**Promoting Effective and Efficient Fiscal Management Part 1**

**Questions and Answers**

1. Does a financial agreement need to be in place prior to the IFSP meeting or prior to the parent actually signing the IFSP?

Conduct financial intakefollowing eligibility determination and prior to the initial IFSP meeting unless the child has Medicaid/FAMIS (in which case the *Family Cost Share Agreement* form must be completed at the intake visit to ensure timely entry of Medicaid/FAMIS data into ITOTS and, as a result, Medicaid reimbursement for all reimbursable services). Practice Manual Chapter 11, p. 9.

1. If the contracted provider agency has their own release to bill insurance, do systems still need to have families sign the FCS pages 2 - 3?

Page 2 of the family Cost Share Agreement is required. Without that page you do not have a signed Family Cost Share. Page 3 (Information Release and Assignment of Benefits) form of the Family Cost Share agreement is optional. However, the billing provider must obtain written permission from the family to bill their insurance. This can be obtained on p. 3 of the Family Cost Share Agreement or on your own agency form.

1. Interpretation/translation: Does this go under Other System Costs on the bottom rather than Other Services under Direct?

It is acceptable to put Interpretation/translation under either Direct: Other Services or under System Operation: Other System Cost. It is important to be consistent in where these services are documented in your local system.

1. A family completes a temporary Family Cost Share (FCS) agreement and opts to begin services. Consequently, they are billed the full fee by the provider for services prior to establishing the family fee through the completion of the permanent FCS agreement. The bill was issued before the expiration of the temporary FCS. If their monthly cap and/ or insurance established responsibility is less than what was paid, who is responsible for reimbursing the family?

Whoever collected the payment from the family would be responsible for reimbursing the family the difference between what they paid and their family fee or insurance co-pay/ patient responsibility. That agency/ company would then bill the appropriate parties (i.e. Insurance company and/or Local Lead Agency) for the remaining balance up to the standard Early Intervention rate. The temporary FCS states: “If I sign a Family Cost Share Agreement Form no later than 30 calendar days after the IFSP, then I will pay in accordance with the terms of that agreement. Otherwise, I will be responsible for the full charge for any services (other than those available at no cost) provided during the 30 calendar day period.”

1. If the family gives permission to bill their insurance while on a temporary FCS agreement, can providers bill the family the difference, even if it’s more than their co-pay/ deductible?

The temporary FCS states: I am aware that I will be obligated to pay for any services (other than those that must be available at no cost) delivered while this temporary agreement is in effect. Since the family has agreed to have their insurance billed, they will be obligated to pay the co-pay or deductible for any services covered by their insurance and the full early intervention rate for any service not covered by insurance. However, if the family signs the full FCS Agreement within 30 days, any monthly cap established by that FCS will be retroactive to the services delivered under the temporary FCS and the family may owe less than the full co-pay, deductible or EI rate.

1. Why would a family pay more than their co-pay/ patient responsibility when they have a flexible spending account?

Families with flexible spending accounts that automatically pay the provider or the family must pay the full cost of any co-pays or deductibles until the funds in their flexible spending account have been exhausted. (Practice Manual Chapter 11, p .14) The FSA account would reimburse for more than the family’s co-pay or monthly cap if they have a required deductible.

1. If a family is dually insured (Private insurance and Medicaid) and has a flexible spending account how does this impact family payment?

In this situation Medicaid will pay the balance not covered by private insurance therefore Part C will not be billing the family.

1. How can a provider bill insurance for more than the standard Early Intervention rate?

Providers are not bound by the standard Early Intervention rate as it relates to billing for services. Providers can bill whatever they have decided on as long as they bill all reimbursement sources the same amount. Reimbursement to providers from Part C funds, Medicaid, and/or family fees cannot exceed the standard reimbursement rate. The sample billing/reimbursement scenarios on page 34 of Chapter 11 in the Practice Manual show several examples where the provider charge is higher than the Part C reimbursement rate (standard rate).

1. Why would Part C have to pay more than the standard EI rate for services?

This could happen if a family must meet their deductible to access insurance, the provider bills more than the Early Intervention standard rate, and the insurance allows more than the EI standard rate. Although this is rare, Part C must pay the difference between the allowable amount and the family fee in this situation, and that difference may exceed the standard EI rate (see Practice Manual Chapter 11, page 34, Scenario 4).

Deductibles and co-payments cannot be bound by the contract rate that the Infant & Toddler Connection system has with a private agency for direct services that are not covered by insurance since the insurance reimbursement rates and co-payment and deductible amounts are determined and set by the insurer. Deductibles and co-payments are an obligation between the subscriber (family) and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-payment from the family. These cannot be waived. Therefore, the full deductible and co-payment (minus the amount the parent pays that month) is the responsibility of Part C. (Practice Manual Chapter 11, p. 34)