hearing, Significant/Progressive, Blind or Visually Impaired, Significant/Progressive, or Deafblind)

- 6. Blind or Visually Impaired, Significant/Progressive

- 16. Deaf or Hard of Hearing, Significant/Progressive
- 17. Deafblind
- 26. Hearing Impairment, Significant/Progressive

iv. Inborn errors of metabolism

v. Disorders reflecting disturbance of the development of the nervous system

(Established central nervous system deficits resulting from hypoxia, trauma, or infection)

- 32. Neurological impairment
- 35. Periventricular Leukomalacia, unresolved
- 24. Fetal Alcohol Spectrum Disorder

vi. Congenital infections

- 2. AIDS or HIV Positive
- 40. Rubella, congenital
- 42. Toxoplasmosis, congenital
- 15. Cytomegalovirus (CMV), congenital

vii. Early childhood mental health disorders, including severe attachment disorders

- 1. Adjustment Disorder
- 3. Anxiety Disorder of Infancy and Early Childhood
- 18. Disorders of Affect
- 36. Posttraumatic Stress Disorder
- 38. Reactive Attachment Disorder
- 19. Disorders of Relating or Communicating
- 5. Autism Spectrum Disorder

viii. Disorder secondary to exposure to toxic substances, including fetal alcohol syndrome

- 24. Fetal Alcohol Spectrum Disorder

ix. [Other] Health impairments

19. Disorders of Relating or Communicating
5. Autism Spectrum Disorder

- 9. Chronic Lung Disease
- 10. Chronic Otitis Media longer than 6 months
- 11. Cleft Palate with or without Cleft Lip
- 12. Complex Seizure Disorder
- 14. Cystic Fibrosis
- 22. Epilepsy
- 23. Failure to Thrive
- 28. Hydrocephaly
- 29. Microcephaly
- 46. Uncontrolled maternal PKU
- 34. Other (Diagnosis typically associated with substantial developmental delay)

*Failed -StatMD autism screening agree and priority

*Cleft lip and palate (or any combination)

*Failure to thrive

*Retinopathy of Prematurity

*Intraventricular hemorrhage

*NAS Neonatal Abstinence Syndrome

*PKU

* Low birth weight

* Prematurity

x. Orthopedic impairments

(Impairments of the normal function of muscles, joints or bones due to congenital anomaly, disease or permanent injury)

- 30. Muscular Dystrophy
- 41. Spina Bifida
- 31. Myelomeningocele
- 4. Arthritis
- 8. Cerebral Palsy
- 33. Orthopedic Impairment

i. Chromosomal Abnormalities

- Down Syndrome; Trisomy 13; Trisomy 18

ii. Genetic or Congenital Disorders

- Dwarfism; Prader-Willi Syndrome; Heart Disease, Congenital; Renal Agenesis; Cornelia de Lange Syndrome

iii. Sensory Impairments

- Blind or Visually Impaired, Significant/Progressive; Deaf or Hard of Hearing, Significant/Progressive; Deafblind

iv. Inborn Errors of Metabolism

v. Disorders Reflecting Disturbance of the Development of the Nervous System

- Neurological Impairment; Periventricular Leukomalacia, Unresolved; Fetal Alcohol Spectrum Disorder

vi. Congenital Infections

- AIDS or HIV Positive; Rubella, Congenital; Toxoplasmosis, Congenital; CMV, congenital

vii. Early Childhood Mental Health Disorders, Including Severe Attachment Disorders

- Adjustment Disorder; Anxiety Disorder; Disorders of Affect; PTSD; Reactive Attachment Disorder; Disorders of Relating or Communicating; Autism Spectrum Disorder

viii. Disorder Secondary to Exposure to Toxic Substances, Including Fetal Alcohol Syndrome

- Fetal Alcohol Syndrome

ix. [Other] Health Impairments

- Chronic Lung Disease; Chronic Otitis Media longer than 6 months; Complex Seizure Disorder; Cystic Fibrosis; Epilepsy; Failure to Thrive; Hydrocephaly; Microcephaly; Uncontrolled Maternal PKU; Cleft Lip and Palate

x. Orthopedic Impairments

- Orthopedic Impairment

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